

***Please note start time and venue***

**GOVERNING BODY MEETING**

**7 September 2017, 9am to 11.50am**

**Knavesmire Room, York CVS, 17 Priory Street, York YO1 6ET**

*On this occasion questions from members of the public will be at the end of the formal agenda.*

The agenda and associated papers will be available at:

[www.valeofyorkccg.nhs.uk](http://www.valeofyorkccg.nhs.uk)

**AGENDA**

<b>STANDING ITEMS – 9am</b>				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 5 to 24	Minutes of the meeting held on 13 July 2017	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 25 to 30	Accountable Officer's Report	To Receive	Phil Mettam – Accountable Officer
6.	Pages 31 to 43	Risk Update Report	To Receive	Rachel Potts – Executive Director of Planning and Governance

<b>FINANCE AND PERFORMANCE – 9.40am</b>				
7.	Pages 45 to 65	Financial Plan 2017-19	To Approve	Tracey Preece – Chief Finance Officer
8.	Pages 67 to 85	Financial Performance Report Month 4	To Receive	Tracey Preece – Chief Finance Officer
9.	Pages 87 to 132	Integrated Performance Report Month 4	To Receive	Caroline Alexander – Assistant Director of Delivery and Performance
10.	Pages 133 to 138	Update on Mental Health Performance: <ul style="list-style-type: none"> <li>• Child and Adolescent Mental Health Services</li> <li>• Improving Access to Psychological Therapies</li> <li>• Dementia Diagnosis</li> </ul>	To Receive	Phil Mettam – Accountable Officer
<b>CARE QUALITY COMMISSION REVIEWS – 10.20am</b>				
11.	Pages 139 to 147	Care Quality Commission Local System Review of Health and Social Care in York – Briefing for Partners	To Receive	Phil Mettam – Accountable Officer
12.	Verbal	Care Quality Commission Thematic Review of Mental Health Services for Children and Young People – North Yorkshire	To Note	Michelle Carrington – Executive Director of Quality and Nursing
<b>STRATEGIC – 10.40am</b>				
13.	Pages 149 to 161	Engagement Update	To Receive	Phil Mettam – Accountable Officer

<b>ASSURANCE – 10.55am</b>				
14.	Pages 163 to 236	Emergency Preparedness, Resilience and Response – NHS Vale of York CCG Arrangements	To Approve	Rachel Potts – Executive Director of Planning and Governance
15.	Pages 237 to 238	Extension of Period of Tenure of Governing Body Lay Member and Chair of the Finance and Performance Committee	To Ratify	Rachel Potts – Executive Director of Planning and Governance
16.	Pages 239 to 243	Executive Committee Terms of Reference	To Approve	Rachel Potts - Executive Director of Planning and Governance
17.	Pages 245 to 279	Business Conduct Policy	To Ratify	Rachel Potts – Executive Director of Planning and Governance
<b>RECEIVED ITEMS – 11.20am</b>				
18.	Pages 281 to 297	Audit Committee Minutes: 5 July 2017		
19.	Pages 299 to 306	Executive Committee Minutes: 17 May and 21 June 2017		
20.	Pages 307 to 336	Finance and Performance Committee Minutes: 22 June and 27 July 2017		
21.	Pages 337 to 346	Primary Care Commissioning Committee: 25 July 2017		
22.	Pages 347 to 352	Quality and Patient Experience Committee Minutes: 14 August 2017		
23.	Pages 353 to 358	Medicines Commissioning Committee Recommendations: 12 July 2017		

**NEXT MEETING**

24.	Verbal	9.30am on 2 November 2017 at West Offices, Station Rise, York YO1 6GA	To Note	All
-----	--------	---	---------	-----

**QUESTIONS FROM MEMBERS OF THE PUBLIC – 11.30am**

Questions or comments from members of the public who have registered in advance their wish to participate.

**CLOSE – 11:50am****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.

A glossary of commonly used terms is available at

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



**Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group  
Governing Body held 13 July 2017 at The Bar Convent, 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
Dr Stuart Calder (SC)	GP, Council of Representatives Member
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Dr Paula Evans (PE)	GP, Council of Representatives Member
Dr Arasu Kuppaswamy (AK)	Consultant Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust – Secondary Care Doctor Member
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN) - part	Executive Director of Transformation and Delivery
Dr Andrew Phillips (AP)	Joint Medical Director
Rachel Potts (RP)	Executive Director of Planning and Governance
Tracey Preece (TP)	Chief Finance Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

**In Attendance (Non Voting)**

Caroline Alexander (CA) – for item 9	Assistant Director of Delivery and Performance
Michèle Saidman (MS)	Executive Assistant
Elaine Wylie (EW)	Strategic Programme Consultant

*For item 7 from Tees Esk and Wear Valleys NHS Foundation Trust*

Ruth Hill (RH)	Director of Operations
Martin Dale (MD)	Strategic Project Manager
Dr Steve Wright (SW)	Deputy Medical Director

**Apologies**

Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Dr Tim Maycock (TM)	Clinical Director
Dr Shaun O'Connell (SOC)	Joint Medical Director
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Ten members of the public were in attendance.

KR welcomed everyone to the meeting. He particularly welcomed DN to her first meeting following her recent appointment.

The following matters were raised in the public questions allotted time.

**Bill McPate**

*It is noted that in the Integrated Performance report (page 88) those children receiving Child and Adolescent Mental Health Services (CAMHS) assessment in less than 9 weeks fell in April to 52%, the lowest since at least September 2016. Given the previous optimism that this service was now set to improve after years of poor performance, it is disappointing to read in the risk update that "the CCG is working with TEWV to understand the actual demand and resources deployed to meet them" and learn that after months of examination into this service the level of demand is still not known and could therefore be much higher with many more children desperately needing early help to avoid the prospect of long term mental health damage. Will the CCG please consider escalating the risk now and giving this service the priority it needs before the meeting it intends to have with NHS England "to discuss options for escalation."?*

**Response**

In responding LB advised that the CAMHS assessment timescales referred to as April 2017 and September 2016 were not measuring like for like. Tees, Esk and Wear Valleys NHS Foundation Trust had introduced an additional step in the access pathway in the form of telephone triage. This enabled an immediate response which could take a number of forms, including early resolution by phone or an earlier appointment. LB advised that, although the graph in the report did not achieve the 90% in nine weeks performance, detailed narrative supported the triage addition to the pathway.

LB reported that Tees, Esk and Wear Valleys NHS Foundation Trust was also undertaking staff training in Talking Therapies and reviewing clinical pathways. Additionally, children had access to a wellbeing worker within their schools. The CCG used a monitoring tool for assurance about progress and would escalate any concerns that arose.

Bill McPate requested the explanation be incorporated in the report for clarity about the level of demand. LB noted that a review of children and young people's mental health services was being undertaken. EW added regarding capacity and demand that Tees, Esk and Wear Valleys NHS Foundation Trust had provided analysis of all Children's Services which would be used to gain a better understanding of capacity across services.

Questions relating to agenda item 7 - Developing a New Mental Health Hospital for the Vale of York for which responses were provided during the presentation:

## AGENDA ITEMS

The agenda was considered in the following order.

### STANDING ITEMS

#### 1. Apologies

As noted above.

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

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

#### 3. Minutes of the Meeting held on 4 May 2017

The minutes of 4 May were agreed.

#### The Governing Body:

Approved the minutes of the meetings held on 4 May 2017.

#### 4. Matters Arising from the Minutes

*Safeguarding Children Annual Report 2015-16:* MC reported that consideration by the Executive Team of options for additional capacity was ongoing.

*Accountable Officer Report – Review of CCG's community bone protection service:* PM requested that an email update be circulated to members by 27 July.

*Public Health Services Report:* PM reported that the letter to City of York Council expressing the CCG's concerns about Public Health services had been sent and a response received from the Director of Health, Housing and Adult Social Care. Members supported PM's proposal that the Executive Team follow up this matter on behalf of the Governing Body and it should therefore be regarded as complete.

*Accountable Officer's Report – Primary care input in joint programmes of work with York Teaching Hospital NHS Foundation Trust:* PM reported that Jim Hayburn (JH), Strategic programme Consultant, was working with partners across the system on joint efficiency programmes. Project plans had been agreed for both Unplanned and Planned Care.

*Accountable Officer's Report – Update on the £3 per head for Practices:* PM confirmed the CCG's commitment to £3 per head and emphasised that its deployment should be progressed. He proposed, and members agreed, that responsibility be delegated to himself and PE who would report to the July meeting of the Primary Care Commissioning Committee.

*Executive Committee Minutes – update on potential extension of HealthNavigator:* Members had received an email update.

## **The Governing Body:**

Noted the updates and agreed associated actions.

### **5. Accountable Officer's Report**

PM expressed appreciation to colleagues who had prepared the extensive meeting papers. He requested that for future meetings consideration be given to a focus on the clinical and patient perspectives as work progressed in respect of service change and reducing cost in the system, also noting the move to bi-monthly meetings and therefore the potential for an increase in agenda items.

PM presented the report which provided updates on turnaround, legal Directions and the CCG's financial position; Operational Plan 2017-19 assurance and delivery; Council of Representatives meeting; engaging and involving local patients and stakeholders; emergency preparedness, resilience and response; and national plans and strategic issues.

In respect of the financial position PM explained that the CCG, working with NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust, was one of 14 parts of the NHS in England in the Capped Expenditure Process. As such the Financial Performance Report at agenda item 8 had been prepared to meet the requirements OF NHS England. PM described the process by which the three organisations had been asked by the regulators, NHS England and NHS Improvement, to deliver a joint financial plan to meet a control total and reduce cost across the system. He noted that it had not been possible to engage with partners to discuss the requirements due to the restrictions of the General Election purdah period but regular meetings had taken place to develop proposals. Feedback on the joint plan submitted to the regulators was now awaited.

PM expressed appreciation to Healthwatch for their support in the Capped Expenditure Process discussions and confirmed that reports in the local media on proposals being considered were correct, however he was unable to provide further information at this time. PM additionally referred to the complexity of the CCG being a statutory organisation but having no flexibility due to legal Directions. He also noted that the CCG's Financial Plan for the current year was not yet approved nor was there any indication of how to meet the reported financial position. PM requested consideration by members to inform correspondence with NHS England for clarity and assurance about the Governing Body's responsibilities in the current position. He noted that NHS Scarborough and Ryedale CCG, a partner commissioning organisation, was not under legal Directions therefore had more flexibility in their response to the regulators.

PE reported that the Council of Representatives had received an update on the Capped Expenditure Process at its June meeting and subsequently a number of GP meetings had taken place for further discussion. She reported that their concerns had been communicated to PM and that further discussion would take place at the next Council of Representatives meeting.

PE advised that work in the localities was progressing and at different stages across the primary care community.

PM referred to the rearranged public engagement events reporting that about 20 people had attended the first meeting in Selby. Robust discussion had taken place on both potential cost reduction in the system and the historic and future contexts of management of the challenging financial position. PM noted that strong views had also been expressed about the CCG's allocation. The aim was to work together with the population through the engagement events to seek views on future quality of services and actions to address the potential financial deficit of c£40m to £50m. PM welcomed continued support from Healthwatch for this engagement.

In respect of national plans and strategic issues PM highlighted the latest Personalised Health and Care Framework, the annual Adult Inpatient Survey and NHS RightCare publications. He noted that the latter provided indication for focus on disease groups and conditions.

EW reported that the Better Care Fund Guidance had been published on 4 July. The Care Quality Commission would lead reviews of a number of Health and Wellbeing Board plans in the autumn. Some information was being channelled via Local Authorities and being shared with the CCG. Members would be kept informed of further details as / when they became available.

In response to DB seeking clarification on the NHS RightCare priorities, the role of the Finance and Performance Committee and the need to ensure appropriate resources, PM advised that the Finance and Performance Committee was the appropriate governance forum for this focus but noted constraints in the context of financial recovery discussions. PM emphasised that the solutions to the financial challenge required system change through working with clinicians, partners and patients. EB added that the Primary Care Team was working on the General Practice Forward View and highlighted that commissioning resources were required to progress the transformation required.

SP expressed concern about the lack of clarity relating to the Governing Body fulfilling its statutory obligations in the context of legal Directions and the current working to three budgets, namely statutory financial targets, the Medium Term Financial Plan and capped expenditure. She noted that External Audit had also raised concern in this regard and emphasised the need to focus on accountability as known.

PE welcomed the NHS England primary care support but highlighted that the CCG still required more capacity in this regard. She also welcomed the proposed incorporation of patient stories, as per the minutes of the Quality and Patient Experience Committee.

PM explained the intention of both improving the focus and capacity on commissioning services from General Practice and primary care more widely and also engaging with Practices as providers in development of out of hospital services. He emphasised the requirement to maintain governance arrangements in terms of GPs as commissioners and providers.

Discussion ensued in response to PM's earlier request for consideration of correspondence with NHS England. This included reiteration of SP's concern about the CCG working to three budgets and the key role of clinicians in service developments, primary care investment and the Capped Expenditure Process. PE emphasised that primary care wished to be involved in view of concerns about impact on patients and MC noted the potential for impact on patient choice and constitutional targets.

PM referred to the NHS England summary letter following the CCG's 2016/17 annual review meeting noting that the formal assessment was expected before the next Governing Body meeting. He highlighted the paragraph that included '...We acknowledged the hard work that has gone into the past year and reflected on the green shoots of recovery that are starting to come through...' PM noted his expectation that it was likely the CCG would be assessed as 'Inadequate' for 2016/17 predominantly due to the £23m deficit highlighting the need to convey the context to staff, partners and the public.

### **The Governing Body:**

1. Received the Accountable Officer's Report.
2. Noted that PM would co-ordinate correspondence with NHS England regarding members' concerns and proposing an approach to work with the regulators.

*Post meeting note: A letter signed by KR and SP was sent to NHS England on 18 July.*

## **6. Governing Body Corporate Risk Update Report**

RP presented the refreshed Risk Report which also included an updated position for the CCG's performance against the Integrated Assurance Framework indicators. She noted that, in addition to financial risks, there were key risks relating to deterioration in care and quality performance and four events had materialised, namely: continuing healthcare systems and processes being non-framework compliant, leading to potential gaps in service; failure to achieve the 67% dementia coding target in General Practice, potentially leading to delays in treatment; an Inadequate Care Quality Commission report on The Retreat, leading to potential gaps in patient services; failure to achieve sustainable Improving Access to Psychological Therapies access and recovery targets within acceptable waiting times; and failure to meet 18 week referral to treatment target, leading to delays in patients receiving treatment.

RP referred to the context of the report in terms of framing discussion throughout the agenda items for assurance and also for consideration in the future for patient focus as per the earlier discussion.

PM noted complexities relating to governance and experience reporting on a recent visit to Practices that were piloting a new telephony system. He highlighted that issues experienced in terms of the system not being suitable for their needs and having potential for patient harm should be included on the risk register. TP noted that the telephony issue was an agenda item at the Executive Committee on 19 July. Discussion ensued on the fact that telephony was an ongoing issue for Practices in general, the opportunity for shared learning from the experience, and the need for the CCG to receive performance information from primary care to understand areas of impact. The potential for the risk register to inform patient centred discussion at Governing Body meetings was highlighted.

In response to concerns expressed in light of the separation of committees for quality and performance, MC assured members about the CCG's engagement in provider significant events. In respect of primary care, agreement had been reached for sharing Significant Event Analysis. The means of doing so was being arranged through PE who

referred to sharing of information in the context of primary care assurance and inclusion of identified risks on the CCG risk register. KR additionally noted that Serious Incidents were regularly discussed in detail at the Quality and Patient Experience Committee.

DB offered to work with RP and colleagues to further develop the risk register. The Director of Healthwatch York, agreed to support this work and PM asked any members of the public who also wished to be involved to contact RP.

### **The Governing Body:**

1. Received the Risk Register report.
2. Noted that DB and the Director of Healthwatch York, with members of the public who wished to be involved, would work with RP to further develop the CCG Corporate Risk Register.

### **STRATEGIC**

*RH, MD and SW attended for this item*

#### **7. Developing a New Mental Health Hospital for the Vale of York**

Questions submitted by members of the public for which responses were provided within the presentation.

#### **Ann Weerakoon**

*Correspondence received indicated that the decision to close Bootham Park Hospital had been taken before establishment of the CCG therefore there appeared to be a lack of democracy in the decision making.*

KR responded that this had not informed any of the CCG's discussions and requested that this concern be progressed outside the meeting.

*Is the Haxby road site available for purchase and from whom?*

*Has planning permission been granted?*

*Has a construction partner been identified and appointed?*

*Have plans been drawn and is the new build specific to the site or is it a formulaic one used for other public buildings? Bearing in mind that York previously had a uniquely beautiful facility and deserves a building of quality.*

*How confident are you that the target date of 2019 is achievable?*

#### **Jo Smith**

*Have soil samples been taken given that the site was for many years used for industry?*

*Have you explored the flood risk?*

*Who owns the site and is the cost of purchase factored in the costings?*

*What future developments are you anticipating?*

**Sylvia Graves**

*Mental Health Action York (MHAY) remains concerned that the standard for older people is different from that of adult wards.*

*We understand that the division is one of diagnosis rather than gender but it could be argued equally that adult service users could be divided in the same way. Therefore this appears to be discriminatory.*

**Presentation – available at <http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/>**

In introducing the agenda item ‘Developing a New Mental Health Hospital for the Vale of York’ EW noted that the update on the consultation report was based on the six themes and eight recommendations of the consultation outcome report received by the Governing Body at the February 2017 meeting. She advised that responses to the questions above had been incorporated and confirmed that there would be continuing dialogue both with the CCG and Tees, Esk and Wear Valleys NHS Foundation Trust.

EW reiterated the goal of the new hospital – to achieve a fundamental improvement in the quality and sustainability of mental health services – and confirmed that the expectation was for the December 2019 delivery date to be met.

In respect of configuration of the beds EW reported that the number of beds had been increased from 60 to 72 in light of consideration of responses to and concerns expressed during the consultation. She explained that Tees, Esk and Wear Valleys NHS Foundation Trust was working on a change of focus from acute to community provision. This required investment in the community to develop estate and consolidate resources to ensure maximum efficiency in respect of both staff and services. The three site community hub model – York East, York West and Selby – was part of estate planning and transition from many teams and locations.

EW referred to the site options summary for the three preferred locations: Bootham Park Hospital, Haxby Road and Clifton Park. The benefits of each site had been scored against the criteria Effectiveness of Clinical Services; Sustainability and Flexibility; Operational and Environmental Suitability; Accessibility, Staff Recruitment, Training and Development; and Achievability. EW confirmed that on this basis Haxby Road was the preferred option recognising that this had not been the first choice of the public. She reported that Haxby Road was owned by BioRad and discussion was taking place regarding sale of the land and confirmed that the required considerations, including discussion with planners, the Environment Agency and Historic England, were ongoing. Detailed consideration of issues such as flood risk and soil samples were part of the ongoing discussions with the appropriate agencies. National and international procurement guidelines were being followed for appointment of a construction partner and the cost of purchase, which was additional to build costs, had been considered in line with assessment of the options.

EW explained that the build design and layout would have fitted on each of the three options but that the Haxby site was the best fit. She also highlighted where the space for the additional 12 beds would be provided and noted the flexibility of the design. MD



explained the design workshops process undertaken to ensure optimum use and emphasised that when the appropriate planning stage had been reached service users and families would be involved.

In terms of potential future developments, EW commented that there were no specific intentions at the moment but that flexibility in the design and site had been part of the option appraisal.

In response to the question raised as to whether the design was formulaic, EW emphasised that it was not but was for flexibility and safety. The division based on diagnosis rather than gender was due to account being taken of the different and distinct needs of patients. SW advised that precedent and guidance on ensuring privacy and dignity had informed the design.

With regard to the themes of continued engagement and issues relating to broader mental health service provision, EW assured members that the involvement of patients, the public and stakeholders would continue. In respect of the three main themes – bed numbers, the new site and community services – EW referred to the information presented on other mental health service developments and underpinning or infrastructure factors. She also noted that feedback opportunities took many forms, including through Healthwatch.

EW explained that Bootham Park Hospital was owned by NHS Property Services, not the CCG or Tees, Esk and Wear Valleys NHS Foundation Trust, referring to the recommendation that notice be given to NHS Property Services that the CCG had no ongoing healthcare need for Bootham Park Hospital. This was also critical to manage the financial risk and avoid payment of void costs. She also noted that consideration would be required of the fact that Tees, Esk and Wear Valleys NHS Foundation Trust did not occupy the whole site. The process of decommissioning Bootham Park Hospital and the associated estate and inventory was under way. RH and SW recognised concerns expressed about valuables and historic aspects of Bootham Park Hospital and provided assurance that appropriate measures, including site security checks, were being implemented.

MD described the community hub model which would provide integrated multiple services within the three localities: York East (Huntington House, Monks Cross), York West (Acomb Garth and Acomb Health Centre) and Selby (Worsley Court). The rationale for Huntington House was the availability, size and accessibility of the site, including 130 parking and 30 cycle spaces. Nine teams providing specialty adult services would be based there with a single booking system and standardised ways of working. MD added that service users had proposed establishing monthly meetings with lead members of staff once the building was operational to review progress.

In response to discussion about aspects of working with primary care SW emphasised the intention of this taking many forms, including the recently established Access and Wellbeing Team. He noted that discussion was taking place with the Local Medical Committee about working with primary care and explained the aim was for the new hospital and community hubs to be part of the resources within the system. SW also advised that the services were being realigned with postcodes for primary care and City of York Council older person's services and that engagement, including leaflets and conversations, was taking place with patients and carers to support the transition.

In terms of the environment and patient safety and experience, RH explained the approach was one of out of hospital care with admission as the last resort. She confirmed the expectation that patients would return to the community more quickly noting that admissions would be for patients with complex needs. RH advised that work was taking place with Local Authorities and the nursing and residential homes sector to reduce length of stay in line with national requirements and ensuring the right treatment at the right time. AK commented that smaller bed numbers and ward sizes provided a better quality service and commended the 9% increase from inpatient to community provision.

In respect of patient safety, particularly fire risk, MD advised that safety in the new build would be improved on the current position. Fire safety was a key consideration in engineering and design and the different ward requirements would be recognised.

MD responded to SP seeking clarification about affordability advising that this had been considered but, due to commercial confidentiality the information was not included. He assured members that account had been taken of risk to the CCG.

PM commended LB and EW for their significant role in this work on behalf of the CCG and expressed appreciation to Tees, Esk and Wear Valleys NHS Foundation Trust colleagues for their participative working approach. Members welcomed the assurance that engagement with service users would continue throughout the process for the new mental health hospital for the Vale of York.

#### **The Governing Body:**

1. Received the update and endorsed Tees, Esk and Wear Valleys NHS Foundation Trust's decision to move to 72 beds and the preferred option of the Haxby Road site.
2. Noted the intention of Tees, Esk and Wear Valleys NHS Foundation Trust to vacate the Bootham Park site in the autumn of 2017 as a consequence of the planned move to Huntington House
3. Gave approval for the CCG to inform NHS Property Services that it had no requirement for the site for on-going healthcare use after that time.
4. Agreed to receive a further update on progress towards completion of the build (scheduled for December 2019) following Tees, Esk and Wear Valleys NHS Foundation Trust's consideration of the full business case (scheduled for January 2018) or at any other time as required.

*RH, MD and SW left the meeting*

## **FINANCE AND PERFORMANCE**

### **8. Financial Performance Report Month 2**

In presenting this item TP referred to discussion at item 5 above in respect of the Capped Expenditure Process. She noted that there was limited information at month 2 for the Financial Performance Report but advised that the report format was being reviewed for month 3 when detailed information would be provided, including demonstration of month on month variance and allocation changes. This would also align with the requirements of the CCG's reporting to NHS England.

TP reiterated that the forecast outturn reflected the Capped Expenditure Process plans submitted but that the Financial Plan was not approved and the risk of non delivery was not shown; this would change in the month 3 report. The financial plan figures reflected the plan last submitted on 30 March. TP highlighted that this plan had an in-year planned deterioration of £16.05m in 2017-18; this would also be updated in the month 3 report.

TP explained that the year to date programme expenditure aligned with the Capped Expenditure Process profiling and delivery of QIPP later in the year. She noted that the QIPP progress figures highlighted in purple represented schemes in which there was confidence of delivery but savings could not yet be evidenced due to availability of data. A level of delivery had therefore been assumed; assurance would be provided on receipt of the data.

In response to SP expressing concern that the financial position reported was not in line with the forecast outturn, lack of evidence of delivery of savings, and risk associated with the transition of Partnership Commissioning Unit functions and in particular continuing healthcare financial pressure, TP advised in respect of the latter that there had to date not been any change in the team providing the information. She explained however that one of the principle risks in the split of the finance and contracting functions was maintaining corporate and system knowledge. There were vacancies within the team due to the uncertainty and the finance and contracting split needed to be expedited to manage the transition both in terms of staff and resource. This was being progressed through the North Yorkshire Chief Finance Officers group with support from the Chief Nurses.

PM emphasised that progress in addressing the historic financial challenge was not possible without system change and support from the regulators; without this the challenging position would be perpetuated. DB added that the Finance and Performance Committee had authorised PM to invoke the escalation clause in the Heads of Terms for a joint review by NHS England and NHS Improvement. PM responded that the CCG needed to escalate the concerns in writing to progress this.

Members supported the proposed approach to escalate concerns about the lack of clarity regarding the delivery and approval of the CCG's 2017-18 Financial Plan and the Governing Body's statutory responsibilities. It was agreed that further discussion would take place in the private meeting later in the day and reported at the September meeting in public.

## **The Governing Body:**

1. Received the Financial Performance Report.
2. Agreed to escalate concerns to NHS England about the about the lack of clarity regarding the delivery and approval of the CCG's 2017-18 Financial Plan and the Governing Body's statutory responsibilities. *Post meeting note as at item 5 above.*

## **9. Integrated Performance Report Month 2**

CA explained that the performance headlines for areas of improvement and deterioration were based on month 1 validated data but she would provide a verbal update for month 2 performance where available.

In relation to improvements CA highlighted that A and E four hour performance had varied between 69% and 100% daily across the two York Teaching Hospital NHS Foundation Trust sites. Unvalidated June data was 93.6%, an improvement on the 92.9% in the report.

With regard to deterioration in performance CA explained that referral to treatment 18 week backlog and admitted was mainly due to consultant capacity in dermatology, urology, general surgery, respiratory medicine and maxillofacial, the latter being a regional concern. There had been a slight improvement in the admitted backlog position in June from 1376 to 1320.

CA reported in respect of cancer that colorectal referrals had increased month on month for the period from April to June 2017 which was having an impact on two week waits. This was a significant pressure on York Teaching Hospital NHS Foundation Trust. The CCG Cancer Lead was meeting with the Lower Gastrointestinal Consultant in the week commencing 17 July in this regard and this would inform the development of further actions to support managing this demand with York Teaching Hospital NHS Foundation Trust. All discussions around this would continue via the Planned Care System Performance Group which represented York Teaching Hospital NHS Foundation Trust and all three CCGs (NHS Vale of York NHS Scarborough and Ryedale and NHE East Riding of Yorkshire).

In respect of dermatology CA advised of the resignation of a consultant that would add to the capacity issue and pressure on the care pathway from September 2017. She noted that 62 day cancer waits were mainly related to dermatology, where there had been 12 breaches for the May/June period. Some of the 62 day breaches were due to the late transfer of complex patients between providers and this was a programme of improvement incorporated into the York Teaching Hospital NHS Foundation Trust and Cancer Alliance 62 day recovery plan. There had been a reduction in GP referrals of 5.8% between February and May 2017 as compared to the same period in 2016, and work was taking place to better understand this alongside the increasing rates of Consultant to Consultant and other referrals through the planned care programme which was led by JH with York Teaching Hospital NHS Foundation Trust and the three CCGs.

CA reported 80 breaches against the cancer 14 day performance target of which 52 had been for skin and 10 for lower gastrointestinal due to patient cancellations. The Planned Care System Performance Group was considering ways to address such cancellations through engagement with primary care.

In regard to diagnostics CA reported that there had been 47 breaches in May, also noting the impact of the cyber attack. The York Teaching Hospital NHS Foundation Trust diagnostics recovery plan was monitored by the Planned Care System Performance Group and also presented at the Finance and Performance Committee.

CA noted that York Teaching Hospital NHS Foundation Trust had been successful in accessing Cancer Alliance funding for improving access to diagnostics (£131,000). Consideration was now being given to its use.

CA reported that there were no areas of escalation but noted the progress of the joint planned care programme with York Teaching Hospital NHS Foundation Trust and the demand management workstream to support the pressures on elective care. She also referred to the refresh of the A and E Delivery Board work plan and advised that the Finance and Performance Committee would be kept informed of the Cancer Alliance work focusing on cancer 62 day performance.

Members discussed in detail concerns about dermatology capacity and impact on performance. EB reported that work on pathway change was taking place with the dermatologists and highlighted opportunities for transformation through learning from models being implemented in other parts of the county. She also noted the impact of a risk averse culture which resulted in increased referrals. DN added that dermatology performance and consultant capacity shortages were a national issue and reiterated the need to prioritise learning from other models of care rather than focus on accessing more capacity.

CA explained that the Heads of Terms for joint working between NHS Vale of York and NHS Scarborough and Ryedale CCGs were for a phased approach for planned care service reviews which had commenced in February 2017 but had experienced some problems with progressing by May 2017. Therefore a refresh of these service reviews, including a refresh of the associated terms of reference, was currently taking place. This included a commitment to service by service review of demand management and identification of capacity requirements, work that was essential to transform the system. This was being led by JH and the Chief Operating Officer of York Teaching Hospital NHS Foundation Trust as part of the joint planned care programme.

In respect of continuing healthcare MC reported that additional information contributing towards the delivery of QIPP and transformation change would be included in the next performance report as these programmes of work were mobilised and work to validate continuing healthcare data with the Partnership Commissioning Unit was progressed.

AP advised that the recommendations from the Emergency Care Improvement Programme (ECIP) and Utilisation Management Review reports were being considered by the A and E Delivery Board which would monitor the associated actions. He also highlighted the requirement for local A and E Delivery Boards in the context of the Sustainability and Transformation Plan nine 'deliverables'. CA highlighted that this A and E Delivery Board refresh formed part of the 'ask' from the new joint NHS England and NHS Improvement regional emergency and urgent care assurance team.

PM emphasised the requirement for a clear understanding across the system of the recommendations and responsibilities for their implementation, including alignment with

the planned care and unplanned care joint work programmes. He requested that AP and CA provide key themes, incorporating the CCG's Medium Term Financial Strategy, the recommendations referred to above and the community bed review to enable the work to be expedited.

With regard to the Utilisation Management Review report TP explained that many of the recommendations related to contracting and included the need for a separate tariff for assessment activity. She advised that formal Activity Query Notices had been raised as there was a lack of willingness by York Teaching Hospital NHS Foundation Trust to negotiate an assessment tariff and noted that the Utilisation Management Review had also identified overall cost to the system of inefficient pathways in terms of quality and patient risk. Discussion was taking place with partners in the Sustainability and Transformation Plan, in particular NHS Hull and NHS East Riding of Yorkshire CCGs, regarding implementing the recommendations of the Utilisation Management Review report.

In response to assurance sought regarding joint working, TP explained that finance and contracting responded to confirmation by the system of a clinical model and verification in terms of cost and patient pathway. PM highlighted the need for a pragmatic approach and clinical input to contract implications. He requested that the GP members of the Governing Body over the summer period consider prioritisation of general issues to inform the CCG's commissioning response.

#### **The Governing Body:**

1. Received the Integrated Performance Report.
2. Requested that AP and colleagues work with the unplanned care programme to ensure that programme incorporated all key themes to expedite a system approach, including the Utilisation Management Review and community bed review.
3. Requested that GP members over the summer period identify general issues to be prioritised.

### **ASSURANCE**

#### **10. 2016-17 Annual Report and Annual Accounts**

KR referred to delegation by the Governing Body to the Audit Committee for approval of the Annual Report and Annual Accounts.

#### **The Governing Body:**

Ratified the 2016-17 Annual Report and Annual Accounts.

#### **13. Conflict of Interests Policy**

RP referred to the updated Conflicts of Interest Policy which had been approved by the Audit Committee on 5 July. She noted a recent Significant Assurance report from Internal Audit. An amendment was required under Policy Amendments Version 5 where 13 July 2017 should replace 7 September 2017 for Governing Body approval.

**The Governing Body:**

Ratified the Conflict of Interests Policy subject to the above amendment.

*DN left the meeting*

**14. Procurement Policy**

TP explained that the updated Procurement Policy, approved by the Audit Committee on 5 July, provided a more flexible approach.

**The Governing Body:**

Ratified the Procurement Policy.

**15. Policy for the Engagement of External Auditors for Non-Audit Work**

TP referred to the Policy for the Engagement of External Auditors for Non-Audit Work which had been approved by the Audit Committee on 5 July to conform with best practice. SP suggested that future similar policies should not be presented to the Governing Body but that responsibility should be delegated appropriately.

**The Governing Body:**

Ratified the Policy for the Engagement of External Auditors for Non-Audit Work.

**RECEIVED ITEMS**

**16. Audit Committee Minutes**

**The Governing Body:**

Received the minutes of the Audit Committee held on 1 March, 26 April and 24 May 2017.

**17. Executive Committee Minutes**

**The Governing Body:**

Received the minutes of the Executive Committee held on 19 April 2017.

**18. Finance and Performance Committee Minutes**

**The Governing Body:**

Received the minutes of the Finance and Performance Committee held on 27 April and 25 May 2017.

## **19. Quality and Patient Experience Committee**

### **The Governing Body:**

Received the minutes of the Quality and Patient Experience Committee held on 13 April and 8 June 2017.

## **20. Primary Care Commissioning Committee**

### **The Governing Body:**

Received the minutes of the Primary Care Commissioning Committee held on 28 March and 30 May 2017.

## **21. Medicines Commissioning Committee**

### **The Governing Body:**

Received the recommendations of the Medicines Commissioning Committee held on 12 April, 10 May and 14 June 2017.

## **ASSURANCE CONTINUED**

### **11. Quality and Patient Experience Report**

MC highlighted a number of areas in the report. In respect of the City of York Council Healthy Child 0-19 Service she reported that, in addition to concerns expressed by the CCG, concerns had been raised at the City of York Health and Wellbeing Board and by the Care Quality Commission following the recent inspection. MC noted however that there were a number of areas where progress had been made, including emergency contraception and enuresis, and that work was continuing to establish improved processes and services.

MC referred to the mandated requirement to achieve a 50% reduction in the number of E. Coli BSI cases over three years based on 2015-16 figures across all settings. She noted that this required significant work and advised that further detail would be included in the next report.

MC advised that, although progress was being made at York Teaching Hospital NHS Foundation Trust in respect of the Duty of Candour, there was continuing concern. Discussion was taking place at Contract Management Board but an action plan was still awaited following an audit undertaken by York Teaching Hospital NHS Foundation Trust.

MC reported that there had been a Never Event earlier in the week at York Teaching Hospital NHS Foundation Trust. This was a case of wrong site surgery on a Vale of York patient despite World Health Organisation process being in place. Further detail would be provided when available.

In respect of maternity and reference to smoking at time of delivery in the NHS England Improvement and Assurance Framework performance assessment, MC noted that



Westfield was the main area of concern. She advised that an audit had identified potential opportunities for improvement and the CCG was working with City of York Council in this regard.

LB reported secondment of a consultant psychiatrist for perinatal mental health who was leading co-ordination of a bid. She noted that discussion was taking place about this applying across the footprint due to the number of patients.

MC noted in respect of screening and immunisation that a plan had been agreed for four particular areas, including vaccine wastage which had a significant cost of c£10k per month. Further information would be provided in the next report.

MC advised that additional support was being arranged for the Patient Experience Officer due to the increasing workload.

With regard to verification of expected death in care homes MC explained that the British Medical Association stated that a doctor was not required and that this was different to certification of death which did require a doctor. The CCG had therefore agreed with out of hours providers that they would not attend for verification of death. However, care homes were not ready for this and work was now taking place via the Care Homes Group to ensure safe implementation.

MC noted that the Care Quality Commission inspection report on The Retreat had been published since issuing of the meeting papers. The assessment was Inadequate overall. MC advised that the CCG had been sighted on the issues and actively working with The Retreat on action plans for improvement. MC also reported that The Retreat was closing the Strensall Unit due to under utilisation of beds. This was a concern as it meant a reduction of beds in the system.

In respect of children and young people MC highlighted concern about the autism assessment service where the average wait was currently 39 weeks against the NICE recommendation of no longer than 13 weeks. She also noted that the All Age Autism Strategy 2017-21 had been ratified at the Health and Wellbeing Board on 12 July.

EB reported that a new nursing home had requested support from the CCG and advised that she had requested City of York Council inform the CCG of new build or reconfiguration in order to account for associated requirements. PM advised that he was requesting closer working with Local Authorities in this regard, particularly in view of the impact of such decisions on General Practice.

### **The Governing Body:**

Received the Quality and Patient Experience Report.

## **12. Care Quality Commission Report: Review of Health services for Children Looked After and Safeguarding in York**

MC reported that an action plan had been submitted in response to the recommendations in the Care Quality Commission report. She explained that in addition to the specific recommendations the CCG had an oversight role for all the recommendations as the commissioner of services for children looked after and safeguarding.

MC explained in respect of the recommendations relating to the Healthy Child Service that Ofsted, not the Care Quality Commission, was the regulator therefore this aspect was not included in the action plan. However, they had agreed to contribute to mitigating actions as part of the Children's Safeguarding Board oversight role of the overall response to the Care Quality Commission report. MC also noted in regard to the Healthy Child Service that the staff consultation had ended but a service offer was still awaited.

MC highlighted that the report had been positive about primary care safeguarding responsibilities. She also, in terms of assurance, advised that all actions had either been completed or were making good progress.

### **The Governing Body:**

Received the Care Quality Commission Report on the Review of Health services for Children Looked After and Safeguarding in York.

## **22. Next Meeting**

### **The Governing Body:**

Noted that the next meeting would be held at 9.30am on 7 September 2017 at Pocklington Arts Centre, 22-24 Market Place, Pocklington, York YO42 2AR.

### **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 13 JULY 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"> <li>• 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</li> <li>• Options were being developed for additional capacity</li> </ul>	MC	
2 March 2017			MC	Ongoing
13 July 2017				Ongoing
2 March 2017	Accountable Officer Report	<ul style="list-style-type: none"> <li>• CCG's community bone protection service to be reviewed in light of the National Osteoporosis Society data.</li> <li>• Update on receipt of report from National Osteoporosis Society</li> <li>• Meeting taking place week commencing 8 May to review data</li> <li>• Email update to be provided</li> </ul>	PE/SOC	
6 April 2017			SOC	
4 May 2017			TM	Ongoing
13 July 2017			TM	Email circulated 1 August 2017

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
4 May 2017	Communication and Engagement Plan	<ul style="list-style-type: none"> <li>Report to September or October Governing Body</li> </ul>	RP	7 September or 5 October 2017
13 July 2017	Integrated Performance Report Month 2	<ul style="list-style-type: none"> <li>AP and colleagues work with the unplanned care programme to ensure that programme incorporated all key themes to expedite a system approach, including the Utilisation Management Review and community bed review.</li> <li>Requested that GP members over the summer period identify general issues to be prioritised.</li> </ul>	AP and colleagues  GP Governing Body Members	7 September 2017

<b>Item Number: 5</b>	
<b>Name of Presenter: Phil Mettam</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting:</b> 7 September 2017	
<b>Report Title – Accountable Officer’s Report</b>	
<b>Purpose of Report</b> To Receive	
<b>Reason for Report</b>  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.	
<b>Strategic Priority Links</b>  <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 type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b>  <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	
<b>Impacts/ Key Risks</b>  <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b>
<b>Emerging Risks (not yet on Covalent)</b>	
<b>Recommendations</b>  The Governing Body is asked to note the report.	
<b>Responsible Executive Director and Title</b> Phil Mettam Accountable Officer	<b>Report Author and Title</b> Sharron Hegarty Head of Communications and Media Relations

## GOVERNING BODY MEETING: 7 SEPTEMBER 2017

### Accountable Officer's Report

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

- 1.1 The CCG is working with NHS England to finalise the delivery timelines and confirm completion of each area in the CCG's Improvement Plan following the 2016-17 annual assessment of CCG performance against the Integrated Assurance Framework (IAF).
- 1.2 NHS England formally reported on the significant progress made by the CCG against the Improvement Plan during 2016-17 and continuing into Q1 of 2017-18 as the CCG entered into the Capped Expenditure planning process. The strength of the quality of CCG leadership submission was specifically highlighted and formal assessment is due to follow in September 2017.
- 1.3 The CCG assessment for 2016-17 IAF remained at 'inadequate' despite this progress against the Improvement Plan and delivering the financial control total agreed as part of the Improvement Plan. However, this rating was anticipated as the CCG retains a significant financial deficit and all CCGs under Legal Directions are rated as 'inadequate'.
- 1.4 The assessment framework for the CCG for 2017-18 is still to be agreed with the local NHS England Assurance Team and nationally the new joint NHS England and NHS Improvement IAF is still to be launched.
- 1.5 Financial recovery and planning for system financial reform continues through the CCG's work with York Teaching Hospital NHS Foundation Trust and Scarborough and Ryedale CCG under the Capped Expenditure process. A further iteration of the joint system plan will be submitted to NHS England and NHS Improvement on the 6 September 2017.
- 1.6 At the same time the CCG has assessed the risks associated with delivering the current Quality, Innovation, Productivity and Prevention (QIPP) programmes and is working with both NHS England and Scarborough and Ryedale CCG to align how the available capacity can be targeted to reduce QIPP delivery risk across the system.
- 1.7 This will also support the development of joint commissioning intentions at the end of September 2017 which the CCGs are seeking to develop with local authority partners.
- 1.8 The Financial Plan as submitted on 12 June 2017 is being considered by the Governing Body at this meeting. The CCG is planning a deficit in-year of £6.35m which would bring its cumulative deficit at the end of the year to

£30.1m. At the end of July 2017, the financial position is slightly better than planned but significant QIPP and Capped Expenditure Programme plans profiled in the latter half of the year are not yet included.

## **2. Operational Plan 2017-19, Assurance and Delivery**

- 2.1 The CCG has reviewed all its programmes of work (QIPP and transformational) during months four and five and assessed the impact on performance improvement, risks to QIPP delivery, the contribution to the joint system financial recovery plan and the delivery of the priorities and objectives originally captured in the two-year Operational Plan and the Medium Term Financial Strategy.
- 2.2 The CCG continues to progress work streams within each of its programmes with partners through the Accountable Care System and recognises the benefits to working with partners to develop the best future services at a locality level, whilst also acknowledging the complexity and challenges to progressing at pace when working as a system.
- 2.3 Additional capacity from NHS England national QIPP support programme is currently being mobilised to drive QIPP delivery and the CCG is adjusting its financial plan and reporting in response to this risk assessment, as well as the incorporation of the remaining gap in the system financial envelope. This is reported to Governing Body this month.
- 2.4 The CCG is also undertaking a review of the current delivery model for driving programmes of transformation and performance improvement, underpinned by a desire for stronger clinician to clinician engagement across and between primary and secondary care. The Executive Committee and Clinical Executive will be considering how a strengthened clinical delivery model can be developed and supported in September 2017.
- 2.5 The CCG has also undertaken a thorough analysis of the clinical areas where performance has been below target for some time or is further deteriorating in Q4 2016-17 and Q1 2017-18. These are also the clinical performance areas highlighted in the 2016-17 IAF year-end assessment as 'requiring further improvement'.
- 2.6 These performance areas are reported on regularly as part of the integrated performance dashboard and remain as high risks on the risk register. However, the opportunity for clinicians and operational leads to review, challenge and refresh the existing action and recovery plans for these areas has been welcomed, informative and constructive. The outputs from the three mental health analyses are reported to Governing Body this month. A&E 4 hour, Referral to treatment and Cancer 62 day target analyses will be undertaken during September 2017. All recovery plans will be updated based on the actions agreed throughout the analyses.

### **3. Council of Representatives meeting**

- 3.1 Among the agenda items at its latest meeting on 20 July 2017, members discussed work with the Local Medical Committee around the Enhanced Services Review. Members received a report on recent practice visits that noted strategic issues, such as premises and workforce and the CCG's aspiration to continue to support Practices. Discussions at the meeting also focused on the General Practice Forward View, specifically Extended Access, E-consultation, Resilience, and Pharmacists. The Ambulance Response Programme was also an item on the agenda.

### **4. Better Care Fund update**

- 4.1 Plans for 2017-19 are currently being developed across the three Health and Wellbeing boards that cover our population in the Vale of York. In line with NHS England assurance processes, which will extend through to the autumn, plans are, in principle, agreed and balanced with documents being prepared for submission on 11 September 2017. The plans focus upon helping people to stay at home, remain independent and get back home quickly (if clinically appropriate) if they do need to be in hospital. Additional funding from local authorities will help to support this work.
- 4.2 To help provide a useful reflection, highlighting what works well and opportunities for improvement, the Care Quality Commission (CQC) is undertaking a system review of health and social care in York. The review will look at how people move between health and social care, including delayed transfers of care. They also include an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources.
- 4.3 The system reviews will not include mental health services or specialist commissioning, but it will look at the experiences of people living with dementia.
- 4.4 The system review, one of many that are taking place across the country, is scheduled to take place from Monday 30 October to Friday 3 November 2017.

### **5. Humber, Coast and Vale STP Leadership Arrangements**

- 5.1 Emma Latimer has stood down from her position as STP lead for Humber, Coast and Vale. Simon Pleydell, who brings a wealth of experience in NHS leadership and management to our STP, will be joining the Humber, Coast and Vale team from 4 September 2017.

### **6. Engaging and involving our local patients and stakeholders**

- 6.1 The CCG has completed its series of summer engagement events and we have collected a huge amount of feedback from those who attended events and drop-in sessions. An update following this recent work is an item on the



agenda but I would like to formally thank patients and members of the public that took the time to share their views.

## **7. Changes to the Governing Body membership**

- 7.1 I am sad to report that two members of the Governing Body, Dr Tim Maycock and Dr John Lethem, have stepped down from their roles on the Governing Body.
- 7.2 Dr Maycock joined the CCG at the very beginning, before its shadow term. As a core member of the senior team Tim principally supported the commissioning and development of services in Primary Care. He provided the challenge and rigour that commissioning demands and steps down to return back to full-time front-line GP service.
- 7.3 After 28 years as a partner at Unity Health practice, Dr John Lethem will be retired on 1 September 2017. The CCG would like to thank Dr Lethem for his commitment and support to the Governing Body, the Council of Representatives and other committees. His expertise and experience have been immensely influential on our journey of transformation and system integration. We would like to wish John a very long and happy retirement.
- 7.4 The CCG thanks both Drs Maycock and Lethem for their hard work, invaluable insight as local GPs and their immense contribution to help shape local healthcare services.

## **8. National plans and strategic issues**


- 8.1 From 2 October 2017, there will be a contractual requirement for GPs to complete all new patient registrations using the new Family doctor services registration (GMS1) form. Copies of the new form will be delivered directly to GP practices ahead of the 2 October 2017 date
- 8.2 Research indicates that people with a learning disability are more likely to experience poor general health and have high levels of unmet physical and mental health needs. They are also more likely to experience poor quality end of life care. Guidance has been developed in partnership by NHS England and the Palliative Care for People with Learning Disabilities (PCPLD) Network. The guide provides resources and good practice examples to support commissioners, providers and staff across the health and care system to reduce inequality in palliative and end of life care for people with a learning disability, and achieve the Ambitions for Palliative and End of Life Care.
- 8.3 The new Mental Health Workforce plan from Health Education England shows how the workforce will increase and improve between now and 2021 to meet the aims set out in the Five Year Forward View for Mental Health. Central to this is a focus on getting the right people in place, through new posts,

retention and re-training. Planning guidance and support will be made available to CCGs soon.

- 8.4 The 2016/17 General Medical Services and Personal Medical Services variation notices and updated contracts have been published. Regions and contractors taking part should ensure they have read and understood the documents. Regional teams should update local contracts where they have not used the new standard contract.
- 8.5 To provide a highly-skilled General Practice Nursing workforce, the General Practice Forward View includes investment to fund a support and development programme for nursing teams in primary care over four years. Led by Professor Jane Cummings, Chief Nursing Officer for England, a ten point action plan aims to raise the profile of general practice nursing as a first destination career, improve access to training, increase the number of pre-registration nurse placements, enhance retention and support return to work schemes for practice nurses. The plan aligns closely with Leading Change, Adding Value; a framework for nursing, midwifery and care staff.
- 8.6 A new education and training framework that supports person-centred care has been published by Health Education England, Skills for Health and Skills for Care. The Person-Centred Approaches framework aims to distil best practice and set out core, transferable behaviours, knowledge and skills. It is applicable across services and sectors (e.g. health, social care and housing) and across different types of organisations. NHS England has contributed to the development of the framework, which supports an integrated approach to prevention and self-care by training teams across boundaries to build shared language and shared purpose.
- 8.7 A national public consultation has been launched on draft commissioning guidance on products which could be considered low priority for funding by the NHS. The deadline for responses is 21 October 2017. The CCG is engaging with their local communities on these proposals, and to share views with the national consultation.

## **9. Recommendation**

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

<b>Item Number: 6</b>	
<b>Name of Presenter: Rachel Potts</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of Meeting:</b> 7 September 2017	
<b>Risk Update Report</b>	
<b>Purpose of Report To Receive</b>	
<b>Reason for Report</b> The CCG risk report is presented to Governing Body for review, discussion and to instigate any additional mitigating actions the Governing Body considers appropriate.  A verbal update will be given in relation to the first meeting of a working group now established to support the CCG in developing a new approach to monitoring and managing risk.	
<b>Strategic Priority Links</b> <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	
<b>Local Authority Area</b> <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	
<b>Impacts/ Key Risks</b> <input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b> All covalent risks flagged as corporate risks managed through the Covalent Integrated Governance system.
<b>Emerging Risks (not yet on Covalent)</b> N/a	
<b>Recommendations</b> The Governing Body is requested to review risks arising and to consider risk appetite for events and high scoring risks.	
<b>Responsible Executive Director and Title</b>  Rachel Potts, Executive Director Planning and Governance	<b>Report Author and Title</b>  Pennie Furneaux, Risk and Assurance Manager

**Annexes:**

**Annex A: Summary of Corporate Events**

**Annex B: Detailed Report of Corporate Red Risks**

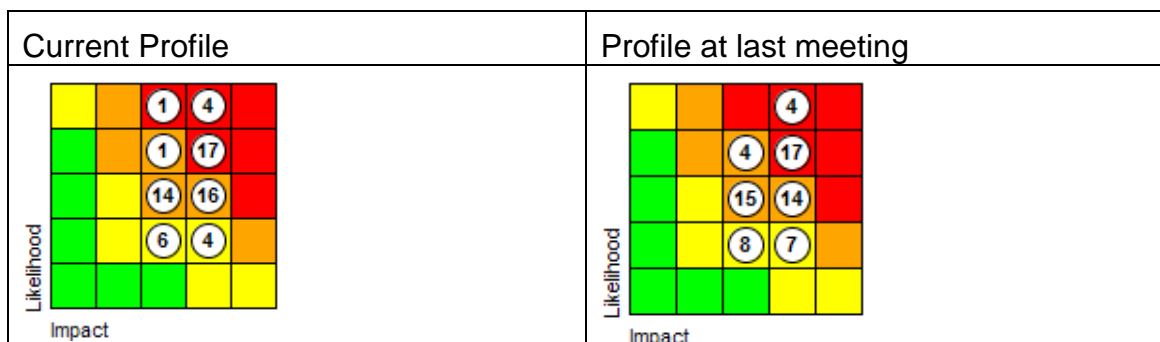
**GOVERNING BODY**  
**RISK UPDATE REPORT**  
**7 SEPTEMBER 2017**

**1. Integrated Assurance Framework Performance**

- 1.1. There is no update to the previous NHS England (NHSE) published CCG Integrated Assurance Framework (IAF) performance position which was reported to the Governing Body in July 2017. A refreshed CCG Integrated Assurance Framework for 17/18 is pending publication.
- 1.2. An update is provided in respect of the four indicators identified by NHSE as falling into the lowest performing quartile nationally Quarter 4 16/17 as follows:
- Quality of life of carers.  
The CCG continues to engage with carers as part of the CCG’s Engagement Action Plan;
  - Early Intervention Psychosis 2-week referral.  
The growing demands have been recognised by the CCG and discussions continue with TEWV regarding this service and future options;
  - Mental Health - Children and Young People.  
Discussions continue with TEWV to understand the actual demand in greater detail and the level of resources deployed to meet demand. It has been agreed to provide additional performance data;
  - Working relationship effectiveness.  
The CCG has developed an action plan to address the issues raised by stakeholders in the 360<sup>0</sup> Survey undertaken 2017. Progress with the plan will be monitored by the Executive Committee.
- 1.3. Risk areas are included in the corporate risk register.

**2. Risk Management**

- 2.1. There are established systems in place to monitor and manage risks arising through sub-committees of the Governing Body and working groups. All corporate risks and mitigating actions have been reviewed and updated during August. A heat map of all corporate risks is provided below.



2.2. Risks are rated according to the perceived impact and likelihood of occurrence, the CCG operates the NHS standard 5 by 5 risk matrix as follows:

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

2.3. Risks scores are rated as follows:

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

### 3. Events this Period (Annex A)

3.1. There are four events detailed within risk registers this month, (i.e. the risk has materialised and the CCG is being impacted); all with an impact rating of 4. This is a decrease of one event reported to Governing Body in July. This is the event relating to non-framework compliant CHC systems which has been de-escalated from corporate events and risk registers to operational management as there is now the and effective infrastructure in place to effectively mitigate.

3.2. Details of on-going events are as follows:

- Failing to achieve Dementia coding 67% target in general practice, potentially leading to delays in access to treatment;
- Inadequate CQC report on The Retreat, leading to potential gaps in patient services;
- Failing to achieve IAPT access and recovery targets;
- Failing to meet 18 week Referral To Treatment target, leading to delays in patients receiving treatment;

3.3. Actions are in hand to mitigate the impact of events,

- the August meeting of the Finance and Performance Committee reviewed detailed reports on recovery plans for Dementia and IAPT;
- this September Governing Body will receive a full report following a single item review on CAMHS with the CCG and provider held in August;
- the Executive Committee will consider the current performance position and recovery plans for Planned Care RTT target in September and a detailed report will be presented to F&P Committee in September 2017; and





- Progress with the action plan to address the issues raised in the CQC Report on the Retreat is being monitored.

3.4. Details of latest action in relation to these events are provided at Annex A.

#### 4. Red Risks This Period (Annex B)

- 4.1. The CCG is carrying an increasing level of corporate risk. There are currently 22 risks rated as red.
- 4.2. Risks may be seen as interdependent, in that failure to appropriately resource and deliver transformation programmes may impact the ability of the CCG to meet financial challenges.
- 4.3. New red risks included in this report are:
  - the risk of failure to meet **Cancer 2 week wait (2WW)** target is newly rated as “red” (i.e. extreme). There will be dedicated review sessions held in September to consider those specialties with the most challenged position in relation to capacity, and the subsequent impact on Cancer 2 WW, Cancer 62 day and RTT planned care performance delivery. The outcome of these sessions and any proposed refresh of recovery plans and commissioning intentions will be presented to the Finance & Performance Committee in September; and
  - following discussions at Finance and Performance Committee and Audit Committee during August 2017, the risk appertaining to delivery of the **Local Digital Roadmap (LDR) Programme** has been escalated to red status. The delivery of LDR locally has been slow due to the lack of capacity at programme manager and Executive lead levels. The Executive Committee will consider the consequences of this LDR programme not being delivered on its programmes of work in the week commencing 4<sup>th</sup> September.
- 4.4. A detailed report of all red corporate risks is provided at Annex B along with mitigating action in hand to manage the risk.
- 4.5. The Governing Body is requested to consider whether the mitigations and approach to risk management outlined in relation to the key red rated risk areas is adequate to reduce risk to acceptable levels.

# Summary of Corporate Events -Risks that Have Materialised

Code & Title	Operational Lead	Lead Director	Latest Note	Latest Note Date	Impact	Status
JC-PROG.01 Dementia - Failure to achieve 67% coding target in general practice.	Paul Howatson	Lead for Unplanned Care and Out of Hospital Services Medical Director	CCG should receive the Intensive Support Team draft recommendations report by the end of August. Project resource has been identified to drive improvements in the rate of coding in primary care. The current rate is 58.7% which is an increase of 0.3% on the previous month. Six practices are now above the national target with a further two practices with a coding rate of over 60%. A paper on progress has been prepared for F&P in August.	17 Aug 2017	4	
JC.24 Risk of increased demand on local system following the Inadequate CQC report on The Retreat	Michelle Carrington	Executive Director Quality and Nursing	A remedial action plan is now received and regular meetings and assurance visits remain in place. Reduction in bed base of one of the community units is planned but related to underutilisation of the bed base.	23 Aug 2017	4	
JC-PROG.02 IAPT - Failure to achieve sustainable access and recovery targets within acceptable waiting times	Sheila Fletcher; Paul Howatson; Beverley Hunter	Lead for Unplanned Care and Out of Hospital Services Medical Director	The Improvement Support Team will be back in September to review TEWV's progress against the new pathways for IAPT The action plan has been agreed and signed off and this is expected to generate improvements to people wishing to access IAPT in a timely manner as well as clearing the backlog. A paper on progress has been prepared for F&P in August.	24 Aug 2017	4	
PLC.05 Constitution target – Planned Care - VoYCCG failure to meet 18 week RTT target	Fliss Wood	Lead for Unplanned Care and Out of Hospital Services Medical Director	Workforce pressures due to nursing and medical vacancies and the lack of locum/bank staff to cover during school holidays has impacted on performance.	10 Aug 2017	4	



## Annex B

### CORPORATE RISK REGISTER 2017/18

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
JC.10 There is a potential risk that the CCG does not receive timely updates to the PCU risk register and may not be fully briefed regarding risk exposure.	The CCG has commissioned the Partnership Commissioning Unit to manage a number of specialist commissioning areas on their behalf. If the PCU fails to provide timely updates to risks then the CCG may not be fully aware of it's risk exposure in specialised commissioning areas managed by the PCU as follows; Continuing Health Care; Children, young people and maternity; Vulnerable Adults (Learning Disabilities and Mental Health); Adult Safeguarding.	Meetings with PCU management, review of processes in place.	The PCU risk register has been discussed at NY PCU Exec Nurse meeting and a proposal for taking this forward being developed to come to next meeting end of July Proposal delayed however all PCU risks from risk register re-aligned to CCG	Jenny Carter; Debbie Winder	Executive Director Quality and Nursing	20	8		17-Aug-2017
JC.22 Risk of not achieving the increased target for Personal Health Budgets	PHB is an area for development and the CCG is identifying the resources required and risks associated with implementation.	Project to work on increasing the uptake of Personal Health Budgets across the North Yorkshire CCGs. Reporting has commenced on uptake and this will be monitored at PCU Management Board. Quarterly audits.  Controls include: Programme meeting and TEWV CMB	Executive Committee agreed Option 2 and the Commissioning and Transformation Manager is now developing a project plan for the activities to support the increase in PHBs.	Paul Howatson	Executive Director Joint Commissioning	20	4		17-Aug-2017
JC.26 CAMHS and Children's Autism Assessments	Very long waiting lists to access Children & Adolescent Mental Health Services, Community Eating Disorder Services and Autism support. This may potentially impact quality of patient experience and outcomes. Potentially detrimental impact to reputation and performance and partners in other agencies services. (e.g. Local Authority).	Service Development Improvement Plan in place Data Quality Improvement Plan in place Capacity and demand gap analysis submitted and under review Community Eating Disorder Deep Dive interim report (July 2017)	Following discussion at Governing Body in July, and at Performance and Finance Committee, a single topic QPEC was held on 14 August to discuss contract performance with TEWV and to develop a recovery plan. Performance against all targets remains low at end Q1 (and below Q1 in 2016/17) and is being pursued with TEWV. A report on the CEDS deep dive was received on 1 August and is being reviewed. A further meeting has been held to discuss workforce capacity and service demands. A further discussion will be had at the Contract Management Board on 21st August to discuss next steps.	Susan De Val; Paul Howatson	Executive Director Joint Commissioning	20	12		17-Aug-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	CCG/PCU leads have devised a comprehensive action plan. CCG to provide focussed support targeting the larger practices with the lowest coding rates.	CCG should receive the Intensive Support Team draft recommendations report by the end of August. Project resource has been identified to drive improvements in the rate of coding in primary care. The current rate is 58.7% which is an increase of 0.3% on	Paul Howatson	Lead for Unplanned Care and Out of Hospital Services Medical Director	20	9		17-Aug-2017



## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
	care or limited choice available to patients  meeting new standards	All practices will be encouraged to re-run the toolkit and review all records identified.  Controls include: Programme meeting and TEWV CMB	the previous month. Six practices are now above the national target with a further two practices with a coding rate of over 60%. A paper on progress has been prepared for F&P in August.						
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.	There is a new programme management arrangement and performance management framework in place within the CCG which bring together all work streams and actions to drive QIPP and system transformation based around five programmes (unplanned care, planned care, primary care, MHLd & complex care and enabling & quality). The NHSE national QIPP support programme report outlined recommendations to reduce risk associated with QIPP delivery including: (a) accessing further capacity/capability, (b) engaging with the national CHC support programme (c) driving Rightcare programmes (Wave 1 & 2) further towards indicated efficiency targets, and (d) improving engagement with partners. Additionally, the CCG undertook an internal review of QIPP delivery to date exercise, and identified a series of lessons learnt which should inform future processes for QIPP delivery.	<b>Capacity - mitigations:</b> The CCG has successfully incorporated additional capacity from NHSE primary care team to support the primary care programme and the programme for primary care will be refreshed based on their review. There has also been a 0.4wte NHSE demand management resource commenced in May 2017. Band 7 additional capacity has now been recruited to resource delivery of the planned care programme. The CCG has also responded to a formal request from NHSE via the national QIPP support programme for Phase 2 for capacity requirements needed to mobilise and drive delivery of the CCG QIPP programme at pace during 17/18 – 18/19. These are focused on CHC nursing, medicines management, BI and programme manager capacity. The CCG is now working with NECS to finalise the specification and agree start dates for additional capacity. The new Executive Director for Transformation has now been successfully appointed and is now mobilising the CHC review and refreshing the unplanned care programme. The prescribing programme has now recruited to the vacant 8A & 8B roles and will receive additional support from NHSE medicines management resources via NECS. The CCG is working to fill the Primary Care Exec Director role and now needs to plan the transition during September as one Exec Director retires and two consultants leave the CCG. The BI team is currently below budgeted establishment and the finance team and contracting team will be under capacity due to maternity leave from June onwards.	Caroline Alexander	Lead for Unplanned Care and Out of Hospital Services Medical Director	16	8		17-Aug-2017

## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
			<p>The CCG has worked in June and July with ERY CCG, S&amp;R CCG and YTHFT to explore how a shared system PMO could be established to support joint programmes of transformation which support the CCG QIPP delivery. This will now be mobilised alongside proposed new system Director roles after September. Governance and accountability frameworks for joint programmes will be refreshed in relation to the joint PMO in September too.</p> <p>Recent resignations and successful secondments to other teams in the CCG has resulted in new vacancies in the PMO and unplanned care programmes which will be considered as part of a current refresh of the CCG structure and resourcing (alongside the development of a system shared PMO).</p> <p><b>Engagement – mitigations:</b> Many of the CCG QIPP schemes are now being delivered through joint programmes of work with partners across the system. This has required significant levels of engagement and added complexity in terms of governance and accountability to make decisions and progress at pace. The general election and associated period of purdah resulted in complete cessation of all public engagement in relation to QIPP programmes and joint delivery with partners. All engagement plans have now been refreshed and the engagement programme is back in delivery.</p>						
ES.13 There is a potential risk that divergent strategies between main acute provider and the CCG which materially impact the CCG's financial position	There is a risk that financial strategies pursued by the York Teaching Hospitals NHS FT, in relation to managing it's own financial position will adversely impact on the CCG strategies to return to financial sustainability.	Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Program	The recent communication from NHSI with regards to CEP demand management schemes puts significant risk on the deliverability of the CEP financial plan as submitted. YTHFT are updating their financial plan as requested by NHSI to reflect this. The CEP financial challenge remains, but this creates a known alignment issue that will need to be closed in another way.	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	4		23-Aug-2017
ES.15 There is a potential risk of inability to create sustainable	Financial modelling of allocation, demographics, tariff changes, business rules, investments, cost pressures, inflation and outturn	Medium Term Financial Strategy Heads of Terms Joint QIPP programme Capped Expenditure Programme	Heads of Terms agreed and signed off and Joint Programme Board established. This Board meets regularly. Significant joint work on capped expenditure taking	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		18-Aug-2017

## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
financial plan	creates an unaffordable financial challenge.		place with revised plans submitted.  However, increasingly divergent financial plans / assumptions between CCG and YTHFT divergent strategies with regards to CEP proposals and Stranded Fixed Costs for 2017/18. Without a formal decision on the CEP schemes this has created increased uncertainty about the main demand management schemes and whilst these have been built into the CCG's current financial plan, YTHFT have removed their impact from their latest submission.						
ES.17 There is a potential risk of failure to deliver a 1% surplus	The scale of the financial challenge for the organisation is such that the CCG will not deliver a 1% surplus in-year or cumulatively in the short term and will likely require a number of years to reach this point.	Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	Heads of Terms agreed and signed off and Joint Programme Board established. This Board meets regularly. Significant joint work on capped expenditure taking place with revised plans submitted.	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		23-Aug-2017
ES.18 There is a potential risk of inability to agree provider contracts	<b>MSK Contract</b> There is no contract in place for the MSK service. The Trust is requesting a significant increase in contract funding over the CCG's assumed contract value to maintain service levels and include the Shared Decision Making (SDM) clinical model. The forecast QIPP savings for planned orthopaedic activity is dependent on the SDM model. In order for the CCG to invest in the SDM model, the Orthopaedic consultants need to commit to delivering 15% savings in planned Orthopaedic activity, currently they are only confident that 5% savings can be achieved. Local prices have not been agreed. <b>TEWV Contract</b> Psychiatric Liaison Service at York FT. The CCG has successfully bid for additional non-recurrent funding for the extension of the Psychiatric Liaison Service, however this will require recruitment of additional staff. In order to progress the initiative implementation of a risk share agreement is required <b>York Contract</b>	Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	All main acute contracts have been agreed and signed off for 2017-19. The main outstanding contract is the YTHFT MSK contract, although work has progressed on this and it is aimed to get this signed in September.  The YTHFT acute contract Heads of Terms are agreed and signed off and Joint Programme Board established. This Board meets regularly. Significant joint work on capped expenditure taking place with revised plans submitted, although the latest financial plans between the CCG and YTHFT are diverging on key assumptions around CEP and Stranded Fixed Costs.  No contract variations have yet been agreed to action QIPP proposals, although there has been significant operational progress.	Liza Smithson	Executive Director Chief Finance Officer	16	5		18-Aug-2017

## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
	There are a number of challenges that may potentially result in an unplanned increase in Contract cost: <ul style="list-style-type: none"> <li>Unbundled Rehab Bed Day Coding: 50% transitional funding arrangement following changes to Rehab bed day coding and counting, additional cost not built into the contract baseline or the CCGs financial plan.</li> <li>Non-Elective increased activity for suspected Assessment Unit activity.</li> <li>The current Contract plan exceeds the affordable value for the CCG.</li> </ul>								
ES.20 There is a potential risk of failure to maintain expenditure within allocation	The scale of the financial challenge for the organisation is such that the CCG will not maintain expenditure within the in-year allocation.	Heads of Terms including Joint QIPP programme Joint Programme Board Capped Expenditure Programme	The CCG's financial plan, including the proposed impact of CEP schemes, delivers the requirement to maintain expenditure within the required control total in 2017-18, but not within the in-year allocation. Should the CEP schemes be successful, the 2018-19 plan is currently to generate an in-year surplus.	Michael Ash-McMahon	Executive Director Chief Finance Officer	16	5		18-Aug-2017
JC.06 Potential non-compliance with CHC national framework	CHC processes and procedures may be non-compliant with the national framework leading to financial, reputational, patient experience and quality and safety risks	CHC transformation programme of work	Data validation and clinical validation of delays in patients awaiting assessment now in place. Exception panels for packages in excess of £700 per week now signed off by new Executive Director. Future focus partnership work with CYC scoped. Weekly reviews with CHC team in place. Contracting and finance CHC team are not yet aligned from PCU.	Paul Howatson	Executive Director Quality and Nursing	16	6		23-Aug-2017
JC.07 PCU staff in transition following restructure	There is a risk that the CCG fails to function effectively due to PCU staff in transition following restructure. Staff redeployment will cause gaps in skills, knowledge and expertise	Agreed actions following internal audit review and paper to Governing Body.	The transition for commissioning and CHC staff took effect from 1/4/2017. Phase 2 staff will TUPE 1st August but the finance and contracting element is likely to form part of a phase 3 approach October 2017 time. Phase 3 consultation due to start September 1st	Jenny Carter; Debbie Winder	Executive Director Quality and Nursing	16	20		17-Aug-2017
JC.09 CHC Retrospective Cases	There is a potential threat of judicial review and appeals relating to recent PUPOC CHC decisions and potential for damage to CCG reputation	External review requested and completed. Restructure underway to enable identification of an appropriate team to address systems, process and risks.	CHC admin team is now aligned to VoY to support clinical team. Phase 3 of PCU consultation during September 2017 will also see finance and contracting to realign to VoY. This will allow further progression of improvement actions. Director of Transformation overseeing CHC improvements now'	Denise Nightingale	Executive Director Transformation and Delivery	16	16		23-Aug-2017


## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
JC.12 There is a risk that the CCG fails to function effectively due to re-alignment of PCU services to CCGs	The risk of realigning PCU to CCGs may negatively impact on the following, Loss of skills crucial to commissioning of service delivery Loss of appropriate specialist commissioning knowledge Risk of damage to CCG reputation Risk of failure to gain assurance regarding financial, quality and performance targets	Local Action Plan under development	Agreement reached regarding redeployment of specified PCU staff into NHS Vale of York CCG structure and risk areas caused by gaps identified. Main risk relates to hosted services by other CCGs and need for SLAs and MOUs to be developed – this is in progress. Further risk relates to the transition of finance and contracting services, IT systems and adopting skills in the CCG. DoF sighted on issues and plan for transition under development.	Michelle Carrington	Executive Director Quality and Nursing	16	16		17-Aug-2017
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	Cost and activity pressures within the system impact on partner abilities to deliver their agreed trajectories.	Continue multi-agency approach to delivery. <b>Strategic</b> Accountable Care System (ACS) arrangements <b>Tactical</b> Locality Delivery Groups <b>Operational</b> City of York Council – Task Group North Yorkshire County Council – Integration and Performance Group Link to individual Health and Wellbeing Boards being considered within ACS reporting / accountability arrangements	The BCF planning requirements document has now been published. There is a single stage assurance process with a submission date of 11th of September requiring HWB approval at that point. Any plans rated as approved but with conditions are to be resubmitted by 31st of October. The planning return template and final list of KLOEs have now been published. Colleagues are working with local authority partners and have agreed the finances and schemes for inclusion, and are now working to develop the narrative for the full submission.	Paul Howatson; Beverley Hunter	Executive Director Joint Commissioning	16	9		17-Aug-2017
JC.17 There is a risk that the provider market does not have capacity or capability to meet the needs of emerging and increasingly complex needs of service users.	There is a need to work jointly with local authority colleagues and locality teams to ensure that the market develops appropriately to meet the needs of the local population.	Executive team to work with STP and local authority colleagues to better understand the local needs and stimulate the market accordingly.	Lack of specific areas of care provision within the local market, leading to delay in transfers of care, have initiated early conversations to progress market stimulation and development and this work now continues. It forms part of a bigger conversation regarding the 'transformed system'.	Paul Howatson; Beverley Hunter	Executive Director Joint Commissioning	16	9		17-Aug-2017
JC.21 Constitution target – Planned Care - VoYCCG failure to meet Cancer 2 week wait target	The % of patients seen within 2 weeks of an urgent GP referral for suspected cancer should equal or exceed 93%. This is a constitution target and failure to meet this target could result in patient safety concerns and financial penalties. Data source is the monthly cancer report supplied by the CSU.	Monitoring YHFT Performance Improvement Plan Majority of 2WW breaches relate to Skin on the East Coast and YHFT have reinstated clinic sessions at Scarborough following the appointment of a Consultant Dermatologist.	Majority of 2WW breaches relate to Skin and lack of outpatient capacity.	Fliss Wood	Executive Director System Resources and Performance	16	8		10-Aug-2017

## Annex B


Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
JC.24 Risk of increased demand on local system following the Inadequate CQC report on The Retreat	Following an inspection prompted by safeguarding alerts raised at The Retreat a number of directly and indirectly funded NHS placements are cared for there and the CCG is establishing how these individuals are affected and are actively seeking assurance that the action plan will deliver the improvements required.	Working with PCU and TEVV to identify number and type of placements. Seeking assurance from The Retreat that the action plan will deliver the required improvements within the timescales.	Remedial action plan now received and regular meetings and assurance visits remain in place. Reduction in bed base of one of the community units is planned but related to underutilisation of the bed base'	Michelle Carrington	Executive Director Quality and Nursing	16	6		23-Aug-2017
JC-PROG.02 IAPT - Failure to achieve sustainable access and recovery targets within acceptable waiting times	Non-delivery of increased mandatory NHSE targets	Engagement with NHSE IST  Regular performance monitoring at formal CMB and Quality and Performance meetings. Provider is aware that failure to achieve will lead to a Performance Improvement Notice. Provider submits regular assurance, action plans and updates to the CCG. NHS England seek further assurance from the CCG on a monthly basis.  Controls include: Programme meeting and TEVV CMB	The Improvement Support Team will be back in September to review TEVV's progress against the new pathways for IAPT  The action plan has been agreed and signed off which should hopefully generate improvements to people wishing to access IAPT in a timely manner as well as clearing the backlog.  A paper on progress has been prepared for F&P in August.	Sheila Fletcher; Paul Howatson; Beverley Hunter	Lead for Unplanned Care and Out of Hospital Services Medical Director	16	9		24-Aug-2017
PLC.05 Constitution target – Planned Care - VoYCCG failure to meet 18 week RTT target	The % of patients on a completed admitted pathway within 18 weeks should equal or exceed 90%. This is a constitution target and failure to meet this target could result in patient safety concerns and financial penalties. The constitution splits this measure into three parts for admitted, non-admitted and incomplete pathways, this internal measure for the risk register is based on admitted adjusted pathways. Data source is the monthly RTT report produced by the CSU.	<input type="checkbox"/> New BMI threshold implemented in January 2017. Anecdotal evidence shows that orthopaedic referrals appear to be down but not evidenced in the performance due to increased backlog, <input type="checkbox"/> The new theatre plan is in place which aims to cut out variation in requests and improved utilisation. Work continues closely with surgical directorates to reduce late starts and to fully utilise the theatre lists.	Workforce pressures due to nursing and medical vacancies and the lack of locum/bank staff to cover during school holidays has impacted on performance.	Fliss Wood	Lead for Unplanned Care and Out of Hospital Services Medical Director	16	12		10-Aug-2017
PrC.PROGRAMM E.05 Estates and Technology Transformation Fund Strategy		Identify Executive leads for Workforce, Premises and Technology strategies to drive this programme forward	ETTF has so far delivered support for only 2 small schemes in Front Street and Posterngate Surgery. The CCG is currently working with NHS England to understand costs and deliverability for 2 further schemes - Carlton Surgery and a potential joint build between South Milford and Sherburn Group. Other bids that were submitted to ETTF, subject to affordability, look unlikely to	Shaun Macey	Executive Director Planning and Governance	16	6		23-Aug-2017

## Annex B

Risk ID & Title	Description of Risk	Mitigating Actions	Latest Update Note	Operational Lead	Lead Director	Current Risk Rating	End of Year Target	Trend	Last Reviewed Date
			attract capital funding from NHS England. The CCG needs to review its estates strategy in the context of the vision around localities and develop prioritised plans (considering affordability) for out of hospital premises - to support the shift of activity from acute to out of hospital settings/services.						
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.	<p>The NHS Vale of York CCG was assigned the lead CCG for Vale of York and Scarborough digital footprint. This programme is mandated by NHS England and is a system-wide enabling piece of work that facilitates transformation of healthcare services. An LDR Steering Group was convened in January to manage this programme of work and engage stakeholders. Meetings of the steering group were suspended in April pending assignment of CCG executive ownership. Assignment of a lead Executive Director and programme support for the programme is still under review.</p> <p>Following discussions at August meetings of the Finance and Performance Committee and the Audit Committee the risk score has been increased to reflect the strategic importance of this programme of work in enabling delivery of a number of other CCG transformational programmes, most importantly the unplanned care system programme. Leadership of the programme and the CCG's capacity to support the programme is being urgently reviewed.</p>	Rachel Potts	Executive Director Planning and Governance	15	9		31-Aug-2017

This page is intentionally blank



<b>Item Number: 7</b>	
<b>Name of Presenter: Tracey Preece</b>	
<b>Meeting of the Governing Body</b> <b>7 September 2017</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Financial Plan 2017-19</b>	
<b>Purpose of Report For Approval</b>	
<b>Reason for Report</b> <p>The attached report provides an update to previous Governing Body presentations to take into account the financial plan submissions that have been made on both the 31<sup>st</sup> March and 12<sup>th</sup> June. The latter of these submissions takes into account the proposed impact of the Capped Expenditure Proposals and is the plan that is currently being used for reporting and monitoring purposes within the CCG and by NHS England nationally.</p>	
<b>Strategic Priority Links</b> <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	
<b>Local Authority Area</b> <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	
<b>Impacts/ Key Risks</b> <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b> 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)**

N/A

**Recommendations**

The Governing Body is asked to approve the proposed plan as submitted on the 12<sup>th</sup> June and the corresponding impact on the relevant expenditures lines as detailed.

**Responsible Executive Director and Title**

Tracey Preece, Chief Finance Officer

**Report Author and Title**

Michael Ash-McMahon, Deputy Chief Finance Officer

# **Financial Plan 2017-19 (31 March submission and 12 June submission)**

**Governing Body  
7<sup>th</sup> September 2017**

# Summary

- The Financial Plan remains rooted in the Medium Term Financial Strategy, approved at Governing Body on 2<sup>nd</sup> March.
- Financial planning assumptions and the development of the plan have been discussed in detail and agreed with NHS England finance colleagues, in Finance & Performance Committee meetings and in Governing Body.
- Two further plan submissions have been made since the 27<sup>th</sup> February, an updated re-submission on the 31<sup>st</sup> March, but still based on the £28.1m forecast outturn deficit, and an additional submission on the 12<sup>th</sup> June.
- The final version of the plan from the 12<sup>th</sup> June is currently being used for reporting and monitoring against both within the CCG and to NHS England. It is based on the £23.8m final reported 2016/17 outturn deficit, the associated underlying position and the first phase of the Capped Expenditure Proposals that close the control total gap. The financial plan is not yet fully aligned with that of York FT and there remain differences in specific planning assumptions which are being reported as risks.

# Summary – Headline Figures

- The year-end position for 2016/17 was a deficit of £23.8m following the release of the 1% risk reserve.
- The associated underlying recurrent deficit position of £21.9m along with the following increases have then been applied to this:

	2017/18	2018/19
Net inflation	£5.1m	£5.2m
Growth	£6.3m	£8.2m
Other recurrent cost pressures	£2.1m	£1.9m
<b>Total</b>	<b>£13.5m</b>	<b>£15.3m</b>
Allocation growth	£8.7m	£9.2m







- The total savings requirement is as follows:

	2017/18		2018/19	
QIPP	£14.4m	3.2%	£13.7m	3.2%
CEP	£7.8m	1.7%	-	-
<b>Total</b>	<b>£22.2m</b>	<b>4.9%</b>	<b>£13.7m</b>	<b>3.2%</b>

- This results in the following planned year-end financial positions:

	2017/18		2018/19	
	31 March submission	12 June submission	31 March submission	12 June submission
In-year Surplus / (Deficit)	(£16.0m)	(£6.3m)	(£9.8m)	£2.9m
Cumulative Surplus / (Deficit)	(£44.1m)	(£30.1m)	(£53.9m)	(£27.2m)

# Summary – Key Metrics

	2016/17	2017/18		2018/19		2019/20	2020/21
	12 June submission	31 March submission	12 June submission	31 March submission	12 June submission	CCG plan	CCG plan
Cumulative Surplus / (Deficit)	(£23.8m)	(£44.1m)	(£30.1m)	(£53.9m)	(£27.2m)	(£15.2m)	£14.4m
In year Allocation		£449.7m		£458.8m		£470.9m	£487.9m
In year Surplus / (Deficit)	(£17.5m)	(£16.0m)	(£6.3m)	(£9.8m)	£2.9m	£12.0m	£29.6m
Improvement of in-year position		£5.7m	£11.2m	£6.2m	£9.2m	£9.1m	£19.6m
% of allocation improvement		1.3%	2.5%	1.4%	2.0%	2.0%	3.6%
1% of allocation – required Improvement		£4.5m		£4.6m		£4.7m	£4.9m
Business Rule for 1% of allocation improvement for Deficit CCG met							
Savings target		£14.4m	£22.2m	£13.7m	£17.5m	£15.4m	£14.4m
Savings % (on recurrent in-year allocation per NHSE model)		3.2%	4.9%	3.0%	3.8%	3.3%	3.0%

# Expenditure Plan

	2016/17 Outturn	2017/18 Plan		2018/19 Plan		2019/20 Plan	2020/21 Plan
		31 March submission	12 June submission	31 March submission	12 June submission	12 June submission	12 June submission
YTHFT	£191.3m	£185.3m	£181.1m	£180.6m	£174.7m	£180.2m	£185.6m
Other Acute Commissioning	£49.4m	£45.4m	£42.3m	£47.3m	£42.5m	£46.4m	£47.5m
Mental Health Services	£44.2m	£44.5m	£44.4m	£44.4m	£43.9m	£44.3m	£44.9m
Community Services	£29.1m	£29.9m	£30.1m	£31.4m	£32.1m	£32.2m	£32.6m
Continuing Care	£26.0m	£26.8m	£25.9m	£26.9m	£26.2m	£28.8m	£32.6m
Funded Nursing Care	£4.8m	£5.0m	£5.0m	£5.2m	£5.2m	£5.4m	£5.6m
Other Commissioning	£23.7m	£28.9m	£28.0m	£31.3m	£30.8m	£33.0m	£33.0m
Primary Care Prescribing	£49.2m	£50.9m	£50.2m	£51.5m	£50.8m	£52.9m	£55.2m
Primary Care	£40.0m	£41.8m	£41.8m	£42.9m	£43.0m	£44.0m	£45.0m
Running Costs	£7.2m	£7.3m	£7.2m	£7.0m	£6.9m	£6.9m	£6.9m
Unallocated QIPP	-	-	-	-	-	<b>(£15.4m)</b>	<b>(£29.8m)</b>
Total Expenditure	£464.9m	£465.7m	£456.0m	£468.6m	£455.9m	£458.9m	£458.3m
<b>Allocation</b>	<b>£441.1m</b>	<b>£449.7m</b>		<b>£458.8m</b>		<b>£470.9m</b>	<b>£487.9m</b>
<b>Surplus / (Deficit)</b>	<b>(£23.8m)</b>	Page 51 of 358 <b>(£16.0m)</b> <b>(£6.3m)</b>		<b>(£9.8m)</b>	<b>£2.9m</b>	<b>£12.0m</b>	<b>£29.6m</b>

# Business Rules performance

	2017/18	2018/19
• CCGs should plan for in-year break-even		
• CCGs should plan to spend 1% of allocation as non-recurrent expenditure		
• Deficit CCG to delivery a in-year breakeven position or deliver 1% of allocation improvement		
• 0.5% of non-recurrent expenditure should be uncommitted as a risk reserve		
• CCGs should plan for 0.5% Contingency		



# Inflation and growth

- Inflation accounts for £5.1m of the overall £13.5m inflation and growth in 2017/18.
- Inflation has been applied in line with national tariff inflation . With the exception of Continuing Care and Primary Care where PCU levels and nationally assumed primary care levels have been used.
- The growth levels that account for £6.3m are based on STP assumptions for growth levels, with the exceptions of Continuing Care and Primary Care where PCU levels and population growth have been used.
- An extensive process of challenge and review took place between NHS England and the CCG on the STP and PCU growth assumptions.

Summary information on key programme expenditure areas on the following pages represent the 12 June submission.

# YTHFT - Acute

	£m
<b>2016/17 Outturn</b>	<b>191.3</b>
Underlying position	191.0
FYE of QIPP and Investments	(0.6)
Inflation	1.2
Growth	4.5
Cost pressures and adjustments	(1.2)
<b>2017/18 plan (before QIPP)</b>	<b>195.0</b>
QIPP target	(9.7)
<b>2017/18 plan (before CEP)</b>	<b>185.2</b>
CEP target	(4.1)
<b>2017/18 plan</b>	<b>181.1</b>

# Other Acute commissioning (NHS)

	£m
<b>2016/17 Outturn</b>	<b>31.9</b>
Underlying position	31.9
FYE of QIPP and Investments	-
Inflation	0.1
Growth	0.5
Cost pressures and adjustments	(2.1)
<b>2017/18 plan (before QIPP)</b>	<b>30.4</b>
QIPP target	(0.4)
<b>2017/18 plan (before CEP)</b>	<b>30.0</b>
CEP target	0.0
<b>2017/18 plan</b>	<b>30.0</b>

# Other Acute commissioning (ISTC)

	£m
<b>2016/17 Outturn</b>	<b>12.0</b>
Underlying position	12.0
FYE of QIPP and Investments	-
Inflation	-
Growth	0.3
Cost pressures and adjustments	(1.1)
<b>2017/18 plan (before QIPP)</b>	<b>11.3</b>
QIPP target	(0.6)
<b>2017/18 plan (before CEP)</b>	<b>10.7</b>
CEP target	(3.3)
<b>2017/18 plan</b>	<b>7.4</b>

# Mental Health

	£m
<b>2016/17 Outturn</b>	<b>44.2</b>
Underlying position	44.1
FYE of QIPP and Investments	0.5
Inflation	0.2
Growth	0.1
Cost pressures and adjustments	-
<b>2017/18 plan (before QIPP)</b>	<b>44.9</b>
QIPP target	(0.3)
<b>2017/18 plan (before CEP)</b>	<b>44.6</b>
CEP target	(0.2)
<b>2017/18 plan</b>	<b>44.4</b>

# Community Services

	£m
<b>2016/17 Outturn</b>	<b>27.5</b>
Underlying position	27.7
FYE of QIPP and Investments	0.1
Inflation	0.1
Growth	-
Cost pressures and adjustments	0.2
<b>2017/18 plan (before QIPP)</b>	<b>28.1</b>
QIPP target	(0.7)
<b>2017/18 plan (before CEP)</b>	<b>27.4</b>
CEP target	-
<b>2017/18 plan</b>	<b>27.4</b>

# YTHFT - MSK

	£m
<b>2016/17 Outturn</b>	<b>1.6</b>
Underlying position	2.2
FYE of QIPP and Investments	-
Inflation	-
Growth	0.1
Cost pressures and adjustments	-
<b>2017/18 plan (before QIPP)</b>	<b>2.3</b>
QIPP target	0.5
<b>2017/18 plan (before CEP)</b>	<b>2.8</b>
CEP target	-
<b>2017/18 plan</b>	<b>2.8</b>

# CHC and FNC

	£m
<b>2016/17 Outturn</b>	<b>30.8</b>
Underlying position	30.3
FYE of QIPP and Investments	-
Inflation	1.2
Growth	1.5
Cost pressures and adjustments	-
<b>2017/18 plan (before QIPP)</b>	<b>33.0</b>
QIPP target	(2.0)
<b>2017/18 plan (before CEP)</b>	<b>31.0</b>
CEP target	-
<b>2017/18 plan</b>	<b>31.0</b>



# Primary Care Co-Commissioning

	£m
<b>2016/17 Outturn</b>	<b>40.0</b>
Underlying position	40.8
FYE of QIPP and Investments	-
Inflation	0.7
Growth	0.2
Cost pressures and adjustments	-
<b>2017/18 plan (before QIPP)</b>	<b>41.8</b>
QIPP target	-
<b>2017/18 plan (before CEP)</b>	<b>41.8</b>
CEP target	-
<b>2017/18 plan</b>	<b>41.8</b>

# Prescribing

	£m
<b>2016/17 Outturn</b>	<b>49.2</b>
Underlying position	49.4
FYE of QIPP and Investments	(0.1)
Inflation	1.3
Growth	1.4
Cost pressures and adjustments	-
<b>2017/18 plan (before QIPP)</b>	<b>51.9</b>
QIPP target	(1.6)
<b>2017/18 plan (before CEP)</b>	<b>50.3</b>
CEP target	(0.1)
<b>2017/18 plan</b>	<b>50.2</b>

# Running Costs

	£m
<b>2016/17 Outturn</b>	<b>7.2</b>
Underlying position	7.4
FYE of QIPP and Investments	-
Inflation	-
Growth	-
Cost pressures and adjustments	0.1
<b>2017/18 plan (before QIPP)</b>	<b>7.5</b>
QIPP target	(0.3)
<b>2017/18 plan (before CEP)</b>	<b>7.2</b>
CEP target	(0.1)
<b>2017/18 plan</b>	<b>7.1</b>

# Savings Plans

QIPP Workstream	2016/17 FYE	2017/18 Plan	2018/19 Plan
Planned Care	£3.2m	£3.6m	£5.0m
Unplanned Care	-	£2.6m	£4.3m
Primary Care	-	£0.1m	£0.1m
Prescribing	£0.3m	£1.3m	£1.6m
MH, LD and Complex Care	£0.9m	£1.9m	£3.0m
Back Office	-	£0.4m	£0.3m
<b>Total</b>	<b>£4.5m</b>	<b>£9.9m</b>	<b>£14.3m</b>

£14.4m

Plus:


CEP	2017/18 Plan
Demand Management	£6.3m
Incorporate fast track into existing palliative service	£0.1m
MH Out of Contract spend	£0.2m
CCG structures and running costs	£0.1m
Decommission non-core services	£0.2m
Non-delivery of 0.5% CQUIN	£0.9m
<b>Total</b>	<b>£7.8m</b>

= Total £22.2m

# Risks

- **Activity based risks** – acute contracts operate on a Payment by Results basis with activity confirmed 2 months in arrears. The CCG is in discussions with YTHFT regarding alternative funding mechanisms and risk share arrangements for specific contract areas for 2017/18. CHC, prescribing and community equipment are also activity driven and therefore inherently more risky for the CCG.
- **Plan alignment** – financial and operational plans in the CCG are based on STP & national planning assumptions but there remains a difference in assumptions between the CCG and YTHFT financial plans which could create a pressure for the CCG. These relate to the expected level of growth which will create an activity based cost pressure if it materialises, the cost of rehab bed days and the reinvestment of stranded fixed costs for the existing QIPP plans.
- **Capped Expenditure Process schemes** – there is significant risk of non-delivery of the two main demand management related schemes within the CEP plan.
- **QIPP** – there is considerable risk to the delivery of the QIPP plan in particular schemes, mainly CHC and unplanned care. The risk relates primarily to the requirement to deliver schemes at pace and the resources this therefore demands. The CCG is accessing additional support from the national QIPP support programme which does mitigate this to a degree.
- **Issues carried forward from 2016/17** – there remain a small number of issues that relate to 2016/17 that will have an impact on the financial position. The contract position with YTHFT is not finalised and the query process within the contract is being followed for this. There is also a continuing case regarding a dispute on the correct responsible commissioner which is likely to resolve in 2017/18.
- **Running costs** – increasing the capability and capacity of the CCG has resulted in a fully committed running cost allocation and is managed closely by the Executive Committee.

This page is intentionally blank

<b>Item Number: 8</b>	
<b>Name of Presenter: Tracey Preece</b>	
<b>Meeting of the Governing Body</b> 7 September 2017	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Financial Performance Report Month 4</b>	
<b>Purpose of Report For Information</b>	
<b>Reason for Report</b>  To brief members on the financial performance of the CCG and achievement of key financial duties for 2017/18 as at the end of July 2017.  To provide details and assurance around the actions being taken.	
<b>Strategic Priority Links</b>  <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	
<b>Local Authority Area</b>  <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	
<b>Impacts/ Key Risks</b>  <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b> 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:

- Various trading positions that vary to plan and / or the reported forecast outturn.
- The CCG has received notification from NHSE that it has not been successful in its arbitration with Warrington CCG as to the responsibility for a patient transferred into their area having previously been in this area, although the estimated cost of around £250k will be risk shared with the other North Yorkshire CCGs. Finally, further work needs to be done to understand the Transforming Care Programme impact within Complex Care.

### **Recommendations**

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

<b>Responsible Executive Director and Title</b>	<b>Report Author and Title</b>
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
- Appendix 3– Updated forecast outturn



# NHS Vale of York Clinical Commissioning Group Financial Performance Report

Report produced: August 2017

Financial Period: April 2017 to July 2017

## Summary of Key Financial Statutory Duties

Duty	Year to Date				Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
In-year running costs expenditure does not exceed running costs allocation					7,548	7,187	361	G→
In-year total expenditure does not exceed total allocation (Programme and Running costs)					452,363	458,708	(6,345)	R→
Better Payment Practice Code (Value)	95.00%	99.58%	4.58%	G	95.00%	>95%	0.00%	G
Better Payment Practice Code (Number)	95.00%	98.68%	3.68%	G	95.00%	>95%	0.00%	G
Cash balance at month end is within 1.25% of monthly drawdown	491	213	278	G				
CCG cash drawdown does not exceed maximum cash drawdown					458,708	458,708	0	G

## Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	2,395	2,325	70	G↑	7,187	7,187	0	G→
Programme spend within plan	152,832	152,622	210	G↓	451,521	451,521	0	G→
Actual position is within plan (In-year)	(2,115)	(1,835)	280	G↑	(6,345)	(6,345)	0	G→
Actual position is within plan (Cumulative)					(30,104)	(30,104)	0	G→
Risk adjusted deficit					(6,345)	(19,446)	(13,101)	R→
QIPP delivery (see section 9)	3,558	2,887	(671)	R↓	14,396	14,396	0	G→

The full finance dashboard is presented in Appendix 1

## Key Messages

- **The CCG is operating under legal Directions issued by the NHS Commissioning Board (NHS England) effective from 1st September 2016.**
- The CCG is reporting against the financial plan submitted to NHS England on 12th June, which includes the estimated impact of the Capped Expenditure (CEP) plans to close the control total gap. Whilst the CCG has not received formal approval of these proposals, it is this plan that is being used by NHS England as part of their national reporting and monitoring processes. The Capped Expenditure plans equate to a £9.73m improvement on the original CCG plan moving the planned in-year deficit from £16.05m to £6.35m.
- Further work was undertaken on the activity impact of these plans and to close the remaining system gap for submission on the 16th June. All of these proposals remain subject to NHS England and NHS Improvement approval.
- The plan is based on a brought forward deficit of £23.75m and an in-year deficit of £6.35m in 2017-18, resulting in a cumulative deficit of £30.10m at the end of the financial year. The

plan at Month 4 was for a deficit of £2.12m; however the actual deficit is £1.85m, which is £280k better than planned.

- The current financial plan includes a QIPP requirement of £14.40m and further savings from CEP of £7.84m (the balance to the £9.73m total CEP plan is from an improvement in the 2016-17 underlying position of £1.89m). The identified QIPP schemes have been allocated across the programme delivery work streams. The planned care and unplanned care delivery groups are working jointly with YTHFT to ensure that schemes are developed collaboratively as outlined in the YTHFT contract Heads of Terms. QIPP delivery year to date is £2.89m, £671k away from plan, although this includes £2.0m estimation for those schemes where it has not yet been possible to quantify the savings. The majority of the CEP savings are profiled with effect from August 2017. Against the full year target the CCG has delivered £2.57m of savings, which is c£830k more than was achieved in 2016-17.
- The CCG has delivered all of its Financial Statutory Duties for the year to date.

### 1. Red / Amber financial statutory duties and measures

- *'In-year total expenditure does not exceed total allocation'* – forecast expenditure is £6.35m higher than the CCG's in-year allocation.
- *'Risk adjusted deficit'* – £13.10m of net unmitigated risk has been identified. This includes £7.12m in relation to non-delivery of the two main demand management CEP schemes and £2.71m of QIPP delivery risk.
- *'QIPP delivery'* – year to date QIPP delivery is 81.1% of plan which equates to £671k under delivery.

### 2. Key actions

- The latest financial plan and how it has been constructed will be presented to the Governing Body for review and consideration on the 7<sup>th</sup> September.
- QIPP monitoring arrangements continue to be reviewed. Having reduced the level of estimation from 78% at Month 3 to 70% at Month 4 it is hoped to further improve on this in the next month.
- Gaps remain within the programme work stream structures and the CCG is expediting the support requirements with North East Commissioning Support. Additional support is being received from the national QIPP initiative which is expected to help delivery of the QIPP programme, but the risk of delivering the plan to time and achieving the planned savings remains high.

### 3. Reported year to date financial position

Description	Value	Commentary / Actions
Contingency	£0.75m	0.5% contingency provided for in plan.
Primary Care Prescribing	£0.48m	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.
Prior Year Balances	(£0.40m)	Payments relating to 2016/17 where estimates were made at year end. The majority of this relates to the final positions with acute providers where the CCG had not agreed a year-end position and the

NHS Vale of York Clinical Commissioning Group  
Financial Performance Report

		Prescribing outturn. The only year-end position remaining is with YTHFT with whom discussions are on-going.
Out of Contract Placements and Specialist Rehabilitation and Brain Injury	(£0.32m)	Increased trading costs in both Out of Contract and SRBI placements.
York Teaching Hospital NHS Foundation Trust	(£0.29m)	Year to date Trauma and Orthopaedic planned activity is £110k above plan offset by underspends on the Ramsay contract.
York Teaching Hospital NHS Foundation Trust - MSK	£0.26m	Contract is currently under trading due to lower levels of activity and vacancies.
Ramsay and Nuffield Health	£0.20m	Ramsay is currently undertrading by £263k however this is offset by an overtrade by Nuffield of £62k.
Other acute contracts	(£0.18m)	Overspends on Hull and East Yorkshire Hospitals NHS Trust (£71k), Mid Yorkshire Hospitals NHS Trust (£71k), Harrogate and District NHS Foundation Trust (£44k) and South Tees NHS Foundation Trust (£37k) offset by an underspend on Leeds Teaching Hospitals NHS Trust (£44k).
Other Prescribing	(£0.18m)	Increased costs on Online Non Prescription Ordering Service offset by an underspend on Primary Care Prescribing
Funded Nursing Care	£0.17m	Funded Nursing Care is currently underspent by £174k which is offset by an overspend in Continuing Healthcare of £106k.
Running costs	£0.07m	Small improvement in year to date position explained further in the running costs dashboard in Appendix 2.
Other variances	(£0.28m)	
<b>Total impact on forecast position</b>	<b>£0.28m</b>	

#### 4. Forecast outturn

The forecast outturn as reported in the ledger remains consistent with Month 3 and delivers the £6.35m in-year deficit. The variances to budget shown in Appendix 1 are as a result of a detailed review of QIPP which led to revised QIPP forecasts on each budget line, offset by an unidentified QIPP figure of £3.65m.

A further review of forecast outturn has been undertaken this month in order to highlight the emerging expenditure trends if the forecasting methodology was applied to the year to date spend and therefore excluding the impact of QIPP schemes that have not yet started, but are due to be implemented (Appendix 3). This presents the CCG and the Committee with additional assurance about the reported trading position, but also a decision as to whether to not to include these in the reported outturn and when. In overall terms the revised forecast is showing £6.16m worse, which largely relates to the way QIPP is forecast and reported as risk. This and the other key variances and the reasons for them are as follows:

NHS Vale of York Clinical Commissioning Group  
Financial Performance Report

Description	Value	Reason
York Teaching Hospital NHS Foundation Trust	(£3.40m)	QIPP schemes forecast to deliver later in the year (£2.8m) plus additional saving (£863k) from re-costed CEP 1 scheme after 12 <sup>th</sup> June submission.
Other acute contracts	(£0.60m)	Overtrading positions
Independent sector	£0.42m	Undertrading positions
York Teaching Hospitals NHS Foundation Trust - Community	(£0.20m)	QIPP scheme forecast to deliver later in the year (£200k)
York Teaching Hospital NHS Foundation Trust - MSK	£0.88m	QIPP scheme investment to deliver later in the year (£500k) plus under trading position (£379k)
Other Community	(£0.29m)	Wheelchairs overtrade until VAT recovery confirmed (£110k), Community Equipment overtrade (£450k) off-set by an underspend against plan with Health Navigator (£356k)
CHC and FNC	£0.51m	Overtrading position on CHC (£191k) and undertrading position on FNC (£697k)
Prescribing	£0.29m	Undertrading position on Primary Care Prescribing (£1.02m) and overtrading position on Other Prescribing (£729k) partly in relation to the ONPOS change described earlier in this report.
Unallocated QIPP	(£3.65m)	QIPP delivery risk described in risk and mitigations before any stranded fixed cost adjustment
<b>Total impact on YTD position</b>	<b>(£6.04m)</b>	

The majority of this difference is accounted for through how QIPP is forecast to come in over the remainder of the year, with a net £2.5m not built into the year to date trading position (£3m of QIPP less £500k investment). The remaining £3.7m difference is the QIPP risk, described and adjusted for stranded fixed costs in the risk section below. This means that the remaining variances from trading positions off-set each other and could be built into the forecast from Month 5 onwards without impacting the overall deficit position.

## 5. Allocations

The following table shows changes to allocation in month 4.

Description	Recurrent/ Non-recurrent	Category	Value
Allocation brought forward			£428.48m
Acute hospital urgent and emergency liaison mental health services	Non-recurrent	Programme	£0.12m
<b>Total allocation at Month 4</b>			<b>£428.60m</b>

The CCG has received a further £124k in Month 4 for acute hospital urgent and emergency liaison mental health services, in addition to the £125k received in Month 3. It is expected that the CCG will received £500k in total in 2017/18 for this service.

## 6. Risks and mitigations and key delivery challenges

The following risks and mitigations to delivery of the CCG's financial plan are identified as at July month end. This includes the additional risks identified as part of the Capped Expenditure process including the system alignment risk, where the CCG's anticipated expenditure with YTHFT does not reflect the Trust's anticipated income. It also includes the non-delivery of the two main demand management Capped Expenditure schemes and the potential impact of QIPP slippage, based on the recent confirm and challenge session, net of any stranded fixed cost adjustment.

At the time of the Month 4 non-ISFE submission to NHS England the CCG was reporting an unmitigated risk of £15.36m and a net mitigated risk of £13.11m.

### Risks

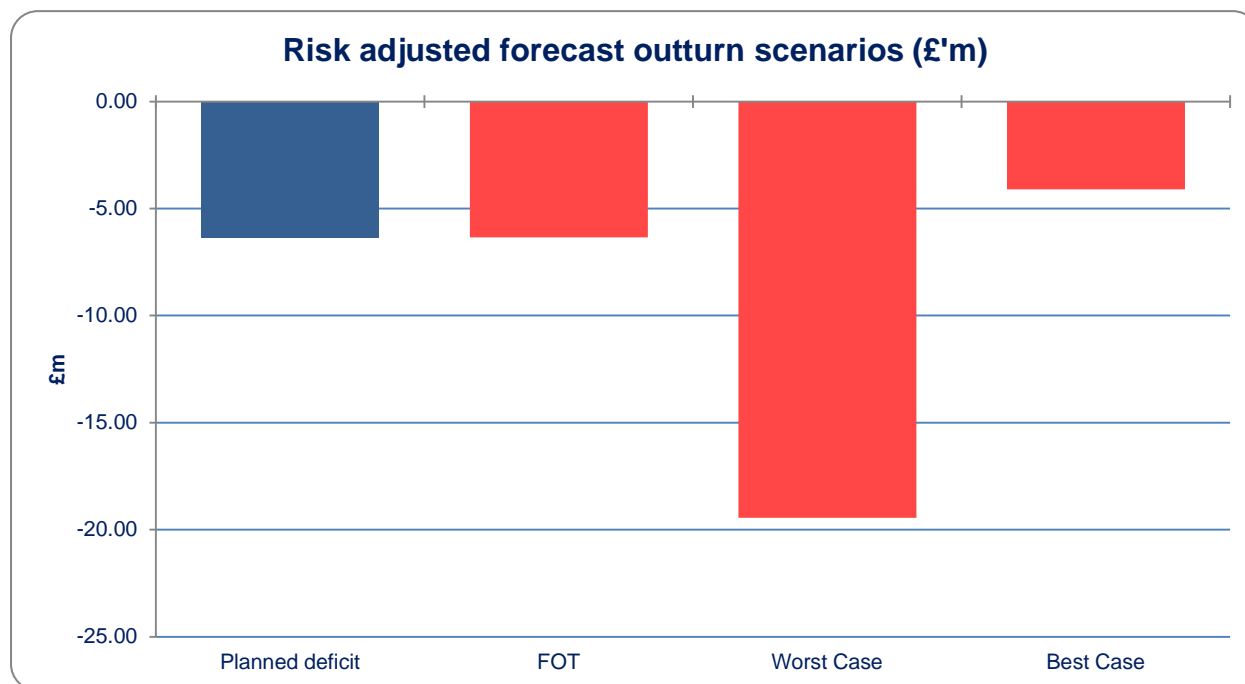
Description	Expected Value	Commentary
Acute SLAs	£5.53m	Plan alignment risk with YTHFT including rehab bed days and reinvestment of stranded fixed costs
Capped expenditure schemes	£7.12m	Non-delivery of two main demand management schemes
QIPP under-delivery	£2.71m	Risk against delivery of £14.4m QIPP, less reduced reinvestment of stranded fixed costs
<b>Total</b>	<b>£15.36m</b>	

### Mitigations and contingencies

Description	Expected Value	Commentary
Contingency	£2.25m	0.5% contingency provided for in plan
<b>Total</b>	<b>£2.25m</b>	

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 4
- 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 month on month 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.

It is important to recognise that within the risks articulated there are a number of further delivery challenges:

- There is risk on our capacity to deliver the number of QIPP and CEP schemes at speed and around the value that the schemes will deliver in year although the CCG is developing a potential joint PMO function with YTHFT to help support some of this.
- There remain gaps within the programme work stream structures and the CCG is expediting the support requirements with North East Commissioning Support in discussions within NHSE. Additional support is being received from the national QIPP initiative which it is expected will help delivery of the QIPP programme, but risk of delivering the plan to time, and achieving the planned savings, is high.
- The CEP plans are largely focused on planned care, and are dependent upon restrictions on capacity and choice to significantly reduce spend in year. These will have an impact on waiting times, and an expanding cohort of patients who need to be managed safely. The CCG actions on managing demand (over current QIPP plans) will be slower to action, and will also take time to work through the system, and will only deliver a fraction of the reductions in spend without restrictions on capacity.



- Consultation will be required on some of the schemes and this makes it a longer process to implement these initiatives.
- A key challenge to delivery of scheme development is clinical capacity (CCG and provider) to support the proposed changes in pathways and referral support. Unplanned care schemes require increased system working and although there is now an agreed and approved PID by the ACS partnership board, there is an increased complexity involved in delivering the associated work streams which align to the three locality plans as well as delivering the contractual requirements. The Executive Programme Board is agreeing the governance and resources to align the ACS Partnership Board with the Executive Programme Board which has responsibility for system financial recovery and all existing CIP and QIPP.
- Engagement with YTHFT as the main acute provider is improved, but is still impacted by capacity to support the range of initiatives, and appropriate governance and programme management to deliver the change. There are still issues around GP practices working across practice boundaries to support schemes, which could delay implementation.

There are a number of emerging risks that have been highlighted as part of the reporting process, but have not been built into the trading positions or risk and mitigations. Firstly, the underlying trading positions identified in section 4 above. The CCG has also received notification from NHSE that it has not been successful in its arbitration with Warrington CCG as to the responsibility for a patient transferred into their area having previously been in this area although the estimated cost of around £250k will be risk shared with the other North Yorkshire CCGs. Finally, further work needs to be done to understand the Transforming Care Programme impact within Complex Care.

## 7. Underlying Position

The underlying position reported at Month 4 is detailed below.

Description	Value
<b>Deficit at month 4</b>	<b>(£6.35m)</b>
Adjust for non-recurrent items in plan -	
IR rules and HRG4+ allocation	£2.16m
IR rules and HRG4+ expenditure	(£2.02m)
Repayment of system support	£0.33m
Familial Hypercholesterolemia business case	£0.03m
1% headroom	£2.01m
Non recurrent QIPP (BMI & Smoking)	(£3.00m)
Non recurrent capped expenditure schemes	(£0.90m)
<b>Underlying financial position</b>	<b>(£7.74m)</b>

## 8. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31<sup>st</sup> July 2017 and all key metrics (see page 1) are green.

## 9. QIPP programme and Capped Expenditure Process schemes

### 9a. 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	
<b>PLANNED CARE</b>							
Anti-Coagulation service	194	Apr-17	63	0	259	108	
Cataract Thresholds	161	Apr-17	100	0	300	150	
Faecal Calprotectin	PC4	Oct-16	35	35	53	53	
Biosimilar high cost drugs gain share	016	Apr-17	146	68	318	201	
Remove SpR block from contract	168	Apr-17	317	317	952	952	In contract, delivery on track
Commissioning for Value (PNRC)	006	Apr-17	50	0	150	75	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	1,000	1,000	3,000	3,000	
RightCare - Circulation (Heart Disease)	008	Oct-17	0	0	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	0	0	750	750	
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	0	0	1,000	500	
<b>UNPLANNED CARE</b>							
Community Podiatry	IC4	May-17	107	107	393	393	In contract, delivery on track
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	140	117	421	352	In contract and delivering but at lower level than in financial plan
Wheelchairs service re-procurement	207	Apr-17	109	109	217	217	In contract, delivery on track
Community Equipment service re-procurement	187	Apr-17	209	51	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	92	0	824	275	
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	252	252	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	0	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



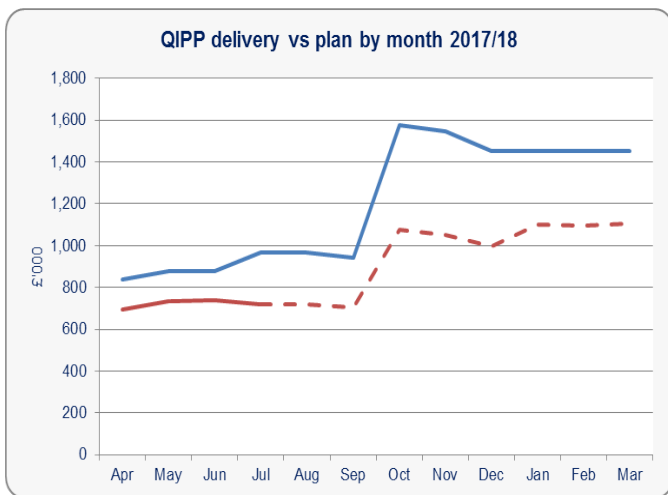
## NHS Vale of York Clinical Commissioning Group Financial Performance Report

Scheme Name	Ref	Planned start date	Year to Date		Forecast Outturn		Comments
			Planned savings £000	Actual savings £000	Planned savings £000	Actual savings £000	
<b>PRIMARY CARE</b>							
Dermatology Indicative Budgets	195	Apr-17	36	36	36	36	
GP IT - NYNET	003	May-17	50	50	183	183	
Roll out indicative budgets to other specialities	020	Jul-17	8	0	75	0	
<b>PRESCRIBING</b>							
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	92	92	277	277	
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	43	43	128	128	
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	35	35	106	106	
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	0	0	75	75	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	25	25	75	75	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	300	300	900	900	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	199	Oct-17	0	0	53	53	
<b>COMPLEX CARE</b>							
Continence Supplies	C1	Apr-17	19	19	23	23	
CHC review 1 to 1 care packages	024a	Apr-17	56	56	98	98	
CHC review: Short Breaks	024b	Apr-17	29	29	51	51	
CHC review panel decisions (jointly funded packages of care)	024c	Apr-17	47	47	83	83	
Complex Care - CHC and FNC benchmarking	024d	Oct-17	0	0	1,550	0	
Recommission MH out of contract expenditure	025	Apr-17	100	0	300	200	
<b>BACK OFFICE</b>							
Commissioning support (eMBED) contract savings	004	Apr-17	69	69	207	207	In contract, delivery on track
Vacancy control	027	Apr-17	18	18	54	54	
<b>Total identified QIPP</b>			<b>3,558</b>	<b>2,887</b>	<b>14,396</b>	<b>10,745</b>	
Unidentified QIPP			0	0	0	3,651	
<b>Total QIPP requirement</b>			<b>3,558</b>	<b>2,887</b>	<b>14,396</b>	<b>14,396</b>	

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

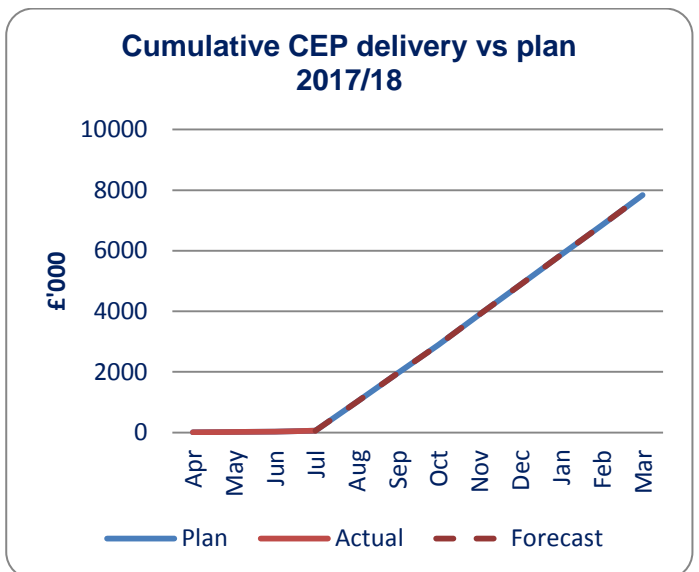
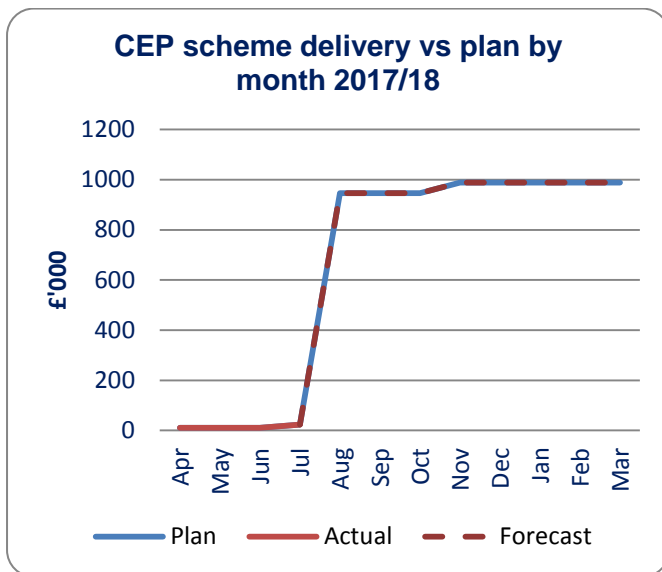
Note that figures highlighted in purple are those where the QIPP scheme is in place and known to be delivering but the savings cannot yet be quantified due to the timing of the information to report the actual position.

9b. QIPP delivery graphs



9c. Capped Expenditure Process Schemes

Capped Expenditure Process schemes totalling £7.84m have been identified. The majority of these are expected to start from August 2017 onwards, with the YTD position including just £44k of savings in relation to CEP schemes. The graphs below show the expected phasing of the CEP schemes.

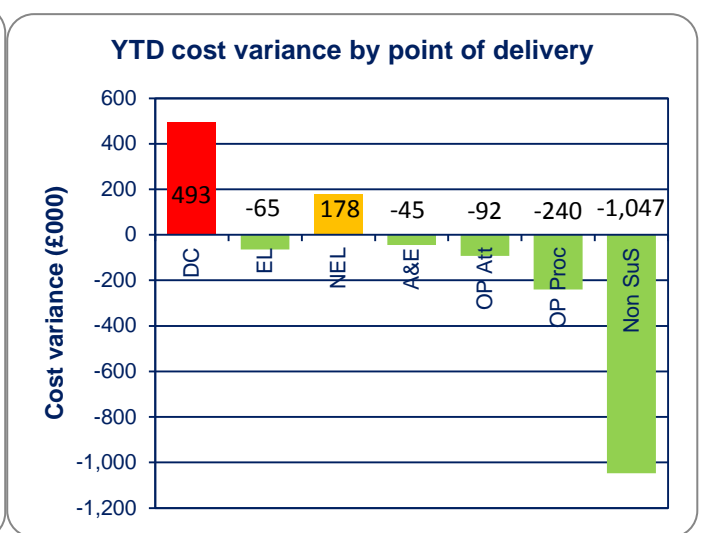
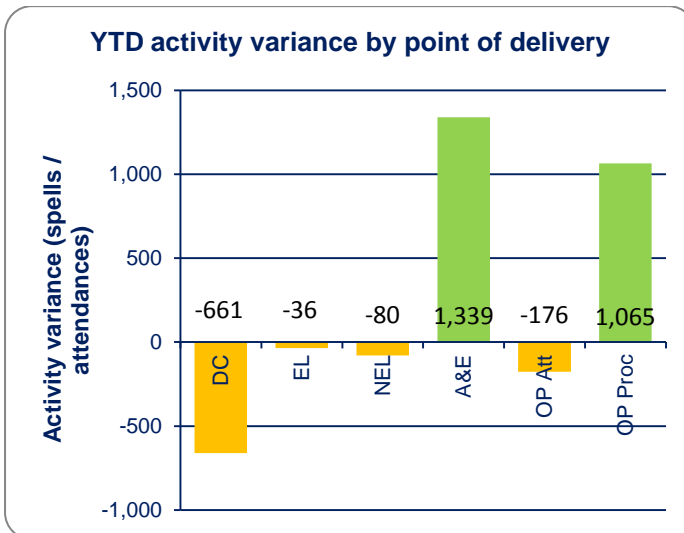


10. Secondary Care Activity

10a. York Teaching Hospital NHS Foundation Trust

The two graphs below show YTD activity and cost variance against plan by point of delivery (POD) with the CCG's main acute provider, York Teaching Hospital NHS Foundation Trust.

Variations are shown as red when they are 10% or more above plan, amber where 5-10% above plan and green where less than 5% above plan or below plan. Year to date covers April to June data in line with acute activity data submissions.



Notes – May data is freeze, June is flex and may change when final freeze data is submitted. The cost graph excludes contract adjustments such as readmissions and marginal rate adjustments, penalties and CQUIN.

Daycase activity is 9% above plan which equates to an overspend of £493k. A&E attendance and outpatient procedures are both below plan at 8% and 10% respectively with corresponding underspends of £45k and £240k.

#### 10b. Other secondary care providers

Overall in balance in the April to July financial position. Overspends with Hull & East Yorkshire (£71k), Nuffield Health (£62k), Mid Yorkshire Hospitals (£71k) and Harrogate (£44k) are offset by underspends with Ramsay (£263k) and Leeds Teaching Hospitals (£44k).

NHS Vale of York Clinical Commissioning Group  
Financial Performance Report

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
<b>Commissioned Services</b>																		
<b>Acute Services</b>																		
York Teaching Hospital NHS FT	62,530	62,823	(293)	47,337	47,430	(93)	15,193	15,394	(201)	181,122	183,232	(2,110)	181,122	183,232	(2,110)	0	0	0
Yorkshire Ambulance Service NHS Trust	4,299	4,299	0	3,224	3,192	32	1,075	1,107	(32)	12,897	12,897	0	12,897	12,897	0	0	0	0
Leeds Teaching Hospitals NHS Trust	2,748	2,703	44	2,061	1,959	102	687	744	(58)	8,243	8,245	(1)	8,243	8,245	(1)	0	0	0
Hull and East Yorkshire Hospitals NHS Trust	995	1,065	(71)	738	825	(87)	257	240	16	2,994	2,994	0	2,994	2,994	0	0	0	0
Harrogate and District NHS FT	617	661	(44)	463	471	(8)	154	190	(36)	1,851	1,851	0	1,851	1,851	0	0	0	0
Mid Yorkshire Hospitals NHS Trust	702	773	(71)	524	654	(130)	177	118	59	2,096	2,096	0	2,096	2,096	0	0	0	0
South Tees NHS FT	421	459	(37)	316	297	20	105	162	(57)	1,264	1,265	(1)	1,264	1,265	(1)	0	0	0
North Lincolnshire & Goole Hospitals NHS Trust	189	192	(3)	142	140	2	47	52	(5)	567	567	0	567	567	0	0	0	0
Sheffield Teaching Hospitals NHS FT	72	72	0	54	54	0	18	18	0	215	215	0	215	215	0	0	0	0
Non-Contracted Activity	1,304	1,304	(0)	978	978	(0)	326	326	(0)	3,912	3,912	0	3,912	3,912	0	0	0	0
Other Acute Commissioning	308	281	27	231	233	(2)	77	48	29	923	923	0	923	923	0	0	0	0
Ramsay	2,193	1,930	263	1,630	1,618	12	562	312	250	4,451	4,451	0	4,451	4,451	0	0	0	0
Nuffield Health	955	1,016	(62)	710	847	(138)	245	169	76	1,940	1,940	0	1,940	1,940	0	0	0	0
Other Private Providers	347	366	(19)	260	279	(19)	87	87	0	1,040	1,040	0	1,040	1,040	0	0	0	0
<b>Sub Total</b>	<b>77,678</b>	<b>77,944</b>	<b>(265)</b>	<b>58,668</b>	<b>58,977</b>	<b>(309)</b>	<b>19,010</b>	<b>18,967</b>	<b>43</b>	<b>223,517</b>	<b>225,629</b>	<b>(2,112)</b>	<b>223,517</b>	<b>225,629</b>	<b>(2,112)</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Mental Health Services</b>																		
Tees Esk and Wear Valleys NHS FT	13,185	13,182	3	9,795	9,757	38	3,390	3,425	(35)	39,306	39,306	0	39,182	39,182	0	124	124	0
Out of Contract Placements and SRBI	1,734	2,057	(323)	1,300	1,364	(64)	433	693	(259)	5,017	5,117	(100)	5,017	5,117	(100)	0	0	0
Non-Contracted Activity - MH	140	155	(14)	105	119	(14)	35	35	(0)	421	421	0	421	421	0	0	0	0
Other Mental Health	78	47	31	58	35	23	19	12	8	233	233	0	233	233	0	0	0	0
<b>Sub Total</b>	<b>15,137</b>	<b>15,441</b>	<b>(304)</b>	<b>11,259</b>	<b>11,276</b>	<b>(17)</b>	<b>3,878</b>	<b>4,165</b>	<b>(287)</b>	<b>44,977</b>	<b>45,077</b>	<b>(100)</b>	<b>44,853</b>	<b>44,953</b>	<b>(100)</b>	<b>124</b>	<b>124</b>	<b>0</b>

## 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
<b>Community Services</b>																		
York Teaching Hospital NHS FT - Community	6,601	6,620	(19)	4,950	4,986	(36)	1,650	1,634	16	19,742	19,811	(69)	19,742	19,811	(69)	0	0	0
York Teaching Hospital NHS FT - MSK	756	496	260	567	409	158	189	87	102	2,767	2,767	0	2,767	2,767	0	0	0	0
Harrogate and District NHS FT - Community	912	957	(45)	690	698	(8)	222	258	(37)	2,686	2,686	0	2,686	2,686	0	0	0	0
Humber NHS FT - Community	346	330	16	260	247	12	87	82	4	1,038	1,038	0	1,038	1,038	0	0	0	0
Hospices	416	415	0	312	311	0	104	104	0	1,247	1,247	0	1,247	1,247	0	0	0	0
Longer Term Conditions	153	150	3	115	115	(0)	38	35	3	458	458	0	458	458	0	0	0	0
Other Community	661	714	(53)	452	554	(102)	209	160	49	2,354	2,320	34	2,354	2,320	34	0	0	0
<b>Sub total</b>	<b>9,844</b>	<b>9,682</b>	<b>162</b>	<b>7,346</b>	<b>7,322</b>	<b>24</b>	<b>2,498</b>	<b>2,360</b>	<b>138</b>	<b>30,293</b>	<b>30,328</b>	<b>(35)</b>	<b>30,293</b>	<b>30,328</b>	<b>(35)</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Other Services</b>																		
Continuing Care	9,066	9,172	(106)	6,800	6,874	(74)	2,267	2,299	(32)	25,948	27,498	(1,550)	25,948	27,498	(1,550)	0	0	0
Funded Nursing Care	1,668	1,494	174	1,251	1,107	145	417	387	30	5,005	5,005	0	5,005	5,005	0	0	0	0
Patient Transport - Yorkshire Ambulance Service NHS Trust	675	668	7	508	498	10	167	170	(3)	2,007	2,007	0	2,007	2,007	0	0	0	0
Voluntary Sector / Section 256	167	200	(33)	115	152	(37)	52	48	4	547	554	(7)	554	554	0	(7)	0	(7)
Non-NHS Treatment	202	197	5	155	142	13	47	55	(8)	580	580	0	580	580	0	0	0	0
NHS 111	271	271	0	203	203	0	68	68	0	813	813	0	813	813	0	0	0	0
Better Care Fund	3,702	3,694	8	2,776	2,834	(58)	925	860	65	11,105	11,105	0	11,105	11,105	0	0	0	0
Other Services	721	730	(10)	536	548	(13)	185	182	3	2,203	2,203	0	2,203	2,203	0	0	0	0
<b>Sub total</b>	<b>16,473</b>	<b>16,428</b>	<b>45</b>	<b>12,345</b>	<b>12,358</b>	<b>(14)</b>	<b>4,128</b>	<b>4,069</b>	<b>58</b>	<b>48,209</b>	<b>49,766</b>	<b>(1,557)</b>	<b>48,216</b>	<b>49,766</b>	<b>(1,550)</b>	<b>(7)</b>	<b>0</b>	<b>(7)</b>

## 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
<b>Primary Care</b>																		
Primary Care Prescribing	16,737	16,258	479	12,402	11,980	422	4,335	4,278	56	50,196	50,196	0	50,196	50,196	0	0	0	0
Other Prescribing	188	371	(183)	141	284	(143)	47	87	(40)	563	563	0	563	563	0	0	0	0
Local Enhanced Services	641	539	101	404	400	4	237	139	98	2,671	2,526	146	1,918	2,211	(292)	753	315	438
Oxygen	88	94	(6)	66	69	(3)	22	25	(3)	263	263	0	263	263	0	0	0	0
Primary Care IT	343	400	(57)	261	280	(18)	82	120	(39)	1,147	1,147	0	1,147	1,147	0	0	0	0
Out of Hours	1,056	1,092	(36)	792	774	18	264	318	(54)	3,167	3,167	0	3,167	3,167	0	0	0	0
Other Primary Care	14	117	(103)	44	41	3	(30)	77	(106)	103	103	0	856	418	438	(753)	(315)	(438)
<b>Sub Total</b>	<b>19,066</b>	<b>18,870</b>	<b>195</b>	<b>14,110</b>	<b>13,827</b>	<b>282</b>	<b>4,956</b>	<b>5,043</b>	<b>(87)</b>	<b>58,111</b>	<b>57,965</b>	<b>146</b>	<b>58,111</b>	<b>57,965</b>	<b>146</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Primary Care Co-Commissioning</b>	<b>13,885</b>	<b>13,855</b>	<b>30</b>	<b>10,410</b>	<b>10,393</b>	<b>17</b>	<b>3,475</b>	<b>3,462</b>	<b>13</b>	<b>41,797</b>	<b>41,797</b>	<b>0</b>	<b>41,797</b>	<b>41,797</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Trading Position</b>	<b>152,082</b>	<b>152,219</b>	<b>(137)</b>	<b>114,137</b>	<b>114,153</b>	<b>(16)</b>	<b>37,945</b>	<b>38,066</b>	<b>(121)</b>	<b>446,904</b>	<b>450,562</b>	<b>(3,658)</b>	<b>446,787</b>	<b>450,438</b>	<b>(3,651)</b>	<b>117</b>	<b>124</b>	<b>(7)</b>
<b>Prior Year Balances</b>	0	403	(403)	0	325	(325)	0	77	(77)	0	0	0	0	0	0	0	0	0
<b>Reserves</b>	0	0	0	0	0	0	0	0	0	2,368	2,361	7	2,361	2,361	0	7	0	7
<b>Contingency</b>	749	0	749	562	0	562	187	0	187	2,248	2,248	0	2,248	2,248	0	0	0	0
<b>Unallocated QIPP</b>	0	0	0	0	0	0	0	0	0	0	(3,651)	3,651	0	(3,651)	3,651	0	0	0
<b>Reserves</b>	<b>749</b>	<b>403</b>	<b>347</b>	<b>562</b>	<b>325</b>	<b>237</b>	<b>187</b>	<b>77</b>	<b>110</b>	<b>4,617</b>	<b>959</b>	<b>3,658</b>	<b>4,610</b>	<b>959</b>	<b>3,651</b>	<b>7</b>	<b>0</b>	<b>7</b>
<b>Programme Financial Position</b>	<b>152,832</b>	<b>152,622</b>	<b>210</b>	<b>114,699</b>	<b>114,478</b>	<b>221</b>	<b>38,133</b>	<b>38,144</b>	<b>(11)</b>	<b>451,521</b>	<b>451,521</b>	<b>(0)</b>	<b>451,397</b>	<b>451,397</b>	<b>(0)</b>	<b>124</b>	<b>124</b>	<b>(0)</b>
<b>In Year Surplus / (Deficit)</b>	<b>(2,115)</b>	<b>0</b>	<b>(2,115)</b>	<b>(1,586)</b>	<b>0</b>	<b>(1,586)</b>	<b>(529)</b>	<b>0</b>	<b>(529)</b>	<b>(6,345)</b>	<b>0</b>	<b>(6,345)</b>	<b>(6,345)</b>	<b>0</b>	<b>(6,345)</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>In Year Programme Financial Position</b>	<b>150,717</b>	<b>152,622</b>	<b>(1,905)</b>	<b>113,113</b>	<b>114,478</b>	<b>(1,365)</b>	<b>37,604</b>	<b>38,144</b>	<b>(540)</b>	<b>445,176</b>	<b>451,521</b>	<b>(6,345)</b>	<b>445,052</b>	<b>451,397</b>	<b>(6,345)</b>	<b>124</b>	<b>124</b>	<b>(0)</b>
<b>Running Costs</b>	<b>2,395</b>	<b>2,325</b>	<b>70</b>	<b>1,796</b>	<b>1,751</b>	<b>45</b>	<b>599</b>	<b>574</b>	<b>25</b>	<b>7,187</b>	<b>7,187</b>	<b>0</b>	<b>7,187</b>	<b>7,187</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total In Year Financial Position</b>	<b>153,112</b>	<b>154,947</b>	<b>(1,835)</b>	<b>114,910</b>	<b>116,229</b>	<b>(1,319)</b>	<b>38,203</b>	<b>38,718</b>	<b>(515)</b>	<b>452,363</b>	<b>458,708</b>	<b>(6,345)</b>	<b>452,239</b>	<b>458,584</b>	<b>(6,345)</b>	<b>124</b>	<b>124</b>	<b>(0)</b>
<b>Brought Forward (Deficit)</b>	<b>(7,920)</b>	<b>0</b>	<b>(7,920)</b>	<b>(5,940)</b>	<b>0</b>	<b>(5,940)</b>	<b>(1,980)</b>	<b>0</b>	<b>(1,980)</b>	<b>(23,759)</b>	<b>0</b>	<b>(23,759)</b>	<b>(23,759)</b>	<b>0</b>	<b>(23,759)</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Cumulative Financial Position</b>	<b>145,193</b>	<b>154,947</b>	<b>(9,754)</b>	<b>#####</b>	<b>116,229</b>	<b>(7,259)</b>	<b>36,223</b>	<b>38,718</b>	<b>(2,495)</b>	<b>428,604</b>	<b>458,708</b>	<b>(30,104)</b>	<b>428,480</b>	<b>458,584</b>	<b>(30,104)</b>	<b>124</b>	<b>124</b>	<b>(0)</b>

Appendix 2 – Running costs dashboard

Directorate	YTD Position			YTD Previous Month			YTD Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Governing Body/ COO/Execs	293	339	(46)	220	225	(5)	73	113	(40)
System Resource & Performance	586	485	101	440	380	60	147	106	41
Planning & Governance	391	360	32	294	283	11	98	77	21
Joint Commissioning	112	89	23	84	65	19	28	24	4
Transformation & Delivery	115	95	20	87	69	17	29	26	3
Medical Directorate	315	316	(1)	236	234	2	79	82	(3)
Finance	322	331	(9)	242	231	11	81	100	(20)
Quality & Nursing	229	163	67	172	129	43	57	34	24
Recharges & PCU	150	148	3	113	135	(22)	38	13	25
Reserves	(33)	0	(33)	(25)	0	(25)	(8)	0	(8)
QIPP	(87)	0	(87)	(65)	0	(65)	(22)	0	(22)
<b>Overall Position</b>	<b>2,395</b>	<b>2,325</b>	<b>70</b>	<b>1,796</b>	<b>1,751</b>	<b>45</b>	<b>599</b>	<b>574</b>	<b>25</b>

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
880	950	(70)	880	950	(70)	0	(0)	0
1,777	1,542	235	1,760	1,532	228	17	10	7
1,175	1,068	107	1,175	1,086	89	0	(18)	18
336	306	30	336	315	21	0	(9)	9
347	328	18	347	326	21	0	2	(2)
945	951	(6)	945	962	(17)	0	(11)	11
967	932	35	967	949	17	0	(17)	17
671	562	109	688	589	99	(17)	(27)	10
451	451	0	451	451	0	0	0	(0)
(100)	358	(458)	(100)	287	(387)	0	71	(71)
(261)	(261)	0	(261)	(261)	0	0	0	0
<b>7,187</b>	<b>7,187</b>	<b>(0)</b>	<b>7,187</b>	<b>7,187</b>	<b>0</b>	<b>(0)</b>	<b>0</b>	<b>(0)</b>

# NHS Vale of York Clinical Commissioning Group Financial Performance Report

## Appendix 3 – Updated forecast outturn


Area	Finance Dashboard Forecast Outturn			Updated Forecast Outturn			Risk
	Forecast Outturn			Forecast Outturn			
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	£000
<b>Commissioned Services</b>							
<b>Acute Services</b>							
York Teaching Hospital NHS Foundation Trust	181,122	183,232	(2,110)	181,122	186,632	(5,510)	(3,400)
Yorkshire Ambulance Service NHS Trust	12,897	12,897	0	12,897	12,897	0	0
Leeds Teaching Hospitals NHS Trust	8,243	8,245	(1)	8,243	8,321	(78)	(77)
Hull and East Yorkshire Hospitals NHS Trust	2,994	2,994	0	2,994	3,129	(135)	(135)
Harrogate and District NHS Foundation Trust	1,851	1,851	0	1,851	2,034	(183)	(183)
Mid Yorkshire Hospitals NHS Trust	2,096	2,096	0	2,096	2,192	(95)	(95)
South Tees NHS Foundation Trust	1,264	1,265	(1)	1,264	1,395	(130)	(129)
North Lincolnshire & Goole Hospitals NHS Trust	567	567	0	567	570	(2)	(2)
Sheffield Teaching Hospitals NHS Foundation Trust	215	215	0	215	215	0	0
Non-Contracted Activity	3,912	3,912	0	3,912	3,912	0	0
Other Acute Commissioning	923	923	0	923	899	24	24
Ramsay	4,451	4,451	0	4,451	3,821	630	630
Nuffield Health	1,940	1,940	0	1,940	2,125	(185)	(185)
Other Private Providers	1,040	1,040	0	1,040	1,062	(22)	(22)
Systems Resilience	0	0	0	0	0	0	0
<b>Sub Total</b>	<b>223,517</b>	<b>225,629</b>	<b>(2,112)</b>	<b>223,517</b>	<b>229,204</b>	<b>(5,687)</b>	<b>(3,575)</b>
<b>Mental Health Services</b>							
Tees Esk and Wear Valleys NHS Foundation Trust	39,306	39,306	0	39,306	39,303	3	3
Out of Contract Placements and SRBI	5,017	5,117	(100)	5,017	5,254	(238)	(138)
Non-Contracted Activity - MH	421	421	0	421	421	0	0
Other Mental Health	233	233	0	233	140	93	93
<b>Sub Total</b>	<b>44,977</b>	<b>45,077</b>	<b>(100)</b>	<b>44,977</b>	<b>45,118</b>	<b>(141)</b>	<b>(41)</b>
<b>Community Services</b>							
York Teaching Hospital NHS Foundation Trust - Community	19,742	19,811	(69)	19,742	20,020	(278)	(209)
York Teaching Hospital NHS Foundation Trust - MSK	2,767	2,767	0	2,767	1,888	879	879
Harrogate and District NHS Foundation Trust - Community	2,686	2,686	0	2,686	2,777	(91)	(91)
Humber NHS Foundation Trust - Community	1,038	1,038	0	1,038	990	49	49
Hospices	1,247	1,247	0	1,247	1,246	2	2
Longer Term Conditions	458	458	0	458	456	2	2
Other Community	2,354	2,320	34	2,354	2,612	(258)	(292)
<b>Sub total</b>	<b>30,293</b>	<b>30,328</b>	<b>(35)</b>	<b>30,293</b>	<b>29,988</b>	<b>304</b>	<b>340</b>



## NHS Vale of York Clinical Commissioning Group Financial Performance Report

Area	Finance Dashboard Forecast Outturn			Updated Forecast Outturn			Risk
	Forecast Outturn			Forecast Outturn			
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	£000
<b>Other Services</b>							
Continuing Care	25,948	27,498	(1,550)	25,948	27,689	(1,741)	(191)
Funded Nursing Care	5,005	5,005	0	5,005	4,308	697	697
Patient Transport - Yorkshire Ambulance Service NHS Trust	2,007	2,007	0	2,007	2,005	3	3
Voluntary Sector / Section 256	547	554	(7)	547	562	(15)	(8)
Non-NHS Treatment	580	580	0	580	572	8	8
NHS 111	813	813	0	813	813	0	0
Better Care Fund	11,105	11,105	0	11,105	11,066	40	40
Other Services	2,203	2,203	0	2,203	2,219	(16)	(16)
<b>Sub total</b>	<b>48,209</b>	<b>49,766</b>	<b>(1,557)</b>	<b>48,209</b>	<b>49,234</b>	<b>(1,026)</b>	<b>531</b>
<b>Primary Care</b>							
Primary Care Prescribing	50,196	50,196	0	50,196	49,175	1,021	1,021
Other Prescribing	563	563	0	563	1,292	(729)	(729)
Local Enhanced Services	2,671	2,526	146	2,671	2,445	226	80
Oxygen	263	263	0	263	272	(9)	(9)
Primary Care IT	1,147	1,147	0	1,147	1,154	(8)	(8)
Out of Hours	3,167	3,167	0	3,167	3,223	(56)	(56)
Other Primary Care	103	103	0	103	170	(67)	(67)
<b>Sub Total</b>	<b>58,111</b>	<b>57,965</b>	<b>146</b>	<b>58,111</b>	<b>57,733</b>	<b>378</b>	<b>232</b>
<b>Primary Care Co-Commissioning</b>	<b>41,797</b>	<b>41,797</b>	<b>0</b>	<b>41,797</b>	<b>41,797</b>	<b>0</b>	<b>(0)</b>
<b>Trading Position</b>	<b>446,904</b>	<b>450,562</b>	<b>(3,658)</b>	<b>446,904</b>	<b>453,075</b>	<b>(6,171)</b>	<b>(2,513)</b>
<b>Prior Year Balances</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Reserves</b>	<b>2,368</b>	<b>2,361</b>	<b>7</b>	<b>2,368</b>	<b>2,361</b>	<b>7</b>	<b>0</b>
<b>Contingency</b>	<b>2,248</b>	<b>2,248</b>	<b>0</b>	<b>2,248</b>	<b>2,248</b>	<b>0</b>	<b>0</b>
<b>Unallocated QIPP</b>	<b>0</b>	<b>(3,651)</b>	<b>3,651</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,651)</b>
<b>Reserves</b>	<b>4,617</b>	<b>959</b>	<b>3,658</b>	<b>4,617</b>	<b>4,610</b>	<b>7</b>	<b>(3,651)</b>
<b>Programme Financial Position</b>	<b>451,521</b>	<b>451,521</b>	<b>(0)</b>	<b>451,521</b>	<b>457,685</b>	<b>(6,164)</b>	<b>(6,164)</b>

This page is intentionally blank

<b>Item Number: 9</b>	
<b>Name of Presenter: Caroline Alexander</b>	
<b>Meeting of the Governing Body</b> <b>7 September 2017</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Integrated Performance Report Month 4 2017/18</b>	
<b>Purpose of Report For Information</b>	
<p><b>Reason for Report</b></p> <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 3 for performance and contracting, and Month 4 for finance and QIPP.</p> <p>In July the Finance and Performance Committee received a high level analysis of the CCG's 2016/17 Integrated Assurance Framework Annual Assessment and noted the five clinical indicators where the CCG was rated as 'requiring further improvement'. These were all noted as being areas where there were long-standing performance issues and which have been regularly reported in the CCG risk register. While recovery and action plans have been in place for all five areas and reporting is provided to the Committee on each of these monthly, there was a desire by the Committee for the CCG to spend some time during August and September reviewing these areas and plans to scrutinise and challenge current delivery models and impact on recovery.</p> <p>This aligns to the work completed in July and August to review the delivery of all CCG QIPP programmes and targets and presented in Item 8 Finance Performance Report Month 4.</p> <p>The integrated performance dashboard therefore presents the current performance position with all five Integrated Assurance Framework clinical target areas indicated as requiring further improvement. Additionally, a Mental Health Performance Specific Report incorporating CAMHS, IAPT and Dementia diagnosis is presented to Governing Body alongside the integrated performance dashboard in Item 10.</p> <p>It is proposed to bring similar detailed reports back to the Finance and Performance Committee in September on A&amp;E 4 hour, Referral to treatment (RTT) and Cancer 62 day target performance.</p>	

<b>Strategic Priority Links</b> <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	
<b>Local Authority Area</b> <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
<b>Impacts/ Key Risks</b> <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b> 30 risks as captured in the Risk report for August 2017
<b>Emerging Risks (not yet on Covalent) n/a</b>	
<b>Recommendations</b> N/A	

<b>Responsible Executive Director and Title</b> Rachel Potts Executive Director of Planning and Governance	<b>Report Author and Title</b> Caroline Alexander Assistant Director of Delivery and Performance
--	--

# Integrated Performance Report



Validated data to June 2017  
Month 03 2017/18

# Acronyms

2WW	Two week wait: Urgent Cancer Referrals Target
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactive Disorder
AEDB	A and E Delivery Board
CAMHS	Child and Adolescent Mental Health Services
CC	Continuing Care
CEP	Capped Expenditure Process
CGA	Comprehensive Geriatric Assessment
CHC	Continuing Healthcare
CMB	Contract Management Board
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (framework)
CRUK	Cancer Research UK
CT	Computerised Tomography Scan
CYC	City of York Council
DNA	Did not attend
DTOC	Delayed Transfer of Care
DEXA	Dual energy X-ray absorptiometry scan
DQIP	Data Quality Improvement Plan (in standard acute contract)
ED	Emergency Department
EDFD	Emergency Department Front Door
EMI	Elderly Mentally Infirm

# Acronyms continued

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

# Acronyms continued

MNET	Medical Non Emergency Transport
MSK	Musculo-skeletal Service
MIU	Minor Injuries Unit
NHSE	NHS England
NHSI	NHS Improvement
NYCC	North Yorkshire County Council
NYNET	NYNET Limited (created by North Yorkshire County Council, provides WAN connectivity and broadband services to private and public sector sites)
ONPOS	Online Non Prescription Ordering Service
OOH	Out of hours
PCH	Primary Care Home
PCU	Partnership Commissioning Unit
PIB	Permanent Injury Benefit
PID	Project Initiation Document
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

## Performance Headlines

### Performance Summary : All Constitutional Targets

## Programme Overviews

### Planned Care

- Contracting
- Quality, Innovation, Productivity and Prevention (QIPP)
- Performance – RTT, Cancer, Diagnostics
- Key Questions – QIPP, Contracting and Performance
- **Prescribing** – QIPP and key questions

### Unplanned Care

- Contracting
- Quality, Innovation, Productivity and Prevention (QIPP)
- Performance – Accident and Emergency, Ambulance Service, Other Services and Measures
- Key Questions – QIPP, Contracting and Performance

### Mental Health, Learning Disability and Complex Care

- Contracting
- Quality, Innovation, Productivity and Prevention (QIPP)
- Performance – Improving Access to Psychological Services, Dementia, CAMHS, Psychiatric Liaison Service
- Key Questions – QIPP, Contracting and Performance

### Primary Care

- Quality, Innovation, Productivity and Prevention (QIPP)
- Performance – primary care dashboard in development (for review at Primary Care Commissioning Committee September 2017)

### Enabling & Quality

- Summary of workstreams August 2017

# Performance Headlines

## IMPROVEMENTS IN PERFORMANCE : June to July 2017

<b>RTT 18 week</b>	Stable and no change in performance – 90.2% against target of 92% and three month upward trend. No 52 week breaches in June after two previous months with breaches.	Working with S&R CCG to align all planned care programme priorities and focus on pathway specific deepdives in Dermatology, colorectal, H&N and rheumatology during September.
<b>Cancer 31 day wait first definitive</b>	Improvement to 96.9% (above target 94%) in June and improvement from 93.8% in May	Cancer 31 day performance is addressed as required through the system planned care performance group.
<b>Cancer 62 days</b>	Improvement to 76.6% in June from 74.3% in May. One of the five clinical indicators assessed as 'requiring further improvement' in 16/17 CCG IAF. Last time this delivered at target was August 2016.	Still below target of 85%. Deepdive review around Cancer Alliance 62 day recovery plan and High Impact Action Plan for York & Scarborough in September and presentation to F&P Committee in September.
<b>Cancer 2 WW</b>	Improvement from May to 90.4% in June against target of 93%. Q1 overall performance 90.2%	Incorporated in cancer deepdive review in September and focus on dermatology, colorectal, H&N.
<b>Diagnostics 6 week wait</b>	Improvement from 3.49% in May to 2.83% in June. Q1 overall performance 2.8%	Diagnostics recovery plan for YTHFT currently being refreshed as part of the overarching YTHFT Return to Operational Standards (RTOS) – due in September 2017
<b>A&amp;E 4 hr</b>	Improvement from 88.1% in May to 91.9% in June (YTH) and 88.64% for VoY CCG in June. Q1 performance 90.9%. Deterioration to 86.99% in July (unvalidated). 20 planned bed closures in WC 21/8/17 and OPEL 3 on 22/8/17.	Winter planning process underway – verbal update to Committee in August. 9 priority areas still progressing through the A&E Delivery Board work programme currently (see Annex 1 for summary)
<b>Ambulance handover 30 mins</b>	Improvement in June to 7% (target 0% but regional performance is between 10-20%) from 10.9% in May. Q1 overall performance was 7.3%	On going monitoring of performance through A&E Delivery Board. Programme lead happy with current performance.
<b>CAMHS</b>	Improvement in June to 66%	Single item review session undertaken on 14 <sup>th</sup> August-verbal feedback to Committee August and detailed report in September after demand & capacity review.
<b>IAPT</b>	Improvement in June to 10.9% from 8.4% in May	Paper presented to F&P Committee August 2017

# Performance Headlines

## DETERIORATION IN PERFORMANCE: June to July 2017

<b>Cancelled Operations</b>	1.9% in June – first time since March 2017	Due to high bed occupancy and staff shortages (see Annex 1)
<b>12 hour trolley waits</b>	One breach in May 2017 (now validated) but none in June 2017	No discussion at A&E Delivery Board to date
<b>Ambulance Cat 1 8 minute response</b>	Further deterioration from 74.1% in May to 68.2% in June against the target of 75%	On-going monitoring through A&E Delivery Board and associated workstreams in plan
<b>Dementia Diagnosis</b>	Slight improvement from 58.3% in May to 58.7% in June but still below target of 62.8% for month and overarching national target 66.7% in March to 58.3% in April (NB. May data not validated) against target of 66.7%	Paper presented to F&P Committee August 2017
<b>CHC</b>	Progress is now being made on the review of the 186 CHC patients and 537 FNC patients with overdue reviews	This is progress against the 215 CHC patients and 557 FCN patients on the backlog in May 2017. Additional capacity is being accessed via NHSE to support these reviews.

## SUGGESTED ISSUES FOR DISCUSSION:

1. DTOCs – resubmission for note
2. IAPT – see separate paper
3. Dementia diagnosis rates - see separate paper
4. CAMHS – verbal update to be given
6. Winter planning and A&E Delivery Board/ A&E 4 hour recovery plan - verbal update (see Annex 1)
7. Selby Dermatology Letter – for information (see Annex 1)

# Performance Summary: All Constitutional Targets 2017/18

Validated data to June 2017 (Month 03)

Planned Care

Indicator	Level of Reporting		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Q1 2017/18	2017/18	2016/17	2015/16	Direction of Travel (last 12 Months)	3 Month Trend
<b>Referral to Treatment</b>																				
Referral to Treatment pathway ays: incomplete	CCG	Actual	91.8%	91.5%	91.6%	91.5%	90.8%	90.6%	90.3%	90.5%	90.7%	89.7%	90.2%	90.2%	90.2%	90.2%	90.7%	92.4%		↑
		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%		
Number of >52 week Referral to Treatment in Incomplete Pathways	CCG	Actual	0	0	0	1	1	0	0	0	2	2	2	0	4	4	5	2		↓
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
<b>Diagnostics</b>																				
Diagnostic test waiting times	CCG	Actual	1.29%	1.37%	0.93%	1.27%	1.21%	1.70%	1.76%	2.00%	2.12%	3.76%	3.49%	2.83%	2.8%	2.8%	2.1%	0.93%		↑
		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%		
<b>Cancer</b>																				
All Cancer 2 week w aits	CCG	Actual	94.7%	91.1%	94.5%	88.1%	92.1%	98.1%	90.2%	97.0%	93.3%	90.5%	89.6%	90.4%	90.2%	90.1%	93.6%	94.1%		↓
		Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		
Breast Symptoms (Cancer Not Suspected) 2 week w aits	CCG	Actual	94.1%	93.9%	96.2%	96.7%	98.2%	95.5%	95.7%	95.7%	98.3%	91.9%	95.5%	96.6%	95.2%	94.7%	96.3%	94.6%		↑
		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%		
Cancer 31 day w aits: first definitive treatment	CCG	Actual	99.5%	98.3%	96.2%	98.0%	96.2%	98.5%	96.3%	98.2%	96.6%	95.0%	98.9%	97.8%	97.5%	97.4%	98.0%	97.8%		↑
		Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%		
Cancer 31 day w aits: subsequent cancer treatments-surgery	CCG	Actual	97.2%	100.0%	92.1%	97.5%	86.7%	84.8%	97.1%	92.1%	100.0%	95.2%	93.8%	96.9%	95.3%	95.3%	95.0%	97.6%		↑
		Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	96.0%	94.0%	94.0%	94.0%	94.0%	94.0%		
Cancer 31 day w aits: subsequent cancer treatments-anti cancer drug regimens	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		-
		Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	96.0%	98.0%	98.0%	98.0%	98.0%	98.0%		
Cancer 31 day w aits: subsequent cancer treatments-radiotherapy	CCG	Actual	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	99.2%	99.2%	99.6%	99.8%		↓
		Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	96.0%	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	84.9%	91.3%	71.8%	75.0%	77.3%	81.7%	82.4%	74.0%	78.7%	83.6%	74.3%	76.6%	77.8%	77.3%	81.8%	84.9%		↓
		Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	CCG	Actual	90.0%	100.0%	83.3%	96.0%	84.6%	94.1%	94.7%	93.3%	85.7%	83.3%	100.0%	100.0%	94.6%	94.6%	91.9%	94.4%		↑
		Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	92.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	CCG	Actual	100.0%	Nil Return	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	Nil Return	100.0%	100.0%	88.5%	86.7%		-
		Target																		
<b>Cancelled Operations</b>																				
Cancelled Operations - York	YFT (Trust wide)	Actual			1.4%			1.0%			7.8%			1.9%	1.9%	1.9%	5.1%	3.1%		↑
		Target			0.0%			3.8%			2.0%			0.0%	0.0%	0.0%	3.1%	3.0%		
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		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
<b>Mixed Sex Accommodation</b>																				
Mixed Sex Accommodation (MSA) Breaches (Rate per 1,000 FCEs)	CCG	Actual	0	0	0	0	0	0	0.1	0	0	0	0	0	0	0	0	1.8		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Number of MSA breaches for the reporting month in question	CCG	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	221		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

## Unplanned Care

Indicator	Level of Reporting		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Q1 2017/18	2017/18	2016/17	2015/16	Direction of Travel (last 12 Months)	3 Month Trend
<b>A&amp;E</b>																				
A&E waiting time - total time in the A&E department. SitRep data	% of YFHT activity (CCG weighted)	Actual	92.7%	90.6%	91.0%	85.5%	81.9%	81.2%	78.3%	81.5%	89.4%	92.9%	88.1%	91.9%	90.9%	89.9%	86.4%	88.0%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	4,816	4,623	4,584	4,717	4,418	4,607	4,302	3,991	4,551	4,485	4,802	4,714	14,001	18,938	55,185	62,882		↑
A&E - % Attendances - Type 1, SitRep data	% of YFHT activity (CCG weighted)	Actual	87.4%	82.7%	84.2%	74.9%	69.4%	68.7%	63.3%	68.7%	81.7%	87.5%	79.6%	86.1%	83.5%	83.5%	76.6%	80.9%		↓
		Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%		
A&E Attendances - Type 3, SitRep data	% of YFHT activity (CCG weighted)	Actual	2,022	2,036	1,799	1,767	1,522	1,555	1,483	1,397	1,652	1,785	1,818	1,730	5,333	7,227	20,011	18,016		↓
A&E Attendances - Total, SitRep data	% of YFHT activity (CCG weighted)	Actual	8,889	8,724	8,219	8,278	7,485	7,741	7,291	6,807	7,881	8,083	8,466	8,201	24,749	33,504	95,514	99,191		↑
A&E Attendances - VoY CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	7,579	7,295	7,279	7,681	7,104	7,268	6,914	6,256	7,898	7,054	7,588	7,242	21,884	22,062	86,952	86,007		↑
A&E waiting time - % of patients seen and discharged within 4 hours -CCG Patients (Includes UCC)	CCG (SUS Data)	Actual	92.99%	91.42%	90.80%	83.54%	77.82%	74.81%	73.33%	79.49%	89.60%	90.36%	83.86%	88.64%	87.53%	87.54%	83.55%	85.85%		↓
		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%		
			no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data				-
			no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data	no data				-
<b>Trolley Waits</b>																				
12 hour trolley waits in A&E - Vale of York CCG	CCG	Actual	0	0	0	1	1	9	6	2	0	0	1	0	1	3	19	15		↑
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12 hour trolley waits in A&E - York	YFT (Trust wide)	Actual	0	0	0	4	3	11	45	6	9	0	3	0	3	5	85	51		-
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		

**Ambulance performance - YAS**

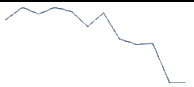
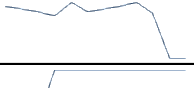
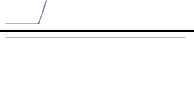
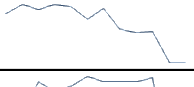


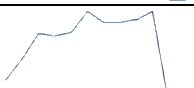
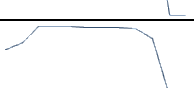
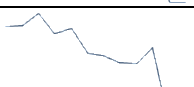
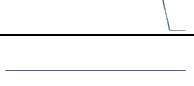
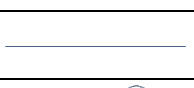
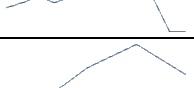

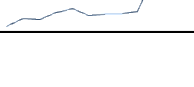

Category 1 - Response w ithin 8 Minutes	YAS (region)	Actual								68.3%	62.9%	62.4%	69.8%	75.4%	75.4%	74.1%	68.2%	68.2%	68.2%	67.8%			↓
		Target								75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%		
Achieved 8 Mn	YAS (region)	Actual								196	242	252	216	265	269	259	261	789	789	1171			↓
Total Calls (C1)	YAS (region)	Actual								287	384	404	309	352	357	390	382	1129	1129	1736			↑
Category 1 - Tail of Performance 75%	YAS (region)	Actual														00:08:03	00:09:06	00:08:30	00:08:30	00:09:00			↑
Category 1 - Tail of Performance 100%	YAS (region)	Actual														00:25:56	00:24:03	00:31:24	00:31:24	00:34:50			↓
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%	86.3%	86.3%	83.0%			↑
Category 2R - Tail of Performance 95%	YAS (region)	Actual														00:24:04	00:30:40	00:27:23	00:27:23	00:41:47			
Category 2R- Tail of Performance 100%	YAS (region)	Actual														00:37:19	01:02:20	00:47:25	00:47:25	01:20:45			
Category 2T (transport) - Response w ithin 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%	77.8%	77.8%	69.5%			↓
Category 2T - Tail of Performance 95%	YAS (region)	Actual														00:31:24	01:01:00	00:42:25	00:42:25	00:43:06			
Category 2T - Tail of Performance 100%	YAS (region)	Actual														01:20:47	23:24:31	09:02:42	09:02:42	02:08:06			
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%	90.9%	90.9%	84.8%			↓
Category 3R - Tail of Performance 95%	YAS (region)	Actual														00:50:41	00:50:10	00:57:09	00:57:09	01:32:12			
Category 3R - Tail of Performance 100%	YAS (region)	Actual														01:41:01	02:21:42	01:54:48	01:54:48	03:14:23			
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%	87.6%	87.6%	80.3%			↓
Category 3T - Tail of Performance 95%	YAS (region)	Actual														00:51:25	15:08:40	05:49:20	05:49:20	02:05:52			
Category 3T - Tail of Performance 100%	YAS (region)	Actual														03:03:13	23:43:28	09:35:12	09:35:12	04:36:04			
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%	88.7%	88.7%	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%	100.0%	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		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Q1 2017/18	2017/18	2016/17	2015/16	Direction of Travel (last 12 Months)	3 Month Trend	
Ambulance handover time - % Delays over 30 minutes (Scarborough General Hospital)	Trust Site	Actual	24.90%	35.20%	24.90%	31.30%	32.00%	27.00%	39.00%	44.20%	21.80%	7.40%	18.30%	14.90%	12.90%	12.90%	29.40%	15.60%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	377	512	343	399	403	369	510	533	294	117	182	222	521	521	4771	2620			
		Den	1514	1456	1375	1274	1258	1367	1307	1207	1346	1572	994	1487	4053	4053	16224	16842			
Ambulance handover time - % Delays over 60 minutes (Scarborough General Hospital)	Trust Site	Actual	10.00%	16.60%	10.60%	13.30%	15.00%	11.80%	17.10%	23.10%	6.00%	2.60%	6.40%	5.00%	4.40%	4.40%	12.90%	6.80%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	151	242	146	170	189	161	224	279	81	41	64	74	179	179	2088	1147			
		Den	1514	1456	1375	1274	1258	1367	1307	1207	1346	1572	994	1487	4053	4053	16224	16842			
Ambulance handover time - % Delays over 30 minutes (York Hospital)	Trust Site	Actual	8.50%	6.50%	8.50%	16.40%	22.20%	26.30%	30.10%	20.00%	7.00%	4.10%	10.90%	7.00%	7.30%	7.30%	16.20%	9.60%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	175	128	167	339	447	530	596	352	131	78	209	126	413	413	3813	2241			
		Den	2069	1981	1972	2063	2009	2017	1978	1760	1869	1906	1921	1794	5621	5621	23476	23442			
Ambulance handover time - % Delays over 60 minutes (York Hospital)	Trust Site	Actual	2.60%	1.80%	2.50%	7.20%	8.30%	13.10%	16.70%	7.80%	0.90%	0.90%	3.70%	1.30%	2.00%	2.00%	7.00%	4.40%		↑	
		Target	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%			0%
		Num	54	35	50	149	167	264	330	137	16	17	71	23	111	111	1655	1036			
		Den	2069	1981	1972	2063	2009	2017	1978	1760	1869	1906	1921	1794	5621	5621	23476	23442			



## Mental Health/ IAPT

Indicator	Level of Reporting	Target	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Q1 2017/18	2017/18	2016/17	2015/16	Direction of Travel (last 12 Months)	3 Month Trend
<b>IAPT</b>																				
% of people w ho have depression and/or anxiety disorders w ho receive psychological therapies	CCG	Actual	1.0%	1.2%	1.1%	1.2%	1.1%	0.9%	1.1%	0.7%	0.6%	0.6%			0.6%	0.6%	13.3%	8.3%		↓
		Target	1.00%	1.00%	1.00%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%	1.25%			0.67%	0.67%	8.57%		
% of people w ho are moving to recovery	CCG	Actual	50.00%	46.43%	44.44%	40.91%	53.85%	44.83%	46.43%	50.00%	53.85%	42.50%			42.50%	42.50%	47.04%	46.15%		↓
		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%			
% of people who have depression and/or anxiety disorders who receive psychological therapies	CCG	Actual	1.0%	1.0%	1.0%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	0.7%	0.7%	8.6%	8.0%		-
Number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey)	CCG	Actual	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260.0	31260	31260	31260	31260		-
Number of people who receive psychological therapies	CCG	Actual	310	375	340	375	350	280	345	220	195	200			200	200	4165	2595		↓
		Target	208	208	208	208	208	208	391	208	208	208			208	208	2679	2496		
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	54.55%	64.71%	93.33%	84.00%	89.29%	100.00%	93.55%	93.33%	93.10%	97.62%			97.62%	97.62%	83.60%	88.20%		↑
		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%			
The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	70.97%	80.00%	98.53%	100.00%	100.00%	98.21%	98.55%	100.00%	100.00%	100.00%			100.00%	100.00%	87.15%	91.33%		-
		Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%			90%	90%	90%			
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	CCG	Actual	27.27%	47.06%	70.00%	68.00%	71.43%	91.18%	80.65%	80.00%	82.76%	90.48%			90.48%	90.48%	66.24%	57.23%		↑
		Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%			75%	75%	75%			
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	CCG	Actual	64.52%	74.67%	95.59%	97.33%	95.71%	94.64%	94.20%	95.45%	92.31%	80.00%			80.00%	80.00%	78.03%	66.67%		↓
		Target	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%			50%	50%	50%	50%		
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	72.73%	73.53%	83.33%	68.00%	71.43%	52.94%	51.61%	46.67%	44.83%	57.14%			57.14%	57.14%	66.56%	35.40%		↑
		Target	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%			40%	40%	40%			
Not Included in VOY Dashboard	CCG	Actual																		
Not Included in VOY Dashboard	CCG	Actual																		
Average number of treatment sessions	CCG	Actual	4	5	6	5	6	6	6	6	7	6			6	6	5	6		↑
% of those patients on Care Programme Approach (CPA) discharged from inpatient care w ho are followed up w ithin 7 days	CCG	Actual			93.5%			96.9%			99.2%				96.2%	96.2%	96.9%	95.5%		
		Target			95.0%			95.0%			95.0%				95.0%	95.0%	95.0%	95.0%		
<b>Dementia</b>																				
Estimated diagnosis rate for people w ith dementia.	CCG	Actual	54.2%	54.9%	54.7%	55.3%	55.7%	55.1%	55.2%	55.1%	55.4%	58.4%	58.3%	58.7%	58.7%	59.1%	55.4%	54.5%		↑
		Target	57.0%	58.0%	59.0%	60.9%	62.8%	64.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	66.7%	53.0%	

Latest validated IAPT data included under MHLDC programme dashboard

## HCAI and Quality

Indicator	Level of Reporting		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Q1 2017/18	2017/18	2016/17	2015/16	Direction of Travel (last 12 Months)	3 Month Trend	
<b>Hospital Infections</b>																					
Incidence of healthcare associated infection (HCAI): MRSA	CCG ATTRIBUTED	Actual	0	1	0	3	0	0	1	1	1	1	1	1	3	3	9	1		-	
		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	5	5	7	5	9	7	4	5	4	4	6	14	17	61	89		↑	
		Target	4	7	6	7	5	9	7	6	6	7	6	8	21	25	78	76			
Healthcare acquired infections (HCAI): MRSA - York FT	YFT TRUST APPORTIONED	Actual	0	2	0	1	0	1	0	0	0	0	0	1	0	1	1	6	8		↑
		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	3	2	1	3	2	8	10	5	5	0	2	4	6	8	46	65		↑	
		Target	4	4	2	3	3	6	3	5	3	3	3	1	3	7	10	45			48
<b>Serious Incidents/ Never Events</b>																					
Number of new serious incidents (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	15	10	12	2	8	12	7	7	5	6	8	11	25	34	117	120		↑	
		Target																			
Number of Never Events (NHS Vale of York CCG)	CCG ATTRIBUTED	Actual	1	0	0	0	0	0	0	0	0	0	0	0	0	0	3	2		-	
		Target																			
<b>Smoking at time of Delivery</b>																					
Maternal smoking at delivery.	CCG	Actual			9.7%			10.3%			12.3%			10.1%	10.1%	10.1%	11.0%	12.1%			
		Target			12.1%			12.1%			12.1%			12.1%	12%	12.1%	12.1%	10.8%			

# Programme Overview

## - Planned Care -

Validated data to June 2017

## PLANNED CARE including PRESCRIBING

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

**Executive Lead:** Exec Director of Systems & Resource

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

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



### CONTRACTING: Month 03

Point of Delivery	Year to Date							
	Activity				Expenditure			
	Plan	Act.	Var.	%	Plan	Act.	Var.	%
<b>Inpatient</b>	9,950	10,663	(713)	(7.2%)	10,979	11,278	(300)	(2.7%)
<b>Outpatient</b>	72,075	71,214	862	1.2%	8,481	8,154	327	3.9%
<b>Other</b>	612,230	564,489	47,741	7.8%	10,842	10,089	753	6.9%
<b>CQUIN</b>					653	526	127	19.44%
<b>Total</b>	<b>694,255</b>	<b>646,365</b>	<b>47,890</b>	<b>6.9%</b>	<b>30,955</b>	<b>30,048</b>	<b>907</b>	<b>2.9%</b>

Please refer to the Contract Trading Report

# QIPP: PLANNED CARE Month 04

ALL SCHEMES	Current month	4	Instructions for populating						MONTHLY PROFILES																	
Scheme Name	Ref	Planned start date	YTD			Forecast Outturn			MONTH 4 QIPP RISK ASSESSMENT				Plan profile													
			Planned savings £000	Expected savings £000	Actual savings £000	Planned savings £000	Expected savings £000	Actual savings £000	QIPP Delivery Confidence	QIPP Profiling Adjustments	Key Challenges (Blockers)	National QIPP Support Prog Phase II resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
<b>PLANNED CARE</b>																										
Anti-Coagulation service	194	Apr-17	63	63	0	259	259	108	medium	Yes - reduced and reprofiled QIPP forecasts by month throughout 17/18	Primary care capacity & capability to deliver new service	PMO	16	16	16	16	16	16	36	36	23	23	23	23		
Cataracts Thresholds	161	Apr-17	100	100	0	300	300	150	medium	Yes - delivery from October not April	Dependency on STP approval/ progress	None	25	25	25	25	25	25	25	25	25	25	25	25	25	25
Faecal Calprotectin	PC4	Oct-16	35	35	35	53	53	53	high (complete)	No	None	n/a	9	9	9	9	9	9	0	0	0	0	0	0	0	
Biosimilar high cost drugs gain share	016	Apr-17	146	146	68	318	318	201	medium	yes - reduced QIPP forecasts over 12 month profile	Requires programme management	n/a	36	36	36	36	36	19	19	19	19	19	19	19	19	
Remove SpR block from contract	168	Apr-17	317	317	317	952	952	952	high	No	none	n/a	79	79	79	79	79	79	79	79	79	79	79	79	79	
Commissioning for Value (PNRC)	006	Apr-17	50	50	0	150	150	75	medium	Yes - delivery from October not April	STP alignment in July but now incorporated into demand mgt	None	13	13	13	13	13	13	13	13	13	13	13	13	13	
Optimising Health Outcomes: BMI & smoking thresholds	064	Mar-17	1,000	1,000	1,000	3,000	3,000	3,000	high	No	None	None	250	250	250	250	250	250	250	250	250	250	250	250	250	
RightCare - Circulation (Heart Disease)	008	Oct-17	0	0	0	100	100	100	high	No	None	None	0	0	0	0	0	0	17	17	17	17	17	17	17	
RightCare - Gastroenterology	009	Apr-18	0	0	0	0	0	0	high	No	Capacity to support	PMO	0	0	0	0	0	0	0	0	0	0	0	0	0	
RightCare - Respiratory (COPD)	010	Apr-18	0	0	0	0	0	0	N/A	18/19	None	n/a	0	0	0	0	0	0	0	0	0	0	0	0	0	
RightCare - Orthopaedics / MSK	011	Oct-17	0	0	0	750	750	750	high	no	None	PMO	0	0	0	0	0	0	125	125	125	125	125	125	125	
Outpatient Transformation and Demand Management (Incl. Consultant Connect, Advice and Guidance or Virtual Clinics)	014	Oct-17	0	0	0	1,000	1,000	500	medium	yes reduced QIPP forecast targets but profiling still from October	capacity to deliver demand management jointly across system at pace and clinical empowerment to support this in both primary & secondary care	PMO & BI	0	0	0	0	0	0	167	167	167	167	167	167	167	

# QIPP: PRESCRIBING Month 04

ALL SCHEMES	Current month			4			Instructions for populating			MONTHLY PROFILES															
Scheme Name	Ref	Planned start date	YTD			Forecast Outturn			MONTH 4 QIPP RISK ASSESSMENT				Plan profile												
			Planned savings £000	Expected savings £000	Actual savings £000	Planned savings £000	Expected savings £000	Actual savings £000	QIPP Delivery Confidence	QIPP Profiling Adjustments	Key Challenges (Blockers)	National QIPP Support Prog Phase II resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
<b>PRESCRIBING</b>																									
PIB and Non-PIB unaligned: Other schemes (branded generics)	196	Apr-17	92	92	92	277	277	277	medium	TBC	Capacity in CCG (4 vacancies) and move to PIB	Pharmacy	23	23	23	23	23	23	23	23	23	23	23	23	23
PIB and Non-PIB unaligned: Therapeutic switches	197	Apr-17	43	43	43	128	128	128	medium	TBC	Capacity in CCG and MMT (8 vacancies) No PM to deliver	Pharmacy	11	11	11	11	11	11	11	11	11	11	11	11	
PIB and Non-PIB unaligned: Gluco Rx - Diabetic Prescribing	198	Apr-17	35	35	35	106	106	106	medium	TBC	Capacity in CCG (4 vacancies). No PM to deliver	Pharmacy	9	9	9	9	9	9	9	9	9	9	9	9	
PIB and Non-PIB unaligned: Minor Ailments Prescribing	176	Oct-17	0	0	0	75	75	75	medium	TBC	Capacity in CCG and MMT (4 vacancies) No PM to deliver	Pharmacy	0	0	0	0	0	0	13	13	13	13	13	13	
CCG wide: Dressings/Woundcare (ONPOS)	201	Apr-17	25	25	25	75	75	75	medium	TBC	Capacity in CCG (4 vacancies)	Pharmacy	6	6	6	6	6	6	6	6	6	6	6	6	
PIB and Non-PIB unaligned: Prescribing schemes - Quality i.e.: Red & black drugs	022	Apr-17	300	300	300	900	900	900	medium	TBC	Capacity in CCG (4 vacancies) No PM to deliver	Pharmacy	75	75	75	75	75	75	75	75	75	75	75	75	
CCG wide: Continence & Stoma Care	199	Oct-17	0	0	0	53	53	53	medium	TBC	Capacity in CCG (4 vacancies) No PM to deliver	Pharmacy	0	0	0	0	0	0	9	9	9	9	9	9	

## QIPP: Planned Care & Prescribing Month 04

### KEY QUESTIONS: UNPLANNED CARE QIPP

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

**What mitigating actions are underway?**

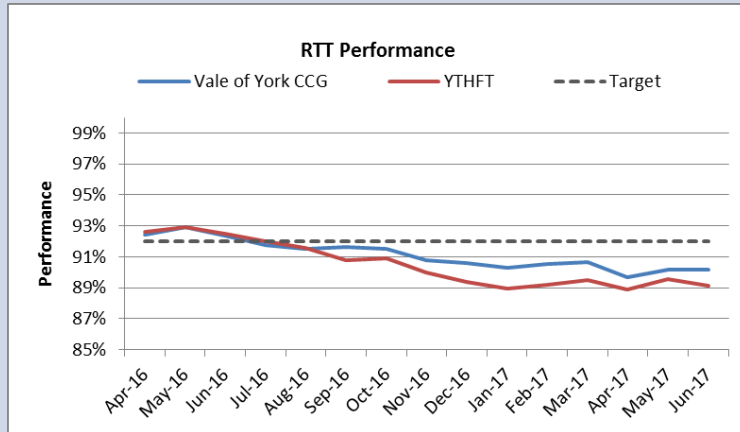
**Is further escalation required?**

See Agenda item 6 M4 Finance report with Supplementary QIPP progress report

# PERFORMANCE PLANNED CARE: REFERRAL TO TREATMENT (RTT)

## Referral to Treatment Time

Vale of York CCG			York Teaching Hospital			YTH - Admitted Backlog		
May	June	DoT	May	June	DoT	May	June	July
90.20%	90.19%	↓	89.56%	89.14%	↓	1,354	1,320	1,418



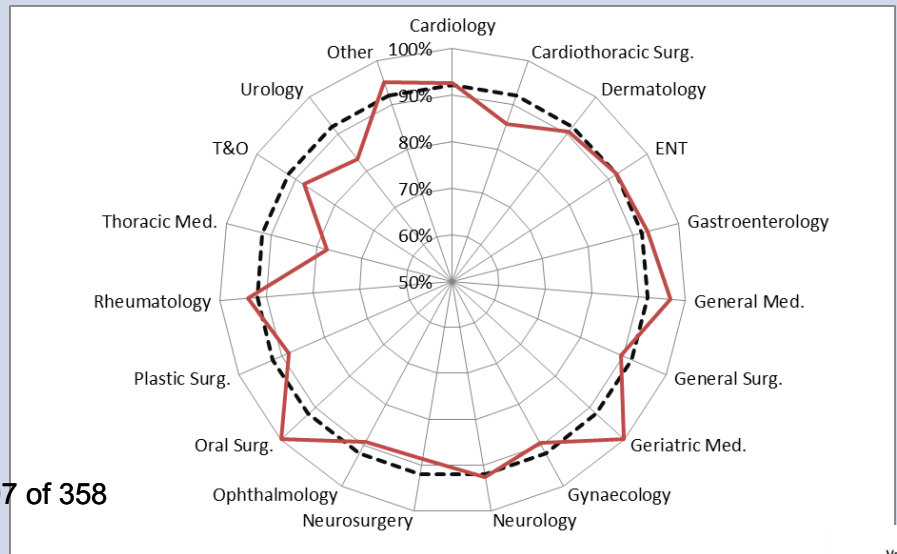
York Teaching Hospitals RTT performance in June 2017 was 89.14% which is a 0.42% reduction from May 89.56%, against the planned trajectory of 90.5%. YHFT were unable to provide a validated RTT performance figure for July 2017 but said it would be in the region of 89.6% and are not expecting to hit the planned trajectory.

At the end of June 2017 the Admitted backlog was slightly down, reflecting the increase in theatre usage and a reduction in cancellations due to bed shortages. However, the Non-admitted backlog (1809) increased due to validation work and first to follow-up appointments. Admitted backlog as at 30 July 2017 is 1418 and Non-Admitted 1868.

Specialties with a non-admitted backlog of greater than 200 include General Surgery, Dermatology and Thoracic Medicine. General Surgery and Dermatology are experiencing high demand in comparison to available capacity in cancer pathways and the alignment of resource to support urgent pathways is likely to impact on RTT non-admitted capacity.

High volume specialties with performance below the national standard or planned STF trajectory of 90.5% include General Surgery, ENT, Urology, Max Fax, Ophthalmology, Gastroenterology, Thoracic Medicine, Neurology, Gynaecology and Rheumatology. Max Fax work is being outsourced to manage the backlog but the risk remains high for 40+ week waits. Specific work to source additional capacity to meet demand is on-going for Gynaecology and Ophthalmology

Specialty	Performance	Breaches	Main Provider
Thoracic Medicine	77.80%	117 of 527	YTH
Urology	83.22%	145 of 864	YTH
Cardiothoracic Surg.	85.71%	1 of 7	SHEF
Trauma & Orthopaedics	88.08%	186 of 1560	YTH (88), LTH (61)
Plastic Surgery	88.34%	19 of 163	LTH (7), HEY (6)
Neurosurgery	88.57%	4 of 35	STH (3)
Ophthalmology	89.15%	273 of 2,515	YTH
General Surgery	89.42%	223 of 2,108	YTH
Gynaecology	89.43%	97 of 918	YTH
Dermatology	90.65%	105 of 1123	YTH
ENT	91.99%	102 of 1274	YTH
<b>Total</b>	<b>90.19%</b>	<b>1,543 of 15,732</b>	YTH



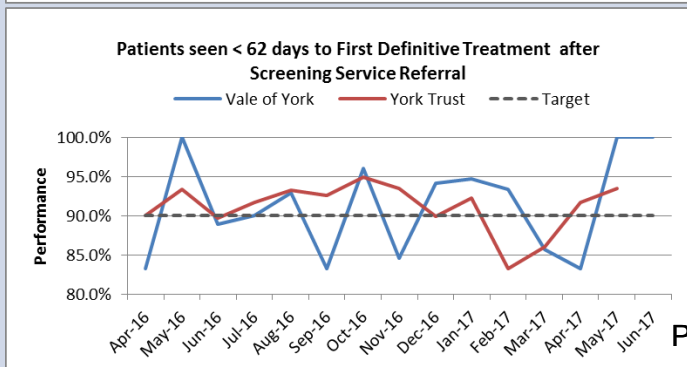
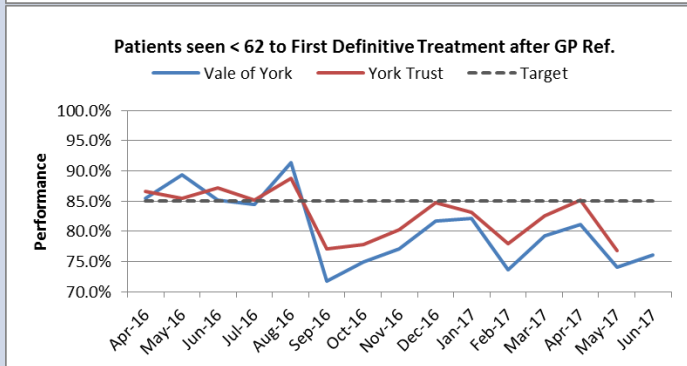
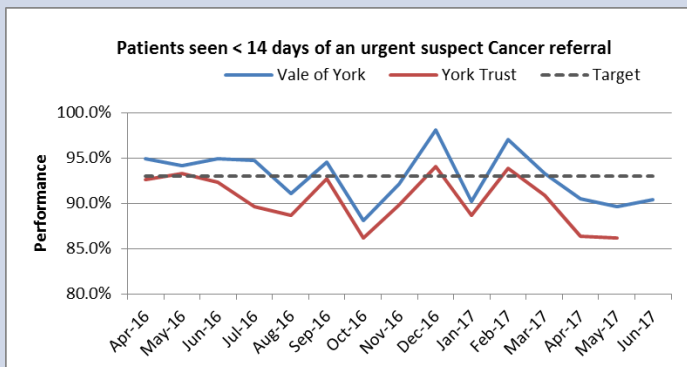
Cancer

14 Day Fast Track

62 Day 1<sup>st</sup> Treatment (GP)

62 Days 1<sup>st</sup> Treatment (SS)

CCG	DoT	Target	CCG	DoT	Target	CCG	DoT	Target
90.4%	↑	93%	76.1%	↑	85%	100%	↑	90%



York Teaching Hospitals NHS Foundation Trust met 5 out of the 7 cancer targets for May 2017 but failed the following:-

14 Day Fast Track (86.2% - 174 breaches of which 54% were diagnosed with no cancer)

62 days first definitive treatment (76.8% - 25 breaches)

VOYCCG failed to meet the **62 Day First Treatment** target in June 2017. There were 22 (18 admitted / 4 non-admitted) breaches in total: 14 York, 6 Leeds and 1 each at Hull and Sheffield.

YHFT continue to work with the Cancer Alliance on the pathways to tertiary centres and the allocation of breaches. YHFT has been allocated £131K funding to enhance the one-stop diagnostics at Malton and pilot 'straight to test' to reduce the number of 62 day breaches by improving diagnostic turnaround times.

The Cancer Alliance is now working with the STP on the refresh of the capital bid which will now focus on diagnostics. We will aim to align the CTF and STP capital bids so that they complement each other and give us the maximum opportunity for transformational change and sustaining improved diagnostic services for the future.

A bid will be resubmitted in September by the Cancer Alliance and which contains elements of early diagnosis, diagnostics and living with and beyond cancer (see Annex 1 for draft submitted to NHSE regional team on 09 August for final submission following further consultation on 01 Sept).

VOYCCG failed to meet the **14 Day Fast Track** target achieving 90.4% in June against 93% target. Skin comprises the vast majority of the breaches (65.5% of the 174 breaches in June) due to the lack of Consultant capacity and ability to deliver outpatient clinics on the east coast and now Selby. The vast majority of these are diagnosed no cancer (80.5%). While the use of dermatoscopes, GPSI training and RSS have supported dermatology referrals, there is an urgent need to work with YTH to change the current service model. S&R CCG are progressing with centralising all dermatology clinics at Malton and YTH has written to VoY CCG notifying them of intention to close dermatology clinics at Selby and centralise on the York Hospital site (see Annex 1). A full update will be given to the Committee in September.

25% of all breaches were due to patient choice. This was raised at sub-CMB in July to ask for support with communication from GPs and directorates are working with Cancer Nurse Specialists to support if possible.

Colorectal referrals have increased, and comprise 10% of breaches in June. The funding to support FIT testing and straight to test will support the demand management of this speciality.



**HIGH IMPACT ACTION PLAN: Outstanding actions:**

- Not all timed pathways are in place
- Demand and capacity modelling has not been completed for diagnostics.
- No review of near misses

Timed pathways: The priority is to implement the optimal pathways for lung and prostate through the alliance pathway groups. The STT elements of the colorectal and Upper GI pathways will be implemented as part of the 62 day recovery plans with other times pathway elements agreed once this is in place. Over the next 18 months, the alliance will be reviewing the pathways for the other tumour sites, learning from timed pathways that have been implemented elsewhere and agreeing the pathways that will be implemented across HCV, building clinical support for implementation. Action: MG to clarify the position re national optimal pathway for prostate.

Demand and capacity for diagnostics: Each provider will be participating in the HCV wide demand and capacity modelling exercise for diagnostics which will begin in September and aims to report in January.

Near misses: Capacity in the system is currently focussed on reducing the number of breaches. Prior analysis of near misses suggests that these patients would be treated by day 60 i.e. not be near misses if GP adherence to NICE guidelines were improved, diagnostic capacity increased and optimal/timed pathways in place. Work to address these key elements is already underway. There is no lack of willingness to review the reason for near misses, but at the moment this is not likely to add value to the understanding of why they occur. In the current system, treatment on days 60, 61 is simply how patients are managed within the 62 day timeframe.

**YTHFT refresh of Return to Operational Standards** underway aligning work to the High Impact Actions.

- Performance pack reporting has been enhanced with a focus on timed pathways, time to diagnosis, IPT targets and long wait patients.
- A refresh of the internal performance structure is underway to ensure senior management oversight on all tracking through Deputy Directorate Managers.
- Validation on long wait patients completed to manage the number of patients waiting over 104 days with suspected cancer.
- Mobilisation of the funding to support colorectal and review of options to support MRI for prostate underway.

## PERFORMANCE PLANNED CARE: CANCER

Jul-17	Indicator	Target	In Target	Out of Target	% in Target	Pass /Fail
1.1	14 day Fast Track	93%	994	233	81.01%	validated, predicted fail
1.2	14 day Symptomatic Breast	93%	99	3	97.06%	validated, predicted pass
2.1	31 day 1st treatment	96%	233	4	98.31%	validated, predicted pass
2.8	31 day subsequent - surgery	94%	39	2	95.12%	validated, predicted pass
2.8	31 day subsequent - drug	98%	102	0	100.00%	validated, predicted pass
3.1	62 day 1 <sup>st</sup> Treat	85%	103.5	22	82.47%	under validation, predicted fail
4.1	62 day screening	90%	20.5	2	91.11%	validated, predicted pass

Aug-17	Indicator	Target	In Target	Out of Target	% in Target	Pass /Fail
1.1	14 day Fast Track	93%	419	88	82.64%	under validation, predicted fail
1.2	14 day Symptomatic Breast	93%	46	1	97.87%	under validation, predicted pass
2.1	31 day 1st treatment	96%	81	4	95.29%	under validation, current fail
2.8	31 day subsequent - surgery	94%	9	0	100.00%	under validation, predicted pass
2.8	31 day subsequent - drug	98%	25	0	100.00%	under validation, predicted pass
3.1	62 day 1st treatment	85%	46.5	11	80.87%	under validation, predicted fail
4.1	62 day screening	90%	9	0	100.00%	under validation, predicted pass

Q2 2017-2018	Indicator	Target	In Target	Out of Target	% in Target	Pass /Fail
1.1	14 day Fast Track	93%	1413	321	81.49%	under validation
1.2	14 day Symptomatic Breast	93%	145	4	97.32%	under validation
2.1	31 day 1st treatment	96%	314	8	97.52%	under validation
2.8	31 day subsequent - surgery	94%	48	2	96.00%	under validation
2.8	31 day subsequent - drug	98%	127	0	100.00%	under validation
3.1	62 day 1st treatment	85%	150	32.5	82.19%	under validation
4.1	62 day screening	90%	29.5	2	93.65%	under validation

### PERFORMANCE AGAINST CANCER ALLIANCE 62 DAY RECOVERY PLAN

Weekly conversations regarding the role of DMs in cancer tracking are developing a better understanding of roles and responsibilities.

The key actions on the recovery plan have had to wait for the funding to be released and will now be able to move forward with weekly updates to the alliance.

**June: Trajectory – 85% actual 80.56%**

Reasons for being below trajectory☺

Skin remains a capacity pressure on the East Coast and this has been raised with the CCG over the last 6 months to a year. The CCG have taken this as a risk on their Contract Board risk log. We are monitoring the position along with our CCG partners to develop solutions but these will not be immediate.

All teams are monitoring patients through their pathways and there is heightened scrutiny on any potential delays with senior escalations where necessary.

Awaiting funds to implement recovery plan and these should now be en route

**July** – expecting to be steady at around 81%

**August** position – at this point expecting to be showing a steady upward trend – whilst this may not achieve 85% for September, hopeful of achieving for October/November

### Further HCV wide actions to improve 62 days

**Cancer Alliance** arranging one to one visits with each provider to discuss the recovery plans in detail.

Cancer Alliance also circulating template which will capture how and when 62 day monies are being spent at each provider.

Agreement that the adoption of optimal pathway will be facilitated by: agreeing the optimal pathway, each provider conducting an audit/mapping against current practice, convening a task and finish group to take implementation forward.

Cancer managers at all three providers to agree timelines and approach for carrying out the mapping and audit work for the optimal lung and pathways work in order to support timely set up of T&F groups.

Optimal lung audit tool being completed in each of the provider organisations. Ambition for CRUK spreadsheet capturing the cycle of practice visits ( use of 2ww, audit, safety netting, clinical decision tools) to be a standing item at all 3 cancer locality groups- support assurance re improving quality of referrals as part of managing capacity for 62 days.

This information will also be shared with NHSE regional team and will form part of the regular north region discussion regarding 62 days and to a lesser extent other performance standards that are not being met. For York/Scarb the other standard that has not been met in May is 2ww referrals

## PERFORMANCE PLANNED CARE: DIAGNOSTICS

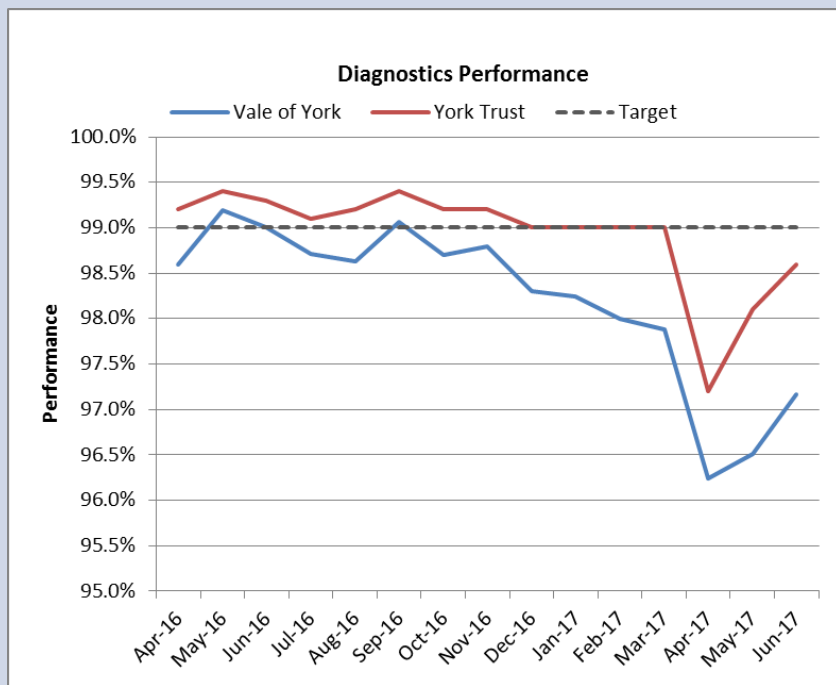
Test	Performance	Activity	Provider
CT	6.27%	43 of 686	HEY (23), BTH (20)
Sleep Studies	51.61%	16 of 31	YTH
MRI	2.43%	15 of 618	YTH (8) NLAG (4)
Flex_Sigmoidoscopy	7.14%	6 of 84	YTH (4) MY (2)
<b>Total</b>	<b>2.83%</b>	<b>98 of 3,457</b>	<b>YTH (39)</b>

Vale of York CCG failed to meet the target of 99% of patients waiting less than 6 weeks for a Diagnostic Test in June 2017. There were a total of 98 breaches out of 3457, which equates to 2.83% against the 1% target. 43 CT breaches - 20 breaches were reported at Bradford Teaching Hospitals due to capacity issues with Cardiac CT. Bradford are outsourcing to external providers to meet demand. Hull & East Yorkshire Hospital reported 23 breaches and have also been struggling with Cardiac CT capacity, with a further 17 breaches reported at Hull for SRCCG patients.

York Teaching Hospitals achieved 98.83% in June against the 99% diagnostic target and will fail again in July 2017. A major contributory factor is Sleep Studies at York Hospital with 16 breaches for VOYCCG and 6 breaches for SRCCG in June 2017. The Trust has now acquired 2 new machines to increase capacity and the position should be recovered at Scarborough in August and at York by the end of September 2017. Cystoscopy breaches reduced to 5 (3 at York and 2 at Scarborough) but there were 8 MRI breaches reported at York and 7 MRI breaches at SRCCG.

The previously reported issues with the DEXA scanner at Scarborough have been resolved and Radiology achieved in all modalities in July 2017.

Stroke (reported 1 month behind due to coding) In May the Trust achieved target for the proportion of patients spending > 90% of their time on a stroke unit and the High Risk TIA target. The Trust failed to achieve target for the proportion of urgent scans within 1 hour and patients scanned within 24 hours.





Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
<p><b>RTT – No</b></p> <p><b>Cancer – No</b></p> <p><b>Diagnostics – No</b></p>	<p><b>RTT</b>  <b>Long-waiters management</b> on a weekly basis, YHFT review every patient who has waited over 40 weeks and put a plan in place. 73 patients are now waiting over 40 weeks. The highest volumes over 40 weeks are Max Fax (57.6%), with Thoracic and General Surgery also comprising over 10% each.            There has been considerable work in June to model clinic utilisation to support the non-admitted pathways and to model changes to demand management and commissioning proposals on the RTT recovery trajectory</p> <p><b>Cancer</b>            YTHFT are hoping to optimise the available capacity by running dermatology clinics at Malton and York as they are unable to recover the position at Scarborough – awaiting confirmation from SRCCG.            YTHFT are working with the Cancer Alliance on the pathways to tertiary centres and the allocation of breaches. YTHFT has been allocated £131K funding to enhance the one-stop diagnostics at Malton and pilot 'straight to test' to reduce the number of 62 day breaches by improving diagnostic turnaround times, however.</p> <ul style="list-style-type: none"> <li>• Primary care education – learning lunches with consultants attending GP practices – proposed Oct-Mar</li> <li>• Run audit of photo quality/quantity through the month of September to assess if theory of photo quality correct and that increased education would be beneficial.</li> <li>• Internal discussions with regards to the involvement of Max Fax in the current skin cancer pathway are underway.</li> <li>• YTHFT scoping the possible development of a one stop MDT clinic for 'cancer lumps and bumps'. The clinic would contain a plastics consultant so the relevant patients could be seen quickly and slot for surgery booked on the same day.</li> <li>• Colorectal increasing 2WW referrals (RSS analysing June) due to change in NICE guidance. Analysis required to assess if we are seeing more cancers now we are seeing more referrals. DC to ask surgeons for their opinion.</li> <li>• Northumbria model - triaged as low, medium or high risk triage – 2 different routes to 2WW. Would need to look at the model to assess whether this model of triage change the end capacity for diagnostics</li> <li>• Quality of pictures vary therefore consultant triage cannot be effective. Consider Exeter example (photo facility at hubs so we can increase quality)</li> <li>• Analysis to identify practices which are struggling - consultant audit of photo quality and quantity to be conducted throughout the month of September.</li> </ul> <p><b>Diagnostics</b></p> <ul style="list-style-type: none"> <li>• Bradford are outsourcing CT scans to external providers to meet demand.</li> <li>• Hull have acquired and extra mobile van to scan 110 cardiac patients and are getting a new scanner in the near future.</li> <li>• The DEXA scanner at York was repaired in May 2017.</li> <li>• Sleep Studies have additional clinic space and equipment purchased to increase capacity through July and August 2017.</li> <li>• There is a further update to the Diagnostics recovery plan due at the end of August and the Planned Care System Performance Group will review this in September.</li> </ul>
Is there a trajectory and a date for recovery / improvement?	Is further escalation required?
<p>York Teaching Hospitals Return to Operational Standards performance improvement plan incorporates the recovery plans for RTT, Cancer and Diagnostics.</p>	<p>York Teaching Hospitals Return to Operational Standards performance improvement plan incorporates the recovery plans for A&amp;E 4 hour, RTT, Cancer and Diagnostics performance. The improvement plan is being refreshed to incorporate the outcomes from the winter planning process underway and will be presented to Trust Board in August and considered by the CCG in September as part of the wider recovery plans for each area of under-performance.</p>

# Programme Overview

## - Unplanned Care -

Validated data to June 2017

## UNPLANNED CARE PROGRAMME

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

**Executive Lead:** Executive Director System & Resources

**Programme Lead:** Fiona Bell, Assistant Director of Transformation & Delivery; Becky Case, Head of Transformation and Delivery

**Clinical Lead:** Andrew Phillips, Medical Director, CCG



### CONTRACTING: Month 03

Point of Delivery	Current Month							
	Activity				Expenditure			
	Plan	Act.	Var.	%	Plan	Act.	Var.	%
Accident and Emergency	17,359	15,954	1,405	8.1%	2,328	2,270	57	2.5%
Inpatient	9,162	9,196	(35)	(0.4%)	16,918	17,050	(132)	(0.8%)
Other	6,076	5,543	533	8.8%	4,286	3,930	356	8.3%
CQUIN					588	469	119	20.2%
<b>Total</b>	<b>32,597</b>	<b>30,693</b>	<b>1,904</b>	<b>5.8%</b>	<b>24,120</b>	<b>23,720</b>	<b>401</b>	<b>1.7%</b>

Please refer to the Contract Trading Report

# QIPP: Unplanned Care Month 04

ALL SCHEMES			Current month 4						Instructions for populating				MONTHLY PROFILES													
Scheme Name	Ref	Planned start date	YTD			Forecast Outturn			MONTH 4 QIPP RISK ASSESSMENT				Plan profile													
			Planned savings £000	Expected savings £000	Actual savings £000	Planned savings £000	Expected savings £000	Actual savings £000	QIPP Delivery Confidence	QIPP Profiling Adjustments	Key Challenges (Blockers)	National QIPP Support Prog Phase II resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
<b>UNPLANNED CARE</b>																										
Community Podiatry	IC4	May-17	107	107	107	393	393	393	high	none	none	n/a														
Patient Transport - contracting review	190a	Apr-17	11	11	11	11	11	11	high	none	none	n/a	11	0	0	0	0	0	0	0	0	0	0	0		
Wheelchairs service re-procurement	207	Apr-17	109	109	109	217	217	217	high	yes	Impact of legacy volumes and financial implications	n/a	27	27	27	27	27	27	27	27	0	0	0	0		
Community Equipment service re-procurement	187	Apr-17	209	209	51	418	418	102	high	yes	As above	n/a	52	52	52	52	52	52	52	52	0	0	0	0		
Integrated Care Team Roll-out (Central locality only)	152	Apr-17	252	252	252	756	756	756	high	none	none	n/a	63	63	63	63	63	63	63	63	63	63	63	63		
<b>Unplanned Care Programme</b> (including urgent care and out of hospital care) Incorporates the following CCG QIPP schemes: (i.) Review of community inpatient services Phase 1 (Archways) (ii.) Review of community inpatient review Phase 2 SEE QIPP PLANNED AND RISK ADJUSTED PROFILE BELOW FOR BED REVIEW QIPP SCHEMES INCLUDED IN THE UNPLANNED CARE PROGRAMME Includes the following A&E Delivery Board work streams: (i.) complex discharge (ii.) health navigator This programme is also critical to delivering the Heads of Term for unplanned care which focuses on the Frail Elderly, Long Term Conditions and Multiple attenders. There are 3 locality delivery plans with emerging priorities for improving out of hospital care as follows (July 2017): 1) <b>South Locality:</b> same day demand (incorporating consideration of Selby MIU); intermediate care and reablement and prevention. 2) <b>Central Locality:</b> self management; care homes; same day access/ integrate care teams; UCPs 3) <b>North Locality:</b> intermediate care teams; self management. There are also a number of cross-cutting work streams which enable service transformation across all 3 localities including: Case finding; system shared care records; estates; workforce; discharge with care; CHC.	149	Jul-17	92	92	0	824	824	275	medium	Yes: Unplanned care programme reprofiled delivery start date from July to January 2017	System engagement and delivery through locality plans creating delay in mobilising	Dedicated BI analyst and additional PMO support requested	0	0	0	92	92	92	92	92	92	92	92	92	92	92
Review of community inpatient services - Phase I (Archways)	019a	Apr-17	140	140	117	421	421	352	medium	Yes	None	n/a	35	35	35	35	35	35	35	35	35	35	35	35		
Review of community inpatient services - Phase II	019b	Oct-17	0	0	0	200	200	200	medium	No	System approach required; work stream under A&E DR	BI	0	0	0	0	0	0	33	33	33	33	33	33		
RightCare Phase 2 - Trauma & Injuries	017	Apr-18	0	0	0	0	0	0	high	Yes	Capacity to date to mobilise	PMO	0	0	0	0	0	0	0	0	0	0	0	0		
Patient Transport project - re-procurement	190b	Apr-18	0	0	0	0	0	0	medium	n/a	YAS contract	n/a	0	0	0	0	0	0	0	0	0	0	0	0		

## QIPP: Unplanned Care Month 04

### KEY QUESTIONS: UNPLANNED CARE QIPP

<b>Are QIPP targets being met and are you assured this is sustainable?</b>	<b>What mitigating actions are underway?</b>	<b>Is further escalation required?</b>
See Agenda item 6 M4 Finance report with Supplementary QIPP progress report	Page 115 of 358	

# PERFORMANCE: ECS & ORGANISATION

## Accident and Emergency

## Ambulance Service

### Type 1 Attendances

### % seen within 4 hrs

### Conversion Rate

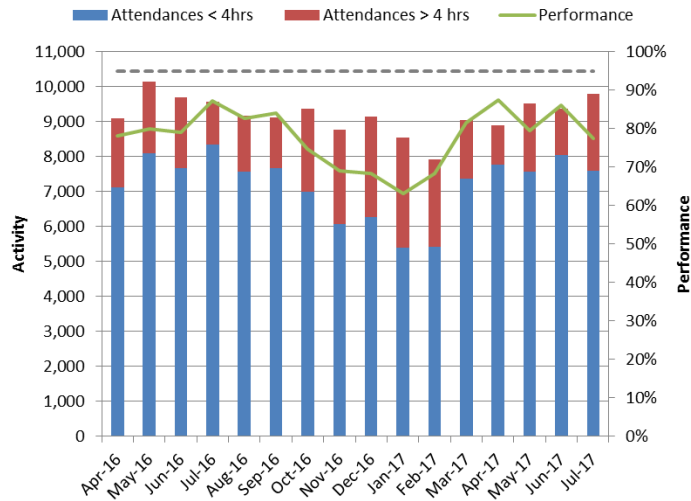
### Cat. 1 Response

### Arrivals at Destination

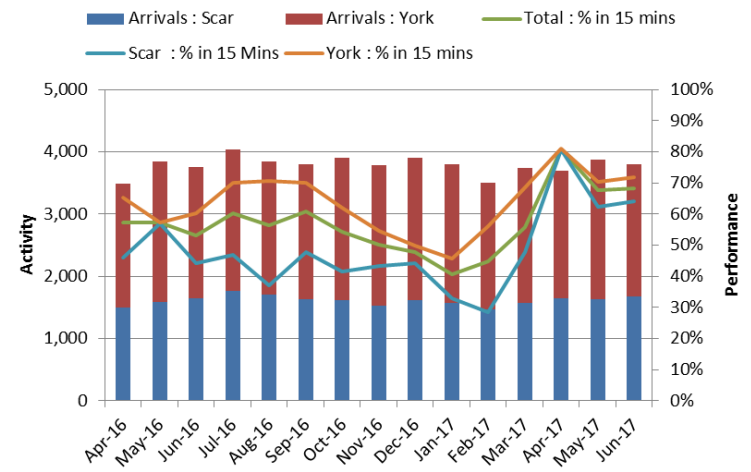
### 15 Min Handover

Type 1 Attendances			% seen within 4 hrs			Conversion Rate			Cat. 1 Response			Arrivals at Destination			15 Min Handover		
May	June	July	June	July	DoT	June	July	DoT	May	Jun	DoT	May	Jun	DoT	May	Jun	DoT
9,531	9,358	9,804	85.79%	77.46%	↓	36.80%	35.90%	↑	74.1%	68.2%	↓	3,876	3804	↑	67.7%	68.4%	↑

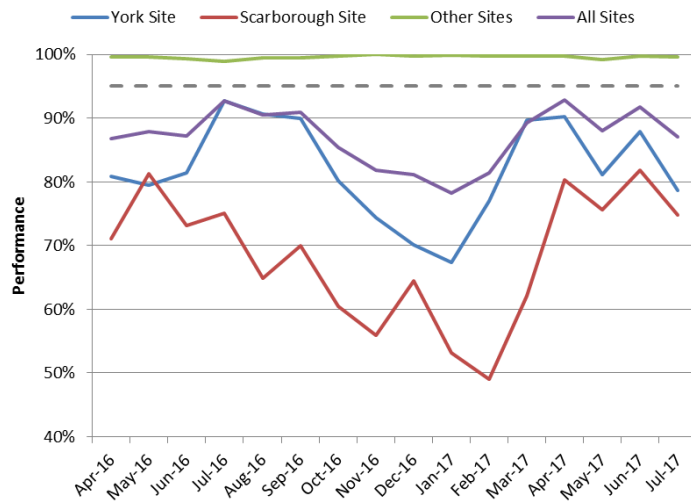
York Trust (All Sites) - Type 1 Attendances and 4 hr Performance



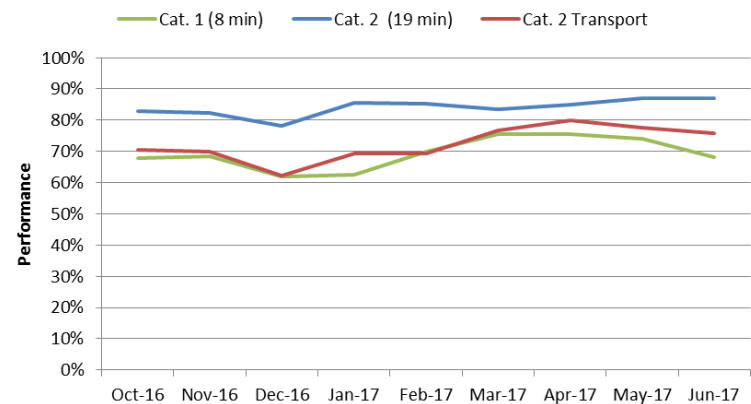
YAS - 15 mins Handover



York Trust - AE 4 Hr Performance by Site



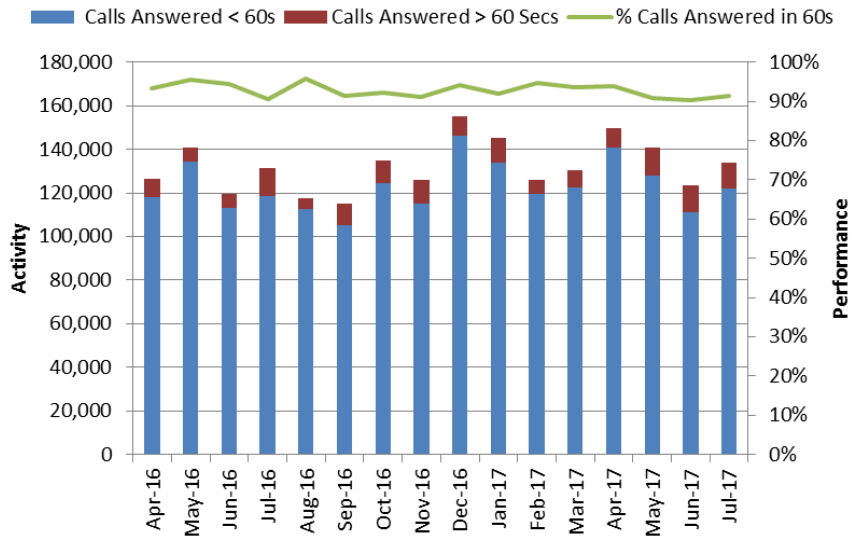
Vale of York CCG - Response Times



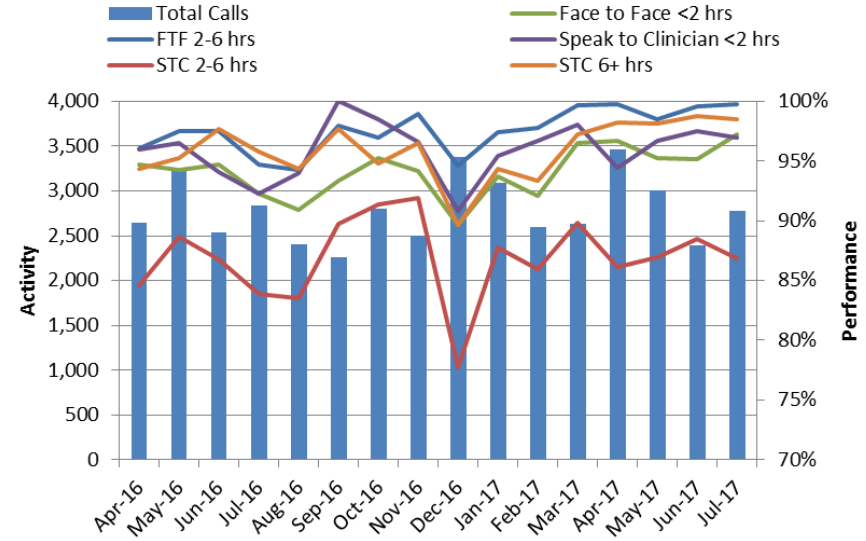


# URGENT CARE SYSTEM SERVICES : PERFORMANCE

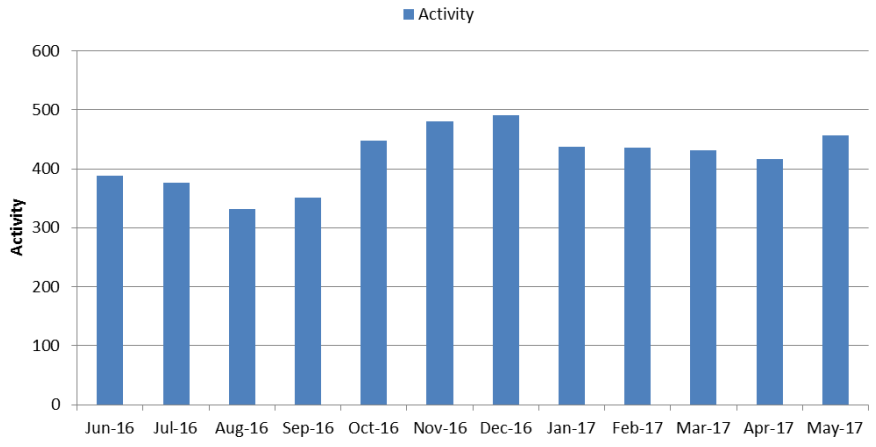
### NHS 111 (Y&H)

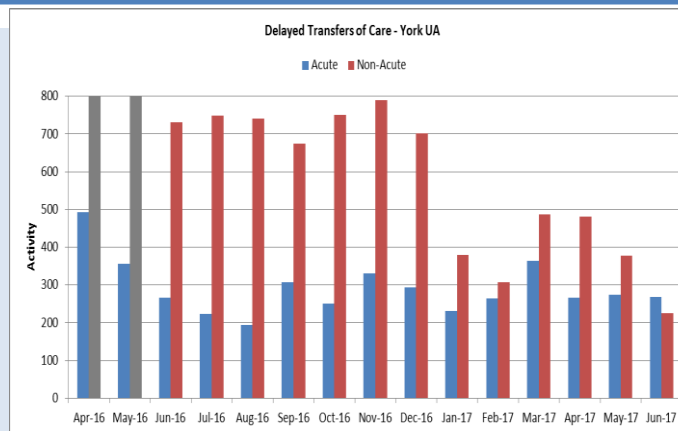


### GP Out of Hours



### Urgent Care Practitioners (YAS)





Delayed transfers of care (DTOCs) is an indicator that is used by the whole system to identify causes of delay/problems discharging people from hospital or community in-patient settings (including mental health). There are regular operational discussions about any delays to help resolve any barriers in the system. On a patient by patient basis, front line staff and service managers actively case manage people identified as delayed. When people spend longer than they need to in a hospital bed it has a significant and negative impact on their health and well-being and long term independence.

#### Common reasons for delay include:

- Continuing Health Care systems and processes are a contributory factor in delays
- Delays in putting packages of care in place to support people in their own home
- Difficulties in sourcing overnight care packages
- 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
- 7 day discharge systems and processes are yet to be embedded across all parts of the system
- Patient Choice - patients sometimes wait in acute beds for their preferred Care Home placement

#### Actions to address the poor performance include:

1. Continuing health care – executive lead in place to direct a programme of work, including systems/process/capacity pressures
2. Care homes, packages of care – CYC market position statement being reviewed, High Impact Change self-assessment undertaken as part of BCF planning
3. Review of community beds – common recurring reasons for delay identified and alternative system solutions being developed by partner agencies
4. 7 day discharges – priority programme within the BCF
5. Patient choice – protocol agreed to support timely discharge

DTOCs is one of our key performance indicators and is reported monthly through UNIFY returns. This issue falls with the remit of the A & E Delivery Board, BCF and a recent community bed review. Nationally, the government has set a target of 3.5% of occupied bed days that are delayed in the acute sector. Additional funding has been directed through local authorities in the form of the improved Better Care Fund (BCF). A distinct BCF trajectory has been set for reduction of DTOCs which is monitored via the BCF assurance regime. This complex picture reflects the challenge for partners in managing/reducing DTOCs.

The Care Quality Commission (CQC) has been commissioned to carry out a programme of local system reviews looking at how well services work together to ensure that people move through the health and social care system as smoothly as possible. The footprint is an early site for this programme of work and will be reviewed in autumn 2017. A separate report to the Governing Body provides more detail on this review.



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

### What mitigating actions are underway?

- **4-hour standard:** this continued to deteriorate in June/July. Doctor and nurse staffing is was very poor prior to the August handover. August is showing signs of recovery.
- **Ambulance Handovers:** Handovers continue to be good.
- **YAS response times:** the response times are still good as flow through the system generally has improved. 8 minute response has slipped slightly; if this is shown to be a trend next month, more investigation will take place.
- **OOH GP:** services continue to perform well against quality targets. Staff satisfaction and plans for continuation beyond 2018 are being reviewed.
- **EDFD:** We are still awaiting the revised figures from 1<sup>st</sup> July 2016. This will have a significant positive impact on the finances of this scheme for the CCG.
- **NHS111:** performance continues to be on target.
- **DTOC:** increased focus on this is driving the discussions in both the Complex Discharge Group and the BCF planning round; the new target will commence in September 2017 and will be closely monitored from this point.
- **Utilisation review:** data is being used in the stranded patient review on 17/08 and for winter planning processes.

- **4-hour standard:** the work around diversionary pathways is continuing across the STP area. Locally staffing is the major problem and YHFT and YDUC are developing joint processes for surge conditions.
- **Ambulance Handovers:** No mitigating actions required at present; monitoring continues.
- **YAS response times:** No mitigating actions required at present; monitoring continues.
- **OOH GP:** No mitigating actions required at present; monitoring continues. The failure of achievement against the 2-hour target will continue to be monitored but until the advanced clinical advisory service is in place and/or national pathways changed this will continue to be an issue. YDUC continue to provide additional clinical triage and comfort calls at regular intervals for this cohort of patients. Staffing is being monitored via the contract.
- **EDFD:** the request for the revised data pack has been reiterated via CMB
- **NHS111:** No mitigating actions required at present; monitoring continues.
- **DTOC:** winter plans will support the achievement of this target
- **Utilisation review:** individual actions from the AEDB are being escalated as required

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

### Is further escalation required?

- **4-hour standard:** a joint trajectory has been agreed for achievement of 95% by March 2018.
- **Ambulance Handovers:** current performance matches that seen regionally; monitoring over the next three months will continue.
- **YAS response times:** current performance meets the target; monitoring over the next three months will continue.
- **OOH GP:** not applicable at present. A review for exec is being prepared.
- **EDFD:** this has been raised at CMB: response by end of August requested
- **NHS111:** not applicable at present.
- **DTOC:** data better understood. Clear trajectory described
- **Utilisation review:** we have requested a set of timescales around the proposals put forward at the Complex Discharge group; awaiting response

- **4-hour standard:** No – winter planning is being undertaken by all system partners through the A&E Delivery Board
- **Ambulance Handovers:** No
- **YAS response times:** No
- **OOH GP:** No
- **EDFD:** Escalation will take place on 24/07 if information not received
- **NHS111:** No
- **DTOC:** has been discussed at BCF planning meetings during August
- Next steps work for the local unplanned system includes monitoring of the above, as well as new workstreams focus on CHC Delayed Transfers of Care, complex discharge and front-door frailty assessment linked to the locality plans.



# Programme Overview

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

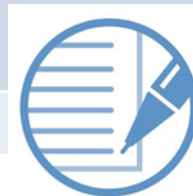
Validated data to June/July 2017

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:** Executive Director of Joint Commissioning

**Programme Lead:** Paul Howatson, Head of Joint Programmes; Bev Hunter, Head of Mental Health Commissioning

**Clinical Lead:** Louise Barker, GP



**Contract Month 3**

	YTD Position Month 4		
	Budget £000	Actual £000	Variance £000
<b>Mental Health Services</b>			
Tees Esk and Wear Valleys NHS Foundation Trust	13,185	13,182	3
Out of Contract Placements and SRBI	1,734	2,057	(323)
Non-Contracted Activity - MH	140	155	(14)
Other Mental Health	78	47	31
<b>Sub Total</b>	<b>15,137</b>	<b>15,441</b>	<b>(304)</b>

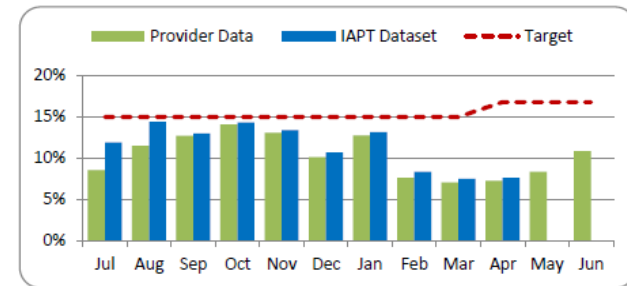
Forecast Outturn			Comments
Budget £000	Actual £000	Variance £000	
39,306	39,306	0	
5,017	5,117	(100)	This is an area to focus on during 2017/18 and includes spend on Section 117 aftercare. Plans for 2017/18 include reviewing and analysing the data available and discussing “in-year” options with the lead provider and local authority colleagues to control spending. <b>2017-18 plan includes -£300k QIPP relating to reducing ‘out of contract’ expenditure.</b>
421	421	0	
233	233	0	
<b>44,977</b>	<b>45,077</b>	<b>(100)</b>	

ALL SCHEMES			Current month 4			Instructions for populating			MONTHLY PROFILES				Plan profile												
Scheme Name	Ref	Planned start date	YTD			Forecast Outturn			MONTH 4 QIPP RISK ASSESSMENT																
			Planned savings £000	Expected savings £000	Actual savings £000	Planned savings £000	Expected savings £000	Actual savings £000	QIPP Delivery Confidence	QIPP Profiling Adjustments	Key Challenges (Blockers)	National QIPP Support Prog Phase II resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
<b>COMPLEX CARE</b>																									
Continence Supplies	C1	Apr-17	19	19	19	23	23	23	high	no	none	n/a	5	5	5	5	5	0	0	0	0	0	0	0	0
CHC review 1 to 1 care packages	024a	Apr-17	56	56	56	98	98	98	medium	TBC	Time consuming and potential additional capacity requirements (TB)	TBC	14	14	14	14	14	14	0	0	0	0	0	0	0
CHC review: Short Breaks	024b	Apr-17	29	29	29	51	51	51	medium	TBC	as above	TBC	7	7	7	7	7	7	0	0	0	0	0	0	0
CHC review panel decisions (jointly funded packages of care)	024c	Apr-17	0	0	47	83	83	83	medium	TBC	as above	TBC	12	12	12	12	12	12	0	0	0	0	0	0	0
Complex Care - CHC and FNC benchmarking	024d	Oct-17	0	0	0	1,550	1,550	0	medium	yes - delivery adjusted to 18/19 from 17/18	as above	TBC	0	0	0	0	0	0	258	258	258	258	258	258	258
Recommissioning MH out of contract expenditure: comprised of two work streams (i) review of MH external placements and high cost cases in order to identify opportunity to reprofile with alternative provider solutions/ packages of care (ii) review of where services are not in current contract and opportunities for bundles of services to be incorporated into contract (so far reviews of chronic fatigue syndrome, adult autism, IFRs and psychosexual services have not indicated any opportunities therefore focus now on review of individual care packages (whether jointly funded nursing packages or fully funded care packages))	025	Apr-17	100	100	0	300	300	200	medium	yes - QIPP delivery to start from August not April	Capacity in CCG	TBC	25	25	25	25	25	25	25	25	25	25	25	25	

KEY QUESTIONS: MH LD CC & Children's 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 6 M4 Finance report with Supplementary QIPP progress report		

Improving Access to Psychological Therapies (IAPT) : Prevalence								
The proportion of people that enter treatment against the level of need in the general population. <b>Target – 16.8% from April-17</b>								Trend
								↓
Nov 16	Dec 16	Jan 17	Feb 17	Mar17	Apr17	May17	Jun17	RAG
13.1%	10.1%	12.7%	7.6%	7.1%	7.3%	8.4%	10.9%	

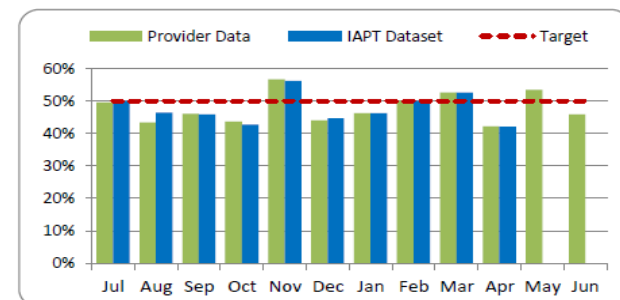


Provider Data

Source: TEVV

Monthly	2016-17						2017-18					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of Referrals	420	383	486	459	438	375	466	400	571	325	383	326
Number Entering Treatment	223	300	331	367	341	264	332	199	184	191	219	284
Monthly Prevalence rate	8.6%	11.5%	12.7%	14.1%	13.1%	10.1%	12.7%	7.6%	7.1%	7.3%	8.4%	10.9%
Rolling 3 month Prevalence rate	10.5%	10.4%	10.9%	12.8%	13.3%	12.4%	12.0%	10.2%	9.1%	7.3%	7.6%	8.8%
Quarterly against target	Target	Q2	Var.	Target	Q3	Var.	Target	Q4	Var.	Target	Q1	Var.
Number Entering Treatment	1172	854	-318	1172	972	-200	1172	715	-457	1319	694	-625
Quarterly Prevalence rate		10.9%			12.4%			9.1%			8.8%	

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. <b>Target – 50%</b>								Trend
								↓
Nov 16	Dec 16	Jan 17	Feb 17	Mar17	Apr17	May17	Jun17	RAG
56.6%	44.0%	46.3%	50.0%	52.7%	42.2%	53.4%	45.9%	



Provider Data

Source: TEVV

Monthly	2016-17						2017-18					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number completing treatment	135	200	157	125	139	171	151	150	143	202	126	130
Number moving to recovery	58	78	65	48	73	66	62	66	69	81	62	56
Number not at caseness	18	20	16	15	10	21	17	18	12	10	10	8
Monthly Recovery rate	49.6%	43.3%	46.1%	43.6%	56.6%	44.0%	46.3%	50.0%	52.7%	42.2%	53.4%	45.9%
Rolling 3 month Recovery rate	47.4%	45.4%	45.9%	44.3%	48.9%	48.1%	48.7%	46.6%	49.6%	47.5%	48.3%	46.3%
Quarterly against submitted plans	Plan	Q2	Var.	Plan	Q3	Var.	Plan	Q4	Var.	Plan	Q1	Var.
Number moving to recovery		201			187			197		195	199	4
Quarterly Recovery rate		45.9%			48.1%			49.6%			46.3%	

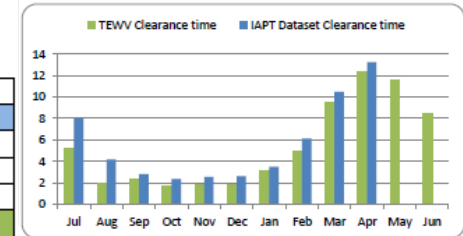
## PERFORMANCE EXCEPTIONS: Mental Health - IAPT & PHBs

### 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		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
NHS Digital Clearance Times in weeks	8.0	4.2	2.8	2.3	2.5	2.6	3.5	6.1	10.5	13.3		
Waiting for treatment at month end (TEWV)	331	122	155	125	144	137	223	297	522	543	528	454
Difference to nationally reported	-314	-198	-65	-70	-61	-63	-37	-98	-88	-82		
TEWV Clearance Times in weeks	5.2	2.0	2.4	1.6	1.8	1.8	3.1	4.9	9.5	12.3	11.6	8.5

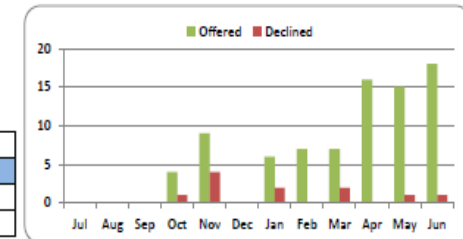


## PERFORMANCE EXCEPTIONS: Mental Health - Personal Health Budgets

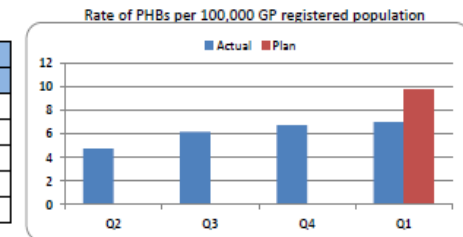
### Vale of York CCG

Source: systmOne

Monthly	2016-17									2017-18		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Personal Health Plan Offered				4	9	0	6	7	7	16	15	18
Personal Health Plan Declined				1	4	0	2	0	2	0	1	1



Plan/Actual/Variance	Q2			Q3			Q4			Q1		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
Quarterly Performance Against Plan												
Number of PHBs in place at the beginning of the quarter	13			17			22			20	24	4
Number of PHBs that began during the quarter	4			5			2			15	1	-14
Total Number of PHBs in the quarter (sum of above)	17			22			24			35	25	-10
GP registered population (total number per CCG)	356,701			356,701			356,701			356,701		
Rate of PHBs per 100,000 GP registered population	4.8			6.2			6.7			9.8		





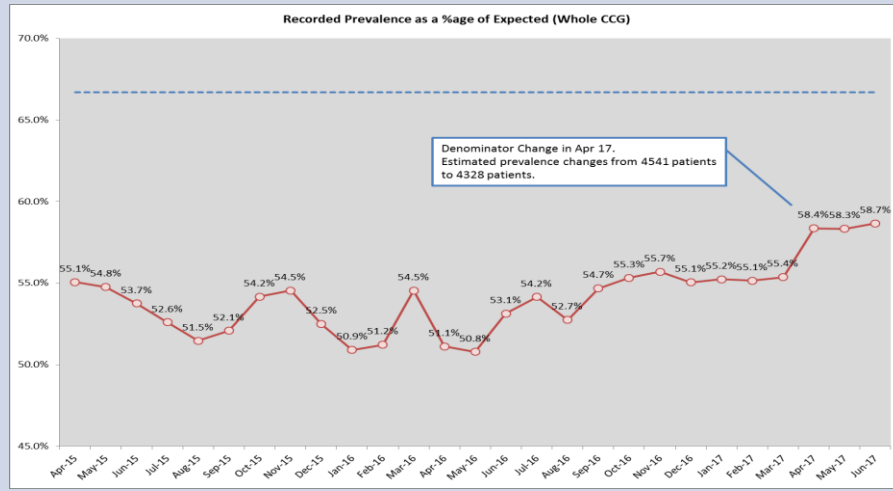
**Estimated Dementia Diagnosis Rate (QoF)**

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

Trend



Nov 16	Dec 16	Jan 17	Feb 17	Mar17	Apr17	May17	Jun17	RAG
55.7%	55.1%	55.2%	55.1%	55.4%	58.4%	58.3%	58.7%	



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

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

Trend



Nov 16	Dec 16	Jan 17	Feb 17	Mar17	Apr17	May17	Jun17	RAG
78%	79%	82%	53%	63%	52%	50%	66%	

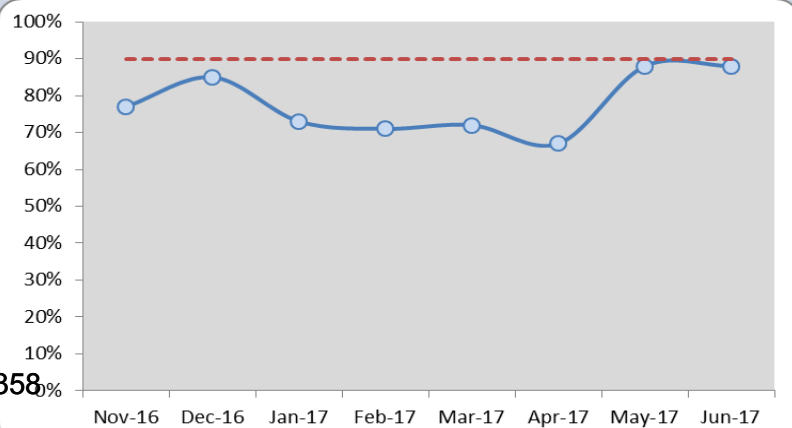
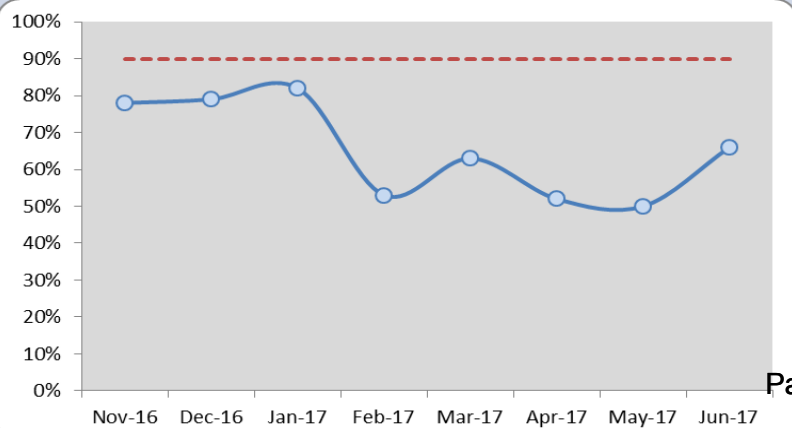
**Psychiatric Liaison Service: % seen within 60 mins of A&E referral**

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

Trend



Nov 16	Dec 16	Jan 17	Feb 17	Mar17	Apr17	May17	Jun17	RAG
77%	85%	73%	71%	72%	67%	88%	88%	

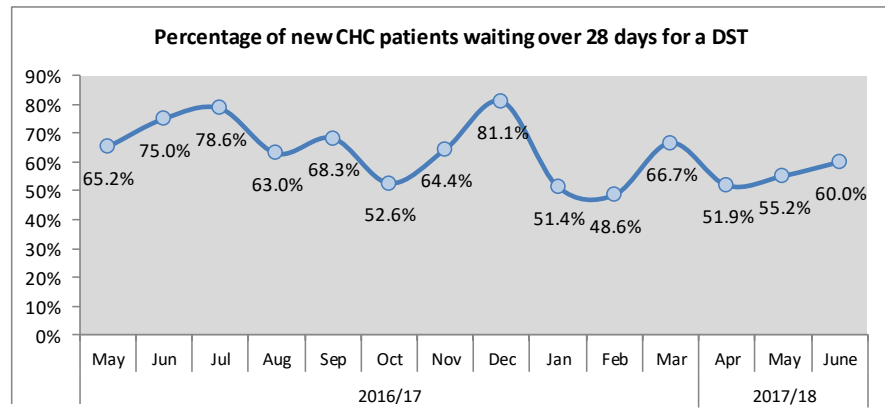
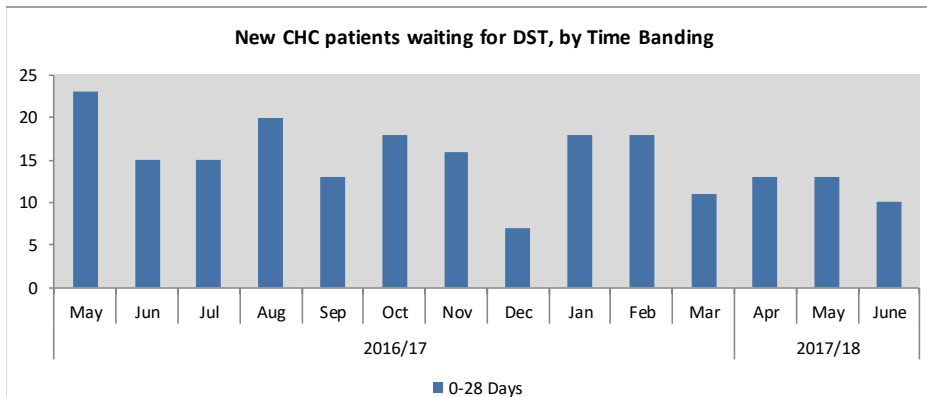


**CHC: Patients waiting for Decision Support Tool**

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

Source: *SystemOne/QA/QAPlus*

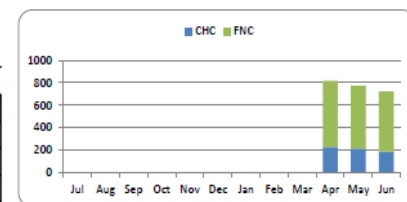
Monthly	2016/17											2017/18		
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
0-28 Days	23	15	15	20	13	18	16	7	18	18	11	13	13	10
Waiting over 28 Days	43	45	55	34	28	20	29	30	19	17	22	14	16	15
Overall	66	60	70	54	41	38	45	37	37	35	33	27	29	25
Percentage Waiting over 28 Days	65.2%	75.0%	78.6%	63.0%	68.3%	52.6%	64.4%	81.1%	51.4%	48.6%	66.7%	51.9%	55.2%	60.0%



**Overdue Reviews**

Source: *systemOne/QAPlus*

Monthly (Fully Funded)	2016-17						2017-18					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CHC										226	215	186
FNC										590	557	537
Total Overdue										816	772	723



**DST conversion to funding:**

Based on 2016/17 data, on average, 39% of completed DSTs led to funding for CHC/FNC

**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 ongoing healthcare needs. The NHS, and not the local authority or individual, pays the total cost of that care.
2. FNC definition: awarding FNC is a subset of the National Framework for Continuing Healthcare and is a nationally set amount which supports individuals assessed as eligible for Funded Nursing Care in care homes under the framework



Are targets being met and are you assured this is sustainable?	What mitigating actions are underway?
<p><b>IAPT</b> Performance remains significantly below target for both access and recovery and was showing a worsening picture from February. The three month rolling average for access has recently increased to 8.8%. The Intensive Support Team flagged issues on reporting first treatment which has impacted on performance.</p> <p><b>Dementia</b> Performance has shown incremental improvement over the year and is now at 58.7% although remains below the national target. Revisions to the estimated prevalence of dementia rates had a positive impact from April.</p> <p><b>CAMHS</b> Performance remains below targets, although some recovery in waiting times for assessment due to implementation of the Single Point of Access with 57% having a second appointment in under 9 weeks in Q1 (10% down on Q1 2016/17). However, eating disorder performance remains low against national standards. There is still no in-year data for autism waiting times as TEWV has not yet completed work within the DQIP to enable reporting from PARIS: interim data is being sought.</p> <p><b>Psychiatric Liaison</b> Performance against the current investment is below target and deteriorating. Additional national monies will support additional workforce in A &amp; E to improve on the service delivery. Discussions are on-going with TEWV regarding recurrent investment beyond the Transformation funding for 2017/18.</p> <p><b>CHC</b> - No</p>	<p><b>IAPT</b> The formal report from NHS England's Intensive Support Team has been received and an detailed action plan has been agreed with the provider. The CCG will monitor progress against this action plan at the CMB.</p> <p><b>Dementia</b> Following the initial feedback from the Intensive Support Team, additional resource has been identified and a project plan drawn up, subject to the full report being issued. Some project meetings have already been arranged with providers across the dementia pathway and tasks identified to ramp up the rate of coding in primary care.</p> <p><b>CAMHS</b> The requested Capacity and Demand analysis is under discussion, and a meeting with TEWV and Governing Body members has clarified areas of concern to the CCG; information is now sought to inform a recovery plan. Single Point of Access is fully operational and enhanced crisis team is now working, which will reduce call on Limetrees clinician time, and YDH state has already reduced numbers of inpatient admissions to YDH via ED.</p> <p><b>Psychiatric Liaison</b> Further actions required by TEWV for improvement based on the current level of investment. A contract variation has been completed to support recruitment of additional staff to deliver the 24/7 service in line with successful bid and agreement with NHS England to release funds. The service is likely to expand over Qtr2 and this will need to be extensively validated to evidence the future funding and service viability.</p> <p><b>CHC</b> currently validating each case from the FNC reviews to assess how many require a full DST and how many an annual review.</p>
Is there a trajectory and a date for recovery / improvement?	Is further escalation required?
<p><b>IAPT</b> Yes – Action plan in place to achieve 15% access and 50% recovery during Qtr4 2017/18. This is lower than the current national target of 16.8% access due to capacity constraints.</p> <p><b>Dementia</b> Yes - Initial action plan has been produced to support delivery of the national target of 66.7% following the IST visit in July and will be updated on receipt of the final report.</p> <p><b>CAMHS</b> Trajectory to be set pending capacity and demand discussion.</p> <p><b>Psychiatric Liaison</b> Once the service is fully staffed the recovery/improvement trajectory will be amended to reflect an expected improvement in performance.</p> <p><b>CHC</b> – this will be clarified once review completed</p>	<p><b>IAPT</b> Paper to F &amp; P Committee 24 August 2017 to identify any further actions.</p> <p><b>Dementia</b> Paper to F &amp; P Committee 24 August 2017 to identify any further actions.</p> <p><b>CAMHS</b> Single item QPEC; capacity and demand meeting; CMB held on 14/16 and 21 August to inform discussion at F &amp; P Committee re options for escalation.</p> <p><b>Psychiatric Liaison</b> No escalation required at this stage.</p> <p><b>CHC</b> No further escalation but request for additional clinical capacity from NHSE national QIPP programme to support continued review of all CHC cases</p>



# Programme Overview

## - Primary care

August 2017

# Primary Care programme QIPP and workstreams: Month 04

ALL SCHEMES														MONTHLY PROFILES																					
Current month		Instructions for populating												Plan profile																					
Scheme Name	Ref	Planned start date	YTD			Forecast Outturn			MONTH 4 QIPP RISK ASSESSMENT																										
			Planned savings £000	Expected savings £000	Actual savings £000	Planned savings £000	Expected savings £000	Actual savings £000	QIPP Delivery Confidence	QIPP Profiling Adjustments	Key Challenges (Blockers)	National QIPP Support Prog Phase II resources																							
														Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar										
<b>PRIMARY CARE</b>																																			
Dermatology Indicative Budgets	195	Apr-17	36	36	36	36	36	36	high	No	None	n/a	12	12	12	0	0	0	0	0	0	0	0	0	0	0	0	0							
GP IT - NYNET	003	May-17	50	50	50	183	183	183	high	No	None	n/a	0	17	17	17	17	17	17	17	17	17	17	17	17	17	17	17							
Roll out indicative budgets to other specialities	020	Jul-17	8	8	0	75	75	0	low	Yes	None	n/a	0	0	0	8	8	8	8	8	8	8	8	8	8	8	8	8							

See Agenda item 6 M4 Finance report with Supplementary QIPP progress report



# Programme Overview - Enabling & Quality

August 2017

Reporting period		Enabling Programme			RED out of timescale (not started/ ended on time)		Gateway RAG rating guide		Add finance RAG								
2017/18 M4					AMBER within timescale (with/without end date)		GREEN completed		(blank) yet to start								
Project	Work stream	Secondary Workstream	Work Area	Team		Geography	Partners	Gateway	Documentation latest position	Expected Value					Finance RAG	Finance Comments	Overview Comments
				Executive Sponsor	Org.					16/17	17/18	18/19	Year to date plan	Year to date actual			
Communication & Engagement	N/a	N/a	Unknown	RachelPotts	VoY CCG	Vale of York		Implementation	Highlights and exceptions need to be reported and date for evaluation set								Comms and engagement plan reporting on financial position, STP, and public involvement in service design. Signed off at SMT, Exec Committee and Gov Bod
Local Digital Roadmaps	Click + to expand	N/a	Paper free at the point of care, SYFV	TBC	VoY CCG	Vale of York & ScaR CCG	ScaR CCG, YTHFT, CYC, NYCC, TEWV	Scoping	Documentation from original LDR programme and meetings up to April 2017								National requirement, delivery across VoY and S&R localities and also at STP
	N3 Migration	N/a	Paper free at the point of care, SYFV	Tracey Preece	VoY CCG	Unknown	Unknown	Scoping	Documentation with finance team								No information
	GP IT (NYNET)	N/a	Paper free at the point of care, SYFV	Tracey Preece	VoY CCG	Unknown	Unknown	Scoping	Documentation with finance team								Telephony transfer to GP practices to start realising savings from April 2017.
Accountable Care System				RachelPotts	VoY CCG	Vale of York	YTHFT, TEWV, Primary Care,, VS, CYC, NYCC	Scoping	Principles have been developed and distributed. An unplanned care PID has been developed and agreed off by the ACS board. However no overarching ACS plan has been developed. No other plans or target dates have been shared								Accountable Care System (ACS) and development of three locality strategies/priorities. Work will include BI and data analysis, new models of care and contracts, workforce review and development, estates and shared assets, quality frameworks and incentives, Pocklington boundary issues and contractual & referral issues from practices. Links to unplanned care programme
North Locality Workstream under ACS? Also listed on unplanned care programme with workstreams	Also listed on unplanned care programme dashboard			RachelPotts	VoY CCG	Vale of York	YTHFT, TEWV, Primary Care,, VS, CYC, NYCC	Scoping	Workstream PIDs are under development. Overarching ACS strategic documents and associated unplanned care system programme documentation at with PMO								These workstreams are linked to the unplanned care QIPP. Partners are not yet aware of savings linked to these projects. Locality working group and task groups for each workstreams have been established. Overarching leadership has not been clarified
	South Locality Workstream under ACS? Also listed on unplanned care programme with workstreams	Also listed on unplanned care programme dashboard		RachelPotts	VoY CCG	Vale of York	YTHFT, TEWV, Primary Care,, VS, CYC, NYCC	Scoping	Workstream PIDs are under development. Overarching ACS strategic documents and associated unplanned care system programme documentation at with PMO								These workstreams are linked to the unplanned care QIPP. Partners are not yet aware of savings linked to these projects. Locality working group and task groups for each workstreams have been established. Overarching leadership has not been clarified
	Central Locality Workstream under ACS? Also listed on unplanned care programme with workstreams	Also listed on unplanned care programme dashboard		RachelPotts	VoY CCG	Vale of York	YTHFT, TEWV, Primary Care,, VS, CYC, NYCC	Scoping	Workstream PIDs are under development. Overarching ACS strategic documents and associated unplanned care system programme documentation at with PMO								These workstreams are linked to the unplanned care QIPP. Partners are not yet aware of savings linked to these projects. Locality working group and task groups for each workstreams have been established. Overarching leadership has not been clarified
	Prevention & Self Help Workstream under ACS? Unplanned care programme? Planned care programme?	See below		RachelPotts	VoY CCG	Vale of York	YTHFT, TEWV, Primary Care,, VS, CYC, NYCC	Scoping	Self care is being developed as part of the South locality, as a workstream. There is also work being undertaken in planned care programme. Overarching ACS strategic documents and associated unplanned care system programme documentation at with PMO								These workstreams are linked to the unplanned care QIPP. Partners are not yet aware of savings linked to these projects. Locality working group and task groups for each workstreams have been established. Overarching leadership has not been clarified
	Imms' vacs / screening programmes			Shaun O'Connell	VoY CCG	Unknown	Unknown	Scoping	TBC								


# Enabling & Quality workstreams: Month 04

Reporting period		Enabling Programme				Gateway RAG rating guide		Add finance RAG									
2017/18 M4						<p><b>RED</b> out of timescale (not started/ ended on time)</p> <p><b>AMBER</b> within timescale (with start/end date)</p> <p><b>GREEN</b> completed</p> <p>(blank) yet to start</p>		<p><b>RED</b></p> <p><b>AMBER</b></p> <p><b>GREEN</b></p>									
Project	Work stream	Secondary Workstream	Work Area	Team Executive Sponsor	Org.	Geography	Partners	Gateway	Documentation latest position	Expected Value	Year to date plan	Year to date actual	Year to date variance	Forecast Outturn Actual	Finance RAG	Finance Comments	Overview Comments
STP collaborative programme	System Workforce Development Strategy Workstream under ACS?	N/a	NHSE C&C	Michelle Carrington	VoY CCG	Vale of York	YTHFT, TEVW, Primary Care, VS, CYC, NYCC	Scoping	Documentation with quality team								
	Click + to expand	N/a		RachelPotts	VoY CCG	STP	ERY CCG, Hull CCG, NE Lines CCG, N Lines CCG, ScAR CCG, CYC, ERYCC, Kingston Upon Hull CC, NE Lines Council, N Lines Council, NYCC, Hull and East Yorkshire Hospitals NHS Trust, Humber NHS Foundation Trust, N Lines and Goole NHSFT, TEVW, YTHFT, YAS	Scoping	Documentation with HCV STP PMO								
	Rationalisation of back office function across STP footprint	N/a		RachelPotts	VoY CCG	STP		Scoping	Documentation with HCV STP PMO								
Vacancy control	N/a	N/a	NHSE C&C	RachelPotts	VoY CCG	Vale of York		Implementation	Documentation with finance team			18	18	18	54		
PCU transition support	N/a	N/a		Michelle Carrington	VoY CCG			Implementation	N/A								
Commissioning Support (eMBED) contract savings	N/a	N/a	NHSE C&C	RachelPotts	VoY CCG			Evaluation	Documentation with finance team			69	69	69	207		
Office Re-design	N/a	N/a		RachelPotts	VoY CCG	VoY CCG	N/a	Evaluation	Documentation with finance team								16 additional desks will be made available on 2nd July 2017. Exclusive use of the Rowntree meeting room from 19 June. One off cost of £30k. Ongoing cost of £10k pa
Care Homes Strategy		N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								Supporting quality improvement in care homes - links to unplanned care programme of work and CHC(contracting). Also links to Community IV
	React to Red (pressure ulcers)	N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								National initiative to reduce pressure ulcers
	Patient Safety Improvement Techniques	N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								Creating more resilient care homes
	Nutrition and Hydration	N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								Linked to react to red and keeping well. Potential to reduce acute admissions
	End of Life Care	N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								Good end of life care including confirmation of expected death - links to fast track (complex care programme)
	Timely Review of Patients	N/a		Michelle Carrington	VoY CCG	VoY CCG	Care homes, CYC, NYCC	Scoping	Documentation with quality team								Linked to Central locality care home workstream
	End of life care			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								
	Introduction of red bags			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								
	Care home bed state tool			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								
	Quality assurance visits linked to contracts			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								
	Dressing project and delirium			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								
	Management urosepsis			Michelle Carrington	Unknown	Unknown	Unknown	Scoping	Documentation with quality team								

Total Programme Projects 9  
Total Programme Work streams 26

Total Delivery 261  
Total Pipeline 0  
Total Business as usual 0  
Total value 0



<b>Item Number: 10</b>	
<b>Name of Presenter: Phil Mettam</b>	
<b>Meeting of the Governing Body</b>  <b>Date of meeting:</b> <b>7 September 2017</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Update on mental health performance</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b>	
<b>Reason for Report</b>  To provide assurance to the Governing Body that the CCG is striving to improve: <ol style="list-style-type: none"> <li>1) performance against the access and recovery targets for IAPT</li> <li>2) coding of dementia diagnoses in primary care</li> <li>3) performance of children's and young people's mental health services</li> </ol>	
<b>Strategic Priority Links</b>	
<input checked="" 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	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b> <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b>  JC-prog.01 Coding of dementia diagnoses JC-prog.02 Access to IAPT services JC-prog.26 CAMHS access and waiting times
<b>Emerging Risks (not yet on Covalent)</b> N/A	
<b>Recommendations</b> For the Governing Body to receive the report, note the actions in hand and consider any further action required to address the issues identified in the delivery of mental health services.	

<b>Responsible Executive Director and Title</b> Denise Nightingale Executive Director of Transformation and Delivery	<b>Report Author and Title</b> Elaine Wyllie Strategic Programme Consultant Paul Howatson, Head of Joint Programmes
---	---

## **Update on mental health performance**

### **Purpose**

This reports aims to provide assurance to the Governing Body that the Vale of York Clinical Commissioning Group is striving to improve services within the mental health programme, particularly across Improving Access to Psychological Therapy (IAPT) services, children and young people's mental health services (CAMHS) and dementia.

### **Background and context**

Following an extensive procurement exercise, the CCG entered into a new contract with Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) on 1 October 2015.

After a number of challenging circumstances and almost two years into the contract, performance for both IAPT and children and young people's services are still not at the expected or required level.

Additionally, the CCG has also struggled with the level of dementia coding in primary care highlighting variation in service provision across the dementia pathway.

### **Improving Access to Psychological Therapies (IAPT)**

#### Problem:

Performance for access to psychological therapies has not yet reached the 2016/17 national access target of 15% in the Vale of York. Although the rate of recovery target of 50% has been achieved, performance has been variable. The CCG is concerned about performance leading to failure of delivery of the target and poor quality service for patients.

#### Actions to date:

In November 2016 Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) was issued with a Performance Improvement Notice by the CCG for not achieving the IAPT targets.

In February 2017 the CCG accepted the offer of the NHS England/NHS Improvement Intensive Support (IST) team to come and review the local IAPT service.

A report issued by the IST in May 2017 highlighted three key areas for improvement:

1. backlog of patients waiting
2. new pathway to support sustainable access and recovery targets
3. appropriate levels of workforce

In July 2017 the CCG agreed an action plan with TEWV. On 10 July 2017 a new pathway was launched at the same time as actions to address the current backlog. Actions include:

- Increasing capacity
- Securing additional training places
- Reviewing current pathway (IST have provided guidance on best practice)
- Assessing capacity and demand; including productivity

Regular monitoring is in place by the CCG to oversee implementation of the action plan and, specifically, the CCG is seeking assurance from TEWV that the agreed actions will deliver sustainable rates of access and recovery by Quarter 4 of 2017/18 as anticipated when the action plan was agreed.

A report on IAPT went to the Finance and Performance Committee on Thursday 24 August 2017 setting out the detail behind the IST report and consequent action plan to recover performance. This will remain an area closely monitored via the Committee.

A follow-up meeting with NHS England is due to take place on 8 September 2017 to ensure progress is being made towards improved performance.

### **Children and young people's mental health services**

#### Problem:

Potential poor quality service for patients as a consequence of long waits for patients to be assessed potentially leading to delays in active treatment. Detailed performance data has not been routinely available to provide assurance to the CCG about all aspects of CAMHS.

Nationally, there has been unprecedented demand on referrals to and access for mental health services for children and young people. The Vale of York has been no exception to this national trend which appears to be consistent with the findings from a local Healthwatch survey.

#### Actions to date:

Since 1 October 2015 TEWV has streamlined pathways, invested an additional £380k into the service and introduced a Single Point of Access which aligns to TEWV's trust-wide joint Children and Adolescent Mental Health Services model.

During Quarter 4 of 2016/17 some non-recurrent funding from NHS England was used to address some waiting list pressures which alleviated local pressure for a time.

The York and North Yorkshire Children and Young People's Community Eating Disorders Service was established on 1 April 2016 and the service has seen a high level demand from service users versus the nationally predicted trajectory for access.

The recently developed crisis liaison service (linked to the hospital) which currently operates from 1 pm to 9 pm will be extended to operate from 10am until 10pm, seven days a week in October 2017.

TEWV was invited to a single item Quality and Patient Experience meeting on 14 August 2017 to explain the current levels of performance and models of operation.

Earlier in the year the CCG requested detailed information regarding the current workforce from TEWV and although some information was received, the CCG requested additional information for a meeting on 16 August 2017 in order to support further improvement actions. The CCG is now checking the workforce information against the details submitted by TEWV in its original bid for children and young people's services.

At the Finance and Performance Committee on 17 August a verbal update was given on Children and Young People's services from the recently held meetings. The Committee requested further regular updates on performance going forward.

## **Dementia**

### Problem:

The local system has struggled with identifying, diagnosing and supporting people with dementia. Despite there being a dementia enhanced service in the recent past, numbers coded in general practice did not rise to the level anticipated by NHS England.

### Actions to date:

There have been several initiatives run locally to drive performance but these did not achieve the 66.7% target of people coded with a dementia diagnosis in primary care. Further support from NHS England was provided through funding a small, care homes project as well as discussions between the CCG and the national clinical director and regional leads.

The CCG have issued a number of communications to practices reminding them to use the data quality toolkit and also head a couple of GP education events.

The CCG also commissioned Dementia Forward to work with practices and support people with dementia as well as their carers.

Additionally, the CCG commissioned [www.dementiacarers.net](http://www.dementiacarers.net) website to provide additional and accessible support for carers of people with dementia.

The CCG invited the NHS England/NHS Improvement Intensive Support Team in to review the local dementia pathway and services in July 2017.

Although the CCG is currently awaiting the draft recommendations report, it has set up a small project group to work more closely with GPs, care homes, TEWV and York Teaching Hospitals Foundation Trust. The CCG has also formulated an action plan based on the immediate feedback of the Intensive Support Team. This action plan will be further developed once the full draft report is released.

## **Summary**

TEWV introduced its patient records system (PARIS) over 12 months ago which created additional pressures on producing reports with reliable information. The national dataset and key performance indicators remain a national challenge and there is further work required at a national level to address these challenges, given the nature of mental health conditions and how best to capture activity surrounding this.

TEWV is committed to PARIS and has now agreed to provide further information to the CCG to give it a greater level of detailed assurance in terms of where people are in the system and how long they are waiting to access treatment across all service lines.

The CCG is committed to improving and transforming mental health care within the resources available and in partnership not just with TEWV but other providers, service users, carers' and also the voluntary and independent sectors.

## **Conclusion**


There are several underlying themes running across each of these service areas which can be summarised as follows:

- Detailed performance information to support decision making and clinical pathway development
- Clarity on workforce requirements to address current backlog of activity (IAPT and CAMHS)
- Understanding and agreement of workforce models to support on-going demand within revised pathways

## **Recommendations**

For the Governing Body to receive the report, note the actions in hand and consider any further action required to address the issues identified in the delivery of the following mental health service elements

1. Performance against the access and recovery targets for IAPT
2. Performance of children's and young people's mental health services
3. Coding of dementia diagnoses in primary care

<b>Item Number: 11</b>	
<b>Name of Presenter: Phil Mettam</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting:</b> 7 September 2017	
<b>Report Title – Care Quality Commission Local System Review of York – Briefing for Partners</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Information</b>	
<b>Reason for Report</b> The Care Quality Commission (CQC) will be carrying out a Local System review of York, looking at how people move through the social care system, particularly focused on the experience of older people in relation to delayed transfers of care. CQC will seek to identify improvements that can be made to our joint working. The review spans a 14 week process, with one week on site in York, week commencing 30 <sup>th</sup> October 2017.	
<b>Strategic Priority Links</b>  <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input checked="" 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	
<b>Local Authority Area</b>  <input type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Covalent Risk Reference and Covalent Description</b>
<b>Emerging Risks (not yet on Covalent)</b>  The review is linked to the additional funding through the improved Better Care Fund which was intended to reduce delayed transfers of care, associated with the national target of 3.5%. Government has stated that areas which fail to improve may lose funding.	

**Recommendations**

- The Governing Body note the report
- The Governing Body contribute to the review, including by providing positive evidence of York's shared vision for the locality and partnership working

**Responsible Executive Director and Title**

Phil Mettam  
Accountable Officer

**Report Author and Title**

Pippa Corner  
Head of Joint Commissioning Programme



## Care Quality Commission Local System Review of York - Briefing for Partners

### 1. Introduction / Purpose of Report

- Inform partner organisations about the forthcoming review
- Provide assurance on the joint work being done to prepare
- Ensure partners are aware of opportunities / requirements to be involved in the review
- To highlight the role of systems leadership in relation to securing better outcomes for local people through joined up approaches and integrated services

### 2. Background to the Review / Strategic Context

2.1 The Better Care Fund (BCF) was established to support improvement in outcomes for people using services and local communities by promoting integration and transformation of health and social care. It focuses on out of hospital care to prevent admissions to and reduce the impact of delayed transfers of care.

2.2 In the budget 2017 the government announced an additional £2 billion nationally, paid directly to councils – the improved Better Care Fund (iBCF). The aims of the fund are:

- Meet adult social care needs
- Reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensure that the local social care provider market is supported

2.3 Following the Spring Budget announcement of additional funding for adult social care, the Department of Health and Department for Communities and Local Government commissioned the Care Quality Commission (CQC) to undertake a programme of targeted reviews of local authority areas. The purpose of the reviews is to ascertain how people move through the health and social care system with a focus on the interfaces, with particular reference to Delayed Transfers of Care (DTC).

2.4 The Local System Reviews are taking place first in areas that have been identified as challenged according to 6 key metrics in relation to “*user access and flow (including high numbers of delayed transfers of care)*”.

2.5 These metrics are summarised in Appendix 1, York's performance is summarised in Appendix 2. However, it should be noted that this does not reflect an up to date, accurate position for York.

- 2.6 The Better Care Fund plan must be submitted by 11<sup>th</sup> September 2017, and following the national assurance process, plans must be finalised and approved by 30<sup>th</sup> November.
- 2.7 All areas have also been required to respond to national targets for the reductions of Delayed Transfers of Care. The national commitment is to achieve no more than 3.5% of occupied bed days being used by a patient who is ready to go home but remaining in hospital.
- 2.8 The reviews will highlight examples of good practice and make recommendations where improvements are needed.
- 2.9 The Care Quality Commission will publish a local report at a local summit for partners as part of their support offer.
- 2.10 The Care Quality Commission will also publish an interim national report in November, and a final national report at the end of the programme of reviews.

### **3. Scope of the Local System Review**

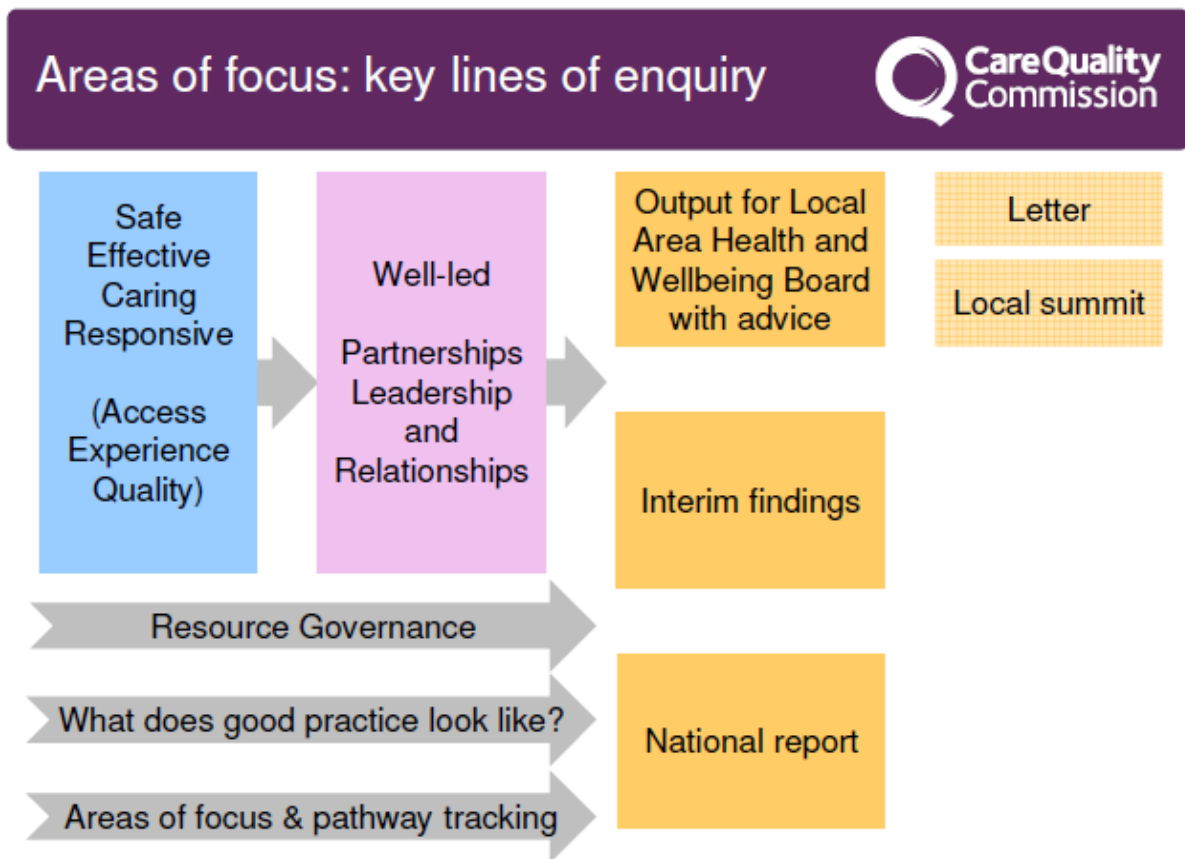
- 3.1 The review is of the whole system, not individual organisations. It will seek to answer the question: “How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?”
- 3.2 The review will focus on older people with complex needs and co-morbidities who become delayed in hospital. It includes dementia, but does not focus on working age adult mental health delays.
- 3.3 An initial cohort of twelve council areas was identified, with a total of forty now being planned over the next year.
- 3.4 Reviews will not result in a rating, but will highlight good practice and articulate recommendations.

### **4 Methodology**

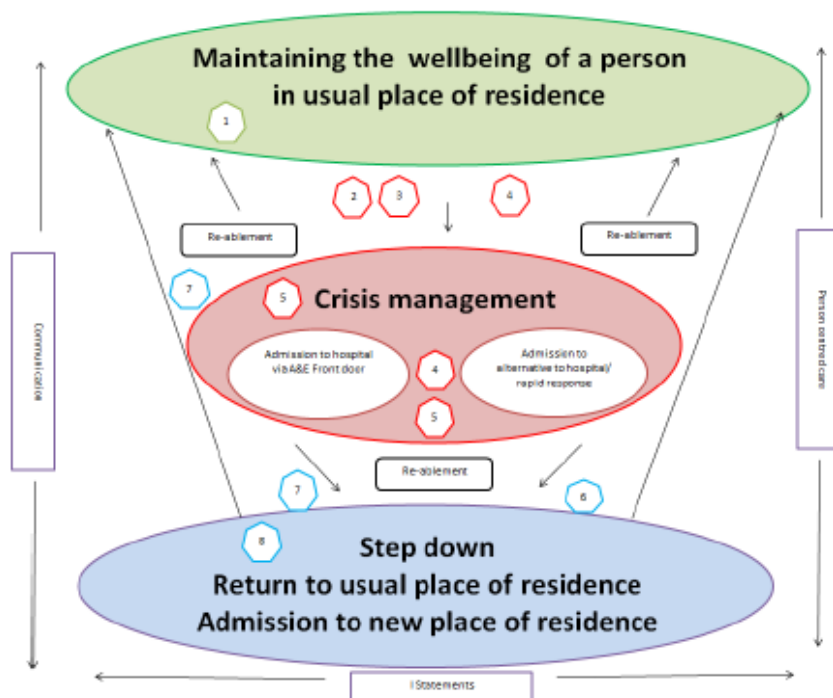
- 4.1 The CQC has published key Lines Of enquiry (KLOEs) and will map all existing evidence from inspections and other available sources against these prior to their visit.
- 4.2 Each area must submit a System Overview Information Return (SOIR) in advance of the review. This will offer a self assessment and allow York to provide information on the work we are already doing to address the challenges we face. It will also allow York to make our case in relation to the financial pressures on our system and the external factors affecting our health and social care economy.

- 4.3 The review will include a “Relational Audit” and case tracking (6 case studies).
- 4.4 CQC will hold preliminary interviews and focus groups as well as consult Scrutiny and Healthwatch prior to their on site week, which takes place in York from 30<sup>th</sup> October to 3<sup>rd</sup> November. Initial feedback will be provided on 3<sup>rd</sup> November.
- 4.5 The review will culminate in a report and a Local Summit with a tailored improvement support offer for each area.

CQC illustrations:



1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative to hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-ablement
8. Transfer from re-ablement



## 5 Local preparation and response

- 5.1 System leaders in York are committed to ensuring that this review is welcomed as a positive opportunity to promote the great developments that are taking place here to reduce dependence on services and foster individual and community resilience. We also welcome the review as an invaluable insight into further improvements which could be made to join up our health and social care system around those people who need it.
- 5.2 The local response is being co-ordinated by the CYC and VOYCCG Head of Joint Commissioning on behalf of the whole system.
- 5.3 A multi agency working group has been established.
- 5.4 Partners are contributing evidence ahead of the CQC timetable in order to fully understand our performance and key issues, and to shape a shared narrative for the System Overview Information Return.

## 6 Opportunities to contribute

- 6.1 The multi agency working group is planning a schedule of briefings and updates for stakeholders to ensure local people are informed about the review.

6.2 The Relational Audit will be disseminated through existing networks to ensure as wide a response as possible, in line with CQC intentions.

6.3 CQC will be inviting groups and individuals to contribute evidence to the review through events, focus groups and interviews.

## 7 Timetable

7.1 CQC expects to formally initiate the review of York by letter during the week commencing 11<sup>th</sup> September 2017.

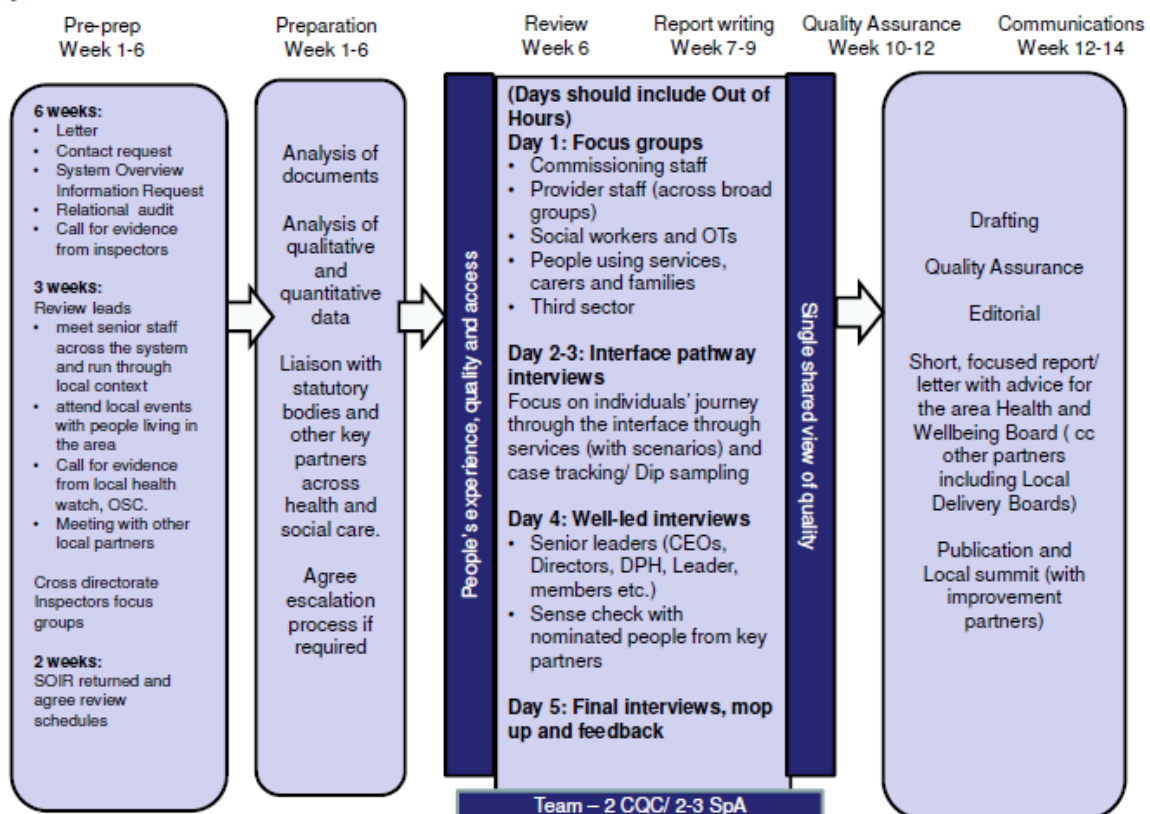
7.2 The System Overview Information return must be submitted by 16<sup>th</sup> October 2017.

7.3 The CQC review team will be on site in York for the week commencing 30<sup>th</sup> October 2017.

7.4 It is expected that the report will be published at the Local Summit during the week commencing 11<sup>th</sup> December 2017.

CQC illustrative timetable:

### System review end to end



## Appendix 1: 6 key performance metrics on which the review is based

ID	Indicators	What this indicates about the system	Full definition
1	Emergency Admissions (65+) per 100,000 65+ population	Can indicate how good collaboration across the health and care system is to support good management of long term conditions	(Emergency admissions for those with identified age (65+) resident in a local authority) divided by; (Local authority population 65+/100,000)
2	90th percentile of length of stay for emergency admissions (65+)	Longer lengths of stay can indicate poor patient flow out of hospital and hence downstream blockages	The 90th percentile length of stay following emergency admission.  e.g. 10% of patients within a local area have a length of stay longer than X days.
3	TOTAL Delayed Days per day per 100,000 18+ population	This indicates how effective the interface is between health and social care and joint working of local partners	Average number of monthly delayed days (ALL) per day Divided by; (Local authority population 18+/100,000)
4	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	This captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement. Reablement services lead to improved outcomes and value for money across the health and social care sectors.	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
5	Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services		The proportion of older people aged 65 and over offered reablement services following discharge from hospital.
6	Proportion of discharges (following emergency admissions) which occur at the weekend	This can indicate successful, joint 24/7 working leading to good flow of people through the system and across the interface between health and social care	Percentage of discharges (following emergency admission) at the weekend

## Appendix 2

### Summary of performance

The table below shows the rank of the systems under review compared to their 15 statistically similar nearest neighbours for each of the indicators.

Local Authority	Emergency Admissions (65+) per 100,000 of 65+ population	90th percentile of length of stay for emergency admissions (65+)	Total Delayed Days per 100,000 18+ population	Proportion of older people (65+) who were still at home 91 days after discharge	Proportion of older people (65+) who are discharged from hospital who receive reablement/ rehabilitation services	Proportion of discharges (following emergency admissions) which occur at the weekend
Birmingham	16	5	14	13	5	9
Bracknell Forest	8	13	13	16	9	8
Coventry	16	14	15	10	15	3
East Sussex	4	16	14	1	14	14
Halton	9	16	15	15	6	10
Hartlepool	10	13	14	7	9	13
Manchester	16	10	11	16	6	8
Oxfordshire	9	1	16	9	8	4
Plymouth	3	7	16	8	5	14
Stoke-on-Trent	15	7	16	12	16	9
Trafford	14	15	16	1	10	6
York	12	8	11	15	12	15


Pippa Corner

Head of Joint Commissioning Programme, City of York Council and NHS Vale of York CCG

August 2017

This page is intentionally blank



<b>Item Number: 13</b>	
<b>Name of Presenter: Phil Mettam</b>	
<b>Meeting of the Governing Body</b>  <b>Date of meeting:</b> <b>7 September 2017</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – Engagement update</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b> <b>And to comment</b>	
<b>Reason for Report</b>  <p>Between 22 June and 22 August, the CCG began a series of ‘big conversation’ public events, supported by sessions in our community. This phase of work is part of the bigger engagement agenda, but had a specific focus on raising the awareness of the financial challenge and asking the public about how they would like to become involved in the formulation of plans and ideas.</p> <p>This engagement update provides a report of the engagement process and the initial analysis of the conversations that were held with the public and the themes that have emerged.</p>	
<b>Strategic Priority Links</b>	
<input 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	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b>	<b>Covalent Risk Reference and Covalent Description</b>
<input type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	

**Recommendations**

Based upon early analysis, we would like to receive initial thoughts and comments from the Governing Body, and to agree the next steps.

**Responsible Executive Director and Title**

Rachel Potts  
Executive Director of Planning and Governance

**Report Author and Title**

Victoria Hirst  
Head of Engagement

# Engagement update

## Governing Body: 7 September 2017

### 1. Background

Between July and August 2017 the Vale of York CCG held a series of public engagement events about its work and to discuss the local financial challenge. The system spends more on health than it can afford. This means that we will have to work in a new way to help improve outcomes and achieve value for money. It is important that the public has an opportunity to have their say about the future of health services. The events focused on enabling the local community to share their views on how we can work together to ensure a sustainable health and social care system.

### 2. Purpose of the events

- To talk openly and honestly about the local £40million financial challenge.
- To focus the discussion on how we can involve our local population in enabling them to have a real input into the formulation of plans and ideas.
- To collate a range of views and feedback and use this as part of our decision-making process.
- To ensure that people attending the events feel listened to and have been able to feed into discussions in a meaningful way.

### 3. The engagement process

Between 22 June and 22 August, the CCG began a series of 'big conversation' public events, supported by sessions in our community. This phase of work is part of the bigger engagement agenda, but has a specific focus on raising the awareness of the financial challenge and asking the public about how they would like to become involved in the formulation of plans and ideas.

Within this time period we arranged and attended **27 sessions** and spoke to over **500 people** from within the local population. We worked with local community hubs and libraries, the voluntary sector



and GP patient participation groups (PPGs) to arrange attendance at different locations and forums across the Vale of York footprint.

### 3.1 'Big conversation' public events: Six sessions

The focus of the engagement was around six 'big conversation' public events across the Vale of York. Two sessions were held in the afternoon, and four in the evening to allow a variety of availability for people to attend. A presentation and discussion format was adopted which included:

- Presentation: Phil Mettam and a clinical lead (Medical Director or Chief Nurse)
- Question and answer session
- Discussion groups



Date	Location	Reach	Attendees
11.7.17	Selby AVS	Public and stakeholders	24
24.7.17	West Offices, York	Public and stakeholders	30
26.7.17	New Earswick Folk Hall	Public and stakeholders, including 15 local voluntary organisations who had a stall	35
3.8.17	Healthwatch special assembly, Priory Street	Healthwatch volunteers and members, public and stakeholders	43
10.8.17	Easingwold	Public and stakeholders	35
17.8.17	Helmsley	Stakeholders (no members of the public attended)	5



### 3.2 Market stalls: Two sessions

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

Date	Location	Reach	Numbers
7.8.17	Selby Market	Public and local shops and stall holders	35
22.8.17	Pocklington Market	Public and local shops and stall holders	42



### 3.3 Library stalls: Eleven sessions

The CCG collaborated with York Explore to hold a number of drop-in stalls at local libraries across York.

Date	Library event location	Numbers of people we spoke to
23.6.17	Fulford	5
27.6.17	Huntington	10
28.6.17	Poppleton	10
29.6.17	Strensall	5
5.7.17	Haxby	15
12.7.17	Bishopthorpe	15
17.7.17	Tang Hall	10
28.7.17	York	25
14.8.17	Dunnington (coffee morning)	21
15.8.17	New Earswick (parent and toddler group)	18
15.8.17	Copmanthorpe	5

Please note that North Yorkshire library events are provisionally booked in for October.

### 3.4 Patient participation groups: Five sessions

GP practices run a number of patient participation groups (PPGs) which meet on a regular basis to discuss the health services on offer, and how improvements can be made for the benefit of patients and the practice.

The CCG is scheduled in to attend and present at PPGs across the Vale of York over the year. Those highlighted below are ones which took place between the selected period and where the financial challenge was specifically discussed.

Date	Patient participation group (PPG)	Numbers (approx. including GP staff)
22.6.17	Kirkbymoorside PPG	10
13.7.17	Pickering PPG	10
18.7.17	Scott Road PPG	12
31.7.17	Pocklington PPG	15
7.8.17	York Medical Group PPG	15

### 3.5 Forums: three sessions

During this period the CCG had an agenda item at several voluntary sector forums. Within these sessions themes of communication and collaboration during challenging times were discussed.

Date	Activity	Numbers (approx.)
21.6.17	Learning Difficulties forum	24
6.7.17	Mental health forum	33
1.8.17	CVS Health and Wellbeing forum	31

## 4. Communication and advertisement

As part of the 'big conversations' a range of methods were adopted to encourage participation and involvement from a variety of patients, the public and stakeholders.

The public events and drop-in sessions were advertised and communicated through a number of channels including:

- CCG stakeholder and public email list
- Newspaper advertising and press release
- GP practice communications



- Partner organisations eg: Councillors' newsletter, Television screens in City of York Council, North Yorkshire County Council
- Local Healthwatch and voluntary sector
- Community groups
- Health and Wellbeing Board
- Posters in shops, libraries and public buildings in the areas where the events were taking place
- Parish newsletters
- Event location websites
- CCG website and twitter account
- Internal staff newsletter

## 5. Key messages and themes

A full audit and analysis of the all the comments is underway, and a comprehensive version will be published in due course.

However, early analysis indicates a number of key themes which are highlighted below:

### 5.1 Access to primary care

People were concerned about access and waiting times for GPs.

In some areas there were pockets of good patient experience, and examples of how new triage systems that have been put in place are relieving the pressure. These included same day appointments, telephone call backs, the ability to book online appointments and seeing a range of staff. Comments included:

- 'I like being able to book my appointments online for my GP'.
- 'I like the duty doctor service during hours, you get a ring back within 30 minutes'.
- 'I like being able to have a telephone appointment, it's easier than traipsing into the surgery'.
- 'I was impressed by the ability to pick nurses and GPs'.
- 'I do think we need to think differently and see other staff instead'.

However, in particular for those who want continuity of care and to 'see the same GP', there was concern with the length of wait for appointment.

- 'It is hard to get an appointment, I had to wait two-three weeks to see my GP'.
- 'It's like you need to plan to be ill'.

There was some frustration at the length of appointment time:

- '10 minute appointments are annoying'.
- 'Appointments are too short when you have a lot of problems'.

It was also noted that not all people wanted to access services online and there needs to still be traditional methods of contact and communication:

- 'They try to get me to book online, but I say I don't have a computer and I struggle with my disability'.

## 5.2 Mental Health

We heard very strong views about the access to, and quality of mental health services. There was the feeling that there were not enough specialists and professionals for the area and that waiting times for certain services and therapies were long. There were also some examples of poor care and the need for better crisis and community services.

- 'Waits for therapies are long'.
- 'Mental Health is always forgotten' or 'bottom of the list for funding'.
- '£30k had been wasted on hospital care for my daughter as she was left to reach the crisis point, earlier intervention could have prevented this'.

Loneliness and anxiety were raised as particular issues and that there could be more schemes to help with this.

## 5.3 Communication, signposting and navigating the system

Concerns were raised around the public and third sectors not making it easy enough for families and carers to learn about what support and care is available outside of the normal traditional methods and routes.

- 'There should be shared directories'
- 'Information for the public and for health professionals should be more readily available'.
- 'Everyone is working in silos; we need to promote each other more'.

Language was a key theme at many of the events and that there is also too much jargon used to describe the system and services, which makes it 'difficult for patients to know where to go'.

There were also thoughts raised around the need to have more coordination between teams and sharing of information and funding.

## 5.4 Prevention and education

Some of the conversations focused on education and prevention:

- 'We need to manage people's expectations and we need prevention and living well education'
- 'It's all about communication and education'



- 'Re-educate people so they don't think they automatically need to go to A&E'.

However, others expressed that:

- 'The biggest challenge being able to put your trust into alternative services, you go to A&E and your GP because you trust them'.

Some people felt that there needs to be more emphasis on the cost of healthcare and using the press and social media to raise awareness.

Many conversations were held around the need to look at other interventions such as social prescribing, and addressing root causes that are not medical, to 'free up time and resources within the system'.

### 5.5 Length of time spent in hospital and discharge

Concern was conveyed with real feeling from families about how long patients have spent in hospital, in particular the view that:

- 'Money is wasted with people sitting in hospital waiting for tests'.
- 'More tests are carried out than was needed'.
- 'Patients have waited all week for a CT scan, others have waited 24 hours in A&E awaiting tests, scans and treatment'.

Frustration was also expressed about the discharge process, and the length of time it takes.

### 5.6 Voluntary services in the community

It was acknowledged that there are many areas where groups and voluntary organisations are very active, and were held up as examples of good practice.

These services are vital and could do more to work within communities to help with signposting, access to services and as support for the vulnerable. However there was a strong feeling that the third sector is under resourced and underfunded and does not have the 'capacity to cover the lack of other services'.

### 5.7 Rurality and local services

During some of the conversations, in particular at locations outside the central area (Selby, Easingwold, Pickering and Kirkbymoorside) there was concern for long traveling times into York for services that could potentially be delivered more locally.

Where there are local hospitals, it was asked if the 'range of services could be extended'. A key issue was for those, in particular the elderly, who may not have access to a car, and where public transport was limited.

- ‘The older you get, the harder it is to get to York’.

There was some discussion around follow-up appointments, one commenting that:

- ‘I would be happy to have the follow-up over the phone, I don’t have to go all the way to York for a two-minute follow up’.

However, some raised that no single hospital can do everything, so grouping services in locations seemed a ‘sensible idea’.

## 5.8 Quality of care and the future of the NHS

It is important to note that at all of the sessions feedback was recorded about the great quality of care that members of the public had received from NHS services.

Comments such as:

- ‘I couldn’t fault the care’
- ‘Excellent service’
- ‘The nurses are great’
- ‘The NHS saved my life’

Overall there was general concern around the future of the NHS. People expressed:

- ‘It is a service we don’t want to lose’
- ‘Long may it last’
- ‘The best country on the world for healthcare’

## 5.9 Workforce and capacity

In some areas opinions were expressed about the ability of the workforce to cope with rising population and increase in more frail, elderly and complex patients.

Discussions were held around workforce and skillset of clinicians and healthcare professionals, and ensuring the workforce is diverse.

Several conversations took place around building community hubs, where many services are available in one place. This was particularly noted in Easingwold.

There was also a discussion at several of the meetings about the spread of specialist and community care, for example that there were not enough specialist nurses and more resource to be allocated to End of Life Care. Some mothers felt that maternity services should be more local.

### 5.10 Technology

There question was raised around whether we can make better use of technology to free up time and reduce cost:

'I have seen a video for an 83 year-old woman who had a GP appointment over skype from her own house, she said it changed her life and it is freeing up time for GPs'.

Sharing of information, patient data and notes was also raised at several sessions.

### 5.11 Waste and duplication

Reuse of equipment and wasted medications were highlighted as areas to cut back on. 'Not being able to return equipment seems a waste of money'.

Sending out multiple appointments by letter, having to start the referral process again if you are unable to make an appointment.

### 5.12 Equality and diversity

Many attendees commented that it is important to respect the diversity our population and not presume that a one size fits all.

Tailoring communication methods for the audience, improving quality of life for those who with a disability, not providing everything online, ensuring a diverse workforce and equality of services across the Vale of York patch were just some of the concerns that were raised.

### 5.13 Importance of feedback

At several of the sessions it was highlighted that it is important to keep the conversation going with the public, be open and transparent. People would like to remain involved and be kept updated with progress.

## 6. Equality and diversity

During the big conversation events it was important to capture views from a cross section of our populations.

We proactively communicated information about the events to community groups that had networks and links with protected groups. We liaised with local councils for voluntary services (CVS) and Healthwatch organisations to help promote the sessions and encourage attendance.

As part of the planning phase we wanted to ensure that the events took place across the geographical spread of the Vale of York footprint. We held public events in Easingwold, Helmsley, New Earswick, Selby, Pocklington and York, as well as additional drop-in sessions in local libraries and attendance at PPGs in the north and south of the patch.

In addition, we are working with the community and voluntary sector to identify specific groups of our population that we may not have had representation from at the events and drop-in sessions. We still have a number of sessions to attend, which are highlighted in section eight.

## **7. Feedback about the quality of the public sessions**

After each session an optional feedback form was provided for attendees to complete. Overall we received 40 responses.

After each 'big conversation' event we reviewed the comments and amended the session where appropriate. For example, after the initial session attendees said they wanted more time for question and answers rather than discussion tables, so we reduced the allocated time for the table top discussions to allow more availability for open question and answers.

### **7.1 Feedback questionnaire responses:**

- 100% said they would like to attend future sessions.
- 95% said they agreed and strongly agreed that the topics covered were appropriate.
- 92% said they agreed and strongly agreed that they felt their contribution was of use and valued.
- 97.36% said they would recommend this session to a friend colleague or family member.
- 85% agreed that it had been explained how their contribution will influence decision making.

### **7.2 Learning for future sessions:**

- Only 65% of attendees felt the session was what they were expecting, indicating that it is important to offer more guidance prior to the event.
- Only 44.11% said they had been told when they will hear back about decisions relating to the event, so it is vital that we provide a timeframe for feedback and regular updates.

## **8. Future sessions**

As highlighted above, a comprehensive review of all comments will be conducted and made available to the public, stakeholders and partners. This will be separated into key themes and locality areas, and verbatim comments will be published.

The 'big conversations' piece of work is only one element of the wider communications and engagement plan. We will be continuing the conversation and will make arrangements to go back out to the public to update on progress.


In addition, we have some future sessions scheduled:

- 18/19 September – York College freshers' week
- 18 September – Wheelchair and community equipment patient group
- 2 October – East Riding Carers' Advisory Group
- 9 November – Student Experience Zone, York St John
- North Yorkshire libraries (Sherburn, Tadcaster, Kirkbymoorside, Helmsley) during October 2017 - We have sessions planned with students of York College

## **9. Recommendations for Governing Body**

Based upon early analysis, we would like to receive initial thoughts and comments from the Governing Body, and to agree the next steps.

This page is intentionally blank

<b>Item Number: 14</b>	
<b>Name of Presenter: Rachel Potts</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting:</b> 7 September 2017	
<b>Report Title – Emergency Preparedness, Resilience and Response – NHS Vale of York CCG Arrangements</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Approval</b>	
<b>Reason for Report</b> Approval of nationally mandated Emergency Preparedness, Resilience and Response arrangements.	
<b>Strategic Priority Links</b>	
<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	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b>	<b>Covalent Risk Reference and Covalent Description</b>
<input type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk included in Governance Team Risk register and action plan for assurance. (G18.01-T)
<b>Emerging Risks (not yet on Covalent)</b>	
<p>NHS organisations are mandated to plan for and be able to respond to a wide range of incidents and emergencies that could affect health or patient care. The Vale of York EPRR Policy; the Vale of York On-Call Policy and supporting procedural documentation are to ensure NHS Vale of York CCG acts in accordance with the Civil Contingency Act 2004, the Health &amp; Social Care Act 2012 and relevant national policy and guidance as issued by the Department of Health in our role as a Category 2 Responder.</p>	

The CCG has assessed itself as “Substantial” overall, in relation to compliance with the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) which is part of the annual EPRR assurance process for 2017/18.

### **Recommendations**

To approve:

- the CCG’s EPRR Assurance Self-Assessment for 2017-18 and current Compliance Level;
- the CCG’s EPRR Action Plan;
- the CCG’s revised EPRR Policy; and
- the CCG’s revised On-Call Policy.

<b>Responsible Executive Director</b> Rachel Potts Executive Director of Planning and Governance	<b>Report Author</b> Fliss Wood Performance and EPRR Manager
--	--

### **Annexes**

- EPRR Self-Assessment
- Statement of Compliance
- EPRR Action Plan
- EPRR Policy
- On-Call Policy

The annexes have been circulated electronically to members of the Governing Body and are available at

<http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/>



Core standard		Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
<b>Governance</b>						
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	<ul style="list-style-type: none"> <li>Rachel Potts, Executive Director of Planning &amp; Governance, is the CCG's Accountable Emergency Officer with overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas for NHS Vale of York CCG.</li> <li>Fliss Wood is the EPRR Manager for NHS Vale of York CCG. She attended and passed the HEP Award Course in April 2015 and can demonstrate an understanding of EPRR principles and attended the JESIP training facilitated by the Police in November 2016.</li> <li>Pennie Furneaux, Risk &amp; Assurance Manager, is responsible for overseeing business continuity management and demonstrate an understanding of BCM principles.</li> <li>Mary Hughes, Business Support Manager attended Loggist Instructor Training Course in June 2017.</li> </ul>	GREEN	Tracey Preece, Chief Finance Officer, will takeover the EPRR portfolio in October 2017.	Rachel Potts	Oct-17
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	OPEL Escalation Plan was developed and implemented by partner organisations across the York & Scarborough A&E Delivery Board in December 2016 including York & Scarborough Hospitals, NHS Vale of York, Scarborough & Ryedale and East Riding CCGs, TEWV, GPOOHs and the Local Authorities. During the winter months both York and Scarborough Hospitals escalated to OPEL 3 - Severe Pressure and as documented in the Escalation Plan, the CCGs held system-wide teleconference calls with partner organisations to understand the pressures and agree what actions to take to rectify the situation. Notes of these teleconf calls and agreed actions were recorded and followed up. When appropriate, the CCGs would email GP practices to advise of pressures in the system and requested mutual aid from partner organisations. This escalation process was implemented during the Cyber Attack on Friday, 12 May 2016 when the CCG was responsible for contacting all GP surgeries via phone to alert them to the ransomware incident which affected IT systems at both York Hospital and 11 GP practices within the Vale of York locality. De-brief reports have been produced by both VOYCCG and Embed (IT Service provider) which incorporates lessons learnt and an action plan. Risk Assessment/Business Continuity Plans are reviewed by SMT. EPRR Action plan and identified risks managed through Covalent	GREEN			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	VOYCCG have a EPRR Policy/York & Scarborough A&E Board Escalation Framework & Business Continuity Plans which are reviewed and updated on an annual basis. Policies are available of shared 'Y' drive to VOYCCG staff.	GREEN			
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Accountable Officer's Report - 1 December 2016 advised Governing Body of NHSE 'Substantial Assurance' compliance rating for EPRR 2016/17. Cyber Attack on Friday, 14 May 2017 impacted the IT systems at York Hospital and 11 GP surgeries within the Vale of York. Accountable Officer briefed Governing Body on the Cyber Attack on 13 July 2017. Embed IT Servies and the CCG produced de-brief reports which were discussed at Senior Mangement Team on 8 August 2017. Following the recent terrorist attacks in Manchester and London, PREVENT training was undertaken with SMT on 8 August 2017.	GREEN			
<b>Duty to assess risk</b>						
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	LHRP review and maintain the regional risk register. VOYCCG maintain risk registers via Covalent. There is monthly review by leads and regular agenda item at Finance & Performance Meeting.	AMBER	Cyber Attack action plan identifies IT issues which need resolving.	Michael Ash-MacMahon/Embed	Nov-17
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	NHS Contracts require providers to evidence BCM policy and arrangements. Lessons learnt from the Cyber Attack in May 2017 have been discussed with SMT and CCG has an action plan to address outstanding actions.	GREEN			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.		GREEN			
<b>Duty to maintain plans – emergency plans and business continuity plans</b>						
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	EPRR Policy, York & Scarborough A&E Board Escalation Framework, Pandemic and Localised Outbreak Flu Plan.	AMBER	Finalise arrangements for localised flu plan	Fliss Wood	Oct-17
9		VOYCCG BCPs BCM Clauses in contracts	GREEN			
10	Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	N/a	Not applicable			
11		VOYCCG EPRR Policy and BCM arrangements. CCG receives Weather Alerts from Met Office and Flood warnings from Environment Agency	GREEN			
12		Pandemic Flu Plan	GREEN			
13		N/a	Not applicable			
14		N/a	Not applicable			
15		VOYCCG EPRR Policy and BCM arrangements	GREEN			
16		York & Scarborough OPEL Escalation Plan	GREEN			
17		VOYCCG EPRR Policy and BCM arrangements	GREEN			
18		CYC Evacuation Plan for West Offices and Staff Induction training	GREEN			
19		N/a	Not applicable			
20		VOYCCG BCM arrangements for utilities and desk top telecomms dependent on CYC lease agreement arrangements.	GREEN			
21		VOYCCG BCM arrangements for IT/mobile phones dependent on YHCS SLA arrangements.	Not applicable			

Core standard		Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
22			Not applicable			
23			Not applicable			
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	York & Scarborough A&E Delivery Board Escalation Framework was approved by the A&E Delivery Board prior to Winter 2016 and details the triggers/escalation processes for partner organisations, including York Teaching Hospital NHS Foundation Trust, YAS, NYCC, CYC, TEWV, GPOOHs and the Vale of York, Scarborough & Ryedale and East Riding CCGs. This escalation policy details OPEL Levels 1-4 and links to the VOYCCG EPRR Plan.	GREEN			
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	VOYCCG has Director on-call 24/7 and On-Call Policy signed off by Governing Body. On-Call Directors have attended or are scheduled to attend Leadership in Crisis Training.	GREEN	Dr Shaun O'Connell, Denise Nightingale and Tracey Preece to attend Leadership in Crisis Training.	SOC/TP/DN	Nov-17
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	BCM arrangements including Action cards	GREEN			
27	Arrangements explain how VIP and/or high profile patients will be managed.		Not applicable			
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	A&E Delivery Board and Unplanned Care Leads from partner organisations defined escalation/communication and de-escalation processes required across the health economy. Assurance involved all partners working together to agree priorities for the Health & Social Care system across York & Scarborough A&E Delivery Board.	GREEN			
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	York & Scarborough A&E Delivery Board Escalation Framework details de-escalation process. Lessons learnt from Winter 2016 have been reviewed by partner organisations and the A&E Delivery Board.	GREEN			
<b>Command and Control (C2)</b>						
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	VOYCCG has Director on-call 24/7 and On-Call Policy signed off by Governing Body. On-Call Directors have or are scheduled to attend Leadership in Crisis Training.	GREEN			
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	New on-Call Directors are scheduled to attend Leadership in Crisis Training in November 2017. PREVENT training for SMT undertaken August 2017.	GREEN	Dr Shaun O'Connell, Denise Nightingale and Tracey Preece booked to attend Leadership in Crisis Training.	SOC/TP/DN	Nov-17
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	EPRR Policy include Action Cards. Directors have their own on-Call pack which includes polices, log book and key contact list and emergency phone numbers for GP practices in VOYCCG.	GREEN			
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	EPRR Policy include Action Cards. Directors have their own on-Call pack which includes polices, log book and key contact list and emergency phone numbers for GP practices in VOYCCG. Decisions are recorded in log-book and notes/actions of teleconferences are recorded - see CCG debrief from Cyber Attack May 2017.	GREEN			
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	York Teaching Hospital NHS Foundation Trust provides daily SitRep reports which are shared with on-Call Director and NHSE. TEWV would also provide daily SitRep info to the CCG in an Emergency.	GREEN			
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Not Applicable to CCG	Not applicable			
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Not Applicable to CCG	Not applicable			
<b>Duty to communicate with the public</b>						

	Core standard	Evidence of assurance	Self assessment RAG  Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.  Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.  Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	York & Scarborough A&E Delivery Board Escalation Framework details the CCGs communications response e.g. at OPEL3 CCG to chair daily telconference call with partner organisations, when to escalate issues to NHSE, and the de-escalation process. Communications process was fully tested during the weekend of the Cyber Attack in May 2017 when all partners in the York and Scarborough health economy joined the weekend teleconference calls. NHSE declared a MAJAX and takeover responsibility for media communications and requested mutual aid to assist with the IT problems being experienced in York. Both York and Scarborough CCGs were in regular contact with GPs over the weekend so that all GP practices were able to open on Monday, 15 May 2017 and the CCG used Twitter and the NHS Vale of York website to inform the Public of developments. CCG also has access to Resilience Direct to enable communication between Emergency responders.	GREEN			

Core standard		Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Detailed in BCMs. During the Cyber Attack when email systems were unavailable, the CCG used the NHS Vale of York website and twitter to communicate messages to the Public and contacted the GPs by phone. VOYCCG also has access to Resilience Direct and this can be used to communicate with partners in an Emergency situation.	GREEN			
<b>Information Sharing – mandatory requirements</b>						
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	Signed Data Sharing Framework Contract with NHS England/NHS Digital and subsidiary agreements. Sign up to NY Overarching ISP since November 2015.	GREEN	Reviewing need for additional agreements with partners.	Pennie Furneaux	Oct-17
<b>Co-operation</b>						
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	Rachel Potts or Designated Deputy attend meetings	GREEN			
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA	VOYCCG representative attends LRF and LHRP meetings.	GREEN			
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	York & Scarborough A&E Delivery Board Escalation Framework details agreed triggers , escalation levels and when mutual aid will be requested from partner organisations. This was signed-off by the York & Scarborough A&E Delivery Board.	GREEN			
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	NHSE to co-ordinate response and VOYCCG to provide support and co-operation in capacity as Category 2 Responder.	GREEN			
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.	NHSE to co-ordinate response and VOYCCG to provide support and co-operation in capacity as Category 2 Responder.	GREEN			
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	York & Scarborough A&E Delivery Board Escalation Framework details agreed triggers , escalation levels and when mutual aid will be requested from partner organisations. This was signed-off by the York & Scarborough A&E Delivery Board.	GREEN			
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared	Flowchart in EPRR Policy	GREEN			
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months	NHSE co-ordinate dates of LHRP on behalf of CCG	GREEN			
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level	Rachel Potts or Designated Deputy attend meetings	GREEN			
<b>Training And Exercising</b>						
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Directors on-Call have attended, or are scheduled to attend, Leadership in Crisis training by November 2017. EPRR Lead attended HEP Award Course in April 2015 and attended the JESIP Initial Amalgamated Course at Easingwold in November 2016. Info from the JESIP Course was shared with on-Call Directors. Mary Hughes attended Logist Instructor Training in June 2017 at Leeds and Loggist training is arranged for CCG & YHFT staff on 8 September 2017. PREVENT training for on-Call Directors and SMT on 8 August 2017.	GREEN			
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Cyber Attack on Friday, 12 May 2017 - CCG implemented OPEL Escalation Framework. VOYCCG Director on-Call chaired system-wide teleconference calls with partner organisations throughout the weekend. Escalated the situation to NHSE who declared MAJAX and tookover responsibility for Media communications and requested mutual aid to assist with the IT problems being experienced by York Hospitals and GP practices in the Vale of York. Both York and Scarborough CCGs were in regular phone contact with GPs over the weekend and all GP practices were able to see patients and access systems on Monday, 15 May 2017. Cyber Attack report and action plan informs lessons learnt and future work.	GREEN			
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises	CYC Exercise Jammi to test Rest Centre Plan with MIRT 29 Sept 2016. TEWV Exercise Ouse to test BCP and Control Rooms for York and Selby 3 October 2016. JESIP training facilitated by NYCC Police - 21 November 2016. Tour de Yorkshire - Planning/De-briefs with Selby District Council (January - April 2017) Operation Kingfisher - Fracking teleconfs with the Police - July 2017.	GREEN			
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	On-Call Directors to record incidents/training EPRR Lead maintains a record of all EPRR training for VOYCCG. Debrief reports from Cyber Attack May 2017 - shared learning with on-Call Directors and Senior Management Team and NHSE.	GREEN			

Core standard		Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
<b>2015 Deep Dive</b>						
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	EPRR 'Substantial Assurance' 2016/17 rating was included in the Accountable Officer's Report to Governing Body on 1 December 2016 (Item 6.1 Page 3) and is published on the NHS Vale of York CCG website. Rachel Potts, Executive Director of Planning & Governance, to present EPRR self-assessment 2017/18 and compliance rating to VOYCCG Governing Body on 7 September 2017.	GREEN	Rachel Potts to present EPRR self-assessment assurance and compliance rating to VOYCCG Governing Board on 7 September 2017.	Rachel Potts	07-Sep-17
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	EPRR 'Substantial Assurance' 2016/17 rating was included in the Accountable Officer's Report to Governing Body on 1 December 2016 (Item 6.1 Page 3) and is published on the NHS Vale of York CCG website.	GREEN	Completed		
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Rachel Potts, Executive Director of Planning & Governance is a member of VOYCCG Governing Body, formally holds the EPRR portfolio for the organisation. She is due to leave the organisation at the end of September 2017 and Tracey Preece, Chief Finance Officer will takeover responsibility for EPRR.	AMBER	VOYCCG needs to identify a lay member and publish the details on the CCG website. Agree the process for briefing outside Governing Body.	Tracey Preece	Nov-17
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	Fliss Wood, Performance & EPRR Manager, Pennie Furneaux, Risk & Assurance Manager, responsible for overseeing business continuity management and Mary Hughes, Loggist Trainer meet regularly to discuss EPRR and Business Continuity issues and update the CCGs policies, procedures and training log. Business Continuity and EPRR arrangements are reviewed through the Information Governance Steering Group. This group meets bi-monthly and meetings are minuted and BCM and EPRR are standing agenda items. The SIRO is the Chair of the Information Governance Steering Group and is the EPRR Lead.	AMBER	BCM and EPRR are to be standing agenda items at the Information Governance Steering Group bi-monthly meetings	Pennie Furneaux Fliss Wood	Oct-17
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	Rachel Potts, the SIRO is the Chair of the Information Governance Steering Group and is responsible for EPRR portfolio at VOYCCG. Bi-monthly updates are provided to Phil Mettam, Accountable Officer, for inclusion in the Governing Body Reports. On-Call Directors/Senior Management Team are made aware of any EPRR issues as they develop e.g. Tour de Yorkshire, flooding/ weather alerts, cyber attack developments, fracking updates, local events which may impact on health services in York. On-Call Directors and SMT were briefed on the York & Scarborough A&E Delivery Board Escalation Framework when this was rolled out in December 2016.	GREEN	Tracey Preece, Chief Finance Officer, takeover SIRO and EPRR portfolio in October 2017	Tracey Preece	Oct-17
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	Fliss Wood, EPRR & Performance Manager is Designated Deputy for Rachel Potts, and has represented VOYCCG at the LHRP and attended 75% of these meetings over the last 12 months. A de-brief of the key points from the LHRP and the minutes are forwarded to both the Accountable Officer and the Executive Director for Planning & Governance.	GREEN	Completed		

**Yorkshire and the Humber Local Health Resilience Partnership (LHRP)  
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018**

**STATEMENT OF COMPLIANCE**

NHS Vale of York CCG has undertaken a self-assessment against required areas of the [NHS England Core Standards for EPRR v5.0](#).

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

<b>Compliance Level</b>	<b>Evaluation and Testing Conclusion</b>
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	12-15 May 2017
A desktop exercise (required at least annually)	5 September 2016
A communications exercise (required at least every six months)	12-15 May 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incident at North Lincolnshire and Goole NHS FT and The Leeds Teaching Hospitals NHS Trust Pathology Incident. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

\_\_\_\_\_  
Date of board / governing body meeting

\_\_\_\_\_  
Date signed

## Yorkshire and the Humber EPRR core standards improvement plan 2017-18

Organisation: NHS Vale of York CCG

### ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
3	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary	Increase the number of on-Call Directors on the rota	New CEO starts October 2016 – need to understand training needs so he can join the on-Call rota.	Completed – currently 6 Directors on on-call rota
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	Align Escalation Plan with NHSE guidance to 4 Levels	UCWG reviewing Trigger/Escalation process in line with NHSE directive to reduce from 6 to 4 Levels and incorporate into A&E Delivery Board Escalation Plan.	Completed – OPEL Escalation Plan December 2016
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolerable Periods of disruption for these	Critical Functions and Tolerance Periods to be included in BCPs.	BCPs and staff contact lists to be updated by October 2016 and stored on 'Y' drive.	Completed

*Add further rows as required*

## Yorkshire and the Humber EPRR core standards improvement plan 2017-18

### **ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS**

<b>Core standard reference</b>	<b>Core standard description</b>	<b>Improvement required to achieve compliance</b>	<b>Action to deliver improvement</b>	<b>Deadline</b>
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Refresh EPRR Policy & On-Call Policy	Submit EPRR and On-Call Policy to VOYCCG Governing Body for sign-off	Sept 2017
5	Assess the risk, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Cyber Attack action plan identifies IT issues which need resolving	Assurance re safety of GP IT systems and Embed contract management to be discussed at October CMB	Nov 2017
8	Effective arrangements in place to respond to risk the organisation is exposed to.	Sign-off of localised flu outbreak plan by Clinical Executive	CCG needs to formalise commissioning arrangements to provide clinical support for a localised flu outbreak	Oct 2017
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	New Directors on-Call are scheduled to attend Strategic Leadership in Crisis Training. PREVENT training for SMT undertaken August 2017.	Medical Director, Chief Finance Officer and Exec Director of Transformation & Delivery are all booked on Strategic Leadership in Crisis Course.	Nov 2017
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Executive Director of Planning & Governance is a member of VOYCCG Governing Body, formally holds the EPRR portfolio for the organisation. She is due to leave the organisation at the end of September 2017 when the Chief Finance Officer will take-over EPRR portfolio.	VOYCCG needs to identify a lay member and publish the details on the CCG website. Agree the process for briefing outside Governing Body.	Nov 2017



Yorkshire and the Humber EPRR core standards improvement plan 2017-18

DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	BCM and EPRR are to be standing agenda items at the Information Governance Steering Group bi-monthly meetings	BCM and EPRR are to be standing agenda items at the Information Governance Steering Group bi-monthly meetings	Oct 2017
-----	--	---	---	----------

*Add further rows as required*

**Please attach a copy of the responses to the governance deep dive standards**

# EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE POLICY

August 2017

<b>Authorship:</b>	Performance & Improvement Manager/ Risk & Assurance Manager
<b>Reviewing Committee:</b>	Senior Management Team
<b>Date:</b>	
<b>Approval Body</b>	Governing Body
<b>Approved date:</b>	September 2017
<b>Review Date:</b>	September 2019
<b>Equality Impact Assessment</b>	
<b>Sustainability Impact Assessment</b>	
<b>Related Policies</b>	COR 18 On Call Policy COR 16 Business Continuity Policy OPEL Escalation Plan A&E Delivery Board Escalation Framework and Delivery Plan On-Call Pack COR 05 Mobile Working Policy HR 20 Home Working Policy
<b>Target Audience:</b>	All employees, members, committee and sub-committee members of the group and members of the governing body and its committees.
<b>Policy Reference No:</b>	COR17
<b>Version Number:</b>	1.1

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.



NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

**POLICY AMENDMENTS**

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

<b>New Version Number</b>	<b>Issued by</b>	<b>Nature of Amendment</b>	<b>Approved by &amp; Date</b>	<b>Date on Intranet</b>
0.1	Performance & Improvement Manager	First Draft		
0.2	Policy & Assurance Manager Performance & Improvement	VOYCCG Policy Formatting Update to definitions Update to accountabilities and responsibilities Updates to Action Cards Checklists APPROVED	Governing Body December 2014	
1.0				
1.1 1.2	Performance Improvement Manager	Remove NHSE tel. number Update NHSE Area Team ref. and incident level definitions to bring into line with NHSE published EPRR framework. SRG ref updated to A&E Delivery Board APPROVED	Governing Body: Oct 16 Chief Operating Officer: 11 Oct 16	
2.0				
2.1	Performance Improvement Manager  Risk and Assurance Manager	Replaced NHSE North Yorkshire & Humber with NHSE Area Team (North).  Para 5.2: addition of reference to CCG Constitution emergency powers Formatting in compliance with CCG Policy on Policies Links to National Risks Update to National Threat Levels Updated risk assessments published by the North Yorkshire Resilience Forum	Governing Body, September 2017	

**To request this document in a different language or in a different format, please contact:**

**Sharron Hegarty, Communications Manager**  
**Telephone: 07718 192232**  
[Sharron.hegarty@nhs.net](mailto:Sharron.hegarty@nhs.net)

## CONTENTS

<b>SECTION A-POLICY</b> .....	<b>4</b>
1. INTRODUCTION .....	4
2. POLICY STATEMENT .....	4
3. IMPACT ANALYSES .....	5
4. SCOPE of POLICY .....	5
5. PRINCIPAL LEGISLATION AND STANDARDS .....	5
6. ROLES / RESPONSIBILITIES / DUTIES .....	6
7. DISSEMINATION, TRAINING & REVIEW .....	8
<b>SECTION B: IDENTIFYING SIGNIFICANT INCIDENTS OR EMERGENCIES..</b> 10	
8. THE ROLE OF THE CCG WITHIN THE LOCAL AREA .....	11
9. PLANNING AND PREVENTION .....	15
10. RISKS .....	16
11. ESCALATION, ACTIVATION AND RESPONSE .....	20
<b>SECTION C: ACTION CARDS</b> .....	<b>23</b>
12. ACTIVATION / ESCALATION FLOWCHART .....	32
13. CONSULTATION, APPROVAL AND RATIFICATION PROCESS .....	33
14. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS .....	33
15. IMPLEMENTATION .....	33
16. TRAINING & AWARENESS .....	33
17. MONITORING & AUDIT .....	33
18. REVIEW .....	34
19. REFERENCES .....	34
20. ASSOCIATED POLICIES/DOCUMENTS .....	34
21. CONTACT DETAILS .....	34
22. LIST OF APPENDICES .....	34
23. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM .....	35
25. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT .....	40
26. APPENDIX 3 ABBREVIATIONS .....	44

## **SECTION A-POLICY**

### **1. INTRODUCTION**

- 1.1. The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).
- 1.2. As detailed in NHS England's framework the emergency preparation, resilience and response role of CCGs is to:
- Ensure contracts with provider organisations contain relevant emergency preparedness, resilience (including business continuity) and response elements
  - Support NHS England in discharging its emergency preparedness, resilience and response functions and duties locally
  - Provide a route of escalation for the Local Health Resilience Partnership (LHRP) should a provider fail to maintain necessary emergency preparedness, resilience and response capacity and capability
  - Fulfil the responsibilities as a Category 2 Responder under the Civil Contingencies Act 2004 including maintaining business continuity plans for their own organisation
  - Be represented on the LHRP
  - Be represented at the LHRP sub-group
  - Seek assurance that provider organisations are delivering their contractual obligation.

### **2. POLICY STATEMENT**

- 2.1. This policy outlines how NHS Vale of York CCG will meet the duties set out in legislation and associated statutory guidelines, as well as any other issues identified by way of risk assessments as identified in the national risk register.
- 2.2. The aims of this procedural document are to ensure NHS Vale of York CCG acts in accordance with the Civil Contingency Act 2004, the Health & Social Care Act 2012 and any relevant national policy and guidance as issued by the Department of Health in our role as a Category 2 Responder.

### **3. IMPACT ANALYSES**

#### **Equality**

- 3.1. As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached.

#### **Sustainability**

- 3.2. A Sustainability Impact Assessment has been undertaken. Positive and negative impacts are assessed against the twelve sustainability themes. The results of the assessment are attached.

### **4. SCOPE OF POLICY**

- 4.1. This policy applies to those members of staff that are directly employed by NHS Vale of York CCG and for whom NHS Vale of York CCG has legal responsibility. For those staff covered by a letter of authority / honorary contract or work experience this policy is also applicable whilst undertaking duties on behalf of NHS Vale of York CCG or working on NHS Vale of York CCG premises and forms part of their arrangements with NHS Vale of York CCG. As part of good employment practice, agency workers are also required to abide by NHS Vale of York CCG policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for NHS Vale of York CCG.

### **5. PRINCIPAL LEGISLATION AND STANDARDS**

- 5.1. The following legislation and guidance has been taken into consideration in the development of this procedural document:
- The Civil Contingencies Act 2004 and associated formal Cabinet Office Guidance
  - The Health and Social Care Act 2012
  - **The requirements for Emergency Preparedness, Resilience and Response Framework.**
  - The requirements for Emergency Preparedness, Resilience & Response as set out in the applicable NHS standard contract
  - NHS England's EPRR documents and supporting materials, including NHS England's Business Continuity Management Framework (service resilience) 2013, NHS England's Command and Control Framework for the NHS during significant incidents and emergencies (2013), NHS England's Model Incident Response Plan (national and regional teams) 2013, and NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- National Occupational Standards (NOS) for Civil Contingencies – Skills for Justice
- BSI PAS 2015 – Framework for Health Services Resilience
- ISO 22301 Societal Security - Business Continuity Management Systems – Requirements

### **The CCG Constitution**

- 5.2. **The section in the CCG Constitution referring to emergency powers and urgent decisions applies**

## **6. ROLES / RESPONSIBILITIES / DUTIES**

### 6.1. LHRP responsibilities

- Facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi agency emergency planning.
- Provide support to NHS England and PHE in assessing and assuring the ability of the health sector to respond in partnership to emergencies at an LRF level.
- Each constituent organisation remains responsible and accountable for their effective response to emergencies in line with their statutory duties and obligations. The LHRP has no collective role in the delivery of emergency response.

### 6.2. NHS England EPRR Guidance 2013 outlines key Responsibilities as:

- the Accountable Officer is responsible for ensuring that the CCG has an incident response plan and is able to respond to an emergency;
- the board is regularly briefed with reports on the CCGs' preparedness;
- additional risks, training and exercises;
- an Accountable Emergency Officer is appointed;
- communications exercise should be carried out every 6 months;
- a table top exercise should be carried out yearly; and
- a live exercise should be carried out every 3 years.

### 6.3. CCG Commitments

- comply with the Civil Contingencies Act 2004 as a category 2 responder;
- comply with the NHS England EPRR guidance 2013;
- publish this plan and distribute it to key partners;
- provide appropriate resources for EPRR;
- undertake regular review and testing of the plan;

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- ensure the NHS Trusts they commission health services from comply with NHS guidance and their duties under the Civil Contingencies Act 2004;
- attend the North Yorkshire Local Health Resilience Partnership;
- contribute to an annual report by the NHS England on the health sectors EPRR capability; and
- produce an annual work programme.

6.4. Overall accountability for ensuring that there are systems and processes to effectively respond to emergency resilience situations lies with the Chief Officer and the Accountable Emergency Officer.

**The Accountable Emergency Officer**

6.5. The Accountable Emergency Officer has responsibility for:

- Ensuring that the organisation is compliant with the Emergency Preparedness Resilience & Response requirements as set out in the Civil Contingencies Act (2004), the NHS planning framework and the NHS standard contract as applicable.
- Ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event
- Ensuring the organisation and any providers it commissions, has robust business continuity planning arrangements in place which reflect standards set out in the Framework for Health Services Resilience (PAS 2015) and ISO 22301
- Ensuring the organisation has a robust surge capacity plan that provides an integrated organisational response and that it has been tested with other providers and parties in the local community(ies) served
- Ensuring that the organisation complies with any requirements of NHS England, or agents thereof, in respect of the monitoring of compliance
- Providing NHS England, or agents thereof, with such information as it may require for the purpose of discharging its functions
- Ensuring that the organisation is appropriately represented at any governance meetings, sub-groups or working groups of the LHRP or Local Resilience Forum (LRF) – which locally is the North Yorkshire LRF.

**Commissioning and Contracting leads**

6.6. Commissioning and contracting leads have responsibility for ensuring emergency preparedness, resilience and response requirements are embedded within provider contracts.



### **The A&E Delivery Board**

- 6.7. **The A&E Delivery Board** has responsibility for effectively managing Surge and Escalation within the area.

## **7. DISSEMINATION, TRAINING & REVIEW**

### **Dissemination**

- 7.1. The effective implementation of this procedural document will support openness and transparency. NHS Vale of York CCG will:
- Ensure all staff and stakeholders have access to a copy of this procedural document via the organisation's website.
  - Communicate to staff any relevant action to be taken in respect of complaints issues.
  - Ensure that relevant training programmes raise and sustain awareness of the importance of effective complaints management.
- 7.2. This procedural document is located on the NHS Vale of York 'Y' Drive, in the Emergency Planning Policy [folder](#).
- 7.3. A set of hardcopy Procedural Document Manuals are held by the Governance Team for business continuity purposes. Staff are notified by email of new or updated procedural documents.

### **Training**

- 7.4. All staff will be offered relevant training commensurate with their duties and responsibilities. Staff requiring support should speak to their line manager in the first instance.

### **Review**

- 7.5. As part of its development, this procedural document and its impact on staff, patients and the public has been reviewed in line with NHS Vale of York CCG's Equality Duties. The purpose of the assessment is to identify and if possible remove any disproportionate adverse impact on employees, patients and the public on the grounds of the protected characteristics under the Equality Act.
- 7.6. This procedural document will be reviewed every three years by NHS Vale of York CCG, and in accordance with the following as and when on a required basis:
- Legislatives changes / Case Law
  - Good practice guidelines
  - Significant incidents reported or new vulnerabilities identified
  - Lessons identified from actual incidents or exercises
  - Changes to organisational infrastructure
  - Changes in practice

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- 7.7. Procedural document management will be performance monitored to ensure that procedural documents are in-date and relevant to the core business of the CCG. The results will be published in the regular Corporate Assurance Reports.

## SECTION B: IDENTIFYING SIGNIFICANT INCIDENTS OR EMERGENCIES

### Overview:

- 7.8. This procedure covers the CCG response to a wide range of incidents and emergencies that could affect health or patient care, referred to in the health service as 'emergency preparedness resilience and response' (EPRR).

### Definition:

- 7.9. A significant incident or emergency can be described as any event that cannot be managed within routine service arrangements. Each requires the implementation of special procedures and may involve one or more of the emergency services, the wider NHS or a local authority. A significant incident or emergency may include;
- a. Any occurrence where the NHS funded organisations are required to implement special arrangements to ensure the effectiveness of the organisation's internal response. This is to ensure that incidents above routine work but not meeting the definition of a major incident are managed effectively.
  - b. An event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. The term "major incident" is commonly used to describe such emergencies. These may include multiple casualty incidents, terrorism or national emergencies such as pandemic influenza.
  - c. An emergency is sometimes referred to by organisations as a major incident. Within NHS funded organisations an emergency is defined as the above for which robust management arrangements must be in place.

### Types of incident:

- 7.10. An incident may present as a variety of different scenarios, they may start as a response to a routine emergency call or 999 response situation and as this evolves it may then become a significant incident or be declared as a major incident. Examples of these scenarios are:
- Big Bang – a serious transport accident, explosion, or series of smaller incidents.
  - Rising Tide – a developing infectious disease epidemic, e.g. Pandemic Flu or Ebola; or a capacity/staffing crisis or industrial action.

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- Cloud on the Horizon – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action.
- Headline news – public or media alarm about an impending situation.
- Internal incidents – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime.
- CBRN(e) – Deliberate (criminal intent) release of chemical, biological, radioactive, nuclear materials or explosive device.
- HAZMAT – Incident involving Hazardous Materials.
- Mass casualties.

**Incident level:**

7.11. As an incident evolves it may be described, in terms of its level, as one to four as identified in the table below.

NHS England Incident levels	
1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

**8. THE ROLE OF THE CCG WITHIN THE LOCAL AREA**

- 8.1. The CCG is a Category 2 Responder and is seen as a ‘*co-operating body*’. The CCG is less likely to be involved in the heart of the planning, but will be heavily involved in incidents that affect the local sector through cooperation in response and the sharing of information. Although, as a Category 2 Responder, the CCG has a lesser set of duties, it is vital that the CCG shares relevant information with other responders (both Category 1 and 2) if emergency preparedness, resilience and response arrangements are to succeed.
- 8.2. A significant or major incident could place an immense strain on the resources of the NHS and the wider community, impact on the vulnerable people in our community and could affect the ability of the CCG to work normally. When events like these happen, the CCG’s

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

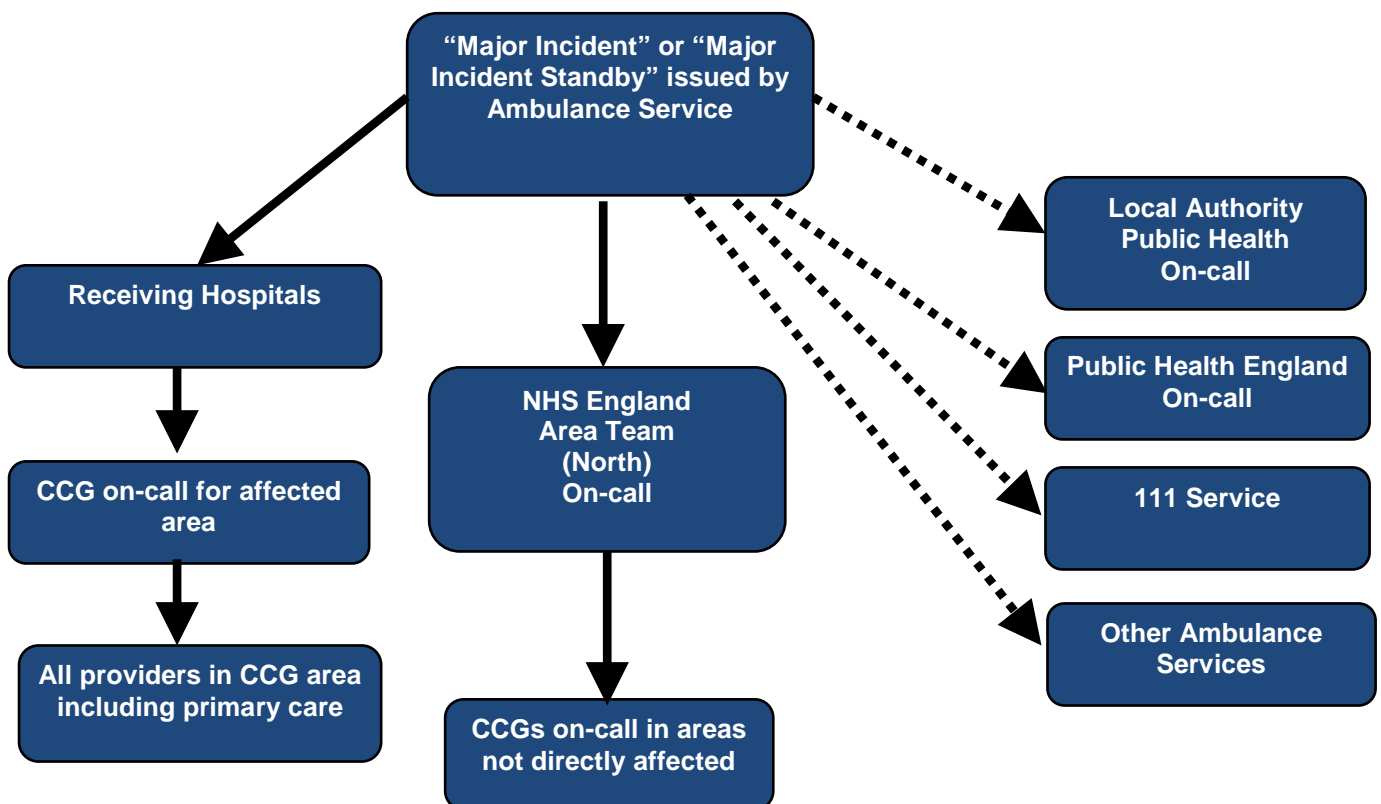
emergency resilience arrangements will be activated. It is important that all staff are familiar with this procedure and are aware of their responsibilities. Staff should ensure that they are regularly updated to any changes in the emergency response, as notified by the Accountable Emergency Officer. Departments / teams must also maintain accurate contact details of their staff, to ensure that people are accessible during an incident.

**Major Incident Declared by an Ambulance Service**

Yorkshire Ambulance Service NHS Trust is responsible for informing receiving hospitals and the NHSE Area Team whenever the service declares a 'major incident' or 'major incident standby'. NHSE Area Team is also responsible for advising the NHS England of any major incidents or other significant incidents.

Key

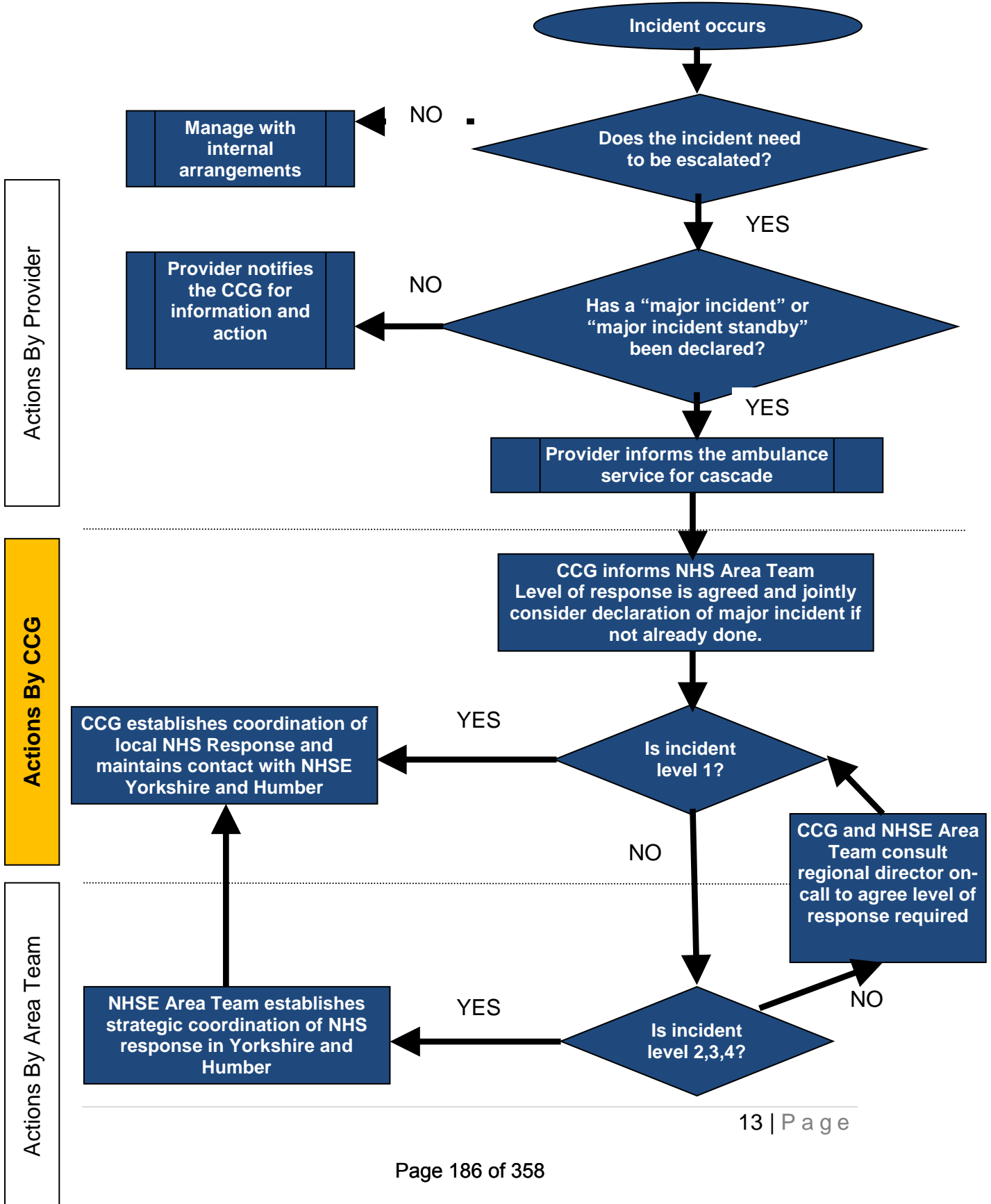
→	Direction of Information for all major incidents and major incident standby declarations
...→	Direction of information flow to services and organisations only informed if scale and nature of incident requires it.



**Major Incident Declared By Provider**

NHS funded organisations are responsible for informing their commissioning CCGs and the ambulance service whenever they are activated or declare a “major incident” or a “major incident standby.”

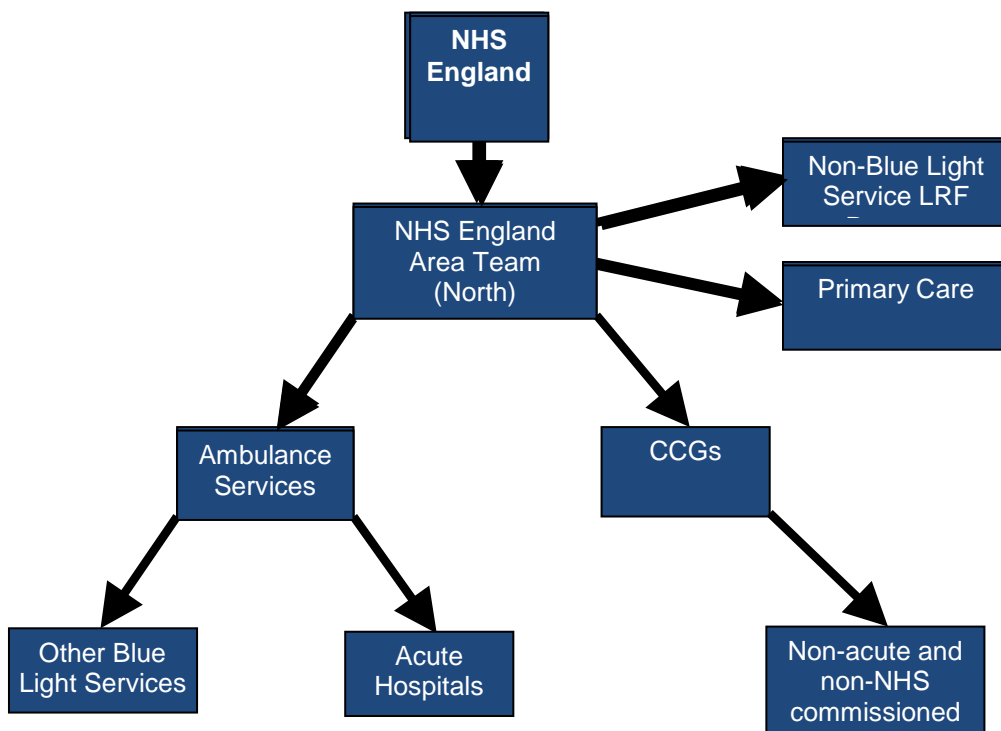
The CCG will then inform NHSE Area Team.



### Major Incident Declared by NHS England

The NHS England Area Team is responsible for informing the ambulance services and CCGs of any national, regional or area “major incident,” “major incident standby,” or similar message where there is a need to respond locally or cross border mutual aid is required. The Ambulance Service will then inform Acute hospitals and the CCG will inform other providers.

### Top Down Cascade by NHS England



### Independent Plan Activation

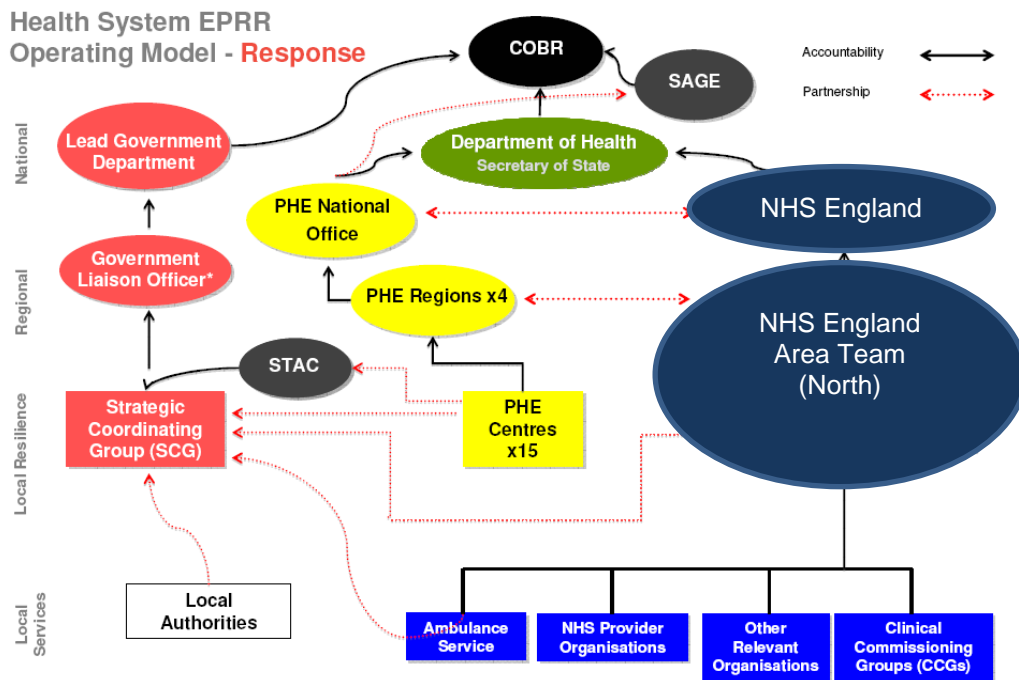
Any on-call manager may activate the Incident Response Plan regardless of any formal alerting message. Such action may be taken when it is apparent that severe weather or an environmental hazard may demand the implementation of special arrangements or when a spontaneous response by members of the public results in the presentation of major incident casualties at any health care setting e.g. acute or community hospital, walk in centre, health centre, GP Practice or minor injuries unit.

## 9. PLANNING AND PREVENTION

- 9.1. *Action Card:* An Action Card detailing roles and responsibilities is appended to this procedure as Action Card 1.
- 9.2. *Contracting responsibilities:* CCGs are responsible for ensuring that resilience and response is “commissioned in” as part of the standard provider contracts and that provider plans reflect the local risks identified through wider multi-agency planning. The CCG will record these risks on the internal risk register. In addition, CCGs are expected to ensure delivery of these outcomes through contribution to an annual EPRR assurance process facilitated by NHS England Area Team. The NHS Standard Contract includes the appropriate EPRR provision and this contractual framework will be used wherever appropriate by the CCG when commissioning services. Contract monitoring and review will encompass the review of EPRR and there may be occasions where the Local Health Resilience Partnership uses the CCG as a route of escalation where providers are not meeting expected standards.
- 9.3. *Partnership working:* In order to ensure coordinated planning and response across our area, it is essential that the CCG works closely with partner agencies across the area, ensuring appropriate representation.
- Category 1 and 2 Responders come together to form Local Resilience Forums (LRF) based on Police areas. These forums help to co-ordinate activities and facilitate co-operation between local responders. The North Yorkshire LRF is the vehicle where the multi-agency planning takes place via a variety of groups which relate to specific emergencies like fuel shortage, floods, industrial hazards and recovery. These plans will be retained by the NHSE Area Team.
  - For the NHS, the strategic forum for joint planning for health emergencies is via the Local Health Resilience Partnership (LHRP) that supports the health sector’s contribution to multi-agency planning through the Local Resilience Forum (LRF).
- 9.4. The diagram below shows the NHS England’s EPRR response structure and its interaction with key partner organisations.



NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY



## 10. RISKS

### LOCAL RISKS

- 10.1. *Hazard analysis and risk assessment:* A hazard analysis & risk assessment is undertaken by the Local Health Resilience Partnership (LHRP) and this includes detailed assessments of potential incidents that may occur. The assessments are monitored through this forum. Risk assessments are regularly reviewed or when such an incident dictates the need to do so earlier. Any external risk may be required to be entered onto the North Yorkshire LRF Community Risk Register if it is felt to pose a significant risk to the population. This action will be co-ordinated through the LHRP. The purpose of producing these lists of hazards and threats is to ensure that each organisation can focus their emergency planning efforts towards those risks that are likely (or could possibly) occur.
- 10.2. A formal risk assessment of hazards and risks is undertaken by a multi-agency LRF risk assessment group every year as required by the Civil Contingencies Act 2004.
- 10.3. *North Yorkshire Community Risk Register:* Like anywhere in the UK, North Yorkshire has a number of natural and manmade hazards. To ensure we are prepared for these hazards the North Yorkshire LRF has created a Community Risk Register which identifies the wide range of risks and emergencies we could potentially face. This Risk Register is then used by the forum to inform priorities for planning, training and exercising. The North Yorkshire Community Risk Register is available to download from: <http://www.emergencynorthyorks.gov.uk/index.aspx?articleid=11778>

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- 10.4. Nine risks have been identified per the Public Risk register **published by the North Yorkshire Resilience Forum May 2017** (version 7) as “Very High Risk” (Very High Risks are classified as “primary or critical risks requiring immediate attention”), as follows:

- Pandemic Influenza.
- Flooding.
- Severe Weather
- Industrial Incident
- Marine Pollution.Disruption or Failure Electrical Network.
- Industrial Action.
- Animal Health.
- Hazardous Transport
- Cyber Security

More details have been published

here: <http://www.emergencynorthyorks.gov.uk/sites/default/files/files/Risk/NY%20Community%20Risk%20Register%20-%20May%202017.docx>

#### **National Risk Register**

- 10.5. The National Risk Register of Civil Emergencies July 2015 has been published and provides an updated government assessment of the likelihood and potential impact of a range of different civil emergency risks (including naturally and accidentally occurring hazards and malicious threats) that may directly affect the UK over the next 5 years.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419549/20150331\\_2015-NRR-WA\\_Final.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419549/20150331_2015-NRR-WA_Final.pdf)

#### **National Threat level**

- 10.6. The level of threat from terrorism is under constant review by the Security Services.

- Low - an attack is unlikely
- Moderate - an attack is possible, but not likely
- Substantial - an attack is a strong possibility
- Severe - an attack is highly likely
- Critical - an attack is expected imminently

- 10.7. The latest threat level can be viewed:

<https://www.mi5.gov.uk/threat-levels>

- 10.8. *Specific local risks:* A number of specific risks that the CCG may potentially have are listed below alongside the planned response. Assurance will be obtained through the contracting route by the Head

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

of Contracting or equivalent, and also via local partnership emergency planning within the local geographic area.

Fuel shortage	<p>International and national shortages of fuel can adversely impact on the delivery of NHS services.</p> <p>The CCG will seek assurance that commissioned services have plans in place to manage fuel shortages and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local risks identified will be escalated appropriately.</p>
Flooding	<p>The Environment Agency provides a flood warning service for areas at risk of flooding from rivers or the sea. Their flood warning services give advance notice of flooding and time to prepare.</p> <p>The CCG will seek assurance that commissioned services have plans in place to manage local flooding incidents and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local risks identified will be escalated appropriately.</p>
Evacuation & Shelter	<p>Incidents such as town centre closures, flooding, or significant damage to healthcare premises could lead to the closure of key healthcare premises.</p> <p>The CCG will seek assurance that commissioned services have plans in place to manage local evacuation and shelter incidents, will work in partnership with the Local Authority, and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local risks identified will be escalated appropriately.</p>
Pandemic influenza	<p>Pandemics arise when a new virus emerges which is capable of spreading in the worldwide population. Unlike ordinary seasonal influenza that occurs every winter in the UK, pandemic flu can occur at any time of the year.</p> <p>The CCG will seek assurance that commissioned services have plans in place to manage local pandemic, will work in partnership with the Local Authority, will cascade local pandemic communications, and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local risks identified will be escalated appropriately.</p> <p>The CCG will work with and through the A&amp;E Delivery Board to manage unplanned care as a result of pandemic influenza and will manage normal local surge and escalation.</p>
Infectious/contagious diseases	<p>E.g. Ebola and Marburg viruses. Alerts are received from NHS England and Resilience Direct.</p> <p>Yorkshire Ambulance Trust and York Hospitals Trust have trained staff</p>

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

	<p>in containment of infectious diseases.</p> <p>CCG staff attended Ebola awareness event 4<sup>th</sup> November 2014.</p>
Heat wave	<p>The Department of Health and the Met Office work closely to monitor temperatures during the summer months. Local organisations such as the NHS and Local Authorities plan to make sure that services reach the people that need them during periods of extreme weather.</p> <p>The CCG will seek assurance that commissioned services have plans in place that align to the national Heatwave Plan, and that will manage local heatwave incidents. The CCG will cascade local heatwave communications, and will work with the LHRP and LRF on wider community resilience. Local risks identified will be escalated appropriately.</p> <p>The CCG will work with and through the <b>A&amp;E Delivery Board</b> to manage unplanned care as a result of heatwave and will manage normal local surge and escalation.</p>
Severe Winter Weather	<p>Each year millions of people in the UK are affected by the winter conditions, whether it's travelling through the snow or keeping warm during rising energy prices. Winter brings with it many hazards that can affect people both directly or indirectly. Severe weather is one of the most common disruptions people face during winter.</p> <p>The CCG will seek assurance that commissioned services have plans in place to manage local severe winter weather, will cascade local winter communications, and will work with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) on wider community resilience. Local risks identified will be escalated appropriately.</p> <p>The CCG will work with and through the <b>A&amp;E Delivery Board</b> to manage unplanned care as a result of severe winter weather and will manage normal local surge and escalation.</p>
Diverts	<p>The North Yorkshire footprint consists of NHS organisations in the NHS England Yorkshire and Humber locality. An ambulance Divert Policy agreed across Yorkshire and Humber is in place to manage this risk. The Divert Policy should only be used when trusts have exhausted internal systems and local community-wide health and social care plans to manage demand. A total view of system capacity should be taken including acute resource, community response, intermediate care and community in-patient capacity.</p> <p>The CCG will monitor the generic email box <a href="mailto:VOYCCG.Emergencyplan@nhs.net">VOYCCG.Emergencyplan@nhs.net</a> and pick up issues on the next working day directly with Providers.</p>

- 10.9. The CCG is a partner in a number of specific plans which have been developed across the health community in order to respond to emergencies and escalate actions appropriately. These include:

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- NHS England Incident Response Plan
- York & Scarborough A&E Delivery Board Escalation Framework
- Business Continuity Plan
- Specific multi-agency plans to which the CCG is party such as Heatwave and Pandemic Flu.

10.10. Assurance in respect of CCG emergency planning will be provided to the CCG Governing Body via the Governing Body Assurance Framework.

## 11. ESCALATION, ACTIVATION AND RESPONSE

- 11.1. *Action Card:* An Action Card describing the activation process is appended to this procedure as Action Card 2.
- 11.2. *CCG:* As a Category 2 Responder under the Civil Contingency Act 2004, the CCG must respond to reasonable requests to assist and co-operate with NHSE or the Local Authority should any emergency require wider NHS resources to be mobilised. Through its contracts, the CCG will maintain service delivery across the local health economy to prevent business as usual pressures and minor incidents within individual providers from becoming significant or major incidents. This could include the management of commissioned providers to effectively coordinate increases in activity across their health economy which may include support with surge in emergency pressures. The **A&E Delivery Board** work plans and meetings provide a process to manage these pressures and to escalate to **NHSE AREATeam** as appropriate.
- 11.3. *NHSE North:* The NHSE operates an on-call system for Emergency Preparedness, Resilience and Response (EPRR). This system is not restricted to major emergencies and could be mobilised to assess the impact of a range of incidents affecting, or having the potential to affect, healthcare delivery within North Yorkshire and the Humber. In respect of EPRR for incidents/risks that only affect the NHS, the NHSE areaTeam covers the following North Yorkshire local authority areas:
- North Yorkshire County Council
  - York City Council
- 11.4. In respect of EPRR for incidents/risks that affect all multi-agency partners, the NHSE Team provides strategic co-ordination of the local health economy and represents the NHS at the North Yorkshire LRF.
- 11.5. The initial communication of an incident alert to the first on-call officer of the NHSE Team is via any of the organisations. An additional role of the NHSE Team is to activate the response from independent contractors as required.

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

- 11.6. *Public Health England:* Public Health England will coordinate any incident that relates to infectious diseases.
- 11.7. *NHS Property Services:* NHS Property Services has robust local contact arrangements which should be used in most cases for local out of hours issues that require the involvement or attention of NHS Property Services. Where local contact cannot be made with NHS Property Services or where situations require escalation to regional and communications team senior managers on-call, messages can be sent via the single number PAGEONE service below
- Dial: 0844 8222888 for NHS Property Services On-Call Escalation
  - A call handler will ask for a group code
  - Ask for NHSPS04 and leave your message and contact details
- 11.8. *Vulnerable People:* The Civil Contingencies Act 2004 places the duty upon Category 1 and 2 Responders to have regard for the needs of vulnerable people. It is not easy to define in advance who are the vulnerable people to whom special considerations should be given in emergency plans. Those who are vulnerable will vary depending on the nature of the emergency. For planning purposes there are broadly three categories that should be considered:
- Those who for whatever reason have mobility difficulties, including people with physical disabilities or a medical condition and even pregnant women;
  - Those with mental health conditions or learning difficulties;
  - Others who are dependent, such as children or very elderly.
- The CCG needs to ensure that in an incident people in the vulnerable people categories can be identified via contact with other healthcare services such as GPs and Social Care.
- 11.9. *Communications:* From a multi-agency response perspective the Police would lead on the communications and media support. From a non-public health incident perspective, the NHSE Team would lead on the communications. Public Health England will lead on communications if the incident was public health related. The CCG role will be to liaise with the communication lead as appropriate, supply information as requested and cascade communications. See Action Card 1 for further information on roles and responsibilities.

### **Recovery**

- 11.10. In contrast to the response to an emergency, the recovery may take months or even years to complete, as it seeks to address the enduring human physical and psychological effects, environmental, social and economic consequences. Response and recovery are not, however, two discrete activities and the response and recovery phases may not occur sequentially. Recovery should be an integral

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

part of the combined response from the beginning, as actions taken at all times during an emergency can influence the long-term outcomes for communities.

**Debriefing and Staff Support**

- 11.11. The CCG will be responsible for debriefing and provision of support to staff where required following an emergency. This is the responsibility of individual line managers coordinated by the Accountable Emergency Officer. De-briefing may also be on a multi-agency footprint.
- 11.12. Any lessons learned from the incident will be fed back to staff and actioned appropriately.

**Testing & Monitoring of Plans**

- 11.13. The CCG emergency resilience plans will be reviewed annually by the Accountable Emergency Officer.
- 11.14. As part of the CCG's emergency preparedness and planning, the organisation will participate in exercises both locally and across the North Yorkshire LRF with our partners. This helps staff to understand their roles and responsibilities when a situation occurs.
- 11.15. Live incidents which require the plans to be evoked will conclude with a debrief process and lead to review/improvements of the plans.

**SECTION C: ACTION CARDS**

**ROLES AND RESPONSIBILITIES**

These action cards describes the general action required and should be adapted as necessary to apply to the specific circumstances of the incident.



### 1. Action Card for Emergency Accountable Officer

<b>Your role</b>	<b>EMERGENCY ACCOUNTABLE OFFICER</b>
<b>Your base</b>	West Offices, Station Rise, York.
<b>Your responsibility</b>	You are responsible for directing NHS Vale of York CCG's emergency response.
<b>Your immediate actions</b>	<p>1. Obtain as much information as practicable and assess the situation. Complete an <b>Initial Risk Assessment</b>, (Template on next page) before implementing the required actions: is this an emergency.</p> <p>METHANE:  <b>M</b>ajor Emergency Declared  <b>E</b>xact Location  <b>T</b>ype of Emergency  <b>H</b>azards present and potential  <b>A</b>ccess / Egress routes  <b>N</b>umber and types of Casualties  <b>E</b>mergency services present and required</p> <p>If the incident is assessed as an emergency, activate the plan. <b>SEE ACTIVATION / ESCALATION ACTION CARD.</b></p> <p>2. Assign ACTION CARDS in accordance with the key functions to support you.</p> <p>3. Proceed to the Incident Control Room.</p>
<b>Ongoing management</b>	<p>Systematically review the situation and maintain overall control of the CCG response.</p> <ul style="list-style-type: none"> <li>• <b>S</b>urvey</li> <li>• <b>A</b>ssess</li> <li>• <b>D</b>isseminate</li> </ul> <p>Approve content and timings of press releases / statements and attend conferences if required.</p>
<b>Stand down</b>	<p>If it can be dealt with using normal resources, notify the appropriate personnel and maintain a watching brief.</p> <p>Continue to reassess the situation as further information becomes available and determine if any additional action is required</p> <p>In the event of any increase in the scale / impact of the incident reassess the risk and escalate as needed.</p>

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE POLICY

**11.1.1.1.1 Initial Risk Assessment completed by Emergency Accountable Officer**

Questions to consider	Information Collected?*
<b>What is the size and nature of the incident?</b>	
Area and population likely to be affected - restricted or	
Level and immediacy of potential danger - to public and response personnel	
Timing - has the incident already occurred/ongoing?	
<b>What is the status of the incident?</b>	
Under control	
Contained but possibility of escalation	
Out of control and threatening	
Unknown and undetermined	
<b>What is the likely impact?</b>	
On people involved, the surrounding area	
On property, the environment, transport, communications	
On external interests - media, relatives, adjacent areas and partner organisations.	
<b>What specific assistance is being requested from the NHS?</b>	
Increased capacity - hospital, primary care, community	
Treatment - serious casualties, minor casualties, worried	
Public information	
Support for rest centres, evacuees	
Expert advice, environmental sampling, laboratory testing, disease control	
Social/psychological care	
<b>How urgently is assistance required?</b>	
Immediate	
Within a few hours	
*Key √ = Yes X = no ? = Information awaited N/A = Not applicable	

## 2. Action Card for Incident Emergency Planning Coordinator

<b>Your role</b>	<b>Incident Emergency Planning Coordinator</b>
<b>Your base</b>	West Offices, Station Rise, York.
<b>Your responsibility</b>	You are responsible for coordinating the CCG's tactical response and ensuring all aspects of the plan are followed. You will establish and maintain lines of communication with all other organisations involved, coordinating a joint response where circumstances require.
<b>Your immediate actions</b>	<ol style="list-style-type: none"> <li>1. Proceed to the Incident Control Room.</li> <li>2. With the Incident Emergency Accountable Officer, assess the facts and clarify the lines of communication accordingly.</li> <li>3. Call in Senior Managers as required.</li> <li>4. Allocate rooms, telephone lines and support staff as required.</li> <li>5. Notify and liaise as necessary with health community and inter-agency emergency planning contacts.</li> <li>6. Record all relevant details of the incident and the response.</li> </ol>
<b>On-going management</b>	Systematically review the situation with the Incident Lead Executive and ensure coordination of the CCG response.
<b>Stand down</b>	<p>Following stand-down, prepare a report for the Chief Officer.</p> <p>Arrange a "hot" de-brief for all staff involved immediately after the incident.</p> <p>Arrange a structured de-brief for all staff within a month of the incident.</p>

## NOTES FOR INCIDENT EMERGENCY PLANNING COORDINATOR

1. Review the status and resources of the local NHS
2. Plan rota
3. Ensure decision logs maintained
4. Monitor staff welfare
5. Confirm emergency contact arrangements to:
  - NHS England Team
  - Yorkshire Ambulance Service
  - Community & Mental Health Trusts
  - York Hospital NHS Foundation Trust
  - Neighbouring CCGs
  - Council Emergency Centres
  - City of York Council
  - Adult and Children’s Services
  - Other relevant responding agencies.
6. Maintain regular contact with the NHS responding agencies
7. Plan for prolonged response and to start working shift
8. Ensure a Recovery Team starts to plan the strategy for recovery after the initial response is organised

### Meetings

Meetings held hourly for 15 minutes, chaired by the Emergency Accountable Officer to an agenda with brief factual reports from each lead

### Decisions

Key decisions logged in the decisions log

### Equipment Availability

Television, Phone, Teleconference facility, Laptops

### Use IS-BAR Briefing Tool

<b>I</b>	<b>Identify</b> Who you are.	Who is present? (Ensure you have all key personnel present for the briefing)
<b>S</b>	<b>Situation</b>	What is the current situation? (If it is the initial brief then an overview of the incident will be required).
<b>B</b>	<b>Background</b>	Where are we up to? Each area gives an update on: <ul style="list-style-type: none"> <li>• Risks</li> <li>• Staffing levels</li> <li>• Resource issues</li> </ul>
<b>A</b>	<b>Assessment</b>	Assessment of needs / concerns.
<b>R</b>	<b>Recommendations</b>	Plan for the next 60 minutes. Be clear what is required of each area / person. Confirm time & location of next briefing (on the hour).

### 3. Action Card for Communication Lead

<b>Your role</b>	<b>Communication Lead</b>
<b>Your base</b>	West Offices, Station Rise, York. (unless a control room is located to another premise)
<b>Your responsibility</b>	You are responsible for preparing and disseminating media information by agreement with the Incident Lead Executive. If necessary, you will organise facilities for media visits and briefings.
<b>Your immediate actions</b>	<ol style="list-style-type: none"> <li>1. Proceed to the Incident Control Room.</li> <li>2. After briefing by the Incident Lead Executive, establish lines of communication with Communication Leads at other organisations involved in the emergency and work in conjunction with multi-agency communication leads as required.</li> <li>3. Draft media releases for Incident Lead Executive approval.</li> <li>4. Coordinate all contact with the media.</li> <li>5. Ensure the nominated spokesperson is fully and accurately briefed before they have any contact with the media.</li> </ol>
<b>On-going management</b>	Make arrangements for any necessary public communications.
<b>Stand down</b>	<p>Participate in a “hot” de-brief immediately after the incident and any subsequent structured de-brief.</p> <p>Following stand-down evaluate communications effectiveness and any lessons learned and report these to the Incident Emergency Planning Coordinator for inclusion in the report to the Chief Officer.</p>

**Page deliberately left blank**

#### 4. Action Card For Loggist

<b>Your role</b>	<b>LOGGIST (Admin and Clerical support)</b>
<b>Your base</b>	West Offices, Station Rise, York. (unless a control room is located to another premise)
<b>Your responsibility</b>	You will help to set up the incident control room, perform secretarial. Administrative or clerical duties as required by the Incident Control Team and ensure a record / log of the incident is maintained.
<b>Your immediate actions</b>	<ol style="list-style-type: none"> <li>1. Proceed to the Incident Control Room as directed.</li> <li>2. Report to the Incident Emergency Planning Coordinator for briefing</li> <li>3. Assist in setting up the Incident Control Room with telephones, computers etc.</li> <li>4. Arrange for all internal rooms to be made available as needed.</li> <li>5. Maintain a log of decisions taken, communications, and actions taken by the incident control team.</li> </ol> <p><b>NB.</b> The record must be made in permanent black ink, clearly written, dated and initialled by the loggist at start of shift. All persons in attendance to be recorded in the log. The log must be a complete and continuous (chronological) record of all issues/ options considered / decisions along with reasoning behind those decisions /actions. Timings have to be accurate and recorded each time information is received or transmitted. If individuals are tasked with a function or role this must be documented and when the task is completed this must also be documented. See Incident Log template overleaf.</p>
<b>On-going management</b>	<p>Provide support services as directed.</p> <p>All documentation is to be kept safe and retained for evidence for any future proceedings.</p>
<b>Stand down</b>	<p>Participate in a “hot” de-brief immediately after the incident and any subsequent structured de-brief.</p> <p>Following stand-down evaluate admin effectiveness and any lessons learned and report these to the Incident Emergency Planning Coordinator for inclusion in the report to the Chief Officer.</p>

## Notes For Loggists

### Completion of Logs

1. Immediately the CCGs start to respond to an incident then a log of actions must be started by key officers and the organisation
2. Master Log – all information entering the information cell must be logged including all incoming phone calls and emails
3. Action log – must be completed by all key Action Card holders
  - Logs will be issued to all Action Card holders who should keep a record of:
  - All instructions received,
  - Actions taken
  - Other information
4. The log should be handed on and signed off if the holder is relieved during the incident and following stand-down it is to be returned to the Emergency Control Centre Co-ordinator for safe storage.
5. Decision log – records the key corporate decisions, the process for deciding and the considered alternatives. A decision log must be kept by the CCG incident commander.

**The Emergency Accountable Officer MUST sign the decision log after each key decision is agreed.**

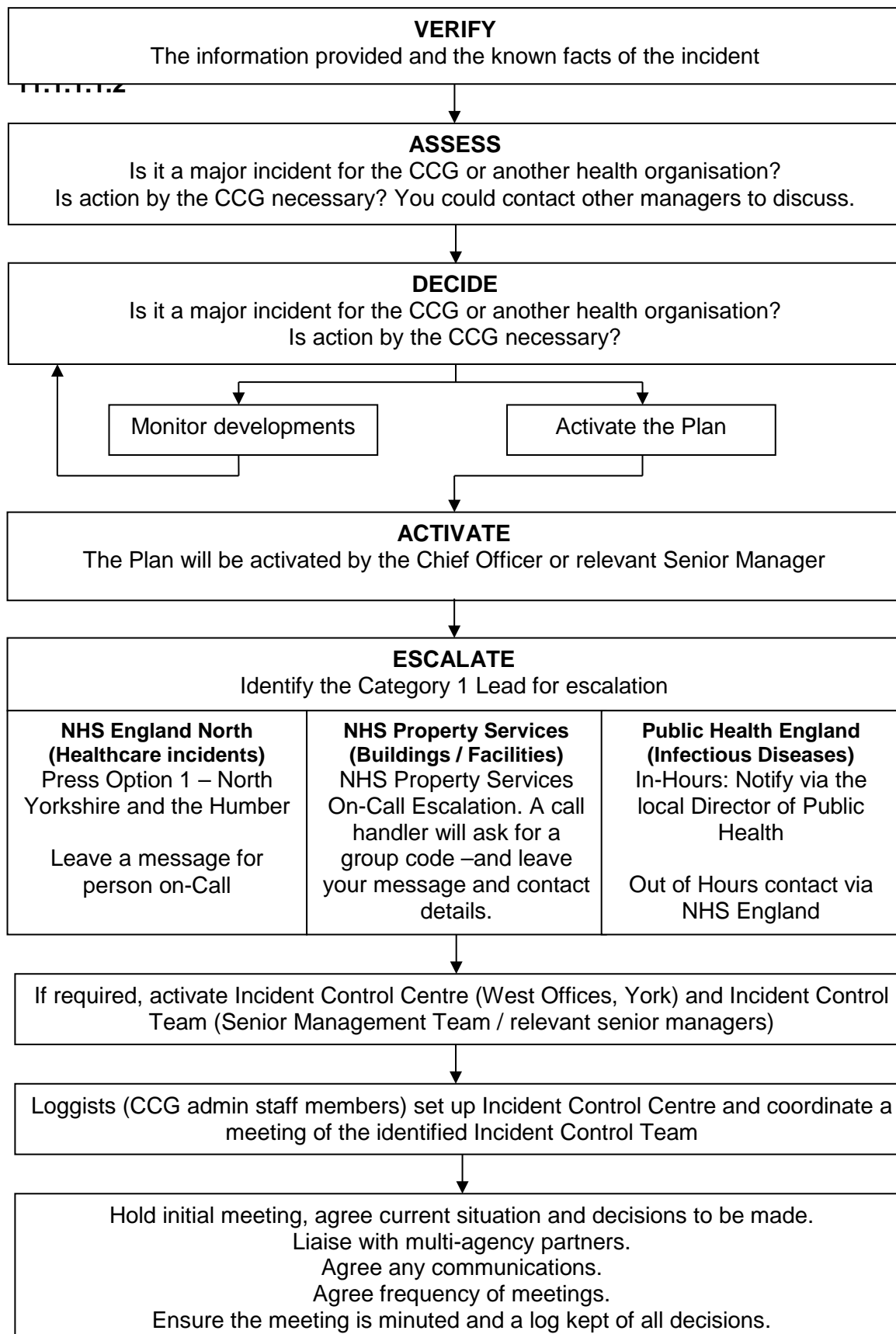
**LOGS MUST BE KEPT WITH DATED & TIMED ENTRIES BY ALL STAFF MAKING DECISIONS IN A MAJOR INCIDENTS ON APPROVED LOG SHEETS: NO RECORDS NO DEFENCE**

### Prepare Shift Arrangements

6. In the event of a significant / major incident or emergency having a substantial impact on the population and health services, it may be necessary to continue operation of the Incident Management Team for a number of days or weeks. In particular, in the early phase of an incident, the Incident Management Team may be required to operate continuously 24/7. Responsibility for deciding on the scale of response, including maintaining teams overnight, rests with the Incident Manager.
7. A robust and flexible shift system will need to be in place to manage an incident through each phase. These arrangements will depend on the nature of the incident and must take into consideration any requirements to support external (for example SCG) meetings and activities. The Incident Manager is accountable for ensuring appropriate staffing of all shifts. During the first two shift changes 1-2 hours of hand over time is required.



## 12. ACTIVATION / ESCALATION FLOWCHART



### **13. CONSULTATION, APPROVAL AND RATIFICATION PROCESS**

- 13.1. The following committees and individuals have been involved in the consultation and development of this policy:
- SMT
  - Local Health Resilience Partnership (LHRP) The policy will be approved/ratified by the committees/CCG Governing Body, in line with the CCG's Policy on Policies.

### **14. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS**

- 14.1. The previous version of this policy will be removed from the intranet and will be available if required by contacting the author.

### **15. IMPLEMENTATION**

- 15.1. This policy will be circulated to all teams to be cascaded to individual members of staff. The document will be made available for staff and users and other stakeholders through the CCG website.
- 15.2. The CCG has mechanisms in place in order to ensure that:
- staff can raise issues of concern with their manager(s);
  - staff are consulted on proposed organisational or other significant changes;
  - managers keep staff informed of progress on relevant issues;
  - service users, their relatives, carers and advocates can identify points of concern or worry by using the complaints process or PALS service;
  - the media are accurately advised of developments in the CCG.
- 15.3. CCG policies are communicated to service providers and support service organisations through commissioning mechanisms and contract requirements.

### **16. TRAINING & AWARENESS**

- 16.1. This policy will be published on the CCG's website.
- 16.2. The policy will be brought to the attention of all relevant new employees as part of the induction process. Further advice and guidance is available from the Corporate Services Manager.

### **17. MONITORING & AUDIT**

- 17.1. The CCG monitors and reviews its performance in relation to EPRR performance and the continuing suitability and effectiveness of the systems and processes in place.

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

- 17.2. The Executive Committee is responsible for monitoring the effectiveness of this policy/strategy and for providing assurance to the Governing Body.
- 17.3. Monitoring of this policy/strategy may form part of the Internal Audit review of governance compliance.

## 18. REVIEW

- 18.1. This framework will be reviewed bi-annually. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

## 19. REFERENCES

- <https://www.england.nhs.uk/wp-content/uploads/2015/11/epr-guidance-chart-oct15.pptx>
- <https://www.england.nhs.uk/ourwork/epr/gf/#summary>

## 20. ASSOCIATED POLICIES/DOCUMENTS

- COR 16 Business Continuity Policy
- COR 18 On Call Policy
- OPEL Escalation Plan
- A&E Delivery Board Escalation Framework and Delivery Plan
- On-Call Pack
- COR 05 Mobile Working Policy
- HR 20 Home Working Policy

## 21. CONTACT DETAILS

### Performance and Improvement Manager

Telephone: 01904 555774

Email: [valeofyork.contactus@nhs.net](mailto:valeofyork.contactus@nhs.net)

Address: NHS Vale of York Clinical Commissioning Group, West Offices,  
Station Rise, York. YO1 6GA

## 22. LIST OF APPENDICES

Appendix 1: Equality Assessment

Appendix 2: Sustainability Assessment

Appendix 3: Abbreviations

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

**23. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM**

<b>1.</b>	<b>Title of policy/ programme/ service being analysed</b>
	Risk Management Strategy and Policy
<b>2.</b>	<b>Please state the aims and objectives of this work.</b>
	<p>To define and document the CCG's approach to risk and risk management to ensure:</p> <ul style="list-style-type: none"> <li>• risks within the organisation are identified, assessed, treated and monitored as part of the corporate governance of the CCG.</li> <li>• robust risk assessment and monitoring mechanisms are in place for all elements of the commissioning process, including needs assessment, tendering, contract management and evaluation.</li> </ul>
<b>3.</b>	<b>Who is likely to be affected? (e.g. staff, patients, service users)</b>
	CCG staff, partner organisations (where applicable), public, patients and member practices. CCG managers and staff (and other providers and partners where applicable). If Risk management arrangements are not effective patients and service providers may be impacted.
<b>4.</b>	<b>What sources of equality information have you used to inform your piece of work?</b>
	NHS England
<b>5.</b>	<b>What steps have been taken ensure that the organisation has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics</b>
	The analysis of equalities is embedded within the CCG's Committee Terms of Reference and project management framework.

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

<b>6.</b>	<b>Who have you involved in the development of this piece of work?</b>	
	<p><b>Internal involvement:</b> Senior Management team</p> <p><b>Stakeholder involvement:</b> Consultation with Senior Managers</p> <p><b>Patient / carer / public involvement:</b> This is an Internal policy aimed at staff employed by the CCG and contractors working for the CCG. The focus is on compliance with statutory duties and NHS mandated principles and practice. There are no particular equality implications.</p>	
<b>7.</b>	<p><b>What evidence do you have of any potential adverse or positive impact on groups with protected characteristics?</b> <b>Do you have any gaps in information?</b> <b>Include any supporting evidence e.g. research, data or feedback from engagement activities</b></p> <p><b>(Refer to Table 1 - Embedding Equality into the Commissioning Cycle if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)</b></p>	
<b>Disability</b>	People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc.
N/a		
<b>Sex</b>	Men and Women	Consider gender preference in key worker, single sex accommodation etc
N/a		
<b>Race or nationality</b>	People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc.

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

N/a	
<b>Age</b> This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.
N/a	
<b>Trans</b> People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
N/a	
<b>Sexual orientation</b> This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
N/a	
<b>Religion or belief</b> Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.
N/a	
<b>Marriage and Civil Partnership</b> Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
N/a	

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

<b>Pregnancy and maternity</b> Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/a	
<b>Carers</b> This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
N/a	
<b>Other disadvantaged groups</b> This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc
N/a	
<b>8. Action planning for improvement</b>	
	Please outline what mitigating actions have been considered to eliminate any adverse impact?
	Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people?
	An Equality Action Plan template is appended to assist in meeting the requirements of the general duty

NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

<b>Sign off</b>
Name and signature of person / team who carried out this analysis <i>Helen Sikora, Policy and Strategy Manager Audit Committee</i>
Date analysis completed <i>December 2014</i>
Name and signature of responsible Director
Date analysis was approved by responsible Director



NHS Vale of York Clinical Commissioning Group  
EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE POLICY

**25. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT**

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Risk Management policy and Strategy
What is the main purpose of the document	To effectively identify, manage and monitor risk within the organisation.
Date completed	November 2014
Completed by	Governance Team

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		
	Will it promote ethical purchasing of goods or services?	0		
Procurement	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	0		
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/a		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		
	Will it increase safety and security in new buildings and developments?	0		
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

## 26. APPENDIX 3 ABBREVIATIONS

Term	Definition
CCA	Civil Contingencies Act (2004)
CCG	Clinical Commissioning Groups
DPH	Director of Public Health
EPRR	Emergency preparedness, resilience and response
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
PHE	Public Health England
COMAH	Control of Major Accident Hazards
DPH	Director of Public Health
EPRR	Emergency Preparedness Resilience & Response
ICC	Incident Control Centre for Major Incidents
IMT	Incident Management Team
IRP	Incident Response Plan
MACA	Military Aid to the Civilian Authorities include <ul style="list-style-type: none"> <li>- Military Aid to the Civil Communities (MACC)</li> <li>- Military Aid to the Civil Ministries (MACM) e.g. assistance in the event of industrial action</li> <li>- Military Aid to the Civil Powers (MACP), assistance to the Police</li> </ul>
MACR	Major Accident Control Regulations
OOH	Out of Hours
PRC	Prepared Rest Centre Local authority organised centre for evacuees from an incident
RH	Receiving hospital A & E Hospital designated to receive casualties from a major incident
REPIIR	Radiation (Emergency Preparedness & Public Information) Regulations 2001
SCC	Strategic Command Centre
SCG	Strategic Coordinating Group
STAC	Science & Technical Advice Cell
TCG	Tactical Coordinating Group - Multi-agency group of operational managers leading the tactical response in North Yorkshire

## ON-CALL POLICY

**August 2017**

<b>Authorship:</b>	Pennie Furneaux, Risk and Assurance Manager
<b>Reviewing Committee:</b>	Executive Committee
<b>Date:</b>	
<b>Approval Body</b>	Governing Body
<b>Approved date:</b>	September 2017
<b>Review Date:</b>	October 2019
<b>Equality Impact Assessment:</b>	Completed
<b>Sustainability Impact Assessment:</b>	Completed
<b>Related Documents:</b>	COR 17 Emergency Preparedness, Resilience and Response Policy OPEL Escalation Plan A&E Delivery Board Escalation Framework and Delivery Plan On-Call Pack COR 05 Mobile Working Policy HR 20 Home Working Policy
<b>Target Audience:</b>	All employees, members, committee and sub-committee members of the group and members of the governing body and its committees.
<b>Policy Reference No:</b>	COR18
<b>Version Number:</b>	1.3

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.



NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

**POLICY AMENDMENTS**

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

<b>New Version Number</b>	<b>Issued by</b>	<b>Nature of Amendment</b>	<b>Approved by &amp; Date</b>	<b>Date on Internet</b>
0.1	Policy and Assurance Manager	First draft		
1.0	Policy and Assurance Manager	Remove contact details to On-Call procedure	Governing Body 05/12/14	
1.1	Performance Improvement Manager	Included on-call pager number 07663 707555	16.1.2015	
1.2	Business Support Manager	Remove Pager details and insert new Flextel on call contact details		
1.3	Performance Improvement Manager Risk and Assurance Manager	Replace Surge & Escalation Plan with OPEL Escalation Plan Updates to job titles per updated organisational structure Formatting of policy to reflect CCG Policy on Policies Additional related documents		

**To request this document in a different language or in a different format,  
please contact:**

**Sharron Hegarty, Communications Manager**  
**Telephone: 07718 192232**  
**[Sharron.hegarty@nhs.net](mailto:Sharron.hegarty@nhs.net)**

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

**CONTENTS**

1. INTRODUCTION .....	4
2. POLICY STATEMENT .....	5
3. ENGAGEMENT .....	5
4. IMPACT ANALYSES .....	5
5. SCOPE of POLICY .....	6
6. ROLES / RESPONSIBILITIES / DUTIES.....	6
7. ON-CALL PACKS .....	8
8. TELECONFERENCE CALLS .....	8
9. POLICY IMPLEMENTATION.....	9
10. TRAINING AND AWARENESS .....	9
11. POLICY REVIEW .....	9
12. CONSULTATION, APPROVAL AND RATIFICATION PROCESS.....	9
13. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS....	9
14. ASSOCIATED POLICIES/DOCUMENTS .....	9
15. POLICY CONTACT DETAILS .....	10
16. LIST OF APPENDICES .....	10
17. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM .....	11
19. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT .....	16



## 1. INTRODUCTION

- 1.1. General statement/background aim of this Policy is to outline the On-Call arrangements in place for Vale of York Clinical Commissioning Group so to ensure there are robust plans in place for 'On-Call' relating to system-wide resilience and an escalation route to Executive Director level in relation to major incidents, including out-of-hours serious media enquiries and significant business continuity issues.
- 1.2. For the purposes of this policy, the North Yorkshire and Humber 'Health System' is defined as the network of NHS providers working within the geographical boundaries of the CCG.
- 1.3. The purpose of this policy is to:
  - Document the requirement and purpose of the CCG's On-Call systems;
  - Explain the distinctive roles of the Directors On-Call in respect of the on-call rota;
  - Explain the roles and responsibilities of all on-call personnel; and
  - Confirm the command and control arrangements for the on-call systems and the link between on-call system resilience, major incident and business continuity planning.
- 1.4. The following extracts from national guidance require CCGs to have a 24/7 On-Call rota in place. The CCG is, therefore, required to:
  - Define a route for providers to escalate issues 24 hours a day, supported by trained and competent staff, in case they cannot maintain delivery of core services.<sup>1</sup>
  - Should providers fail to maintain their performance levels, CCGs need to provide their commissioned providers with a route of escalation on a 24/7 basis.<sup>2</sup>
  - If a provider of NHS funded care has a problem either in or out of normal business hours, they must be able to escalate the matter through the CCG. This requires CCGs to draw up their own on-call rotas.<sup>3</sup>
  - Each Clinical Commissioning Group must take appropriate steps for ensuring that it is properly prepared for dealing with a relevant emergency.<sup>4</sup>

---

<sup>1</sup> NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR) (2013)

<sup>2</sup> 'NHS CB Frequently Asked Questions (FAQs) on the future arrangements for health EPRR (2013)'

<sup>3</sup> 'NHS Commissioning Board Command and Control Framework (2013)'

<sup>4</sup> 'Section 46 of Health and Social Care Act 2012'

## 2. POLICY STATEMENT

- 2.1. The Vale of York Clinical Commissioning Group, (the CCG) is required to show leadership and coordination of the system during pressures/incidents **and all** the NHS funded healthcare providers.

## 3. ENGAGEMENT

- 3.1. In developing this policy the Senior Management Team were consulted.

## 4. IMPACT ANALYSES

### Equality

- 4.1. In applying this policy, the CCG will have due regard to the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

### Sustainability

- 4.2. A Sustainability Impact Assessment has been undertaken. Positive and negative impacts are assessed against the twelve sustainability themes. The results of the assessment are attached.

### Bribery Act

- 4.3. The Bribery Act is relevant to this policy. Under the Bribery Act it is a criminal offence to:
- Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
  - Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.
- 4.4. These offences can be committed directly or by and through a third person and other related policies and documentation (as detailed on the CCG intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.

- 4.5. Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist

## 5. SCOPE OF POLICY

- 5.1. This policy applies to all employees of the CCG required to perform on-call duties.

## 6. ROLES / RESPONSIBILITIES / DUTIES

### Directors on Call

- 6.1. All Directors on-call should:
- ensure that their On-Call Pack is kept up-to-date with all standard 'Inserts' from the Incident Emergency Planning Coordinator, as well as all important communications and updates sent by email;
  - be on-call for the duty period of one week (7 days) commencing on a Friday morning at 0900 and finishing on the following Friday morning at 0900 hours;
  - be available and contactable on the **CCG Flextel number** (contact details and procedure are available within the 'Emergency Planning folder on Y:Drive) or mobile telephone 24 hours a day, 7 days a week during the period of on-call in order to manage system resilience and system pressures;
  - ensure that you can travel within 1 hour to the CCG's Incident Control Centre;
  - During your duty period maintain a log of all telephone calls, messages, decisions made and actions taken in accordance with log taking best practice. This includes indicating in the logbook when you started and finished your shift;
  - undertake on-call training at least annually;
  - be able to respond appropriately to an emerging emergency situation should the need arise and give clear advice;
  - escalate to the NHS England Area Team Executive Director On-Call if there is a likely requirement for the local system (including the local hospital and community services) to move from OPEL 3 – Severe Pressure to OPEL 4 – Extreme Pressure (major incident – all contingencies deployed – system requires external support);

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

to

- ensure you have your On-Call Pack to hand and that your mobile telephone is fully operational (switched on, audible and with battery fully charged);
- have access to the mobile telephone numbers of On-Call Directors and Managers (these are provided on in the on-call pack);
- ensure that any change of contact details (telephone numbers) is communicated to the On-Call Coordinator immediately. Currently, this is the Performance and Improvement Manager;
- ensure any shift changes are notified to the On-Call Coordinator;
- abstain from drinking alcohol during duty periods as it may be necessary to drive to the Incident Control Centre and make clear decisions;
- carry your NHS photo ID at all times; and
- ensure efficient handover of responsibility to the next On-Call Director/manager, including full briefing of any outstanding issues yet to be resolved and/or identification of potential issues on the horizon (use the Handover Action Card in Annex 2 of this Policy). The CCG operates a 'PUSH' system where the person on-call proactively makes contact with the next person on-call and 'pushes' the handover process, including all relevant information.

### **Specific Responsibilities of the Incident Emergency Planning Coordinator**

- 6.2. The CCG has a nominated manager (the Performance and Improvement Manager) will act as the Incident Emergency Planning Coordinator, (IEPC); who is responsible for system management during normal working hours.
- 6.3. The Business Support Manager is responsible for preparing and distributing the CCG's On-Call rotas and administration of the master copy of the On-Call Pack.
- 6.4. The Performance and Improvement Manager is responsible for updating and distributing On-Call Packs for all Directors and Managers on the On-Call Rotas.
- 6.5. The Performance and Improvement Manager is responsible for ensuring that Directors and Managers on the On-Call Rotas are adequately trained for their responsibilities and to arrange annual update training.
- 6.6. The Performance and Improvement Manager is responsible for updating the On-Call Director with any resilience issues / updates going into the out-of-hours period
- 6.7. The Performance and Improvement Manager provides co-ordination and leadership of the local health system for capacity issues and diversion

during periods of extraordinary demand fluctuation within normal working hours.

- 6.8. The Performance and Improvement Manager should advise the Director On-Call if there is a likely requirement for the local system (including the local hospital and community services) to move from OPEL 3 – Severe Pressure to OPEL 4 – Extreme Pressure (major incident – all contingencies deployed – system requires external support).
- 6.9. The Performance and Improvement Manager is responsible for ensuring that all necessary local health system contact numbers are provided in the On-Call Pack; and that these are kept up to date.
- 6.10. The Performance and Improvement Manager must be familiar with the CCG’s Emergency Preparedness, Resilience and Response Policy and Business Continuity Policy and Plan (BCP) to ensure that issues are raised with the Director On-Call which may develop into a significant issue or major incident and then assist him/her to activate either or both of the plans.
- 6.11. Cover for the Performance and Improvement Manager for the role of IEPC will be provided by the Risk and Assurance Manager.

## **7. ON-CALL PACKS**

- 7.1. On-Call Pack will be issued to each nominated person on the On-Call Director rotas. All On-Call personnel should familiarise themselves with the contents of this Pack and gain clarification on any issues as necessary. It is the responsibility of the pack owner to keep it up-to-date with standard ‘inserts’ as supplied by the On-Call Coordinator, communications regarding current events in the system and plans. The Pack contains the following documents:

- Emergency Preparedness Resilience and Response Policy
- York & Scarborough A&E Delivery Board Escalation Framework
- SRCCG Winter Escalation Contacts
- NHS Vale of York CCG Contact Numbers
- two blank Incident Log books
- NHS England Ebola (EVD) Guidance for CCG On Call Director’s Pack
- On-Call Rota
- GP Emergency Contacts

## **8. TELECONFERENCE CALLS**

- 8.1. A local system-wide teleconference call may be requested by a provider organisation if they are reporting OPEL 3 – Severe Pressure and have undertaken all related actions within the escalation policy and have genuine concerns about managing the situation on a wider basis. In addition any organisation can request a health system teleconference to support the management of system resilience.

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

- 8.2. The CCG Director On Call will chair the system-wide teleconference. Details for setting up a teleconference are contained within the York & Scarborough A&E Delivery Board Escalation Framework (located in the On-Call Pack).

## **9. POLICY IMPLEMENTATION**

- 9.1. Following approval by the policy a copy will be circulated to:
- all staff on the On-Call rota;
  - NHS England; and
  - all partner across the healthcare system

## **10. TRAINING AND AWARENESS**

- 10.1. All CCG On-Call Directors and Managers will undergo initial familiarisation training and yearly refresher training thereafter. They will also be required to attend designated training modules and exercises as quoted in the CCG EPRR Training and Exercise programme.

## **11. POLICY REVIEW**

- 11.1. The policy will be reviewed after twelve months and then every two years or when required/requested.

## **12. CONSULTATION, APPROVAL AND RATIFICATION PROCESS**

- 12.1. The following committees and individuals have been involved in the consultation and development of this policy:
- Executive Directors
- 12.2. This policy will be approved/ratified by the committees/CCG Governing Body named on the cover of the policy, in line with the CCG's Policy on Policies.

## **13. DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS**

- 13.1. The previous version of this policy will be removed from the intranet and will be available if required by contacting the author.

## **14. ASSOCIATED POLICIES/DOCUMENTS**

- COR 17 Emergency Preparedness Resilience and Response Policy
- On-call Pack
- A&E Delivery Board Escalation Framework and Winter Plan
- CCG Constitution,(includes Standing Orders)

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

- COR 16 CCG Business Continuity Policy
- CCG Business Continuity plans and action cards

**15. POLICY CONTACT DETAILS**

**Performance and Improvement Manager**

Telephone: 01904 555774

Email: [valeofyork.contactus@nhs.net](mailto:valeofyork.contactus@nhs.net)

Address: NHS Vale of York Clinical Commissioning Group, West Offices,  
Station Rise, York. Y01 6GA

**16. LIST OF APPENDICES**

Appendix 1: Equality Assessment

Appendix 2: Sustainability Assessment

17. APPENDIX 1: EQUALITY IMPACT ANALYSIS FORM

1.	<b>Title of policy/ programme/ service being analysed</b>
	On Call Policy
2.	<b>Please state the aims and objectives of this work.</b>
	To define and document the CCG's on call arrangements to support EPRR systems and processes
3.	<b>Who is likely to be affected? (e.g. staff, patients, service users)</b>
	CCG on call directors.
4.	<b>What sources of equality information have you used to inform your piece of work?</b>
	NHS England guidance
5.	<b>What steps have been taken ensure that the organisation has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics</b>
	The analysis of equalities is embedded within the CCG's Committee Terms of Reference and operational framework.
6.	<b>Who have you involved in the development of this piece of work?</b>
	<b>Internal/stakeholder involvement:</b> Senior Management team Consultation with Senior Managers
7.	<b>What evidence do you have of any potential adverse or positive impact on groups with protected characteristics? Do you have any gaps in information? Include any supporting evidence e.g. research, data or feedback from engagement activities</b>
	<b>(Refer to Table 1 - Embedding Equality into the Commissioning Cycle if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)</b>



NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

<b>Disability</b> People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)	Consider building access, communication requirements, making reasonable adjustments for individuals etc.
N/a	
<b>Sex</b> Men and Women	Consider gender preference in key worker, single sex accommodation etc
N/a	
<b>Race or nationality</b> People of different ethnic backgrounds, including Roma Gypsies and Travelers	Consider cultural traditions, food requirements, communication styles, language needs etc.
N/a	
<b>Age</b> This applies to all age groups. This can include safeguarding, consent and child welfare	Consider access to services or employment based on need/merit not age, effective communication strategies etc.
N/a	
<b>Trans</b> People who have undergone gender reassignment (sex change) and those who identify as trans	Consider privacy of data, harassment, access to unisex toilets & bathing areas etc.
N/a	

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

<b>Sexual orientation</b> This will include lesbian, gay and bi-sexual people as well as heterosexual people.	Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.
N/a	
<b>Religion or belief</b> Includes religions, beliefs or no religion or belief	Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.
On-call duties may conflict with faith commitments. Scheduling will give due consideration	
<b>Marriage and Civil Partnership</b> Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
N/a	
<b>Pregnancy and maternity</b> Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/a	
<b>Carers</b> This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
Carer commitments may impact, scheduling to give due consideration.	

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

<p><b>Other disadvantaged groups</b> This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.</p>	<p>Consider ease of access, location of service, historic take-up of service etc</p>
<p>N/a</p>	
<p><b>8.</b></p>	<p><b>Action planning for improvement</b> Please outline what mitigating actions have been considered to eliminate any adverse impact?</p> <p>Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people?</p> <p>An Equality Action Plan template is appended to assist in meeting the requirements of the general duty</p>

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

**Sign off**

Name and signature of person / team who carried out this analysis

Date analysis completed

Name and signature of responsible Director

Date analysis was approved by responsible Director

NHS Vale of York Clinical Commissioning Group  
ON CALL POLICY

**19. APPENDIX 2: SUSTAINABILITY IMPACT ASSESSMENT**

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.


Title of the document	On Call Policy
What is the main purpose of the document	To provide effective cover for CCG on-call duties.
Date completed	August 2017
Completed by	Governance Team

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		
	Will it promote ethical purchasing of goods or services?	0		
Procurement	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	0		
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/a		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		
	Will it increase safety and security in new buildings and developments?	0		
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		



<b>Item Number: 15</b>	
<b>Name of Presenter: Rachel Potts</b>	
<b>Meeting of the Governing Body</b>	
<b>Date of meeting: 7 September 2017</b>	
<b>Report Title – Extension of Period of Tenure of Governing Body Lay Member and Chair of the Finance and Performance Committee</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Ratify</b>	
<b>Reason for Report</b>	
<p>David Booker's tenure as Lay Member of the Governing Body expired on 31 July 2017. As David is also Chair of the Finance and Performance Committee, a key role in the CCG's governance, the Executive Committee agreed extension of his tenure. This extension is proposed from 1 August 2017 on a one year rolling contract, to be reviewed annually, for a maximum of three years on the basis of the CCG's need for continuity at this time.</p> <p>As this appointment would be outwith the terms of the CCG's Constitution, which requires lay members to be appointed through an external process for a three year term of office, Dr Paula Evans, Chair of the Council of Representatives, was consulted. She supported the extension of David Booker's tenure on the above basis in light of the CCG's current exceptional circumstances and the crucial role of Chair of the Finance and Performance Committee but with emphasis that this in no way set a precedent.</p>	
<b>Strategic Priority Links</b>	
<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 checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Financial Sustainability <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b>	<b>Covalent Risk Reference and Covalent Description</b>
<input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	

**Emerging Risks (not yet on Covalent)**

**Recommendations**


The Governing Body is asked to ratify the reappointment of David Booker as Lay Member and Chair of the Finance and Performance Committee for one year on a rolling contract, to be reviewed annually, with effect from 1 August 2017 and for a maximum of three years.

**Responsible Executive Director and Title**

Rachel Potts  
Executive Director of Planning and Governance

**Report Author and Title**

Rachel Potts  
Executive Director of Planning and Governance

<b>Item Number: 16</b>	
<b>Name of Presenter : Rachel Potts</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting:</b> <b>7 September 2017</b>	
<b>Report Title – Executive Committee Terms of Reference</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Ratify</b>	
<b>Reason for Report</b>	
<p>The Internal Audit Draft report on governance arrangements dated 08 May 2017 made a number of recommendations on committee Terms of Reference. In relation to the Executive Committee Terms of Reference, the report states :</p> <ul style="list-style-type: none"> <li>• Decision making primarily rests with the Executive Committee. The terms of reference state that it has decision making authorities as set out in the terms of reference. However, these are not defined in the terms of reference. The decision making authorities would be clearer if the terms of reference stated that the authorities are as defined in the scheme of delegation.</li> <li>• The Committee is described as being accountable to the Governing Body but the terms of reference do not clearly state how it will report to it. In addition, no annual report is required to provide assurance to the Governing Body on how it has delivered its role.</li> <li>• No voting arrangements are defined for the Executive Committee should a vote be required in relation to a decision to be taken</li> </ul> <p><u>And makes the following recommendations :</u></p> <p>Recommendation 8 : Cross reference the decision making authorities of the Executive Committee in its terms of reference to the detailed scheme of delegation.</p> <p>Recommendation 9 : Confirm in the terms of reference how the Executive Committee will be accountable to the Governing Body and how it will report.</p> <p>Recommendation 10 : Include arrangements for voting in the terms of reference for the Executive Committee and how disagreements on decisions are escalated if required.</p> <p>The proposed amendments to reflect the above recommendations are highlighted in yellow on the attached Executive Committee Terms of Reference.</p>	

Also, the membership of the Committee has been amended to reflect the recent changes in the organisation. Again, these changes are highlighted in yellow.

These Terms of Reference were approved by Executive Committee on 19 July 2017.

The Clinical Executive asked for the following to be added to the Terms of Reference for the Executive Committee : “The Executive Committee gives delegated authority to the Clinical Executive to approve Medicines Commissioning Committee recommendations unless either or both of the Medical Directors believe the recommendation should be escalated to the Executive Committee.”

This amendment was approved by Executive Committee on 16 August 2017.

**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 checked="" 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**

- Financial
- Legal
- Primary Care
- Equalities

**Covalent Risk Reference and Covalent Description**

G.17.01- There is a potential risk that the organisation's governance structures are not efficient and effective

**Emerging Risks (not yet on Covalent)**

**Recommendations**

Governing Body is asked to ratify the recommended additions to the Executive Committee's current Terms of Reference.

**Responsible Executive Director and Title**

Rachel Potts  
Executive Director of Planning and Governance

**Report Author and Title**

Rachael Simmons  
Corporate Services Manager

**Annexes**

- Current Executive Committee Terms of Reference.

## EXECUTIVE COMMITTEE

### Terms of Reference

#### 1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group Governing Body resolves to establish an Executive Committee which has delegated decision making authority as set out in these Terms of Reference. The Executive Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires from any employee and all employees are directed to co-operate with any request made by the Executive Committee. The Executive Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference.

#### 2 Purpose of the Committee

The Executive Committee is responsible for the management of executive decisions which relate to the organisational objectives.

#### 3 Remit

- To ensure the CCG fulfils the functions, duties and responsibilities set out in the CCG's constitution.
- To ensure processes are in place to deliver the Improvement and Assessment Framework expectations, including in-year targets, clinical, operational and financial.
- To develop, implement and monitor the CCG's Strategic and Operational Plan under the direction of the Governing Body.
- Prioritise programmes of work, investment and de-commissioning proposals across the CCG and ensure appropriate resource allocation.
- To oversee the development of the CCG as an effective healthcare commissioner and local leader building strong relationships with stakeholders and patient and public groups.
- Approval of HR policies and corporate policies.
- Strategic management and clinical oversight of all CCG functions and statutory duties, including equalities.
- Equalities, diversity and human rights development and implementation of the action plan.
- Review services changes ensuring service developments and CCG processes and policies are compliant with national regulations and law, including equalities legislation.
- To oversee emergency planning (EPRR).

- To be responsible for and review the organisation's corporate risks.
- OD and staff engagement.
- To ensure day to day running of the CCG.

#### 4 Frequency

The Executive Committee will meet once a month.

#### 5 Membership

Accountable Officer  
 Executive Director of Planning and Governance  
 Executive Director of Quality and Nursing  
 Chief Finance Officer  
 Medical Director x 2  
 Executive Director of Transformation and Delivery

#### In Attendance

Strategic Programme Consultant x 2

#### 6 Quoracy

A minimum of three members, one of whom is the Accountable Officer or an Executive Director, will constitute a quorum.

#### 7 Accountability

The Executive Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Executive Committee minutes.

Comment [WU1]: Recommendation 9

The Executive Committee gives delegated authority to the Clinical Executive to approve Medicines Commissioning Committee recommendations unless either or both of the Medical Directors believe the recommendation should be escalated to the Executive Committee.

Comment [WU2]: Request from Clinical Executive

#### 8 Decision Making

Comment [WU3]: Recommendations 8 and 10

The decision making authority of the Executive Committee is defined in the scheme of delegation within the constitution.

When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.

#### 9 Effectiveness

The Executive Committee shall undertake an annual review of its effectiveness.

## 10 Review of Terms of Reference


The Executive Committee shall review its terms of reference at least annually and sooner if changing circumstances dictate.

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Executive Committee
Approval Date	Governing Body – 02 March 2017
Issue Date	
Review Date	
Version Number	0.4

Author	Rachael Simmons Corporate Services Manager
Committee Approved and Date)	Executive Committee 19 July 2017 / 16 August 2017
Ratification and Date	Governing Body
Issue Date	
Review Date	
Version Number	5

This page is intentionally blank



<b>Item Number : 17</b>	
<b>Name of Presenter : Rachel Potts</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting : 7 September 2017</b>	
<b>Report Title – Business Conduct Policy</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Ratify</b>	
<b>Reason for Report</b>	
<p>The Business Conduct Policy has been refreshed in line with the CCG organisational change and also to incorporate revised Conflicts of Interest Guidance from NHS England as issued June 2017. The amendments are highlighted in yellow for ease of review and include :</p> <ul style="list-style-type: none"> <li>• Change of job title / responsibility.</li> <li>• Changes in thresholds in relation to gifts and hospitality - Section 15.</li> <li>• Declarations of Gifts and Hospitality Form amended to incorporate changes to thresholds.</li> <li>• References to the CSU amended / removed as necessary.</li> </ul> <p>This Policy was reviewed by the Audit Committee on 30 August 2017.</p>	
<b>Strategic Priority Links</b>	
<input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Transformed MH/LD/ Complex Care <input 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 type="checkbox"/> Sustainable acute hospital/ single acute contract	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b>	<b>Covalent Risk Reference and Covalent Description</b>
<input type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<p>G.17.04.02-T - Potential for damage to individuals arising from Col and Fol publications.</p> <p>G.17.06 - There is a potential risk that the Conflict of Interests statutory requirements</p>

may not be adequately discharged and managed

G17.01.4-T - Failure to effectively communicate governance standards and embed into practice.

**Emerging Risks (not yet on Covalent)**

**Recommendations**

The Governing Body is asked to review the Business Conduct Policy and ratify the amendments.

**Responsible Executive Director and Title**

Rachel Potts  
Executive Director of Planning and Governance

**Report Author and Title**

Rachael Simmons  
Corporate Services Manager

**Annex**

- Business Conduct Policy

The annex has been circulated electronically to members of the Governing Body and is available at

<http://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/>

## POLICY ON BUSINESS CONDUCT

### MONTH 2017

<b>Authorship :</b>	Corporate Services Manager
<b>Reviewing Committee :</b>	Audit Committee
<b>Date :</b>	
<b>Approval Body :</b>	Governing Body
<b>Approved Date :</b>	
<b>Review Date :</b>	TBC – 2 years from approval date.
<b>Equality Impact Assessment :</b>	Completed
<b>Sustainability Impact Assessment :</b>	Completed
<b>Related Policies :</b>	<ul style="list-style-type: none"> <li>• Sponsorship Policy</li> <li>• Whistleblowing Policy</li> <li>• Conflict Of Interest Policy</li> <li>• Procurement Policy</li> <li>• Local Anti-Fraud, Bribery and Corruption Policy</li> </ul>
<b>Target Audience :</b>	All employees, members, committee and sub-committee members of the group and members of the governing body and its committees.
<b>Policy Reference No. :</b>	COR01a
<b>Version Number :</b>	2.2

The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

Vale of York Clinical Commissioning Group  
BUSINESS CONDUCT POLICY

**POLICY AMENDMENTS**

Amendments to the policy will be issued from time to time. A new amendment history will be issued with each change.

<b>New Version Number</b>	<b>Issued by</b>	<b>Nature of Amendment</b>	<b>Approved by and Date</b>	<b>Date on Website</b>
1.1	P Furneaux	Separate Business Conduct and Conflict of Interest policies. Addition of NHS England guidance, CCG specific links, responsibilities and arrangements Duty of Candour	Audit Committee 10/09/14	
1.2	Audit Committee	Update to Nolan Principles, (Seven Principles of Conduct in Public Life) Reference to GP Code of Conduct	Audit Committee 10/09/14	
2.1	P Furneaux	To reflect NHS England Assurance requirements, ref. to Professional Standards Authority Guidance: "Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England" new para. 6.4 and reference, section 25 Professional Standards Authority	SMT 01/09/2015	
2.2	R Simmons	To reflect the change in the organisational structure of the CCG. To incorporate updated Conflicts of Interest Guidance from NHS England.		

To request this document in a different language or in a different format, please contact NHS Vale of York Clinical Commissioning Group :

[valeofyork.contactus@nhs.net](mailto:valeofyork.contactus@nhs.net) or 01904 555 870

## CONTENTS

1.	Introduction.....	4
2.	Policy Statement.....	4
3.	Impact Analyses .....	4
4.	Scope .....	4
5.	Policy Purpose / Aims and Failure to Comply .....	4
6.	Definitions – the Law and Other Guidance.....	5
7.	Roles / Responsibilities / Duties.....	8
8.	Declarations of Interest.....	9
9.	Casual Gifts.....	9
10.	Gifts of Money .....	9
11.	Hospitality.....	9
12.	Other Employment and Private Practice .....	11
13.	Preferential Treatment in Private Practice.....	12
14.	Contracts .....	12
15.	Commercial Partnership .....	13
16.	Intellectual Property Rights.....	13
17.	Political Activities .....	14
18.	Personal Conduct.....	14
19.	Confidentiality .....	15
20.	Duty of Candour .....	15
21.	Implementation .....	15
22.	Training and Awareness .....	16
23.	Monitoring and Audit.....	16
24.	Policy Review .....	16
25.	References .....	16
26.	Associated Documentation .....	17
27.	Contact Details .....	17
28.	Appendix 1 : Equality Impact Analysis Form .....	18
29.	Appendix 2 : Sustainability Impact Assessment.....	22
30.	Appendix 3 : Extract from HSG(93)4 Standards of Business Conduct for NHS Staff .....	26
31.	Appendix 4 : The Seven Principles of Public Life (The Nolan Principles) .....	27
32.	Appendix 5 : Register of Gifts and Hospitality .....	28
33.	Appendix 6 : The Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics.....	31
34.	Appendix 7 : Non-Disclosure Agreement .....	33

## 1. INTRODUCTION

- 1.1. It is a long established principle that public sector bodies must be impartial and honest in the conduct of their business and that employees should remain beyond suspicion. The Vale of York Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and responsibility and has an obligation to ensure that strict ethical standards are maintained. The Vale of York CCG Group also ensures that NHS resources are protected from fraud and corruption.
- 1.2. It is acknowledged that, in general, NHS staff have an outstanding sense of commitment to the ideals of the service and a very high sense of propriety in the way they conduct both their public duties and their private affairs.
- 1.3. Section 8 of the Vale of York Clinical Commissioning Group's Constitution sets out how conflicts of interest should be managed. These arrangements are reflected in a separate Conflicts of Interest Policy.

## 2. POLICY STATEMENT

- 2.1. The Vale of York Clinical Commissioning Group aspires to the highest standards of corporate behaviour and responsibility. All NHS Vale of York CCG staff are required to comply with this policy.

## 3. IMPACT ANALYSES

### Equality

- 3.1. As a result of performing the screening analysis, the policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. The results of the screening are attached.

### Sustainability

- 3.2. A Sustainability Impact Assessment has been undertaken. No positive or negative impacts were identified against the twelve sustainability themes. The results of the assessment are attached.

## 4. SCOPE

- 4.1. This policy applies to all CCG employees, Council of Representatives, Members of the Governing Body, members of its committees and sub-committees, Lay Members, any staff seconded to the CCG and contract and agency staff. Any reference to staff or individuals applies to all the aforementioned.

## 5. POLICY PURPOSE / AIMS AND FAILURE TO COMPLY

- 5.1. This policy seeks to describe the public service values which underpin the work of the NHS and to provide clarity and guidance to individuals on the standards of conduct expected of them when carrying out their duties for the CCG.
- 5.2. Alleged breaches of this policy will be promptly considered and fairly and reasonably investigated. If the individual under investigation is the **Accountable Officer Chief Officer** or other Senior Officer, the investigation will be conducted by individuals not employed by the CCG.

***Proven breaches of this policy will be treated as misconduct and will be dealt with under the CCG's disciplinary procedure. In serious cases, dismissal may result. Staff could also be the subject of a criminal investigation conducted by the Local Counter Fraud Specialist and/or under the Bribery Act, which could result in prosecution and/or civil recovery proceedings.***

## 6. DEFINITIONS – THE LAW AND OTHER GUIDANCE

### **The Code of Conduct and Code of Accountability in the NHS (second revision July 2004)**

- 6.1. This Code sets out the general principles of business conduct and includes three public service values which are central to the work of the NHS :
- **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
  - **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, officers and members and suppliers, and in the use of information acquired in the course of NHS duties.
  - **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the CCG and its staff, patients and the public.

### **HSG(93)5 Standards of Business Conduct for NHS Staff**

- 6.2. This guidance sets out the general ethical standards which should be maintained by everyone (see summary at Appendix 3).

### **The Seven Principles of Public Life as revised by the Committee on Standards in Public Life 2013 (The Nolan Principles)**

- 6.3. All individuals within the CCG must abide by these principles which are included as an Appendix to the Constitution. (See Appendix 4)

### **Standards for Members of NHS boards and Clinical Commissioning Group Governing Bodies in England, Professional Standards Authority, 2013**

- 6.4. The Professional Standards Authority requires that all members of CCG governing bodies *“should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.”* See [Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England](#).

### **The Bribery Act 2010**

- 6.5. The Bribery Act is particularly relevant to this policy. The CCG has a responsibility to ensure that all staff are made aware of their duties and responsibilities arising from the Bribery Act 2010 which came into force on 01 July 2011 and repeals, in their entirety, the Prevention of Corruption Acts 1906 to 1916 and the common law.

Vale of York Clinical Commissioning Group  
BUSINESS CONDUCT POLICY

- 6.6. All individuals should be aware that in committing an act of bribery they may be subject to a penalty of up to 10 years imprisonment, an unlimited fine, or both. They may also expose the organisation to a conviction punishable with an unlimited fine because the organisation may be liable where a person associated with it commits an act of bribery.
- 6.7. The Act makes bribery a criminal offence and there are four offences :
- Bribing, or offering to bribe, another person (section 1);
  - Requesting, agreeing to receive, or accepting a bribe (section 2);
  - Bribing, or offering to bribe, a foreign public official (section 3);
  - Failing to prevent bribery (section 7).
- 6.8. It should be noted that there need not be any actual giving and / or receiving of financial or other advantage to be gained, to commit an offence.
- 6.9. All individuals should be aware that in committing an act of bribery they may be subject to a penalty of up to 10 years imprisonment, an unlimited fine, or both. They may also expose the organisation to a conviction punishable with an unlimited fine because the organisation may be liable where a person associated with it commits an act of bribery.
- 6.10. All individuals should also be aware that a breach of this Act, or of this policy, renders them liable to disciplinary action by the CCG, whether or not the breach leads to prosecution. Where a material breach of this guidance is found to have occurred, the likely sanction will be loss of employment and superannuation rights.
- 6.11. It is, therefore, extremely important that staff adhere to this and other related policies and documentation (as detailed on the CCG's intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.
- 6.12. Further information on the Bribery Act can be found at <https://www.gov.uk/government/publications/bribery-act-2010-guidance>

### **The NHS Constitution**

- 6.13. The CCG is committed to achieving the principles, values, rights, pledges and responsibilities detailed in the NHS Constitution. The NHS Constitution outlines important legal duties for staff, including :
- A duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
  - A duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
  - A duty to act in accordance with the express and implied terms and conditions of your contract of employment.
  - A duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.



- A duty to protect the confidentiality of personal information that you hold.
- A duty to be honest and truthful in applying for a job and in carrying out that job.

6.14. The NHS Constitution also includes a number of expectations that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

#### **Freedom of Information Act 2000**

6.15. This Act is part of the Government's commitment to greater openness in the public sector. It gives a right of access to anyone to recorded information that is held by public organisations, subject to certain exemptions.

#### **Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies**

6.16. All individuals must carry out their duties in accordance with the CCG's Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies (SOs), which set out the statutory and governance framework in which the CCG operates. There is some overlap between the contents of this policy, the Conflicts of Interest Policy and the provisions of the SOs. In the event of any conflict arising between the details of policy and SOs, the provisions of the SOs shall prevail.

#### **Anti-Fraud, Bribery & Corruption**

6.17. The CCG is keen to prevent fraud and corruption and requires all individuals to always act honestly and with integrity to safeguard the public resources they are responsible for. The CCG will not tolerate any fraud perpetrated against it and will actively pursue recovery of any loss suffered.

6.18. The Local Anti-Fraud, Bribery & Corruption Policy outlines the roles and responsibilities for the prevention and detection of fraud, bribery and corruption within the CCG.

6.19. Any individual with concerns or reasonably held suspicions about potentially fraudulent activity or practice is encouraged to report these **immediately** to the Local Counter Fraud Specialist (LCFS) for North Yorkshire and the Chief Finance Officer. If the Chief Finance Officer is implicated, it should be reported to the **Accountable Officer** ~~Chief Officer~~ and the LCFS.

6.20. Individuals should not ignore their suspicions, pursue an investigation themselves, or tell anyone else about their suspicions. Under no circumstances should suspicions be discussed with the suspect. The LCFS, Chief Finance Officer and a representative from the **eMBED** Workforce Team will liaise and decide how to proceed with the investigation.

6.21. If individuals prefer, they may call the NHS Fraud & Corruption Reporting Line on Freephone 0800 028 40 60 between 08:00 – 18:00, Monday – Friday or report online at [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk). This provides an easily accessible and confidential route for the reporting of genuine suspicions of fraud within or affecting the NHS. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so. This would be the suggested contact if there is a concern that the LCFS or the Chief Financial Officer themselves may be implicated in suspected fraud, bribery or corruption.

- 6.22. Staff may also report suspicions via the Whistleblowing Policy.
- 6.23. The Audit Committee will keep under review arrangements for countering fraud, approve the counter fraud work programme and review the outcomes of counter fraud work.

## 7. ROLES / RESPONSIBILITIES / DUTIES

### **Accountable Chief Officer Responsibilities**

- 7.1. The **Accountable Chief Officer** of the CCG is responsible for ensuring that this policy is brought to the attention of all individuals and that processes are in place to ensure that it is effectively implemented and monitored. This will be achieved by :
- Notifying all individuals within the scope of this policy when the policy is approved and how to access it.
  - Ensuring the policy and any supporting policies are placed on the CCG's website and included in any induction packs.
  - Instructing all senior managers to ensure their teams are adhering to the policy.
  - Ensuring all corporate registers are maintained and reported upon.

### **Senior Officers and Line Managers**

- 7.2. Senior Officers and line managers at all levels are responsible for ensuring that their teams are aware of and fully understand this policy and associated documents and are in a position to deal with, or report, any breach of the policy standards and requirements.
- 7.3. It is the responsibility of Senior Officers and line managers to ensure that new employees are made aware of this policy and associated documents during induction.
- 7.4. Managers are expected to check compliance with all governance responsibilities during the PDR process.

### **All individuals**

- 7.5. It is the responsibility of everyone covered by the scope of this policy to ensure they comply with this policy.
- 7.6. In most instances, it is for the individual to use their judgement to avoid situations which compromise, or which could appear to compromise, their integrity. A guiding principle to what is acceptable is whether disclosure of the 'benefit' would cause embarrassment to the CCG or the individual.
- 7.7. If there is any doubt, advice should be sought from the line manager and line managers should seek advice from the **Accountable Chief Officer** or the Chief Finance Officer ~~or the CSU Corporate Strategy and Policy Manager~~. The CCG does, however, have guidelines to apply in certain frequently occurring situations as detailed in this policy.

## 8. DECLARATIONS OF INTEREST

- 8.1. Arrangements for the management, recording and reporting of declarations of interest are set out in Section 8 of the Vale of York Clinical Commissioning Group's Constitution and are the subject of the Vale of York CCG's separate Conflicts of Interest Policy.

## 9. CASUAL GIFTS

A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit at less than its commercial value.

- 9.1. All gifts of any nature, whatever their value, offered to any member of CCG staff or committee member or GP member practice staff by a contractor or supplier (current or prospective) to the CCG's business should be declined. The person to whom the gifts were offered must declare said offer to the Corporate Services Manager for inclusion on the register.
- 9.2. Subject to this, low cost branded promotional aids (diaries, calendars, etc.) may be accepted where they are under the value of the common industry standard of £6 in total, and need not be declared.
- 9.3. Tokens of thanks from sources such as work undertaken for other organisations whilst on NHS duties e.g., facilitation, lecturing etc. may be accepted if the value is reasonable (up to £25) but must be declared using the form at Appendix 5
- 9.4. All other offers, including unreasonably generous gifts, should be politely but firmly declined and material / unreasonably generous offers should be recorded on the form at Appendix 5.

## 10. GIFTS OF MONEY

- 10.1. All offers of cash or cash equivalents (e.g., tokens) whatever the value **must be declined** and must be reported using the form at Appendix 5.
- 10.2. If any inducements continue to be offered after disclosure of the CCG policy to decline acceptance, the Chief Finance Officer should be informed immediately.

## 11. HOSPITALITY

- 11.1. NHS funds for hospitality should be used sparingly and modestly and only after each case has been carefully considered. All expenditure on these items should be capable of justification as reasonable and authorised by the relevant budget holder. Petty cash should not be used to provide hospitality.
- 11.2. Whenever possible meetings should be arranged within CCG premises. If this is not possible, other NHS establishments should be the preferred choice. If this is not possible the meeting should be arranged at the most economic rate, taking into account room and refreshment charges.
- 11.3. Meetings during the lunch period should be avoided.

### Hospitality - Acceptance

- 11.4. To be acceptable, hospitality must be secondary to the purpose of the meeting or event. The level of hospitality offered in these circumstances should be appropriate and not out of proportion to the occasion e.g., a meal during the course of an event or visit away from base. Hospitality cannot in these circumstances be extended to spouses / partners.
- 11.5. Individuals should decline all other offers of hospitality or entertainment even if they would occur in their own time. All offers of hospitality **with a value of over £25** which have been accepted must be reported on the relevant form (see Appendix 5).
- 11.6. Utmost discretion should be exercised in accepting offers of hospitality from contractors or their representatives, other organisations or individuals concerned with the supply of goods or services. Individuals should be especially cautious of accepting small items of value, or hospitality over that afforded in a normal meeting environment (i.e., beverages) during a procurement process or from bidders/potential bidders. This avoids any potential claim of unfair influence, collusion or canvassing.
- 11.7. Individuals need to be aware that accepting hospitality may compromise their strict independence and impartiality. If in doubt, advice should be sought from the line manager. Further advice is available from the Chief Finance Officer, the Accountable Chief Officer or the **CSU Corporate Services Strategy and Policy Manager**.
- 11.8. In summary re. meals and refreshments :
- i) Under a value of £25 may be accepted and need not be declared.
  - ii) Of a value between £25 - £75 may be accepted but must be declared.
  - iii) Over a value of £75 must be refused unless (in extreme circumstances) senior approval is given. A clear reason for acceptance must be recorded on the CCG's gifts and hospitality register.
  - iv) A common sense approach must be applied in the valuing of meals and refreshments, using the actual amount if known.
- 11.9. Offers of funding from private companies for events (e.g., training events for clinicians), which may include the provision of hospitality, must be approved prior to acceptance. Such circumstances are covered by the separate Policy and Guidance Sponsorship (the principles of which apply to all private companies).

### Register of Gifts and Hospitality

- 11.10. Details of all gifts and hospitality declared will be incorporated into a register maintained, on behalf of the Chief Officer, by the **Policy and Assurance Corporate Services Manager**.
- 11.11. The register will be reviewed by the Audit Committee at least annually with an assurance report provided annually to the Governing Body. Details will be available on the CCG's website.

## 12. OTHER EMPLOYMENT AND PRIVATE PRACTICE

- 12.1. The CCG considers that any work with the CCG is an employee's principal employment with the exception of Lay Members, Independent Contractors, Secondary Care Doctor and Lead Nurse.
- 12.2. The CCG has statutory duties under the Working Time Regulations to ensure that the 48 hour Working Time Directive is not breached by its employees. To fulfil this duty the CCG must ensure that staff are not working in excess of 48 hours a week in their CCG job or in a combination of their CCG job and any other employment.
- 12.3. Individuals are required to inform the CCG if they are engaged in or wish to engage in outside employment and/or private practice in addition to their work with the CCG. Other employment should be declared on the CCG's Declaration of Interests and Secondary Employment/Private Practice form (the same form as for declaring conflicts of interest, found in the CCG's Conflict of Interest Policy). Completed forms should be sent to the **Policy and Assurance Corporate Services** Manager. Should there be a change in circumstances then an updated form must be completed by the individual as soon as practicable. Copies should be retained on personal files.
- 12.4. Should any concerns arise regarding other employment/private practice then these will be discussed with the individual. Whilst the CCG will not unreasonably raise a concern, it is acknowledged that there may be occasions where the other employment/private practice presents a conflict of interest that cannot be adequately managed. In these circumstances it will not be permissible for the situation causing the conflict to continue.
- 12.5. Staff must ensure that their manager is aware of any other employment even if the other employment hours are greater than those for the CCG. All proposed other employment should be discussed with the manager before commencement.
- 12.6. Staff are advised not to engage in outside employment which may conflict with their NHS work or be detrimental to it. Examples of work which might conflict with the business of the CCG include:
- employment with another NHS body;
  - employment with another organisation which might be in a position to supply goods/services to the CCG;
  - self-employment, including private practice, in a capacity which might conflict with the work of the CCG or which might be in a position to supply goods/services to the CCG.
- 12.7. Any manager who feels that any other employment may be conflicting with their duties for the CCG, should discuss it immediately with their Director and/or the **CSU eMBED** Workforce Team.
- 12.8. Managers must review declarations around other employment within the PDR process and ensure that individuals make any relevant declarations to keep their information up to date. New staff will be asked about other employment during the induction process.

### 13. PREFERENTIAL TREATMENT IN PRIVATE PRACTICE

- 13.1. Individuals should not seek or accept preferential rates, or benefits in kind for private transactions carried out with companies or organisations with which they have had, or may have, official dealings on behalf of the CCG.
- 13.2. This does not apply to concessionary agreements negotiated with companies by the local health family or recognised staff groups on behalf of all staff, or those offered to all NHS employee.

### 14. CONTRACTS

- 14.1. The CCG may only enter into contracts within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:
- the Group's Standing Orders;
  - the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
  - take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.
- 14.2. The CCG has duties under European and UK procurement law and staff must comply with Prime Financial Policies in relation to all contract opportunities.
- 14.3. All individuals acting on behalf of the CCG who are in contact with suppliers and contractors, including external consultants and in particular those authorised to sign purchase orders or place contracts for goods, materials or services or are involved in decisions about where orders should be placed should adhere to the Code of Ethics from the Chartered Institute of Purchasing and Supplies (see Appendix 6).
- 14.4. Individuals involved in the awarding of contracts and tender processes must take no part in the selection process if a personal interest or a conflict of interest is known. Such an interest must be declared using the form at Appendix 7 (refer also to the Conflicts of Interest Policy).

#### **Favouritism in Awarding Contracts**

- 14.5. Fair and open competition between prospective contractors or suppliers is a requirement of the CCG's Prime Financial Policies. These should always be adhered to. This means that :
- No private, public or voluntary organisation or company, which may bid for NHS business, should be given any advantage over its competitors, such as advance notice of requirements. This applies to all potential contractors, whether or not there is a relationship between them and the CCG, such as a long-running series of previous contracts.
  - Each new contract should be awarded solely on merit in accordance with evaluation criteria, taking into account the requirements of the CCG and the ability of the contractors to fulfil them.
- 14.6. The CCG must ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or relevant managerial

Vale of York Clinical Commissioning Group  
BUSINESS CONDUCT POLICY

capacity. Contracts may be awarded to such businesses where they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially and that staff who are known to have a relevant interest play no part in the selection process.

- 14.7. Individuals invited to visit organisations to inspect equipment (e.g., software or training aids) for the purpose of advising on its purchase will be reimbursed in accordance with the travel expenses policy laid down by the CCG. Such expenses should not be claimed from other organisation to avoid compromising the purchasing decisions of the CCG.

#### **Warning to Potential Contractors**

- 14.8. All invitations to tender to prospective bidders for CCG business must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the CCG, its employees or officers concerning the contract opportunity tendered. The consequence of offering inducements to staff will be termination of the contract, and recovery of any loss resulting from the contract termination. If contractors or potential contractors offer any member of staff inducements, staff should immediately inform the Chief Finance Officer.
- 14.9. Offers of pro bono work from prospective bidders for CCG business should be politely refused.

### **15. COMMERCIAL PARTNERSHIP**

- 15.1. The CCG has a separate policy covering issues of probity around sponsorship, the contents of which must be observed prior to entering into any arrangement around sponsorship by, and/or joint working with, private companies.

### **16. INTELLECTUAL PROPERTY RIGHTS**

- 16.1. As a general principle any financial gain resulting from external work where use of Vale of York Clinical Commissioning Group time or title is involved (e.g., speaking at training events/conferences, writing articles etc.) and/or which is connected with NHS Vale of York Clinical Commissioning Group business will be forwarded to the Chief Financial Officer.
- 16.2. Any patents, designs, trademarks or copyright resulting from the work (e.g., research) of an employee of the NHS Vale of York Clinical Commissioning Group carried out as part of their employment by the Vale of York CCG shall be the Intellectual Property of the Vale of York CCG.
- 16.3. Approval from the appropriate line manager should be sought prior to entering into an obligation to undertake external work connected with the business of the NHS Vale of York Clinical Commissioning Group, e.g., writing articles for publication, speaking at conferences.
- 16.4. Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances the NHS Vale of York Clinical Commissioning Group's reputation or results in financial gain for the Vale of York CCG, consideration will be given to rewarding employees subject to any relevant

guidance for the management of Intellectual Property in the NHS issued by the Department of Health.

## 17. POLITICAL ACTIVITIES

- 17.1. Any political activity should not identify an individual as an employee of the CCG. Conferences or functions run by a party political organisation should not be attended in an official capacity, except with prior written permission from the relevant Senior Officer.

## 18. PERSONAL CONDUCT

### Lending or Borrowing

- 18.1. The lending or borrowing of money between staff should be avoided, whether informally or as a business, particularly where the amounts are significant.
- 18.2. It is a particularly serious breach of discipline for any member of staff to use their position to place pressure on someone in a lower pay band, a business contact or a member of the public to loan them money.

### Gambling

- 18.3. No member of staff may bet or gamble when on duty or on CCG premises, with the exception of small lottery syndicates or sweepstakes among immediate colleagues related to national events e.g., The Grand National.

### Trading on Official Premises

- 18.4. Trading on official premises is prohibited, whether for personal gain or on behalf of others. Canvassing within the office by, or on behalf of, outside bodies or firms (including non-NHS CCG interests of staff or their relatives) is also prohibited. Trading does not include small tea or refreshment arrangements solely for staff.
- 18.5. The promotion of trade unions is permitted but approval must be sought from the CCG **Accountable Chief Officer** prior to each event taking place and/or prior to distribution of promotional information.

### Collection of Money

- 18.6. Charitable collections must be authorised by the CCG **Accountable Chief Officer**. Other flag day appeals are not permitted and collection tins or boxes must not be placed in offices. With line management agreement, collections may be made among immediate colleagues and friends to support small fundraising initiatives, such as raffle tickets and sponsored events. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage or a new job.

### Bankrupt or Insolvent Staff

- 18.7. Any member of staff who becomes bankrupt or subject of an individual involuntary arrangement or some other formal arrangement with their creditors must inform their line manager and the **eMBED** Workforce Team as soon as possible. Staff who are



Vale of York Clinical Commissioning Group  
BUSINESS CONDUCT POLICY

bankrupt or insolvent may need their role reviewing if they have duties which involve the handling of public funds.

### **Arrest or Conviction**

- 18.8. A member of staff who is arrested or convicted of any criminal offence must inform their line manager at the earliest opportunity. Staff who are currently under investigation should also notify their line manager. Line managers may need to seek advice from the Workforce Team or a Senior Officer.

## **19. CONFIDENTIALITY**

- 19.1. Information concerning the CCG which is not in the public domain must not at any time be divulged to any unauthorised person. Similarly, patient data or personal data concerning staff must not be divulged as defined by the Data Protection Act. This duty of confidence remains after termination of employment and applies to all individuals working in, or on behalf of, the CCG.
- 19.2. *Note* – the CCG recognises and confirms that nothing in, or referred to in, this policy (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined by the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the CCG, Governing Body, Committees or Sub-Committees or any employee, nor will it affect the rights of any worker (as defined in that Act) under that Act.
- 19.3. Staff should guard against providing information on the operations of the CCG which might provide a commercial advantage to any organisation (private or NHS) in a position to supply goods or services to the CCG. For particularly sensitive procurements/contracts, staff may be asked to sign a Non-Disclosure Agreement, a copy of which can be found at Appendix 7.

## **20. DUTY OF CANDOUR**

- 20.1. A new statutory Duty of Candour will become effective from 1<sup>st</sup> October 2014. This introduces a general duty of openness and transparency. The CCG is committed to implementing a culture of transparency and openness in all its dealings in line with statutory duties. The CCG as commissioners of healthcare services looks for assurance that all our provider organisations are open, honest and transparent in all dealings with patients.
- 20.2. All staff working for the CCG should make any disclosures they deem relevant, (using the Whistleblowing Policy, if appropriate). In case of doubt, the employee or member should seek advice from a senior manager, or if that is not considered possible to the Chair of the Audit Committee.

## **21. IMPLEMENTATION**

- 21.1. Following approval by the Governing Body policy will be sent to:
- ~~The Communications Manager who will disseminate to all staff via the team newsletter process.~~
  - The Corporate Services Manager who will publish the policy on the CCG's website and advise staff accordingly.

Vale of York Clinical Commissioning Group  
BUSINESS CONDUCT POLICY

- The Chairs of the Governing Body, the Council of Members and all other committees and sub committees for dissemination to members and attendees.
- The Practice Managers of all member practices for information.

## 22. TRAINING AND AWARENESS

- 22.1. This policy will be published on the CCG's website and will be available to staff on the organisation's intranet.
- 22.2. The policy will be brought to the attention of all new employees as part of the induction process. Further advice and guidance is available from the **Planning Policy and Assurance Manager**.

## 23. MONITORING AND AUDIT

- 23.1. The Audit Committee is responsible for monitoring the effectiveness of this policy to provide assurance to the Governing Body that the business of the CCG is being conducted in line with this policy, the associated policy documents, relevant legislation and other statutory requirements. The Audit Committee will receive annual reports on all the corporate governance registers.
- 23.2. Monitoring of this policy may form part of the Internal Audit review of governance compliance.

## 24. POLICY REVIEW

- 24.1. This policy will be reviewed in two years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance.

## 25. REFERENCES

- NHS Codes of Conduct and Accountability (NHS Appointments Commission and Department of Health – amended July 2004)
- Standards of Business Conduct for NHS Staff (DH HSG(93)5)
- Professional Standards Authority document [Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England](#)
- Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services <http://www.england.nhs.uk/wp-content/uploads/2012/09/c-of-c-conflicts-of-interest.pdf>
- The Code of Conduct for NHS Managers;
- *Seven Principles of Public Life*, Committee on Standards in Public Life (the Nolan Principles)
- Principles and Rules for Cooperation and Competition (NHS & DH July 2010)
- Procurement Guide for Commissioners of NHS Funded Services (NHS & DH July 2010)
- Bribery Act 2010
- Freedom of Information Act 2000

## 26. ASSOCIATED DOCUMENTATION

- Vale of York CCG's Constitution, incorporating Standing Orders and Prime Financial Policies
- Conflict Of Interest Policy
- Procurement Strategy
- Whistleblowing Policy
- Induction Policy
- Local Anti-Fraud, Bribery and Corruption Policy
- Sponsorship Policy (*principles apply to working with all private companies*)

## 27. CONTACT DETAILS

Corporate Services Manager

Telephone: 01904 555 870

Email: [valeofyork.contactus@nhs.net](mailto:valeofyork.contactus@nhs.net)

Address: NHS Vale of York Clinical Commissioning Group, West Offices, Station Rise,  
York. YO1 6GA

## 28. APPENDIX 1 : EQUALITY IMPACT ANALYSIS FORM

<b>1.</b>	<b>Title of policy/ programme/ service being analysed</b>
	<b>Business Conduct Policy</b>
<b>2.</b>	<b>Please state the aims and objectives of this work.</b>
	This Business Conduct policy describes the public service values which underpin the work of the NHS and to provide clarity and guidance to individuals on the standards of conduct expected of them when carrying out their duties for the CCG.
<b>3.</b>	<b>Who is likely to be affected? (e.g. staff, patients, service users)</b>
	Staff need to comply with the principles and practices outlined in this policy.
<b>4.</b>	<b>What sources of equality information have you used to inform your piece of work?</b>
	NHS England guidance
<b>5.</b>	<b>What steps have been taken ensure that the organisation has paid <u>due regard</u> to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics</b>
	The analysis of equalities is embedded within the terms of reference of the CCG's committees and project management framework.
<b>6.</b>	<b>Who have you involved in the development of this piece of work?</b>
	<b>Internal involvement :</b> Senior Management Team <b>Stakeholder involvement :</b> Consultation with Senior Managers <b>Patient / carer / public involvement :</b> This is an Internal policy aimed at staff employed by the CCG and contractors working for the CCG. The focus is on compliance with statutory duties and NHS mandated principles and practice. There are no particular equality implications.
<b>7.</b>	<b>What evidence do you have of any potential adverse or positive impact on groups with protected characteristics?</b> <b>Do you have any gaps in information?</b> <b>Include any supporting evidence e.g. research, data or feedback from engagement activities</b>
	<b>(Refer to Error! Reference source not found. if your piece of work relates to commissioning activity to gather the evidence during all stages of the commissioning cycle)</b>

<p><b>Disability</b> People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)</p>	<p>Consider building access, communication requirements, making reasonable adjustments for individuals etc.</p>
<p>N/A</p>	
<p><b>Sex</b> Men and Women</p>	<p>Consider gender preference in key worker, single sex accommodation etc.</p>
<p>N/A</p>	
<p><b>Race or nationality</b> People of different ethnic backgrounds, including Roma Gypsies and Travellers</p>	<p>Consider cultural traditions, food requirements, communication styles, language needs etc.</p>
<p>N/A</p>	
<p><b>Age</b> This applies to all age groups. This can include safeguarding, consent and child welfare</p>	<p>Consider access to services or employment based on need/merit not age, effective communication strategies etc.</p>
<p>N/A</p>	
<p><b>Trans</b> People who have undergone gender reassignment (sex change) and those who identify as trans</p>	<p>Consider privacy of data, harassment, access to unisex toilets &amp; bathing areas etc.</p>
<p>N/A</p>	
<p><b>Sexual orientation</b> This will include lesbian, gay and bi-sexual people as well as heterosexual people.</p>	<p>Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc.</p>
<p>N/A</p>	
<p><b>Religion or belief</b> Includes religions, beliefs or no religion or belief</p>	<p>Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc.</p>

N/A	
<b>Marriage and Civil Partnership</b> Refers to legally recognised partnerships (employment policies only)	Consider whether civil partners are included in benefit and leave policies etc.
N/A	
<b>Pregnancy and maternity</b> Refers to the pregnancy period and the first year after birth	Consider impact on working arrangements, part-time working, infant caring responsibilities etc.
N/A	
<b>Carers</b> This relates to general caring responsibilities for someone of any age.	Consider impact on part-time working, shift-patterns, options for flexi working etc.
N/A	
<b>Other disadvantaged groups</b> This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV.	Consider ease of access, location of service, historic take-up of service etc.
N/A	
<b>8. Action planning for improvement</b> Please outline what mitigating actions have been considered to eliminate any adverse impact?  No adverse equality impact has been identified.  Please state if there are any opportunities to advance equality of opportunity and/ foster good relationships between different groups of people?  An Equality Action Plan template is appended to assist in meeting the requirements of the general duty	

<b>Sign off</b>
Name and signature of person / team who carried out this analysis Corporate Services Manager
Date analysis completed 28 June 2017
Name and signature of responsible Director
Date analysis was approved by responsible Director

**29. APPENDIX 2 : SUSTAINABILITY IMPACT ASSESSMENT**

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document	Business Conduct Policy
What is the main purpose of the document	This Business Conduct policy describes the public service values which underpin the work of the NHS and to provide clarity and guidance to individuals on the standards of conduct expected of them when carrying out their duties for the CCG.
Date completed	28 June 2017
Completed by	R Simmons, Corporate Services Manager

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Travel	Will it provide / improve / promote alternatives to car based transport?	0		
	Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)?	0		
	Will it reduce 'care miles' (telecare, care closer) to home?	0		
	Will it promote active travel (cycling, walking)?	0		
	Will it improve access to opportunities and facilities for all groups?	0		
	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery?	0		



Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
Procurement	Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		
	Will it promote ethical purchasing of goods or services?	0		
Procurement	Will it promote greater efficiency of resource use?	0		
	Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)?	0		
	Will it support local or regional supply chains?	0		
	Will it promote access to local services (care closer to home)?	0		
	Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled?	0		
	Will it reduce water consumption?			
Workforce	Will it provide employment opportunities for local people?	0		
	Will it promote or support equal employment opportunities?	0		
	Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)?	0		
	Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
	Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	N/a		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)?	0		
	Will it increase safety and security in new buildings and developments?	0		
	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)?	0		
	Will it provide sympathetic and appropriate landscaping around new development?	0		
	Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes?	0		
	Will it promote prevention and self-management?	0		
	Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?	0		

Domain	Objectives	Impact of activity Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	Brief description of impact	If negative, how can it be mitigated? If positive, how can it be enhanced?
	Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

### 30. APPENDIX 3 : EXTRACT FROM HSG(93)4 STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF

References are to paragraphs in Part B of "Standards of business conduct for NHS staff' (Annex to HSG(93)5

#### Do :

- Make sure you understand the guidelines on standards of business conduct, and consult your line manager if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict (3).
- Declare to your employer any relevant interests (10 - 14). If in doubt, ask yourself:
  - am I, or might I be, in a position where I could gain from the connection between my private interests and my employment?
  - do I have access to information which could influence purchasing or procurement decisions?
  - could my outside interests be in any way detrimental to the PCT or to patients' interests?
  - do I have any other reason to think I may be risking a conflict of interest?

#### If still unsure - **Declare it!**

- Adhere to the ethical code of the Institute of Purchasing and Supply if you are involved in any way with the acquisition of goods and services (16);
- Seek your employer's permission before taking on outside work, if there is any question of it adversely affecting your NHS duties (special guidance applies to doctors);
- Obtain your employer's permission before accepting any commercial sponsorship (26).

#### Do not:

- Accept any gifts, inducements or inappropriate hospitality (see 7);
- Abuse your past or present official position to obtain preferential rates for private deals;
- Unfairly advantage one competitor over another or show favouritism in awarding contracts (18);
- Misuse or make available official "commercial in confidence" information.

### 31. APPENDIX 4 : THE SEVEN PRINCIPLES OF PUBLIC LIFE (THE NOLAN PRINCIPLES)

**Extracted from: Standards Matter : A review of best practice in promoting good behaviour in public life.**

The principles of public life apply to anyone who works as a public office-holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the civil service, local government, the police, courts and probation services, NDPBs, and in the health, education, social and care services.

All public office-holders are both servants of the public and stewards of public resources. The principles also have application to all those in other sectors delivering public services.

- **Selflessness** Holders of public office should act solely in terms of the public interest.
- **Integrity** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty** Holders of public office should be truthful.
- **Leadership** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

<https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2>

**32. APPENDIX 5 : REGISTER OF GIFTS AND HOSPITALITY**

**Gifts :**

Contractors and Suppliers : All gifts of any nature, whatever their value, offered to any member of CCG staff or committee member or GP member practice staff by a contractor or supplier (current or prospective) to the CCG's business should be declined. The person to whom the gifts were offered must declare said offer to the Corporate Services Manager for inclusion on the register.

Subject to this, low cost branded promotional aids (diaries, calendars, etc.) may be accepted where they are under the value of the common industry standard of £6 in total and need not be declared.

From patients and other sources : seek advice from the Corporate Services Manager

**Hospitality :**

- Under a value of £25 may be accepted and need not be declared.
- Of a value between £25 - £75 may be accepted but must be declared.
- Over a value of £75 must be refused unless (in extreme circumstances) senior approval is given. A clear reason for acceptance must be recorded on the CCG's gifts and hospitality register.
- A common sense approach must be applied in the valuing of meals and refreshments, using the actual amount if known.

Recipient Name:	
Position:	
Date of Offer :	
Date of Receipt (if applicable):	
Details of Gift / Hospitality:	
Estimated Value:	
Supplier / Offeror Name and Nature of Business:	
Details of Previous Offers or Acceptance by this Offeror / Supplier:	
Details of the Officer Reviewing and Approving the Declaration Made and Date:	
Declined or Accepted?	
Reason for Declining or Accepting:	

Other Comments :	
------------------	--

I confirm that the information provided above is complete and correct. I acknowledged that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

*The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.*

I do / do not (*delete as applicable*) give my consent for this information to be published on registers that the CCG holds. If consent is NOT given, please give reasons:

	Name	Position	Date
Signed By:			
Senior/Line Manager			

**Please return completed form to : The Corporate Services Manager Policy and Assurance Manager**





### 33. **APPENDIX 6 : The Chartered Institute of Purchasing and Supply (CIPS) Code of ETHICS**

*(REPRODUCED BY KIND PERMISSION OF THE CIPS)*

#### **Introduction**

All members sign up to the code of ethics when they join CIPS. The Code was approved by the CIPS Council on 11 March 2009.

#### **Use of the Code**

Members of CIPS are required to uphold this code and to seek commitment to it by all those with whom they engage in their professional practice.

Members are expected to encourage their organisation to adopt an ethical purchasing policy based on the principles of this code and to raise any matter of concern relating to business ethics at an appropriate level.

The Institute's Royal Charter sets out a disciplinary procedure which enables the CIPS Council to investigate complaints against any of our members and, if it is found that they have breached the Code of Ethics to take appropriate action. Advice on any aspect of the Code of Ethics is available from CIPS.

#### **Code of Professional Ethics**

Members agree they will:

- maintain the highest standard of integrity in all my business relationships
- reject any business practice which might reasonably be deemed improper
- never use my authority or position for my own personal gain
- enhance the proficiency and stature of the profession by acquiring and applying knowledge in the most appropriate way
- foster the highest standards of professional competence amongst those for whom I am responsible
- optimise the use of resources which I have influence over for the benefit of my organisation
- comply with both the letter and the intent of:
  - the law of countries in which I practice
  - agreed contractual obligations
  - CIPS guidance on professional practice
- declare any personal interest that might affect, or be seen by others to affect, my impartiality or decision making
- ensure that the information I give in the course of my work is accurate
- respect the confidentiality of information I receive and never use it for personal gain

/cont ....

- strive for genuine, fair and transparent competition
- not accept inducements or gifts, other than items of small value such as business diaries or calendars
- always to declare the offer or acceptance of hospitality and never allow hospitality to influence a business decision
- remain impartial in all business dealing and not be influenced by those with vested interests

**34. APPENDIX 7 : NON-DISCLOSURE AGREEMENT**

You have been requested to be involved in [INSERT DETAILS] (the ‘Project’).

Vale of York CCG or other parties participating in the Project may provide you with, as part of your role in respect of the Project, access to certain confidential information relating to the Project (whether before or after the date of this letter), in writing, by email, orally or by other means (including from or pursuant to discussions with any other party or which is obtained through attendance at meetings related to the Project) and trade secrets including, without limitation, technical data and know-how relating to the Project, including in particular (by way of illustration only and without limitation) [EXAMPLES] and including (but not limited to) information that you may create, develop, receive or obtain in connection with your engagement on the Project, whether or not such information (if anything other than oral form) is marked confidential (the “Confidential Information”).

Accordingly we draw to your attention that as part of your role for the CCG you are required to:

- 1.1 maintain the Confidential Information in the strictest confidence and not divulge any of the Confidential Information to any third party without the prior written permission of Vale of York CCG; and
- 1.2 not make use of, reproduce, copy, discuss, disclose or distribute the Confidential Information other than for use as part of your role in the Project.

The above obligations in respect of this Confidential Information are supplemental to any prior representation, understanding and commitment (whether oral or written) between us. The terms of this Letter can only be changed by a written document, agreed upon by both of us and signed by duly authorised persons. These provisions shall be governed and construed by English law.

Yours faithfully

**For and on behalf of  
 NHS Vale of York Clinical Commissioning Group**

By signing this letter you agree to comply with these terms

Signed :	
Date :	
Print Name :	

Please return signed copy to the **Corporate Services Policy and Assurance Manager**.

This page is intentionally blank

**MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON  
5 JULY 2017 AT WEST OFFICES, YORK**

**Present**

Sheenagh Powell (SP)  
David Booker (DB)

Chair  
Lay Member and Chair of Finance and  
Performance Committee

**In attendance**

Cath Andrew (CA)  
Michael Ash-McMahon (MA-M)  
Anne Ellis (AE)  
Pennie Furneaux (PF) –  
for items 23 to 25  
Rachel Potts (RP)  
Michèle Saidman (MS)

Senior Manager, Mazars  
Deputy Chief Finance Officer  
Audit Manager, Audit Yorkshire  
Corporate Services and Assurance Manager  
  
Executive Director of Planning and Governance  
Executive Assistant

**Apologies**

Arasu Kuppuswamy (AK)

Consultant Psychiatrist, South West Yorkshire  
Partnership NHS Foundation Trust - Secondary  
Care Doctor Member  
Chief Finance Officer

Tracey Preece (TP)

The agenda was considered in the following order.

**STANDING ITEMS**

**1. Apologies**

As noted above.

**2. Declarations of Interest**

Declarations of interest were as per the Register of Interests. There were no declarations of members' interests in relation to the business of the meeting.

**3. Minutes of the meetings held on 24 May 2017**

The minutes of the meeting held on 24 May were agreed.

**The Committee:**

Approved the minutes of the meetings held on 24 May 2017.

Confirmed Minutes

#### **4. Matters Arising**

*Constitution, Scheme of Delegation and Detailed Financial Policies:* RP referred to previous discussions about the Scheme of Delegation and the Constitution. She reported that the Executive Committee and Chair of the Council of Representatives had agreed an October deadline for a full review of the Constitution to ensure it was fit for purpose in the context of the changes expected within this timeframe. RP advised that the main risks related to the fact that the current CCG Constitution was out of date. Legal advice was being sought in respect of the actions in terms of mitigating risk and in the context of the CCG being under legal Directions. Members noted that the Scheme of Delegation was not affected, supported the full review of the CCG's Constitution by the end of October and requested a report detailing associated risks and mitigations for the next meeting.

*Internal Audit - Commissioning Support Contract Management:* MA-M apologised for the fact that a report had not been provided as requested but assured members that the recommendations were being progressed. He reported that he and Michelle Carrington (MC) had now met with North of England Commissioning Support who provide the CCG with the Individual Funding Request function, the Data Services for Commissioners Regional Office (DSCRO) providing the safe haven for data management and processing for the CCG's business intelligence function and the Non-Contract Activity processing service. With regards to the eMBED contract all except two primary key performance indicators had been agreed and agreement on these was expected imminently. Further work was required but contract management board meetings had been established. SP requested that a report detailing risks to service delivery and mitigations for the next meeting. RP advised that the executive lead for this area would be confirmed at the Executive Team Time Out on 12 July.

*Governance principles for the system financial envelope joint working between NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust to be scoped:* Members requested a report for the next meeting.

*Conflicts of Interest Policy:* RP confirmed that the recommendations of the governance review had been incorporated in the updated policy.

A number of matters were noted as agenda items, completed or still requiring action.

#### **The Committee:**

1. Noted the updates.
2. Requested a report providing an update on progress with the Constitution, particularly in respect of risks and mitigation.
3. Noted that the report on commissioning support contract management would be presented at the next meeting.
4. Requested a report on the governance principles developed for joint working in relation to the Capped Expenditure Process between NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust.

## **5. Audit Committee Work Plan**

SP referred to the review of the effectiveness of external audit scheduled for the next meeting. Following discussion of the need to ensure clarity and relevance of the questions, AE agreed to circulate the previous survey for comment.

### **The Committee:**

1. Agreed the Committee work plan, subject to addition of the April and May 2018 meeting dates.
2. Requested that AE circulate the previous survey for comment. *Post meeting note: Survey was circulated on 7 July*

*Post meeting note: Correction to section on Counter Fraud which, as agreed at the meeting on 1 March, should read reports to March and August meetings with exception reporting as required.*

## **INTERNAL AUDIT**

### **6. Periodic Report**

AE presented the report which comprised an executive summary, an overview of assurance levels by audit area, analysis of audit days, and progress with the audit programme, namely a Continuing Healthcare Audit Report, assessed as Limited Assurance. AE additionally referred to the client directed draft Vale of York Clinical Network Report at item 28 which had taken 7.5 days. In respect of these additional days members noted the potential for this to be covered by either additional invoicing and / or a reduction in days for other areas of the plan, to be agreed by MA-M and AE.

Detailed discussion ensued regarding the Continuing Healthcare Report and members emphasised the need for assurance to be provided both in terms of structural changes and the significant financial risk.

RP explained that Denise Nightingale (DN), who was taking up post as Executive Director of Transformation and Delivery, would take on the executive lead for continuing healthcare and MA-M reported that, following the recent North Yorkshire Chief Finance Officers' meeting, NHS Vale of York CCG was undertaking the work on staffing costs for phase two of the transition – transfer of finance and contracting resource - on behalf of the four CCGs. The first phase of the transition – transfer of the clinical resource – had been overseen by MC and the principles for the finance and contracting transfer had been agreed, however arrangements were still being finalised.

MA-M confirmed that financial reporting for continuing healthcare was currently continuing as previously and the team was still hosted by NHS Scarborough and Ryedale CCG. In response to members expressing concern about uncertainty for staff, MA-M advised that there were gaps and noted that recruitment was taking place as appropriate.

Members requested that DN attend the next Committee meeting and that a detailed report be provided, including an update on outstanding actions and definitive finance and contracting information.

In response to members seeking clarification about the CCG's legal support, RP reported that, in light of failure to appoint to a legal and governance post, support provided by NHS Scarborough and Ryedale CCG's legal adviser would continue. This would be reviewed for April 2018.

#### **The Committee:**

1. Received the Internal Audit Periodic Report.
2. Requested that DN attend the next meeting.
3. Requested a detailed report to provide an update on concerns relating to continuing healthcare outstanding actions and the finance and contracting arrangements.

#### **7. Recommendations Status Report**

AE highlighted that recommendations arising from the CCG Internal Audit programme and those relating to the transfer of Partnership Commissioning Unit services were presented separately and in different formats. She confirmed that the regular monitoring arrangements would apply to all the recommendations and that the recommendations from the Continuing Healthcare Report presented at the previous agenda item were included.

AE noted that a further 18 recommendations had been completed since the last report, including both CCG and Partnership Commissioning Unit recommendations. Following completion of the 2016/2017 Audit Programme 93 recommendations had been added. There were 80 open recommendations, of which 48 were not yet due and 32 were in progress with revised target dates.

Members sought clarification on a number of the recommendations and requested continuation of the format of the report, i.e. separate presentation of the CCG and Partnership Commissioning Unit recommendations. They also requested inclusion of an explanatory summary sheet for recommendations that were overdue or where implementation dates had changed.

#### **The Committee:**

1. Received the Recommendations Status Report.
2. Requested that the CCG internal Audit programme recommendations and Partnership Commissioning Unit services recommendations continue to be presented in the separate format.
3. Requested inclusion of an explanatory summary sheet for recommendations that were overdue or where implementation dates had changed.



## **FINANCE GOVERNANCE**

### **8. Review of Losses and Special Payments**

MA-M advised there were no losses or special payments to report.

#### **The Committee:**

Noted there had been no losses or special payments.

### **9. Update and assurance on key financial policies**

MA-M reported that the Scheme of Delegation was up to date and had been published. The Detailed Financial Policies would be updated as part of the Constitution review, as discussed earlier. In response to SP seeking assurance, MA-M agreed to provide an addendum confirming the current Detailed Financial Policies are in operation for the August meeting.

#### **The Committee:**

1. Noted the update.
2. Requested an addendum confirming the current Detailed Financial Policies in operation for the next meeting.

### **10. Review risks and controls around financial management**

MA-M advised that there was nothing specific to report in addition to the agenda items and noted that the CCG's latest financial position reflected the capped expenditure process.

### **11. Review progress against financial recovery plan**

MA-M referred to the outline of the capped expenditure process and timeline that had been proposed by the regulators. He reported that NHS England had advised that the forecast outturn position should include plans to close the initial control total gap.

MA-M highlighted three areas of the capped expenditure ask: the £13.7m control total shortfall across NHS Vale of York and NHS Scarborough and Ryedale CCGs, the £7.8m pressure from alignment of plans between commissioner and provider and £4.7m slippage of QIPP savings across the system. MA-M reported that the month 2 finance report had included the forecast impact of the proposals to close the £13.7m control total gap and that the month 3 position would include a planned position to take account of these areas and noted that delivery of capped expenditure schemes and proposals, such as demand management, would impact on other commissioners, in particular NHS East Riding of Yorkshire CCG.

MA-M reported that feedback was awaited from NHS England on the capped expenditure proposals. However, in the meantime the Chief Executive of NHS

Improvement had written to all provider Chief Executive Officers within the capped expenditure process stating the requirement to safeguard quality as well as safety of services and for constitutional targets to be met, in particular 18 week referral to treatment and patient choice. York Teaching Hospital NHS Foundation Trust was therefore resubmitting their financial plan excluding capped expenditure demand management schemes. MA-M reported that meetings with NHS England and NHS Improvement were continuing to take place in the context of managing within allocation.

CA expressed concern at the updated financial position noting that a Public Interest Report had been avoided due to the fact that the CCG's Medium Term Financial Strategy was realistic. SP additionally noted that the Governing Body had approved the Medium Term Financial Strategy, but not the capped expenditure proposals, expressing concern in the context of accountability especially if the plan was now in the CCG's financial ledger.

MA-M agreed to provide a summary financial analysis for the Part II Governing Body meeting on 13 July.

**The Committee:**

1. Noted with concern the update on the CCG's financial position.
2. Requested that MA-M provide a summary of the capped expenditure financial position for the Part II Governing Body meeting on 13 July. *Post meeting note: Presentation at the Part II Governing Body meeting.*

**12. Policy on Non Audit Work by External Audit**

MA-M presented the Policy on Non Audit Work by External Audit which had been developed in line with best practice. This included information from similar policies at other CCGs. Members noted that to date External Audit had not undertaken any non audit work for the CCG.

**The Committee:**

Approved the Policy on Non Audit Work by External Audit.

**CORPORATE GOVERNANCE**

**13. Update and assurance – review other reports as appropriate**

RP noted that this would be covered under the following agenda items.

**14. Review of Current Procurement Programmes**

MA-M presented the report which provided an update on the CCG's two current procurement programmes in respect of Podiatry and Patient Transport Service. Work was taking place to resolve final queries relating to key performance indicators for the former for which it was noted that the Patient Advice and Liaison Service was receiving complaints and comments about toenail cutting.

MA-M explained that the Patient Transport Service procurement had been delayed for three months.

SP additionally sought an update on the recent wheelchair and community equipment procurement. RP confirmed that the associated issues, including the backlog for which the CCG had accrued funding in 2016/17, had been considered at the Executive Committee but the formal lessons learned from the procurement had not yet been undertaken. MA-M explained there were two elements: the actual procurement and development of the specification. Members requested a report on the outcome of this procurement for the next meeting.

**The Committee:**

1. Received the update on the current procurement programmes.
2. Requested a report on the outcome of the wheelchair and community equipment procurement.

**15. Note business of other committees, review relationships**

RP noted that the clarity of the respective roles of the Audit Committee and Finance and Performance Committee had been established but would continue to be reviewed. She advised that forward plans were being developed for committees that did not yet have them.

**The Committee:**

Noted the update.

**16. Review assurance from other committees and Partnership Commissioning Unit and Commissioning Support (3rd party assurance)**

RP referred to the discussion at previous agenda items.

RP reported that a review of the Partnership Commissioning Unit Board was taking place as part of the transition. The Board would be disbanded when this was completed.

**The Committee:**

Noted the update.

**17. Review Assurance Framework**

RP reported that work was continuing to link the Assurance Framework with the Internal Audit Plan and risk reporting. Key programmes of work were linked to delivery of the CCG's strategic and operating plan. The Finance and Performance meeting had received the new format report which would also go to the Governing Body on 13 July.

**The Committee:**

Noted the ongoing development of the Assurance Framework.

**18. Primary Care Commissioning Assurance**

CA noted that internal control for primary care commissioning was a national issue for which clarification was being sought from the National Audit Office. She explained that service organisations did not have appropriate controls in place.

RP advised that the CCG's Primary Care Commissioning Committee had reviewed its terms of reference and was holding meetings in alternate months which complied with them.

**The Committee:**

Noted the update.

**19. Managing Conflicts of Interest – CCG Improvement and Assessment Framework**

RP referred to the report which comprised the CCG's annual and quarterly self assessment demonstrating compliance with NHS England's revised statutory guidance on managing conflicts of interest. These had been submitted on 7 April 2017.

**The Committee:**

Received the annual and quarterly Conflict of Interest Indicator assessments.

**20. Amendment to Conflicts of Interest Policy**

RP referred to the amendment to the Conflict of Interest Policy which was required following updated statutory guidance from NHS England on 16 June 2017 for managing conflicts of interest and supporting documents.

Members expressed the view that declarations of interest should be checked at the end of the financial year to ensure accuracy for the annual report and annual accounts and requested that a reminder be added to the Committee Chair's briefing to remind members to amend their declaration in the event of any change.

**The Committee:**

1. Approved the amendment to the Conflicts of Interest Policy.
2. Requested that declarations be checked at the end of the financial year.
3. Requested that a reminder be included in the Committee Chair's briefing regarding the need to amend declarations in the event of any change.

## **21. Procurement Policy Update**

Members requested an amendment to the Procurement Policy under Roles/Responsibilities/Duties Section 7.1 prior to presentation for ratification by the Governing Body. This should now read:

'Procurement Support – NHS Vale of York CCG does not have its own internal procurement resource. The Procurement service is currently commissioned externally for professional advice, guidance and support in delivering projects in line with NHS Vale of York CCG's requirements. Where it is required and considered appropriate procurement support may also be provided by a CSU and/or in the case of collaborative projects by another CCG. The CCG will have systems in place to assure itself that the business processes from any external support are robust and enable the CCG to meet its duties in relation to procurement.'

Members sought clarification about the procurement support for 2017/18 and, in response to their request for assurance about the approval process, MA-M agreed to circulate the report that had been presented at the Executive Committee.

### **The Committee:**

1. Approved the Procurement Policy update subject to the above amendment.
2. Requested that MA-M provide assurance about the process for 2017/18 procurement support.

*Post meeting note: The Procurement Options Paper presented to the CCG's Executive Committee was circulated on 6 July.*

## **22. Management of Freedom of Information Requests Update Report**

RP referred to the report which detailed Freedom of Information request activity since the December report to the Committee and provided an update on a request in that report relating to Cobweb, a centralised management prescribing system for stoma and continence products. She highlighted that a number of requests received a response within 16 days

### **The Committee:**

Received the update on management of Freedom of Information requests.

## **EXTERNAL AUDIT**

### **26. Progress Reports and Briefing**

CA referred to the report which described the requirements for the 2017/18 audit work and noted national publications and other updates relating to Managing Conflicts of Interest, Financial Sustainability of the NHS and Next Steps on the NHS Five Year Forward View.

### **The Committee:**

Received the progress report and briefing.

*PF joined the meeting*

### **27. Receive/consider the External Audit Annual Audit Letter**

CA presented the Annual Audit Letter for the year ended 31 March 2017 which comprised an executive summary, audit of the financial statements, value for money conclusion, other reporting responsibilities and future challenges. She noted that this was the final element of the 2016/17 audit work.

Members commended the clarity of the Annual Audit Letter and requested that it be presented to the Governing Body with the 2016/17 Annual Report and Annual Accounts at its meeting on 13 July.

### **The Committee:**

1. Received the External Audit Annual Audit Letter.
2. Requested that the Letter be presented to the Governing Body with the 2016/17 Annual Report and Annual Accounts on 13 July.

*Post meeting note: The Governing Body received the Annual Audit Letter at its meeting on 13 July.*

## **INFORMATION GOVERNANCE**

### **23. Update and assurance**

PF explained that NHS Digital had not yet published the 2017/18 Information Governance Toolkit but that there was an expectation for this to include changes.

### **The Committee:**

Noted the update.

### **24. Note business of the Information Governance Steering Group meeting and Agree Work Plan**

PF reported that General Data Protection Regulations, expected to have more stringent requirements, were due in May 2018. The Information Governance Steering Group met regularly and its action plan ensured compliance with Level 2 of the Information Governance Toolkit.

PF referred to the Information Governance Steering Group Work Plan highlighting aspects relating to the Partnership Commissioning Unit services being brought in house. She noted that policies would be reviewed to ensure relevance to the whole organisation and that capacity would be kept under review.

PF noted that lessons had been learned from the recent cyber incident and that eMBED would now be providing regular briefings to ensure any similar future risks were identified.

In respect of the work plan members requested that future iterations include commentary and timescales.

**The Committee:**

1. Noted the business of the Information Governance Steering Group.
2. Ratified the Information Governance Steering Group Work Plan, requesting that future iterations include commentary and timescales.

**25. Report on Information Governance Incident**

In presenting this report PF noted that the incident had been reported through the Information Governance Toolkit due to the sensitivity of the information. She advised that no further comment had been received from the patient about the incident.

PF assured members that lessons had been learned from the recent incidents including introduction of a clear desk policy to avoid a recurrence. No disciplinary action had been taken.

**The Committee:**

Received the Information Governance Incident report.

*PF left the meeting*

**OTHER ACTIVITIES**

**28. Vale of York Clinical Network Report**

SP described the background to the CCG's request to Internal Audit to undertake a review of the financial and governance arrangements relating to funding provided to the Vale of York Clinical Network in 2016. AE explained that the review had focused on two key areas: the reputational, relationship and financial risks associated with this and future similar funding arrangements, to enable proportionate control to be established; and the governance over Council of Representatives meetings, confidentiality of reports and the role of members. AE noted that, as the report presented was a draft, amendments could still be incorporated.

DB referred to the lessons learned included in TP's original report, noting there were still areas that required addressing. He emphasised the need for the CCG to ensure that all policies and procedures were fit for purpose and that accountability was required for any investment by the CCG.

Members discussed in detail concern about the CCG's systems and processes highlighting that there had been a breach of governance procedures but emphasising there was no evidence of fraud or inappropriate action by the Vale of York Clinical Network.

MA-M explained the business case process but noted the need for potential reinforcement of the control mechanisms. He agreed to consider this with AE and report back to the Committee.

Members requested a number of amendments to the draft report including anonymisation were appropriate, clarity of the scope of the review and reiteration of the fact that there was no evidence of fraud or misappropriation.

RP advised that an action plan would be developed for the recommendations and she would progress those relating to the Council of Representatives. All recommendations would be monitored through the regular processes.

In conclusion SP reiterated the Committee's concerns about the breach of governance and business case procedures and confidentiality issues. It was noted that the Audit Committee was satisfied with the recommendations which would be monitored to prevent a repetition. SP noted that she would discuss with the Accountable Officer and the Chair of the Council of Representatives next steps, if any, for the report.

SP expressed appreciation to AE for providing the report in such a short timescale.

**The Committee:**

1. Received the draft Vale of York Clinical Network Report.
2. Requested a report on control mechanisms for the business case process.
3. Requested that AE incorporate a number of amendments in to the final report.
4. Noted that SP would discuss with the Accountable Officer and the Chair of the Council of Representatives next steps for the report.

**MINUTES FROM OTHER MEETINGS**

**29. Finance and Performance Committee Minutes**

DB highlighted that the Committee had expressed similar concerns relating to the financial position and procedures to those discussed at earlier agenda items. He also noted that at its June meeting the Committee had been particularly concerned about the trading position with York Teaching Hospital NHS Foundation Trust and had authorised the Accountable Officer to invoke the escalation clause in the Heads of Terms for a joint review by NHS England and NHS Improvement.

**The Committee:**

Received the minutes of the Finance and Performance Committee meetings held on 27 April and 25 May 2017.

Confirmed Minutes



### **30. Quality and Patient Experience Committee Minutes**

Members discussed the ongoing concerns relating to City of York Council Public Health and the City of York Council Healthy Child Service.

#### **The Committee:**

Received the minutes of the Quality and Patient Experience Committee meeting held on 13 April 2017.

### **31. Executive Committee Minutes**

#### **The Committee:**

Received the minutes of the Executive Committee meeting held on 19 April 2017.

### **32. Information Governance Steering Group Minutes**

#### **The Committee:**

Received the minutes of the Information Governance Steering Group meeting held on 23 May 2017.

### **33. Key Messages to the Governing Body**

- In the light of a further Limited Assurance report for continuing healthcare, the Committee asked the executive lead and the finance lead to attend the August meeting to provide assurance on actions being taken and ongoing improvement.
- Whilst the Committee accepted reasons for delay in finalising the revised Constitution, they asked for a further update at the August meeting, particularly relating to risks and mitigation.
- The Committee approved updates to the Conflicts of Interest Policy and Procurement Policy, a new Policy for the Engagement of External Auditors for Non-Audit Work, and the Information Governance Steering Group Work Plan
- The Committee was very concerned about the issues raised in the draft Vale of York Clinical Network Report relating to serious breach of governance procedures, business case procedures and confidentiality. They were satisfied with the recommendations which would be monitored to prevent a recurrence.

#### **The Committee:**

Agreed the above would be highlighted by the Committee Chair to the Governing Body.

### **34. Next meeting**

30 August at 2pm.

**NHS VALE OF YORK CLINICAL COMMISSIONING GROUP AUDIT COMMITTEE**

**SCHEDULE OF MATTERS ARISING/DECISIONS TAKEN: 5 JULY 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS**

<b>Meeting Date</b>	<b>Item</b>	<b>Action Required/Decisions Taken</b>	<b>Responsible Officer/Body</b>	<b>Action Completed/ Due to be Completed by (as applicable)</b>
1 March 2017	Annual Review of Effectiveness of Internal Audit	<ul style="list-style-type: none"> <li>Action plan for proactive sharing of learning</li> </ul>	HK-T	Ongoing
26 April 2017 24 May 2017 5 July 2017	Constitution, Scheme of Delegation and Detailed Financial Policies	<ul style="list-style-type: none"> <li>Summary to be provided for meeting chairs</li> <li>Report detailing risks and mitigations relating to the Constitution</li> </ul>	RP  RP	30 August 2017
26 April 2017	Internal Audit - Commissioning Support Contract Management	<ul style="list-style-type: none"> <li>Report on commissioning support contract management to be presented at the July meeting</li> </ul>	Executive lead	5 July 2017 Deferred to 30 August 2017
24 May 2017	2016/17 Periodic Report and Internal Audit Reports	<ul style="list-style-type: none"> <li>Governance principles for the system financial envelope joint working between NHS Vale of York CCG, NHS Scarborough and Ryedale CCG and York Teaching Hospital NHS Foundation Trust to be scoped.</li> </ul>	HK-T / MK	1 June 2017

Meeting Date	Item	Action Required/Decisions Taken	Responsible Officer/Body	Action Completed/ Due to be Completed by (as applicable)
		<ul style="list-style-type: none"> <li>Report requested to August Committee</li> <li>Feedback to be provided on implications for social care resulting from the audit of management of commissioning of aftercare under Section 117 of the Mental Health Act</li> </ul>	<p>HK-T</p> <p>AE/HK-T</p>	30 August 2017
24 May 2017	Annual Review of Internal Audit Charter and Working Together Protocol	<ul style="list-style-type: none"> <li>A “user friendly” version to be developed for circulation to CCG staff.</li> </ul>	HK-T	
5 July 2017	Internal Audit Periodic Report – Continuing Healthcare	<ul style="list-style-type: none"> <li>DN to be asked to attend the August meeting</li> <li>Detailed report to provide an update on concerns relating to continuing healthcare outstanding actions and the finance and contracting arrangements</li> </ul>	<p>RP</p> <p>RP/DN/MA-M</p>	<p>30 August 2017</p> <p>30 August 2017</p>
5 July 2017	Internal Audit Recommendations Status Report	<ul style="list-style-type: none"> <li>CCG internal Audit programme recommendations and Partnership Commissioning Unit services recommendations to be presented in the separate format.</li> </ul>	AE	30 August 2017

Meeting Date	Item	Action Required/Decisions Taken	Responsible Officer/Body	Action Completed/ Due to be Completed by (as applicable)
		<ul style="list-style-type: none"> <li>An explanatory summary sheet to be included for recommendations that were overdue or where implementation dates had changed.</li> </ul>	AE	30 August 2017 and ongoing
5 July 2017	Update and assurance on key financial policies	<ul style="list-style-type: none"> <li>Addendum updating the current Standing Financial Instructions</li> </ul>	MA-M	30 August 2017
5 July 2017	Review of current procurement programmes	<ul style="list-style-type: none"> <li>Report on the outcome of the wheelchair and community equipment procurement.</li> </ul>	MA-M	30 August 2017
5 July 2017	Amendment to Conflicts of Interest Policy	<ul style="list-style-type: none"> <li>Declarations of interest to be checked at the end of the financial year</li> <li>Reminder to be included in the Committee Chair's briefing regarding the need to amend declarations in the event of any change</li> </ul>	RP  RP	

Meeting Date	Item	Action Required/Decisions Taken	Responsible Officer/Body	Action Completed/ Due to be Completed by (as applicable)
5 July 2017	Vale of York Clinical Network Report	<ul style="list-style-type: none"> <li>• Report on control mechanisms for the business case process</li> <li>• A number of amendments to be incorporated in to the final report.</li> <li>• Next steps for the report, if any, to be discussed with the Accountable Officer and the Chair of the Council of Representatives</li> </ul>	MA-M  AE  SP	30 August 2017

This page is intentionally blank

**Minutes of the Executive Committee, meeting held on**  
**17 May 2017 at West Offices, York**

**Present**

Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Medical Director
Dr Shaun O'Connell (SO)	Medical Director
Tracey Preece (TP)	Chief Finance Officer
Rachel Potts (RP)	Executive Director of Planning and Governance
Michelle Carrington (MC)	Executive Director of Quality and Nursing

**In Attendance**

Elaine Wyllie (EW)	Strategic Programmes Consultant
Jim Hayburn (JH)	Strategic Programmes Consultant
Victoria Hirst (VH)	Head of Engagement

*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 19 April were approved. It was agreed that these minutes would be included in the Governing Body agenda for information.

The Executive Committee noted various amendments to the action tracker and were assured that the appropriate changes would be made.

**4. Finance, QiPP and Contracts****4.1 Month 1 Financial Position & Running cost position**

The Committee noted that there was no current data to report for Month 1 and was assured with the running cost position.

**4.2 Utilisation Management**

An agreement was made to defer this agenda item to a conversation outside of the Committee at a later time.

**4.3 System Financial Envelope**

The Committee considered the latest position and agreed to communicate directly with NHS England to clarify a number of related

issues. It was proposed to meet the lay members to take advice from a governance perspective.

*The Committee break for 10 minutes*

#### **4.4 Better Care Fund**

EW updated the Committee on the Better Care Fund. It was confirmed that discussions were on going with both North Yorkshire County Council and City of York Council around the investment profile for 2017/19. The Technical guidance had still not been received.

#### **4.5 Voluntary Sector Funding**

EW briefed the Committee around the conversations that had been held to date around reviewing the current arrangements with regards to contracts with the voluntary sector.

The Committee were in support of the recommendations in the report on the basis that TP and EW would work together to align finance and contracting assumptions, in particular this related to Patient Transport.

### **5. PMS Update**

TP confirmed that following discussions at the Primary Care Commissioning Committee, £200,000 had been identified to support involvement in the locality work. There was a paper going to the Council of Representatives which would provide an update on the process put in place to access this funding.

### **6. QIPP Delivery and Capacity**

The Committee noted that the Intensive Support Team (IAPT) report still had not been received. Concern was raised regarding the cancellation of the A&E Delivery Board and PM agreed to follow this up with the Chair of the Board. Work was on going to ensure alignment of capacity with QIPP priorities.

### **7. Governing Body Agenda**

There were no reported changes to the Governing Body agenda. It was suggested that the location of the next meeting was reviewed due to concerns around the suitability of the accommodation.

### **8. Service Quality and Safety**

MC confirmed that the CCG were currently in Phase 2 of the Partnership Commissioning Unit (PCU) change of base consultation. MC stated that the Finance and Contracting split had still not been resolved, however a decision in principle had been agreed for when services were split the associated support services should also follow. The Committee acknowledged that the admin support with contracting, finance and PCU would need to be reviewed.



The Committee also noted that a registered nurse had been placed to care for the highly complex case previously notified to the Executive Committee.

## **9. Strategy**

### **9.1 Mental Health Out of contract**

The Committee supported in principle the approach to deliver the required savings in the short, medium and long term. It was agreed that EW should determine any governance issues around this going forward.

There were concerns around case management details being shared and EW confirmed she would follow this up to ensure this was resolved.

### **9.2 Accountable Care Partnership Board feedback**

RP updated the Committee and confirmed that all members present at the Accountable Care Partnership Board were in agreement with the vision, values and principles paper.

### **9.3 Declaration as Surplus – St Andrew’s Psychotherapy Centre**

The Committee noted the report and agreed to go ahead with the proposal and declare St Andrew’s Psychotherapy Centre surplus.

The land opposite Acomb Gables surplus / disposal was not approved by the Committee, it was requested to keep this site open for a period of no more than six months whilst the CCG work through with their mental health provider whether this land may facilitate their preferred solution with regards to LD beds. Once the outcome of this is known and the preferred solution identified it would be communicated to the correct people.

## **10. Co-commissioning Primary Care**

### **10.1 Gluten Free-scheme**

Following considerations of the previously circulated options paper, the Committee were in agreement to go ahead with the proposal of means testing the gluten free products on the NHS. It was noted that this preferred option had been considered and was recommended by the Clinical Executive (CE) and the Committee supported this.

### **10.2 Bariatric Surgery**

SO outlined the proposed approach to the commissioning of the Bariatric Surgery. It was suggested that an STP wide commissioning statement would be the preferred option. The Committee agreed that SO should discuss the approach with NHSE colleagues with regard to a regional position on this. It was noted that if there were any financial risks then this would need following up with TP.

## **11. Corporate**

### **11.1 Office Accommodation Update**

RP stated that the arrangements had been confirmed with City of York Council which included exclusive use of the Rowntree Room and a new meeting space seating up to 8 people. It was also noted that the costing's for this had previously been approved.

### **11.2 Staff Structure and appointments**

The Committee discussed various staff recruitment and capacity issues and agreed that the support to the Locality programmes should be moved across to the Project Management Office as vacancies were being recruited to.

The functioning and alignment of the admin team should also be reviewed.

### **11.3 North Yorkshire Developments**

PM updated the Committee on the Joint Commissioning arrangement across North Yorkshire. It was confirmed that there would be a meeting in June which would move things forward.

PM agreed to keep the committee updated on progress and the impact of these arrangements on the CCG.

## **12. People, Support and Development**

### **12.1 GP Roles**

The Committee acknowledged the roles of GP's and their responsibilities, outlined in the agenda and papers. There were minor concerns which would be picked up outside of the meeting.

### **12.2 GPs at GB membership**

PM explained that there had been a discussion regarding the requirement for the CCG GP clinical leads to attend GB meetings. PM confirmed that the Council of Representatives would be asked to reflect on this matter.

## **13. AOB**

The Committee noted the e-Referral Service, Paper Switch-Off Programme letter that had arrived from NHS England.

## Minutes of the Executive Committee, meeting held on

21 June 2017 at West Offices, York

### **Present**

Phil Mettam (PM)	Accountable Officer
Dr Andrew Phillips (AP)	Medical Director
Dr Shaun O'Connell (SO)	Medical Director
Tracey Preece (TP)	Chief Finance Officer
Rachel Potts (RP)	Executive Director of Planning and Governance
Michelle Carrington (MC)	Executive Director of Quality and Nursing

### **In Attendance**

Elaine Wyllie (EW)	Strategic Programmes Consultant
Jim Hayburn (JH)	Strategic Programmes Consultant
Caroline Alexander (CA)	
Carl Donbavand (CD)	<i>(For Items 3 and 4)</i>
Laura Angus (LA)	<i>(For Item 7)</i>
Natalie Fletcher (NF)	<i>(For Item 7)</i>

*The agenda was discussed in the following order:*

#### **1. Apologies**

As noted above

#### **2. Declaration of Members' Interests in the Business of the Meeting**

SO reported that he had been appointed to the Medical Regional Committee, which meets 4 times a year.

#### **3. RightCare Circulation – statin optimisation proposal**

The Committee were in support of the proposal on the basis that the Medicine management capacity issue would be prioritised and the Committee were reassured that it would be included in the mainstream QIPP programme.

#### **4. £1.18M QIPP opportunities through the Innovation Technology Tariff (ITT)**

The Committee agreed for this to be progressed on the basis that TP and AP would work with CD to understand the benefit that there should be for the CCG. It was noted that a number of the opportunities would be for the providers to make efficiencies in the event that there were benefits to the CCG, and then it was agreed these should be mainstreamed into the Capped Expenditure Programme (CEP) or one of the CCG's other QIPP Programmes.

#### **5. Matters Arising**

The Executive Committee noted various amendments to the action tracker and were assured that the appropriate changes would be made.

### Staff Structure and Running Cost Position

The Committee agreed that there were no proposed changes and this was still on going.

### Office Accommodation Update

RP reported that the planned office move was on track to be completed by 3<sup>rd</sup> July.

### Medicines Management Service

SO reported that the principle of moving towards a model where resources would be deployed was still on going and a further update would be provided at a later date.

### Primary Care Estates

The Committee agreed that this matter would need addressing further and for a Primary Care strategy stocktake to take place at SMT the forthcoming week.

### Review of LES

TP reported that this was on going, and 5 local enhanced services had been agreed which would all now need a clinical and price review. It was confirmed that David Illey was the NHS England lead on this and that a paper would be going to the Primary Care Commissioning Committee at the end of July.

### Patient Transport Services

TP reported that Harrogate and Rural District CCG, Hambleton Richmondshire & Whitby CCG were now in agreement to be part of the procurement for Patient Transport Services. This would now require 3 month extension therefore this would commence on 1<sup>st</sup> July and it was confirmed that all project leads had been appointed.

The Executive Committee noted all of the various amendments to the action tracker and were assured that the appropriate changes would be made.

*The Committee break for 10 minutes*

## **6. Month 2 Financial Position & Running Cost Position**

The Committee noted the month 2 position and considered the following specific issues;

The reported risks were under Continuing Healthcare, QIPP and Out of Hospital care. The Committee agreed that JH and TP would create an action plan with York FT in relation to the in-year position.

MC reported that Phase two had finished in regards to the PCU Realignment and the Committee welcomed the arrival of CHC admin staff into the CCG. TP confirmed that she would be attending a meeting on 21 June to agree arrangements for the Finance and Contracting split associated with CHC. A discussion took place around the need for external support to carry out the outstanding reviews on CHC as there were still an unacceptable volume of reviews outstanding. The Committee agreed that a paper would come back to the Executive on 19 July.

SO reported that the BMI Smoking thresholds had begun to have an impact in the last few weeks. It was confirmed that the Rightcare programme had progressed under the CEP and was moving at pace as part of the Planned care Programme and demand management.

*The Committee break for 10 minutes*

## **7. Prescribing Indicative Budgets**

LA and NF presented the model which had been work in progress and had previously been supported by the Executive Committee. The Committee approved sign off for the final model which would go live on the 1<sup>st</sup> July and also requested that the proposal be shared with Lay members to validate the Memorandum of Understanding from a patient and conflict of interest point of view.

## **8. VCS Grants**

EW updated the Committee on the progress with the proposal in regard to VCS Grants. She reported on the workshop involving the voluntary sector to consider options where positive discussions had taken place which had resulted in the proposal out forward to be agreed by the Committee. The Committee were in agreement to support the proposal, removing the funding for the York Older People's Assembly, reducing funding by c.40% to the York Council for Voluntary Sector, reducing by c. 25% other grants awarded to agencies in York, and to invest the remaining balance around Voluntary sector developments with TEWV in line with the CCG's strategic priority to develop mental health services. This approach maintains investment via grant monies at a reduced level for 2017/18 in line with the financial plan/QIPP target for this project.

## **9. Capped Expenditure**

The Committee noted the correspondence from GPs on behalf of the Council of Representatives. It was agreed that PM would respond formally on behalf of the CCG.

#### **10. 2016/17 Annual Review letter**

The Committee noted the letter from NHS England and agreed this should go to Governing Body for information and be published on the CCG website.

#### **11. Draft Governing Body agenda**

The Committee agreed that the Annual Review letter would need to be added to the agenda for information, the Mental Health development would be a presentation and the Conflicts of Interests policy should be added for the Governing Body to ratify.

#### **12. Executive Report- Preparation for SEND Inspection**

The Committee noted the expectation of an imminent expected SEND inspection and they were assured that the team were well prepared to respond to the inspection request.

#### **13. Personal Health Budgets**

The Committee approved option 2, to identify dedicated resource from within the CCG to augment existing PCU progress and identify patients in line with the Bassetlaw model.

#### **14. Corporate - Constitution Update**

The Committee were in support of the agreement to work up a revised constitution in early October. It was agreed that an assessment be made of the risks within the existing constitution and the actions to mitigate this up to October.

#### **15. AOB**

MC reported concerns around the need to consider fully the impact on patients when CCG commissioning decisions were made. Specifically this related to demands placed on individual members of staff. The Committee noted that a helpful script would need to be issued to staff and more resource would need to be dedicated to this area going forwards.

**Minutes of the Finance and Performance Committee Meeting held on  
22 June 2017 at West Offices, York**

**Present**

David Booker (DB) – Chair	Lay Member
Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Fiona Bell (FB)	Assistant Director of Transformation and Delivery
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Phil Mettam (PM) - part	Accountable Officer
Dr Shaun O’Connell (SOC)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer

**In attendance**

Rachel Cooke (RC)	Head of Finance
Jim Hayburn (JH)	Strategic Programme Consultant
Keith Ramsay (KR)	CCG Chairman
Zena Robertson (ZR)	Deputy Director of Nursing, NHS England
Michele Saidman (MS)	Executive Assistant
Liza Smithson (LS)	Head of Contracting
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)
Elaine Wyllie (EW)	Strategic Programme Consultant

**Apologies**

Dr Andrew Phillips (AP)	Joint Medical Director
Rachel Potts (RP)	Executive Director of Planning and Governance
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair

The agenda was discussed in the following order.

**1. Apologies**

As noted above.

**2. Declarations of Interest in Relation to the Business of the Meeting**

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

**3. Minutes of the meeting held on 25 May 2017**

The minutes of the previous meeting were agreed.

**The Committee:**

Approved the minutes of the meeting held on 25 May 2017.

#### **4. Matters Arising**

*Financial Performance Report:* KR sought and received confirmation from TP that the annual accounts had been submitted and published within the required timescale.

*F&P22 Vale of York Clinical Network Financial Report:* TP reported that work was currently being undertaken by Internal Audit who would provide a report to the Audit Committee on 5 July. Depending on the outcome the Finance and Performance Committee would be updated accordingly. DB emphasised that the report had been requested in terms of lessons being learnt.

F&P23 Contract Report and F&P24 QIPP Update on 2017/18 Programme Mobilisation were within agenda items.

#### **The Committee:**

Noted the updates.

#### **“Good News”**

MC reported on a change in care package to a personal health budget for a paraplegic child whose mother had advised that this had transformed their life.

CA reported that initial feedback from the CCG's participation in the Wave 1 RightCare Programme had indicated NHS Vale of York CCG had the highest impact on RightCare targets of any CCG in England. Discussion was now taking place about Wave 2. The final report would be shared with the Committee when available.

EW noted, as per item 8 on the agenda, that reduction in the in year voluntary sector budget would be achieved and welcomed the potential for a partnership arrangement.

SOC reported that funding had been secured for 20 more dermatoscopes which meant that all Practices could now participate in this project. Funding had also been secured to train GPs in use of this equipment.

SOC also reported that the Executive Committee the previous day had agreed to the York Healthy Heart project which had estimated savings of c£180k. He noted that this would help to address one of the RightCare areas where the CCG was currently an outlier.

JH reported that the Accountable Care System Partnership Board had signed off a joint project initiation document to commence deliverable unplanned care work. He particularly noted contributions from CA, FB and EW to this achievement.

In returning to the formal agenda DB highlighted that the timing was three months into the financial year and requested that discussion should identify what position the CCG should be in, the current position, and actions to address disparity if required.



## 5. Risk Report

In presenting the Risk Report CA highlighted the revised format noting that the CCG had undertaken a refresh of the approach to both programme management and performance management to support the delivery of the 2017/18 to 2018/19 Operational Plan. All risks were in the process of being refreshed as part of the CCG's transition to the 2017/18 programmes of work and the first risk review by programme was included. CA noted that all risks had been aligned to the CCG's Joint "Local Place" Plan programmes and priorities and that an updated position for the CCG's performance against the NHS England Integrated Assurance Framework indicators was included in the report.

CA highlighted two corporate events – dementia coding and improving access to psychological therapies (IAPT) – and eight risks that were RAG (Red, Amber, Green) rated as 'red':

- Child and Adolescent Mental Health Service, Improving Access to Psychological Therapies, Continuing Healthcare and Personal Health Budgets (services previously under the remit of the Partnership Commissioning Unit)
- Delivery of QIPP programmes
- Agreement of some key healthcare contracts
- CCG financial challenges
- Two risks relating to managing transitioning of Partnership Commissioning Unit staff
- Two specific risks escalated from programmes risk registers to corporate, and which had been raised as events, relating to IAPT, access to services and ongoing risk relating to dementia coding

CA explained that mitigating actions were in place at programme level for these risks.

CA noted that the only emerging risk, which was also a risk that had recently been identified nationally, related to implementation of the national Maternity Services Strategy. She highlighted that this would be developed as a Sustainability and Transformation Plan strategy with local Vale of York strategy within this.

In response to DB seeking clarification about the CCG's performance about data from the 2016/17 Improvement and Assurance Framework where the CCG's leadership was assessed as 'red', PM explained that this assessment would remain until the Executive Team structure was resolved. He referred to the CCG's response to legal Directions and establishment of a new Executive Team structure reporting that, due to tax regulations which affected JH and EW, the substantive posts of Executive Director of System Resources and Performance and Executive Director of Joint Commissioning were vacant. The newly appointed Executive Director of Transformation and Delivery would be taking up post in mid July. PM advised that he was in discussion with NHS England about the structure and also noted that discussion was taking place with commissioning partners in the context of capped expenditure which required a system wide approach.

EW provided clarification about the two corporate events. In respect of the IAPT risk there was an underlying need for Tees, Esk and Wear Valleys NHS Foundation Trust to

increase the level of trained workforce; further assurance was being sought on their plan in response to the CCG's Financial Improvement Notice issued in January. With regard to dementia coding, registers were not currently identified as a priority by GPs although patients were being treated in this regard. EW advised that work on dementia was taking place with the Intensive Support Team in early July. SOC noted that concerns about dementia coding had been discussed in many forums and that Louise Barker was working with Practices to improve coding rates. He also requested that GPs be provided with information about IAPT waiting times.

#### **The Committee:**

1. Received the risk report noting that this would inform discussion of later agenda items.
2. Noted that EW would arrange for GPs to be provided with information about IAPT waiting times.

#### **6. Financial Performance Report Month 2**

TP advised that the month 2 financial position had been finalised prior to submission of the revised plan submitted on 12 June and was therefore reported against the plan submitted on 31 March. She confirmed that release of the £4.3m 1% risk reserve at the end of 2016/17 had resulted in the planned cumulative deficit figure being reduced from £44.1m to £39.8m. TP noted that, although the month 2 report figures did not include any capped expenditure proposals, these were reflected in the forecast outturn in accordance with advice from NHS England therefore there was greater variance in the forecast.

In respect of the in year position TP reported that no schemes other than QIPP had been implemented and there was currently a £2.85m overspend. This position was £138k worse than plan and was reflected in the dashboard at appendix 1. TP noted, however, that the capped expenditure proposals were phased from August onwards and that the position reported was largely in line with the original plan. She also noted that no prescribing data had yet been received for 2017/18 but that the 2016/17 data had been consistent. There had additionally been a high level of uncoded data from York Teaching Hospital NHS Foundation Trust due to the cyber attack and £200k carried over from 2016/17 relating to Ramsay and Nuffield Hospitals, Leeds Teaching Hospital NHS Trust and York Teaching Hospital NHS Foundation Trust where year end positions had not been agreed. TP noted that two twelfths of contingency was reflected in the report but this was subject to approval from NHS England.

TP referred to the risks, reported to NHS England, namely: the remaining system alignment gap between the CCG and York Teaching Hospital NHS Foundation Trust plans, QIPP and the move to market rent.

TP clarified the presentation of the QIPP programme information relating to schemes carried forward from 2016/17. These were delivering but, as data was not yet available, assumptions had been made as to their impact. She highlighted the key areas of risk as outpatients, out of hospital care mainly due to timing slippage, and continuing healthcare. In respect of the latter, the principle risk, TP reported that evidence of

delivery of the action plan was not yet available and that there was a c£0.5m overspend month 2 which included slippage on the QIPP target.

In response to KR seeking clarification about the apparent overspend on the wheelchair services contract, MA-M referred to the procurement when lack of information from the previous provider had been highlighted. He explained that the volume of community equipment activity was significantly higher than anticipated and confirmed that the backlog, which was separate and related to the wheelchair service, had been provided for in 2016/17. MA-M also noted that discussions were taking place with other CCGs across the county who had a contract with the same equipment services provider. They had been able to recover their position and improve on the original procurement through opportunities such as working with patients to give them confidence in changing equipment and the development and implementation of an assessment toolkit by the provider of equipment functionality needed to enable the most cost effective equipment to be provided. A meeting of clinicians had considered the new clinical products and catalogue changes agreed on the back of this. In response to DB enquiring about a control mechanism for this contract, MA-M explained that this was an activity based contract for equipment purchases, but that productive contractual discussions were taking place in the context of working within a financial envelope and that engagement was taking place with the other commissioners of the service who supported the approach being taken. Members expressed concern at the contract team resource required to manage the position.

In response to JS seeking clarification about accounting treatment of the £317k 'Other Community' overspend, TP reported that actions were being taken to try and manage this and there would be more clarity in future reports. MA-M added that the actual year to date overspend was reflected but was not in the forecast.

Members discussed QIPP which was reported as an overall risk of £2.7m and £3.6m forecast as unidentified. MA-M explained that the £3.6m slippage resulted from an internal confirm and challenge but a proportion of QIPP related to alignment with York Teaching Hospital NHS Foundation Trust stranded fixed costs. The overall QIPP risk as reported in the capped expenditure process was £2.7m. TP reported that there was a working paper detailing QIPP, capped expenditure and alignment with other CCGs noting that the risk reported was in line with the expenditure gap.

Discussion ensued in the context of the CCG's forecast to not exceed the maximum cash drawdown of £455,999 and the York Teaching Hospital NHS Foundation Trust cash position. TP described their position in terms of national support for Scarborough Hospital and noted that as an organisation they were now at a £9m deficit operationally. She emphasised their reliance on the £12m Sustainability and Transformation Fund.

In respect of the forecast outturn with York Teaching Hospital NHS Foundation Trust - £185,250m budget and £183,232m actual – TP explained that this related to the capped expenditure to close the control total but that authority had not yet been provided to progress the planned care proposals. JH emphasised that for the longer term the only solution was to take cost out of the system.

TP referred to the tabled amended appendix 1 finance dashboard which included both the in year and cumulative positions for clarity and alignment of reporting to NHS England and the Committee. Future reports would continue this approach.

Detailed discussion ensued on a number of areas of concern. Activity transferred from York Teaching Hospital NHS Foundation Trust to Ramsay and Nuffield Hospitals was cash being taken out of the system. It related to the 18 week referral to treatment performance target, and in particular the BMI and smoking thresholds. This would continue unless NHS England and NHS Improvement permitted an extension to this timescale. JH explained that there were two elements to this: York Teaching Hospital NHS Foundation Trust was using the spare capacity from the transfer of activity and the fact that the activity should be sub contracted, not transferred, to Ramsay and Nuffield Hospitals. In response to members noting that 18 week referral to treatment was a CCG Constitutional requirement JH explained that the contract value was the mechanism by which this should currently be addressed and discussion should take place at the Executive Programme Board. He also noted that the clause in the Heads of Terms to trigger escalation to NHS England and NHS Improvement would be invoked if an agreement could not be reached.

*Post meeting note: York Teaching Hospital NHS Foundation Trust was also required to deliver Constitutional targets through its authorisation conditions as a Foundation Trust by NHS Improvement.*

In response to DB enquiring about the current position in comparison with the forecast position, TP advised that she had relative confidence in the reported year to date position. As discussed the position across acute providers was broadly in line with plan and the biggest risks were continuing healthcare and slippage on QIPP. TP highlighted concern at the pace of implementation of the capped expenditure proposals once approved. PM expressed concern at the year to date position and the impact of the forthcoming summer holiday period in terms of work to address this.

Detailed discussion ensued to inform consideration of triggering the Heads of Terms escalation clause. JH explained ongoing work with York Teaching Hospital NHS Foundation Trust and primary care to deliver QIPP and close the gap. The former was detailed under headings of planned care, unplanned care, overall and independent sector. JH noted a number of areas where progress had been achieved in planned care, including and transfer of anticoagulation to the community from September 2017 and agreement to accelerate system wide demand management through 100% electronic referrals, robust triage and review of procedures not routinely commissioned. JH also advised that the terms of reference for the specialty reviews were being revised to drive cost out of the system more quickly and a draft project plan was being presented at the Executive Programme Board.

JH noted that the unplanned care work had been overtaken by the whole system programme but a number of areas of progress had also been achieved here. There was sign up to a joint plan but not a joint contract value. Detailed discussion ensued on the need to urgently develop a proposal for alternate contracting mechanisms to replace payment by results. If agreement could not be reached on such a system change the Head of Terms escalation clause would be triggered.

PM highlighted that any changes agreed could not be implemented quickly enough to affect quarters 1 and 2. He proposed that, in discussion with NHS Scarborough and Ryedale CCG and NHS England, a joint commissioning position and a plan for a system approach be developed for discussion at the Programme Board on 26 June. If agreement could not be reached then the escalation clause should be triggered. PM noted concern in this event in the context of the planned joint engagement events, the need for a system approach to manage demand and potential impact on 2018/19.

JS supported the approach described and noted the joint approach through the capped expenditure process of NHS England and NHS Improvement. In the event of escalation they would provide a joint response.

KR additionally reported on meetings with the chairs of York Teaching Hospital NHS Foundation Trust and NHS Scarborough and Ryedale CCG. Further meetings were planned for July.

### **The Committee:**

1. Received the financial performance report.
2. Requested that a joint commissioning position between NHS Vale of York and NHS Scarborough and Ryedale CCG, in discussion with NHS England, be developed for discussion at the Programme Board on 26 June 2017.

### **7. Capped Expenditure Process (System Financial Envelope)**

TP introduced an outline of the process and timeline that had been proposed by the regulators; this included reference to the schemes being explored in an attempt to reduce costs. These included an initial £13.7m control total requirement and a further gap of £14.4m

TP highlighted in 2017/18 a commitment across the system to explore and develop alternative contracting models to increase certainty of expenditure. This included reviewing various models that had the potential to replace payment by results and seeking evidence where different approaches had been implemented. The information would be reported to the Executive Programme Board.

CA explained the modelling exercise that had been developed and used to assess the potential impact of the capped expenditure proposals. Members discussed the assumptions and impact assessment of the potential approaches for capped expenditure to manage referral to treatment backlog and incomplete position performance. MC highlighted that there may also be unintended consequences, such as impact on primary care, and JH added that the modelling assumed demand would remain at the same level. PM advised that feedback on the proposals was awaited from NHS England and NHS Improvement and noted the potential for conditional acceptance with the requirement for further work to address the gap. The Programme Board, comprising NHS Vale of York and NHS Scarborough and Ryedale CCGs and York Teaching Hospital NHS Foundation Trust, would implement and monitor plans, including public engagement.

SOC expressed concern about potential impact on primary care as a result of the proposed measures and highlighted, from the commissioning perspective, the need to ensure sustainable and resilient General Practice. PM emphasised the need for General Practice, in their role as commissioners, to be involved in progressing this work but with recognition of conflict of interest as they were also providers. He also noted potential for consideration of strengthening the Programme Board to include GPs and other partners.

PM proposed that, once feedback had been received from the regulators, the Executive Committee should develop a plan for consideration by the Governing Body. If this was approved the Executive Committee, on behalf of the Finance and Performance Committee, would progress implementation providing progress reports and, if required, escalating concerns. PM also proposed that the Committee ask him to seek advice from the Chair of the Council of Representatives about engaging with GPs as commissioners outside of the Council of Representatives.

#### **The Committee:**

1. Received an outline of the capped expenditure process and related submission.
2. Requested that, following receipt of feedback from the regulators, the Executive Committee present a plan for the capped expenditure proposals to the Governing Body.
3. Requested, on assumption of Governing Body approval, that the Executive Committee, on behalf of the Finance and Performance Committee, implement the plan providing regular updates and escalating concerns if appropriate.
4. Requested that PM seek advice from the Chair of the Council of Representatives about engaging with GPs as commissioners outside of the Council of Representatives.

#### **8. CCG Grant Funding of Voluntary Sector Activities in the City of York**

In presenting this report EW referred to discussion at previous meetings and the review of services directly commissioned from the voluntary sector during quarter 1. This review of the nine grants at a total value of £188,375.79 had taken place through and with York Council for Voluntary Service. EW noted that, in addition to removal of the previous protection for these arrangements, a 25% reduction in funding was applied as a contribution to the CCG's financial recovery strategy which resulted in the requirement for a saving of £47,100 from this grant funding.

EW reported that, following discussion with the providers, a proposal had been received suggesting reductions in investment to a number of schemes. This proposal had been approved by the Executive Committee at its meeting on 21 June.

EW noted that, as part of this collaborative approach, the sector had suggested the formation of a voluntary sector 'prevention partnership' for going forward. She commended the responsiveness demonstrated by the voluntary sector which was a sound footing for building sustainability and transformation highlighting this as a new approach for working with partners.

### **The Committee:**

1. Ratified implementation of the QIPP project for CCG grant funding of voluntary sector activities in the City of York.
2. Welcomed and commended the partnership working.

### **9. Better Care Fund**

EW reported on the position with the CCG's three Better Care Funds.

East Riding of Yorkshire Council Better Care Fund arrangements for 2017/18 had been signed.

Discussions with City of York Council were being finalised in relation to the financial investment. Principles had been agreed based on the 2016/17 fund, risk share, inflation and new investment available as a consequence of the national monies allocated through the improved Better Care Fund. The narrative was being developed against draft key lines of enquiry and in the absence of national guidance.

North Yorkshire County Council, the fund manager for that Better Care Fund, had proposed a workshop with the four CCGs as the current investment proposals, which included new ways of working and transformation, exceeded the money available. EW reported that North Yorkshire County Council had categorised the proposals against the Improved Better Care Fund criteria: the care market, managing delayed transfers of care and relieving pressure on the NHS. In response to EW noting they were not adopting a CCG population basis approach, discussion ensued in light of the fact that NHS Vale of York CCG was 25% of the North Yorkshire County Council population and the need to ensure value for money for the CCG's population.

EW highlighted that the Care Quality Commission would be undertaking specific assurance visits in a number of localities and, in view of the previous issues with City of York Council and North Yorkshire County Council Better Care Funds, visits were likely.

KR requested a report to the November or January Governing Body on Better Care Fund outcomes, achievements and impact.

MA-M commended EW's achievements in respect of the Better Care Fund process noting that the focus would now be on delivery and implementation.

### **The Committee:**

1. Noted the Better Care Fund update.
2. Commended EW and the team involved in the Better Care Fund process/
3. Requested a report on the Better Care Fund to the November or January Governing Body.

### **10. Contract Report**

LS presented the report which comprised four sections: the 2016/17 outturn contract trading position, 2017/18 month 1 contract trading position, other contracting issues and

risks, and early assessment of fast track activity and referrals at York Teaching Hospital NHS Foundation Trust.

#### *2016/17 outturn position*

LS reported that £700k of challenges with York Teaching Hospital NHS Foundation Trust remained outstanding. She noted the expectation that, following receipt of their response to these, c£270k would be resolved but negotiation would be required by TP for c£0.5m. TP referred to the historic position of challenges noting prioritisation focused on areas of materiality. She also noted discussion about an amnesty on coding and counting in relation to capped expenditure but this could not be implemented whilst payment by results remained in place. JS added that there were other potential ways to challenge contracts, including via the information in the recent Utilisation Management report.

#### *2017/18 position*

LS noted a number of caveats relating to the 2017/18 position that meant there was not the usual level of confidence, and also referred to the fact that the under trade against the plan with York Teaching Hospital NHS Foundation Trust was based on the contract value of £194m, not the £185m in the CCG's financial plan and the target baseline as set out in the Heads of Terms agreement. TP sought clarification regarding the latter as the month 2 financial position reported an under trade against the £185m.

LS explained that contract challenges related to rehabilitation bed days which were not in the contract baseline plan and suspected Assessment Unit activity was being recorded and charged as non elective admissions. In respect of the latter LS reported on discussions about potential local price negotiations with York Teaching Hospital NHS Foundation Trust but advised that, as their calculations had been similar to the average national tariff, they considered it appropriate to continue to charge the national rate. LS noted that the Utilisation Management report suggested assessment unit activities should be taken off tariff and she was going to contact other CCG's about other potential options and models. EW additionally noted that incorrect coding of non elective admissions had a wider impact in terms of Better Care Fund performance. KR noted concern that all risk lay with commissioners.

#### *Other contracting issues and risks*

LS referred to the musculo skeletal (MSK) contract with York Teaching Hospital NHS Foundation Trust and reported that they were requesting additional resource to maintain the level of service as the current contract value did not meet the cost of delivering the service. The Trust would also require a further £250k to implement Shared Decision Making. LS noted that a pilot for 100 patients was taking place during July to assess effectiveness of shared decision making to determine whether further investment into the contract would return the savings required in planned trauma and orthopaedic admissions, and also highlighted risk in view of there being no current signed contract for the service. TP reported that these issues had been discussed at the last Contract Management Board and that she was continuing discussion with York Teaching Hospital NHS Foundation Trust Director of Finance. TP emphasised that the focus must be on the new service model and QIPP delivery.



In respect of the Tees, Esk and Wear Valleys NHS Foundation Trust Core 24 Liaison model, EW highlighted the need for strategic discussion for recruitment to the new posts following the success of this partnership bid.

In response to JH referring to the Yorkshire Doctors Urgent Care contract, which would expire on 31 March 2018 but was a three year plus two year contract, SOC expressed the view that any extension should be on the basis of one plus one. There should also be contract variation to account for the requirement to introduce extended primary care access and establish 8am to 8pm opening hours. In response to SOC noting that work was required in this regard JH advised that this would be progressed within the Unplanned Care Programme.

PM referred to the previous discussion about potentially triggering the Heads of Terms escalation process and the issues raised in the contracting report which continued unresolved despite the best efforts of the Contracting Team. He proposed that JH and TP seek potential alternatives to the contract management board for engagement, noting that NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs were also part of that forum, and that this be included in discussion at the Programme Board on 26 June. PM emphasised the need for clinicians to be part of the arrangements and also noted that discussion was required at the Accountable Care System Partnership Board in the context of the changing landscape.

#### **The Committee:**

1. Received the contract trading report.
2. Requested that JH and TP seek alternatives to contract management board.

*PM left the meeting*

#### **12. Primary Care Rebate Schemes Policy – New Rebates**

TP referred to a new available drug rebates from which the CCG stood to benefit presented in accordance with the Primary Care Rebate Schemes Policy.

Following discussion regarding this regular agenda item, it was agreed that the current governance arrangements should be maintained.

#### **The Committee:**

Agreed the rebate 017.

#### **11. Integrated Performance Report Month 2**

CA presented the report which presented a triangulated overview of CCG performance across all NHS Constitutional targets for 2016/17 and by each of the 2017/18 programmes incorporating QIPP, contracting and performance information.

CA referred to the performance headlines noting: improvements in both A and E four hour waiting times and generally in emergency performance, although with some daily variations remaining; no A and E 12 hour trolley waits; and, with the exception of

dementia for which diagnosis rates had increased, mental health performance data was currently being validated and an update would be provided to the Committee when this was available.

Areas of deterioration related to referral to treatment 18 week backlog and the admitted pathway; cancer 62, 14 and 31 days performance, and diagnostics. CA noted the mitigation described and highlighted areas for discussion as referral to treatment and elective care demand management within the system financial envelope and feedback from the A and E Delivery Board. In respect of the latter, which had met the previous week, CA reported that the work plan was being reviewed in terms of performance and transformation and in response to a request from regional NHS England and NHS Improvement leads for a refresh of all A&E Delivery Board plans going forward, as well as effectiveness of leadership.

In response to clarification sought by members about cancer performance, CA explained that inter provider transfers was one of the biggest issues. She noted the increased national focus on 62 day performance for managing complex cancer pathways and management of patients with 'vague symptoms', and advised that York Teaching Hospital NHS Foundation Trust had provided a draft report on high impact actions; a similar report was awaited from Hull and East Yorkshire Hospitals NHS Trust. CA highlighted that there were less than 10 breaches a month at the former but further resilience was required. She also remarked that the system Planned Care Steering Group had received the plans but there were a number of issues locally, including diagnostics capacity, workforce capacity and patients cancelling appointments for the 14 days urgent breast referrals.

Discussion ensued on inclusion of dashboards for primary care and further development of the dashboard for mental health and learning disabilities in relation to continuing healthcare performance information. In respect of the former, MC referred to discussion at the Primary Care Commissioning Committee and also noted that the CCG did not currently have information on GP operational activity, such as activity and demand data. A draft primary care dashboard was being developed and would be shared with the Committee when ready for review.

In respect of continuing healthcare patients MC highlighted that some performance indicators were now included; more narrative would be incorporated within the next report to the Committee. She noted that there was a new national indicator for not more than 15% of Decision Support Tools to be done in hospital and that this target was being met. MC advised that she had proposed investment for two additional nurses to address the current c1000 backlog of patients and to move to a sustainable position. JH proposed that a summary of the continuing healthcare position be circulated to members for information. *Post meeting note: The information was circulated on 28 June.*

Members expressed appreciation to the team who had developed the report noting that it provided assurance on programmes and priorities across all aspects of work. This included contracting, finance and quality.

In response to DB seeking assurance about discussion of the information, CA confirmed that the report provided triangulation based on the CCG programmes

monitoring a wide variety of performance information, assessing any early warnings of performance deterioration and that there were currently no areas for escalation. She also noted that initial discussions were taking place with NHS England about phase 2 additional QIPP support via the national QIPP support programme and the CCG would receive feedback from NHS England on 26 June in relation to the 'offer' of additional capacity.

**The Committee:**

1. Received the month 2 Integrated Performance Report.
2. Requested that MC circulate a summary of the continuing healthcare position.

**13. Key Messages to the Governing Body**

The Committee expressed concern about the CCG's financial position, exacerbated by the capped expenditure programme, and authorised the Accountable Officer to discuss with the regulators invocation of the Heads of Terms escalation clause with York Teaching Hospital NHS Foundation Trust.

**The Committee:**

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

**14. Next Meeting**

9am to 2pm, 27 July 2017

**NHS VALE OF YORK CLINICAL COMMISSIONING GROUP FINANCE AND PERFORMANCE COMMITTEE**

**SCHEDULE OF MATTERS ARISING/DECISIONS TAKEN ON 22 JUNE 2017 AND CARRIED FORWARD FROM THE PREVIOUS MEETING**

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
F&P16	23 March 2017	A and E	<ul style="list-style-type: none"> <li>Information on A and E performance levels throughout the year to be sought</li> </ul>	JS	Ongoing
F&P21	25 May 2017	Risk Report	<ul style="list-style-type: none"> <li>Single page describing major risks to be incorporated</li> </ul>	RP	22 June 2017 and ongoing
F&P25	22 June 2017	Risk Report	<ul style="list-style-type: none"> <li>GPs to be provided with information about IAPT waiting times.</li> </ul>	EW	
F&P26	22 June 2017	Financial Performance Report	<ul style="list-style-type: none"> <li>Joint commissioning position between NHS Vale of York and NHS Scarborough and Ryedale CCGs, in discussion with NHS England, be developed for discussion at the Programme Board on 26 June</li> </ul>	JH/TP	26 June 2017
F&P27	22 June 2017	Capped Expenditure Process	<ul style="list-style-type: none"> <li>PM to seek advice from the Chair of the Council of Representatives about engaging with GPs as commissioners outside of the Council of Representatives</li> </ul>	PM	

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
F&P28	22 June 2017	Better Care Fund Update	<ul style="list-style-type: none"> <li>Report to November or January Governing Body on Better Care Fund outcomes, achievements and impact</li> </ul>	EW	2 November 2017 or 4 January 2018
F&P29	22 June 2017	Contract Report	<ul style="list-style-type: none"> <li>JH and TP seek alternatives to contract management board</li> </ul>	JH/TP	

This page is intentionally blank

**Minutes of the Finance and Performance Committee Meeting held on  
27 July 2017 at West Offices, York**

**Present**

David Booker (DB) – Chair	Lay Member
Caroline Alexander (CA)	Assistant Director of Delivery and Performance
Fiona Bell (FB)	Assistant Director of Transformation and Delivery
Phil Mettam (PM)	Accountable Officer
Dr Shaun O’Connell (SOC)	Joint Medical Director
Dr Andrew Phillips (AP)	Joint Medical Director
Tracey Preece (TP)	Chief Finance Officer

**In attendance**

Jim Hayburn (JH) - part	Strategic Programme Consultant
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Keith Ramsay (KR)	CCG Chairman
Michele Saidman (MS)	Executive Assistant
Liza Smithson (LS)	Head of Contracting
Jon Swift (JS)	Director of Finance, NHS England North (Yorkshire and the Humber)
Elaine Wyllie (EW)	Strategic Programme Consultant

**Apologies**

Michael Ash-McMahon (MA-M)	Deputy Chief Finance Officer
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Rachel Potts (RP)	Executive Director of Planning and Governance
Zena Robertson (ZR)	Deputy Director of Nursing, NHS England (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.

**3. Minutes of the meeting held on 22 June 2017**

The minutes of the previous meeting were agreed.

**The Committee:**

Approved the minutes of the meeting held on 22 June 2017.

#### **4. Matters Arising**

*F&P16 A and E performance information:* This was part of ongoing performance reporting within the meeting papers.

*F&P21 Risk Report – Single page describing major risks:* The new format Risk Report was presented at agenda item 5.

*F&P26 Financial Performance Report – Joint commissioning position between NHS Vale of York and NHS Scarborough and Ryedale CCGs:* CA reported that the CCGs' QIPP programmes (both Vale of York and Scarborough and Ryedale CCGs) and York Teaching Hospital NHS Foundation Trust's Cost Improvement Programme (CIP) had been provided for the Executive Programme Board on 26 June but detailed discussion had not taken place due to time constraints. The next meeting of the Programme Board had been extended to enable this discussion. JH emphasised the requirement to align QIPP schemes and the Cost Improvement Programme and for there to be clarity of the savings to be delivered.

*PM and EW joined the meeting*

*F&P27 Capped Expenditure Process – Engagement with GPs:* PM reported on discussions with the seven GPs on the Accountable Care System Partnership Board regarding the Capped Expenditure Process submission and subsequent requirement for cost reduction. He had followed this up with discussion on a GP federation basis to establish their positions for the associated work requirements. PM advised that the GPs had expressed concern about consequences of the proposed measures in respect of progress with out of hospital care and, from a provider perspective, increase in demand and potential destabilisation. They had emphasised that their professional responsibility should in no way be compromised.

*F&P25 Risk Report – GPs to be provided with information about Improving Access to Psychological Therapies:* EW reported that information had been circulated about the service provision. She additionally noted that further communication to GPs was required regarding all mental health indicators.

*F&P29 Contract Report – Alternatives to payment by results to be sought:* TP reported on discussion with finance colleagues, including JS, across the Sustainability and Transformation Plan footprint. The potential for NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs to take on specific lead areas was being considered. JH reported that discussion had also taken place at the Executive Programme Board. It had been agreed that the CCGs would develop an alternative offer for consideration by York Teaching Hospital NHS Foundation Trust. However, under the current contract there was no alternative to continuing to monitor closely under payment by results.

#### **The Committee:**

Noted the updates.



## “Good News”

SOC reported:

- The first Prescribing Indicative Budget contract had been signed with CAVA (City and Vale GP Alliance) who would work to reduce prescribing costs on the basis of shared savings. Dr Stuart Calder, Deputy Chair of the Council of Representatives and Lecturer in Medical Ethics at the University of Leeds, had undertaken an ethical analysis of the Prescribing Indicative Budget project that supported the CCG’s development of this scheme.
- The CCG had been successful in its application to NHS England for funding for seven full time clinical pharmacists to support 12 local Practices with GP workload pressure. Priory Medical Group had agreed to be the clinical pharmacists’ main employer initially.

KR reported that he and SP had written to the NHS England Director of Commissioning Operations (Yorkshire and the Humber) following concerns expressed by the Governing Body at the July meeting. A response to this letter was received during the Committee meeting.

CA reported that York Teaching Hospital NHS Foundation Trust was receiving £131k funding to support the 62 day cancer pathway as part of the Cancer Alliance 62 day recovery plan. Impact was expected from September 2017.

PM reported on the patient engagement events and noted that themes were emerging: waiting times for a GP appointment; time spent in hospital waiting for tests or results; concerns about mental health services; and the need for clarity of the system in terms of availability of and access to alternatives to GP services to enable appropriate choice.

PM also reported on attendance at York Teaching Hospital NHS Foundation Trust’s Board meeting on 26 July. He requested regular attendance by a member of the management team.

AP reported on the Clinical Summit on 19 July which had been attended by about 150 clinicians. The Summit’s aims were building trust through collaboration and for there to be one clinical voice across the CCG, York Teaching Hospital NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust. Speakers had included Jim Mackie, Chief Executive of NHS Improvement who spoke on the high achievement of the NHS in terms of performance benchmarked against other western economies despite a low comparative spend of GDP, and Dr David Black, NHS England Medical Director, who spoke about the need for any service change to have consultation and involvement of the local community. Seven workshops had covered a wide variety of topics including individual and workforce resilience, clinical handover and transition, cardiovascular disease service redesign, medically unexplained symptoms linked to mental health interventions, system financial challenges and York Care Collaborative. AP noted the intention of arranging a Clinical Summit in 2018 at a different time of the year.

Prior to discussion of agenda items DB highlighted the challenge in the overall financial position and the need for clarification in respect of budgetary reporting; the Heads of Terms for joint working with York Teaching Hospital NHS Foundation Trust; the CCG's letters to the NHS England Director of Commissioning Operations (Yorkshire and the Humber) and the York Teaching Hospital NHS Foundation Trust Chief Executive; the risk of affordability of the CCG's contract with York Teaching Hospital NHS Foundation Trust; and the challenge of the QIPP target. DB also commended the clarity of the meeting papers.

## **5. Risk Update Report**

CA reported that the CCG's 2017/18 Quarter One Improvement and Assessment Framework checkpoint meeting with NHS England was taking place on 27 July. She presented an extract of the 2016/17 analysis which would be part of the discussion at that meeting. This also described the current performance, recovery trajectory, programme and lead, and mitigations and next steps for the five clinical areas where the CCG had been rated as 'requiring further improvement', which were all within the Better Care domain: 18 week referral to treatment, cancer 62 day target, Improving Access to Psychological Therapies recovery, dementia diagnosis rates, and A and E) CA noted that these areas were all within the Risk Report as corporate risks and were reported on monthly as part of the integrated performance report to Finance and Performance Committee.

CA explained the aspiration for risk to be incorporated in the Integrated Performance Report instead of as a separate agenda item. She also advised that, as requested by the Governing Body at the July meeting, the Risk Report to the September Governing Body meeting would provide a full review of programme level risk.

The Risk Report comprised finance and performance corporate events, an update on the finance and performance corporate risk register, a summary of programme, risks arising from NHS England's latest Improvement and Assurance Report, and risks arising from the latest NHS England Integrated Operational Report.

CA highlighted the five corporate events as previously reported - 18 week referral to treatment, cancer 62 day target, Improving Access to Psychological Therapies recovery, dementia diagnosis rates, and A and E – and three risks relating to managing Partnership Commissioning Unit areas of spend. There were 14 'amber' rated risks. CA also noted that areas of reduced risk were included which demonstrated progress achieved.

CA referred to five new risks added to the Complex and Continuing Healthcare Programme Risk Register confirming that action plans were being developed. She noted that the Executive Director of Transformation and Delivery was now in post and work had commenced to further scope and mobilise this programme of continuing healthcare review

PM referred to the analysis of the 2016/17 Improvement and Assessment Framework indicators and proposed that the Committee request a detailed recovery plan, developed by clinicians and management, in respect of 18 week referral to treatment, the cancer 62 day target, Improving Access to Psychological Therapies and dementia diagnosis rates. CA agreed to lead this work and report back to the September meeting at the latest.

Members discussed in detail the CCG's assessment in the Well-led Domain of the Improvement and Assessment Framework for which three areas were outliers and two – working relationship effectiveness and quality of leadership – were in the worst quartile in England. CA explained that the results of the 360 degree stakeholder survey, comprising around 50 different questions, were incorporated in this assessment, noting that, although the scoring was low, there had been a number of supportive statements. CA also referred to recognition by NHS England of progress in their letter following the 2016/17 Annual Review Meeting and advised that an action plan was included in the CCG's Organisational Development Plan. JH additionally noted that, due to the timing of the annual survey, current engagement work was not reflected. It was agreed that clarification be sought from NHS England at the meeting on 28 July to inform further work and also address reputational implications, particularly in the context of the CCG being the leader in the system transformation.

Discussion ensued on potential risk relating to Public Health prevention services in the context of reduced funding to Local Authorities. This was highlighted in respect of concerns about services for improvement both for prevention and self-care. JH explained the intention of incorporating these aspects in the approach to all programmes of work. Areas identified that could be picked up as workshops for discussion by attendees at future Clinical Summits would also be incorporated.

PM referred to the potential that the cost reduction and turnaround programme may not be sufficient to achieve progress from 'Inadequate' to at least 'Needs Improvement' for 2017/18. He emphasised that the CCG would continue to lead the system transformation and noted that discussion with NHS England on 28 July would include achieving a balance between this work and the Improvement and Assessment Framework requirements around performance improvement. JH added that any CCG that had undergone a capacity and capability review was assessed as 'Inadequate' regardless of subsequent improvement, emphasising that the assessment did not reflect the current leadership team.

### **The Committee:**

1. Received the Risk Update Report.
2. Noted the intention of incorporating risk reporting within the Integrated Performance Report.
3. Requested recovery plans at the August or September meeting for 18 week referral to treatment, cancer 62 day target, Improving Access to Psychological Therapies and dementia diagnosis rates.

### **6. Financial Performance Report Month 3**

In presenting this report TP advised that it provided an in depth review of quarter one and detailed information pertaining to key delivery challenges, as requested by NHS England. She explained that the Capped Expenditure Process control total was now reflected both in the plan against which the CCG was now reporting and in the ledger, noting that the plan was not yet formally approved. TP also provided clarification in respect of this plan, the previously submitted plan that did not include capped expenditure, and the Medium Term Financial Strategy.

TP explained that the Capped Expenditure Process plan included release of the 0.5% Commissioning for Quality and Innovation reserve withheld from York Teaching Hospital NHS Foundation Trust due to non achievement of the Sustainability and Transformation Fund in 2016/17 to improve the control total gap. TP tabled a letter from the NHS England Chief Finance Officer dated 26 July requesting that CCGs hold this 0.5% uncommitted. Following discussion with JS, She proposed to show that the CCG had used this resource to close the Capped Expenditure Process gap rather than amend the plan. This would mean that the CCG's plan did not comply with the letter. TP was working with JS in respect of a return that was required by 8 August.

TP explained that the CCG's deficit plan was for an in year deterioration of £6.35m under the Capped Expenditure Process. The quarter one deterioration was planned at £1.32m but the actual position at the present time was £267k better than this. TP noted that the Capped Expenditure Process savings were profiled with effect from August and many QIPP schemes would not take effect until later in the year. She highlighted that the forecast was for achievement of the control total but expressed concern about deliverability and the fact that a system plan had not yet been agreed.

TP provided clarification of the quarter one position in respect of an undertrade with York Teaching Hospital NHS Foundation Trust, reduced referrals and an apparent underspend in prescribing. She also noted that continuing healthcare was not achieving the QIPP saving but this budget was not significantly overspent. Overall, early information indicated performance was in the main aligned with the Medium Term Financial Strategy.

JH reported that York Teaching Hospital NHS Foundation Trust Director of Finance had advised that a revised plan had been submitted to NHS Improvement that aligned their financial plan with the orthopaedic QIPP programme. He noted discussion would take place at the Programme Board on 15 August in respect of working within the allocation spend. JH highlighted that, although there had been some progress, a joint contract value had not yet been established. TP additionally noted that the York Teaching Hospital NHS Foundation Trust control total may not yet have been formally signed off.

PM referred to his attendance at York Teaching Hospital NHS Foundation Trust Board meeting and reported that discussion had included their continuing aspiration to achieve £3m surplus, workforce pressures, a freeze on non clinical posts and focus on their Cost Improvement Programme. He expressed concern about potential consequences on joint working noting that he had written to the Chief Executive confirming the CCG's commitment to work with all partners to bring the whole health economy back into financial balance and offering a number of opportunities for support from commissioners. PM noted that York Teaching Hospital NHS Foundation Trust Board was holding a private meeting in August to fully assess their position.

TP highlighted that the CCG was expediting 80 days additional support from North East Commissioning Support as part of the national QIPP support programme to address remaining resource gaps within the programme work stream structures, with particular reference to continuing healthcare, RightCare and the Programme Management Office. Additional support was also being received from the national QIPP initiative to help address risk to delivery of the QIPP programme to time and achieving the planned savings. TP noted the need to identify further support required in other areas and ensure that either this was sourced or that some of the 80 days was prioritised for critical areas.

TP reported that NHS England had confirmed all CCGs should profile cash payments to providers in twelfths in line with the NHS Standard Contract. She advised that payments could be profiled to reflect QIPP plans.

TP noted that risk of non delivery of capped expenditure schemes was reported for the first time. This related to two main demand management schemes with the expected value of £7.12m. Other principal activity based risks related to acute activity, continuing healthcare, prescribing and community equipment. Discussion ensued in respect of the latter in terms of the procurement due diligence process with particular reference to the information from the former service provider, Harrogate and District NHS Foundation Trust. Whilst recognising the CCG did not have any means of formal recourse, members expressed the view that moral pressure should be brought to bear.

TP highlighted the detailed QIPP information noting that areas of risk were as previously reported. In respect of capacity for the work JH referred to the previous discussion with North East Commissioning Support and noted that particular skills were needed to support the Programme Management Office, the continuing healthcare backlog reviews and the challenges to York Teaching Hospital NHS Foundation Trust.

SP, as Audit Committee Chair, expressed concern from the governance perspective of lack of clarity about which budget was being reported against, deliverability of the Capped Expenditure Process plans and the CCG's accountability. She also referred to her previous concerns relating to stranded fixed costs in the Capped Expenditure Process plans for services decommissioned by York Teaching Hospital NHS Foundation Trust. TP explained that this was a planning assumption which was not yet confirmed and could neither be implemented under payment by results nor until the services were operational.

JS explained that the Capped Expenditure Process plan was the control total. The plan submitted by the CCG was now part of the NHS England aggregated plan and he did not expect there to be formal sign off. This plan should now be subject to the CCG's governance process for approval. TP therefore advised that Governing Body approval would be sought at the September meeting.

#### **The Committee:**

1. Received the Financial Performance Report.
2. Expressed continuing concern about the finalised budget to which the CCG was working.
3. Noted that approval of the revised Financial Plan, including Capped Expenditure Process plans, would be sought at the September Governing Body meeting.

#### **7. Capped Expenditure Process**

PM referred to the earlier discussion and the letter from KR and SP to NHS England.

In respect of triggering the Heads of Terms escalation clause to NHS England and NHS Improvement, PM advised that this had not as such taken place but referred to the discussion at the Executive Programme Board for commissioners to propose an alternative to payment by results within seven to 10 days. If York Teaching Hospital NHS Foundation Trust accepted the offer its implementation should be accelerated, otherwise urgent consideration would be required due to their cash position.

With regard to the regulators, PM reported that the NHS England Regional Director (North) was arranging a meeting in the third week of August to review progress. Arrangements required clarification due to PM and TP being on annual leave at that time.

TP detailed discussions between York Teaching Hospital NHS Foundation Trust's three main commissioners – NHS Vale of York, NHS Scarborough and Ryedale and NHS East Riding of Yorkshire CCGs – regarding potential alternatives to payment by results. She was writing up an evidence based proposal for an incentive framework to change contracting behaviours and work within the system control total.

PM emphasised that the CCG was leading system change for the benefit of patients and the population, noting this priority alongside the Committee's focus on financial turnaround. SOC additionally noted the need for increased investment in prevention in the context of cuts to Local Authority budgets.

### **The Committee:**

Noted the update and commended the development of a proposed alternative to payment by results for presentation to York Teaching Hospital NHS Foundation Trust as a matter of urgency and in the context of the wider system issue.

## **8. Better Care Fund**

EW reported that the final technical guidance, milestones and timetable had been received but not the key lines of enquiry by which the Better Care Fund would be assessed.

In respect of the City of York Council footprint EW advised that there was agreement on the vast majority of the £15.3m Better Care Fund with a resolution expected imminently on the one outstanding line of investment, the Fulford beds. She explained that the Better Care Fund had been developed on a number of assumptions: continued investment, added inflation and added effect of risk share. This left approximately £1m of the £2.8m City of York Council Improved Better Care Fund available to spend on new schemes within which former System Resilience Group schemes had been absorbed.

Investment of the £9.6m North Yorkshire County Council Better Care Fund was being considered through the A and E Delivery Boards. This was more complex due to the number of CCGs across the Health and Wellbeing Board footprint.

EW referred to the metric for delayed transfers of care, a national condition of the Better Care Fund, and detailed concerns about associated impact. The NHS focus was on delivery of 3.5% reduction by September 2017 but Local Authorities did not think this was achievable. EW advised that discussion was ongoing to agree a partnership improvement trajectory for delayed transfers of care with the aim of achieving 3.5% by the end of the year, based on analysis of evidence from the last nine months. She confirmed that there was no additional risk to the CCG's financial position and noted some additional capacity for the Better Care Fund work.

EW explained that causes of delayed transfer of care were being reviewed in terms of nine criteria, each of which had been analysed across the last 12 months. EW noted that c100 delayed transfers of care per month were due to patient choice and highlighted the need for culture change and escalation of discharge processes.

Shortage of nursing home places was also a concern. EW advised that action plans needed to be developed for a number of the nine criteria; others required consideration within the Complex Care Bed Review. She confirmed that mental health delays were incorporated in the calculations for delays.

Discussion included recognition of the need for governance arrangements and the requirement for partnership working. EW noted that the Improved Better Care Fund investment was at the discretion of Local Authorities.

EW reported that the Care Quality Commission would be reviewing City of York Council in respect of system and partnership working, including Better Care Fund criteria and investment, with a visit scheduled for 30 October. EW noted the potential for the Care Quality Commission to remove funding if it was not being spent appropriately.

PM commended EW's work to reach the current position with the Better Care Fund.

#### **The Committee:**

1. Noted the Better Care Fund update.
2. Commended EW and colleagues for their work in relation to the Better Care Fund.

#### **9. Contract Trading Report**

Earlier discussion had included many aspects of the Contract Trading Report. LS additionally highlighted continuing risk, particularly in respect of coding of assessment unit activity. In response to DB commending the detailed information but seeking clarification about the level of challenge, LS explained that much of this related to counting and coding issues. She also noted that the CCG had requested York Teaching Hospital NHS Foundation Trust identify this activity separately to enable recognition of trends and impact of associated QIPP.

JS added that counting and coding issues were a consequence of a transaction based system. Contract challenges should be continued until a different contract was in place. JH noted the requirement for addressing any existing challenges to be included in any new proposed contract arrangements.

SP commended the report and requested that information be added in respect of impact against the CCG's £185m contract as well as the York Teaching Hospital NHS Foundation Trust £194m contract. She also referred to the Utilisation Management Review and asked whether a similar approach could be adopted for an independent review in to both organisations. In this regard TP referred to the earlier discussion on development of a proposed alternative to payment by results which included review and direct support by an independent clinician.

In providing an update on mental health services outside the Tees, Esk and Wear Valleys NHS Foundation Trust contract, EW reported:

- Tees, Esk and Wear Valleys NHS Foundation Trust did not wish to take on adult autism but wanted to focus on other areas. She would also report this to the other North Yorkshire CCGs.
- The CCG intended to continue with the Chronic Fatigue Service as currently commissioned.
- Individual Funding Requests from 2016/17 had been reviewed. The largest group totalled £5k which indicated it was not appropriate to bring this function in to the core contract.

EW advised that opportunities outside the mental health services contract had been explored and progressed appropriately. She noted that the Partnership Commissioning Unit finance and contracting resource continued to be a concern.

#### **The Committee:**

1. Received the contract trading report.
2. Noted the update on mental health services outside the Tees, Esk and Wear Valleys NHS Foundation Trust contract.

#### **10. Integrated Performance Report Month 3**

JH referred to QIPP performance noting that work was taking place to ensure alignment of finance and QIPP reporting. He highlighted focus on the musculoskeletal service and orthopaedics to manage demand in planned care noting that costs were increasing although referrals were going down. With regard to unplanned care JH cited examples to illustrate that, although work was progressing, there were delays in achieving partnership working across the system.

JS noted previous success in Medicines Management and prescribing QIPP schemes and advised that there was potential national support in this regard. There was also an opportunity to learn from NHS Greater Huddersfield CCG where similar schemes had been successful.

*JH left the meeting*

CA referred to the earlier discussion of the headlines of the Improvement and Assessment Framework and noted that the Integrated Performance Report, which comprised month 2 validated data, confirmed the appropriate focus on recovery and improvement, also illustrating achievements, pressures and variability of performance against all targets. The report aimed to triangulate information relating to delivery and assurance.

CA reported that A and E performance had deteriorated in month 3 and advised that the A and E Delivery Board was refreshing its programme of work as a matter of urgency in response to guidance around Winter Planning as well as the recent delayed transfers of care improvement trajectory submissions to NHS England (and additionally for Better Care Fund) The winter plan was required for submission on 8 September.

CA advised that the planned care system performance group monitored performance against the 62 day cancer target and that recovery was being driven by the Cancer



Alliance through a 62 day recovery plan as part of a national recovery programme. Cancer performance in some tumour sites was closely linked to those specialties where there were capacity issues and subsequently shared performance issues with referral to treatment. CA also noted that York Teaching Hospital NHS Foundation Trust was updating their return to operational standards plan in August in response to the latest winter planning guidance and delayed transfers of care submissions, the 62 day cancer recovery plan and also recovery work around diagnostics.

Members commended the development and clarity of the integrated performance report. Discussion of levels of confidence in QIPP achievement ensued in response to DB seeking clarification in this regard.

PM referred to the earlier discussion regarding Improving Access to Psychological Therapies, dementia coding and the 62 day cancer target. He proposed a meeting of clinicians and managers be arranged to consider levels of assurance before the next Committee meeting and also noted concern about the A and E Delivery Board plan.

CA explained, in response to JS seeking clarification about the CCG Planned Care Programme relating to referral to treatment performance, that all CCG function teams were involved in delivery of recovery plans, and that the Planned Care system performance group reviewed waiting times and performance by specialty. JS advised that more in depth analysis of referral to treatment performance and waiting lists was going to be required and noted the potential for additional expert capacity in this regard.

EW reported that performance relating to Improving Access to Psychological Therapies, dementia coding and child and adolescent mental health services was managed through the Tees, Esk and Wear Valleys NHS Foundation Trust Contract Management Board. She noted that, although this was a block contract, the Early Intervention Psychosis Service was being provided at higher than the contract commissioned level; prioritisation of additional capacity was required through clinical discussion. EW additionally reported that a single item Quality and Patient Experience Committee meeting was being arranged in response to concerns expressed by the Governing Body about the child and adolescent mental health service.

### **The Committee:**

1. Received the month 3 Integrated Performance Report.
2. Noted that a meeting would be arranged to consider Improving Access to Psychological Therapies, dementia coding and the 62 day cancer target before the September Committee meeting.
3. Noted that a single item Quality and Patient Experience Committee was being arranged to consider concerns relating to child and adolescent mental health services.

### **11. Key Messages to the Governing Body**

- The Committee requested a detailed recovery plan for 18 week referral to treatment, the cancer 62 day target, Improving Access to Psychological Therapies and dementia diagnosis, four of the areas contributing to the Inadequate rating for the Improvement and Assessment Framework indicators

- The Committee expressed continuing concern about the finalised budget to which the CCG was working
- The Committee commended preparation and presentation of alternative contractual arrangements to York Teaching Hospital NHS Foundation Trust as a matter of urgency

**The Committee:**

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

**12. Next Meeting and Forward Plan**

DB noted the Committee's forward plan, presented for the first time.

The next meeting would be 9am to 1pm 24 August 2017.

**NHS VALE OF YORK CLINICAL COMMISSIONING GROUP FINANCE AND PERFORMANCE COMMITTEE**

**SCHEDULE OF MATTERS ARISING/DECISIONS TAKEN ON 27 JULY 2017 AND CARRIED FORWARD FROM THE PREVIOUS MEETING**

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
F&P27	22 June 2017	Capped Expenditure Process	<ul style="list-style-type: none"> <li>PM to seek advice from the Chair of the Council of Representatives about engaging with GPs as commissioners outside of the Council of Representatives</li> </ul>	PM	
F&P28	22 June 2017	Better Care Fund Update	<ul style="list-style-type: none"> <li>Report to November or January Governing Body on Better Care Fund outcomes, achievements and impact</li> </ul>	EW	2 November 2017 or 4 January 2018
F&P29	22 June 2017	Contract Report	<ul style="list-style-type: none"> <li>JH and TP seek alternatives to contract management board</li> </ul>	JH/TP	Ongoing
F&P30	27 July 2017	Risk Update Report	<ul style="list-style-type: none"> <li>Recovery plans for 18 week referral to treatment, cancer 62 day target, Improving Access to Psychological Therapies and dementia diagnosis rates.</li> </ul>	CA	24 August or 28 September 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
F&P31	27 July 2017	Financial Performance Report Month 3	<ul style="list-style-type: none"> <li>Approval of the revised Financial Plan, including Capped Expenditure Process plans, to be sought at the September Governing Body meeting</li> </ul>	TP	7 September 2017
F&P32	27 July 2017	Integrated Performance Report Month 3	<ul style="list-style-type: none"> <li>Meeting to be arranged to consider Improving Access to Psychological Therapies, dementia coding and the 62 day cancer target</li> </ul>	CA	Before 24 August Committee meeting

**Minutes of the Primary Care Co-Commissioning Committee held on  
25 July 2017 at West Offices, York**

**Present**

Keith Ramsay (KR) - Chair	CCG Lay Chair
David Booker (DB)	Lay Member and Chair of the Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing
Heather Marsh (HM)	Head of Locality Programmes, NHS England (Yorkshire and the Humber)
Phil Mettam (PM)	Accountable Officer
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Tracey Preece (TP)	Chief Finance Officer

**In Attendance (Non Voting)**

Caroline Alexander (CA) – for item 7	Assistant Director of Delivery and Performance
Dr Lorraine Boyd (LB)	GP, Council of Representatives Member
Dr Jan Hewitson (JH)	GP, Council of Representatives Member
Shaun Macey (SM)	Head of Transformation and Delivery
Dr Shaun O'Connell (SOC)	Joint Medical Director
Dr Andrew Phillips (AP)	Joint Medical Director
Michèle Saidman (MS)	Executive Assistant

**Apologies**

Kathleen Briers (KB)	Healthwatch York Representative
Dr John Lethem (JL)	Local Medical Committee Liaison Officer, Selby and York
Sharon Stolz (SS)	Director of Public Health, City of York Council.

*Unless stated otherwise the above are from NHS Vale of York CCG*

There was one member of the public in attendance and no questions had been submitted by members of the public.

The agenda was considered in the following order.

**1. Welcome and Introductions**

KR welcomed everyone to the meeting. He particularly welcomed JH and HM. KR advised that HM had replaced Chris Clarke on the Committee and expressed appreciation for his contribution during his membership.

KR advised that JL, who was unable to attend the meeting, was retiring from medical practice on 2 September. KR highlighted JL's significant contribution to the CCG during his time as Local Medical Committee Liaison Officer and expressed appreciation for his involvement. PM added his gratitude and noted that a formal record of appreciation would be arranged.

## **2. Apologies**

As noted above.

## **3. Declarations of Interest in Relation to the Business of the Meeting**

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

## **4. Minutes of the meeting held on 30 May 2017**

The minutes of the meeting held on 30 May were agreed.

### **The Committee**

Approved the minutes of the meeting held on 30 May 2017.

## **5. Matters Arising**

*PCC6 Primary Care Commissioning Committee Terms of Reference – Role of the Committee in the context of the Accountable Care Partnership Board:* KR advised that this was still ongoing.

*PCC12 South Milford Surgery and Tadcaster Proposals to move to Leeds North CCG:* SM reported NHS Leeds North CCG had stated that at the present time they did not wish to further progress discussion with South Milford Surgery and Tadcaster Medical Centre. These Practices would therefore remain with NHS Vale of York CCG.

The remaining matters were noted as agenda items or would be included in discussion of items.

### **The Committee:**

Noted the updates.

## **7. Primary Care Dashboard Development**

In presenting the initial 'proof of concept' of a Primary Care Dashboard MC advised that the ongoing work included further development of prescribing indicators and ambition of primary care. She commended the team involved in bringing together the data for the first time and reported on discussion with Dr Paula Evans, Chair of the Council of Representatives who had also commended the progress and requested inclusion of locality work and Quality and Outcomes Framework. MC confirmed that consideration had also taken place in the context of the CCG's other reporting mechanisms and the NHS England CCG Improvement and Assessment Framework.

Unconfirmed Minutes

SP referred to a Limited Assurance Primary Care Commissioning Audit Report and, whilst recognising progress, expressed concern at the delay in development of the dashboard, also noting loss of previous historic dashboards. MC responded that the main delay had been due to prioritisation of Business Intelligence capacity for the amount of available data and the fact that the indicators required discussion with primary care before being published. She noted data from Public Health and the GP Survey were already in the public domain and could be presented at the next meeting, also advising that a decision was needed in terms of timescale as some data was annual and other data may be up to two years out of date.

Members welcomed the progress to date and discussed a number of aspects of further development, including how the dashboard would be used; incorporation of Public Health expected prevalence data; process issues such as patient access, fulfilling prescriptions and skill mix in Practices; comparison with NHS costs; expansion of immunization beyond flu; and the context of collaborative working which required a system approach to the information. PM emphasised the need to prioritise creation of a transformation plan to address the significant financial deficit. He noted that General Practice was key to development of locality based out of hospital care, the Care Quality Commission assessment of 'Good' for all 26 Practices in the CCG and the strategic need to incentivise out of hospital providers. The dashboard would provide intelligence that helped inform development of new models of care to manage population health.

HM highlighted complexity due to the need to triangulate many sources of data, including relating to General Practice, other primary care providers, Public Health disease prevalence registers and the Quality and Outcomes Framework.

CA referred to the integrated performance report and proposed development of the primary care dashboard be incorporated in this work to inform prioritisation of business intelligence resources. MC additionally noted areas that needed improvement, such as Learning Disabilities Registers for which information was not routinely captured therefore annual health checks were not always provided.

MC referred to the next steps detailed which members supported. It was also agreed that a small group be established to progress this work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation, and that available information be shared as soon as practicable.

#### **The Committee:**

1. Endorsed the draft dashboard and supported the next steps outlined.
2. Agreed that a small group be established to progress this work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation, and that available information be shared as soon as practicable.

*CA left the meeting*

Unconfirmed Minutes

## **6. Primary Care Commissioning Financial Report**

TP presented the report which provided information on financial performance of primary care commissioning as at month 3 of 2017/18. She noted that both the year to date position and the forecast outturn were almost in line with the CCG's 2017/18 financial plan which had been updated for the capped expenditure process.

TP explained that the forecast spend offsetting the £56k variance on Personal Medical Services funding was reported under Primary Care in the CCG dashboard and agreed to also include this clarification in the financial report to the Committee. She also noted the year to date overspend of £38k, due mainly to increased costs within administration for new retainers and ongoing sickness claims, and that detailed Quality and Outcomes Framework information was not presented in accordance with discussion at the previous meeting.

In respect of the Personal Medical Services monies TP referred to discussion at the previous meeting of the Committee and highlighted the indicative costs pertaining to the three parts:

- 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.

TP advised that the indicative costs had been discussed with the Council of Representatives and that a process for submission of a 'plan on a page' for the uncommitted funding under (iii) would be expedited. She also confirmed that backdated requests for reimbursement for meeting attendance would be paid.

Discussion ensued regarding flexibility for the uncommitted funding, including in the context of the GP Forward View. LB noted the need for support to Practices to progress a locality approach.

### **The Committee:**

1. Noted the financial position of primary care commissioning as at month 3.
2. Noted the suggested split for Personal Medical Services monies.
3. Requested that subsequent reports include identification of variance on Personal Medical Services funding.

## **8. Practice Visits: Update**

KR noted that this item arose from discussion at the previous Committee meeting and it would become a standing agenda item.

Unconfirmed Minutes



AP reported that Practice visits and engagement took place in many ways, including individually, on a locality basis, and via the Council of Representatives where ongoing discussion included extended access. AP also noted the requirements of the General Practice Forward View. He advised that a plan was currently being developed for working with Practices based on feedback from the initial visits, as per the report presented at the last Committee meeting.

In respect of the request at the previous meeting for a matrix SM explained that a paper was being developed for strategic support to General Practice in the context of demand management and system transformation. A further paper was being developed regarding the practicalities and resource requirements of working with Practices for a longer term system approach.

SOC highlighted the various approaches for Practice visits, both formal and informal, emphasising their importance in terms of relationship building and gaining an understanding of varying issues. A flexible approach enabled Practices to raise concerns. LB supported the value of the visits.

PM welcomed the additional capacity and expertise that HM and her team were providing in terms of supporting Practices on specific issues and endorsed HM's view that Executive Directors also undertake visits to support resilience. PM requested that, in addition to SOC and AP regularly visiting Practices, Executive Team members should make three to five visits per year.

Further discussion recognised the need to ensure resources for development of the localities, a priority to achieving change; the management role of improving patient outcomes; and the intention that Practice visits would become part of "business as usual". KR added that all Governing Body members could be utilised for Practice visits.

#### **The Committee:**

1. Noted the update.
2. Agreed that Practice Visits become a standing agenda item.

#### **9. Enhanced Services Review**

TP presented the report which provided an update on current Enhanced Services commissioned by the CCG, the financial position pertaining to this area of spend, next steps on the review of all Enhanced Services, Enhanced Services contract uplift, Near Patient Testing – Amber Drugs, moving drug bandings, new drugs and continuation of drugs. A number recommendations required consideration.

In respect of Near Patient Testing – Amber Drugs SOC, as Joint Medical Director, expressed the view that the proposed uplift should be backdated to 1 April 2017 as some Practices had taken on this responsibility prior to that date. He also explained that one of the roles of the Medicines Management Committee was to agree standard shared care guidelines; these were circulated to Practices who were expected to comply. SOC also noted Practice medico-legal responsibilities highlighting that if Practices declined to provide these services there would be a cost

Unconfirmed Minutes

to the CCG through outpatient attendances. TP, however, advised that there was currently no contractual or monitoring requirement for Practices to provide evidence to support backdating the payment and provide assurance from a financial governance perspective. LB noted that even the 1 August timescale would pose difficulty for Practices to provide correct and consistent data and JH expressed concern both about the cost to Practices to provide the information and the content of the specification. In regard to the latter she received confirmation that thyroid function and diabetes testing were included.

Members sought clarification on a number of aspects of the report and discussed in detail the Near Patient Testing – Amber Drugs proposal, including the funding implications. TP referred to the £93,420 earmarked for the Local Enhanced Services review advising that a further c£5k would be required for a full year effect on a recurrent basis, also noting JL's email support for this option. She highlighted that this option would mean there would be no funding available in 2017/18 to support other priority schemes.

HM and SM referred to the wider transformation agenda, progression of out of hospital care, and the need to agree a baseline for core General Practice services and consistency of Enhanced Services. MC also noted the planned systematic strategic review for 2018/19.

TP confirmed her recommendation for the 1 August 2017 implementation for Near Patient Testing – Amber Drugs advising that, if approved, Practices would be informed and support would be provided in terms of data submission from that date. TP agreed to liaise with LB outside the meeting in respect of data collation.

### **The Committee:**

1. Supported the development of a working group to review the priority Enhanced Services as part of reviewing all in the coming months with a view to implementing any agreed service changes from the start of next financial year, 1 April 2018.
2. Supported the uplift of all Enhanced Service agreements by 1% effective 1 April 2017 (with the exception of Near Patient Testing) to support primary care.
3. Approved the YORLMC request to update the Near Patient Testing – Amber Drugs Service Specification, through a contract variation, by including the monitoring of anti-psychotic drugs, and additional drugs included in the NHS Harrogate and Rural District CCG model, with effect from 1 August 2017 whilst the wider Enhanced Service review was undertaken.
4. Confirmed the preferred funding arrangements for 2017/18 with a further proposal to come to resolve this recurrently in 2018/19 as part of the wider review.

### **10. Notional Rents**

TP referred to the report which sought approval for notional rent adjustments as notified by the NHS England Primary Care Finance Team in respect of: Gale Farm

Unconfirmed Minutes

Surgery, Millfield Surgery, MyHealth, Drs Jones and McPherson, Front Street Surgery, Terrington Surgery and Beech Tree Surgery.

LB explained that the Millfield Surgery increase was substantially more than the other Practices due to expiry of funding from Hull York Medical School.

**The Committee:**

Approved the notional rent adjustments for Gale Farm Surgery, Millfield Surgery, MyHealth, Drs Jones and McPherson, Front Street Surgery, Terrington Surgery and Beech Tree Surgery.

**11. Quality and Outcomes Framework**

HM advised that a quality review, rather than the financial perspective, of the Quality and Outcomes Framework was currently taking place. In the meantime an overview of the aims and principles of the Quality and Outcomes Framework was presented to provide members with a better understanding. HM advised that the Quality and Outcomes Framework had supported systemised care and LB emphasised that the payments were integral to the survival of General Practice.

**The Committee:**

Supported the recommendations to:

1. Utilise the national annual report which provided a systematic review
2. Establish a small team (clinician, commissioning manager and data analyst) which would also be linked to the Primary Care Dashboard development
3. Review disease register size compared to expected prevalence as evidenced by population demographics, RightCare information and Public Health data
4. Compare exception reporting levels
5. Carry out Practice review visits to outliers to discuss the potential reasons for this and provide support to Practices where appropriate

**12. NHS England Primary Care Update**

HM referred to the report which provided updates in respect of the Estates and Technology Transformation Fund, Dispensing Services Quality Scheme, GP Clinical Waste, Resilience Funding, Practice Based Pharmacist Scheme and rent reviews. In respect of the latter HM highlighted that NHS England was working with the small number of Practices where rent reviews were outstanding and requested that return of the required paper work be expedited.

**The Committee:**

Noted the updates.

Unconfirmed Minutes

### **13. Key Messages to the Governing Body**

- The Committee welcomed the development of the Primary Care Dashboard noting that the ongoing work included increasing relevance of information
- The Committee noted the all members of the Executive Team and Governing Body would be asked to undertake Practice visits
- The Committee approved recommendations relating to Enhanced Services

#### **The Committee:**

Agreed the above would be highlighted by the Committee Chairman to the Governing Body.

### **14. Next meeting**

9.30am on 19 September 2017 at West Offices.

**NHS VALE OF YORK CLINICAL COMMISSIONING GROUP PRIMARY CARE COMMISSIONING COMMITTEE**

**SCHEDULE OF MATTERS ARISING FROM THE MEETING HELD ON 25 JULY 2017 AND CARRIED FORWARD FROM PREVIOUS MEETINGS**

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC6	28 February 2017	Primary Care Commissioning Committee Terms of Reference	<ul style="list-style-type: none"> <li>• Discussion to take place of the role of the Committee in the context of the Accountable Care Partnership Board with the Executive Director of Planning and Governance</li> </ul>	SM	Ongoing
	28 March 2017			<ul style="list-style-type: none"> <li>• KR to discuss with PM</li> </ul>	
PCC21	30 May 2017	General Practice Visits – Summary to April 2017	<ul style="list-style-type: none"> <li>• Further report to include a matrix of the issues, proposed next steps, resource implications and expected outcomes</li> <li>• To become a standing agenda item</li> </ul>	SM	25 July 2017
	25 July 2017				With effect from 19 September 2017
PCC22	25 July 2017	Financial Performance Report	<ul style="list-style-type: none"> <li>• Variance on Personal Medical Services funding to be included in the financial report</li> </ul>	TP	With effect from 19 September 2017

Reference	Meeting Date	Item	Description	Responsible Officer	Action Completed/ Due to be Completed by (as applicable)
PCC23	25 July 2017	Primary Care Dashboard Development	<ul style="list-style-type: none"> <li>A small group to be established to progress the work comprising representatives from across the CCG teams, also including Lay Member(s) and NHS England Primary Care representation</li> </ul>	MC	
PCC24	25 July 2017	Quality and Outcomes Framework	<ul style="list-style-type: none"> <li>A small team (clinician, commissioning manager and data analyst), also be linked to the Primary Care Dashboard development, to be established</li> </ul>	HM	

**Minutes of the Single Item – Child and Adolescent Mental Health Services – Quality and Patient Experience Committee held on 14 August 2017 at West Offices, York**

**Present**

Michelle Carrington (MC) - Chair	Executive Director of Quality and Nursing
David Booker (DB)	Lay Member and Finance and Performance Committee Chair
Susan de Val (SdV)	Commissioning Specialist
Barry Dane (BD)	Healthwatch, York
Karen Hedgley (KH)	Designated Nurse Safeguarding Children
Paul Howatson (PH)	Head of Joint Programmes
Beverly Hunter (BH)	Head of Mental Health and Learning Disabilities
Michèle Saidman (MS)	Executive Assistant
Sheenagh Powell (SP)	Lay Member and Audit Committee Chair
Elaine Wyllie (EW)	Strategic Programme Consultant

**From Tees, Esk and Wear Valleys NHS Foundation Trust (The Trust)**

Katherine Davies (KD)	Clinical Director, Children and Young People's Services
Ruth Hill (RH)	Director of Operations
Jennifer Illingworth (JI)	Director, Quality Governance
Carol Redmond (CR)	Head of Service, Children and Young People's Services
Pam Saunders (PS)	Assistant Corporate Performance Manager

**Apologies**

Jenny Carter (JC)	Deputy Chief Nurse
Keith Ramsay (KR)	CCG Lay Chair and Quality and Patient Experience Committee Chair

**Purpose of the meeting**

In welcoming invitees to the single item meeting on Child and Adolescent Mental Health Services MC explained that it had been arranged in response to concerns, including from members of the Governing Body and questions from the public at Governing Body meetings, about lack of assurance on a number of aspects of service delivery. She emphasised that it was a forum for open discussion to aid understanding of issues and means of recovery to improve services, to review confidence in preparation for 2020 and to assess levels of confidence. Subsequent discussion would take place with partner organisations.

RH welcomed the opportunity for open discussion noting that due to the timing of the meeting more senior representation from the Trust had not been possible. She highlighted that issues included the need for understanding data, the change of IT system, national changes to data collection, the context of Child and Adolescent Mental Health Services in localities and the evolving process towards the 2020 trajectories. RH highlighted the need for a collective understanding of challenges relating to investment and workforce.

**Presentation and Discussion**

Unconfirmed Minutes

CR and KD gave a presentation on York and Selby Child and Adolescent Mental Health Services including: progress in the two years since the CCG's contract with the Trust: adoption of the national THRIVE model which was super imposed on the service model implemented in January 2017; establishment of the Single Point of Access and its aspirations; participation in Children and Young People's Improving Access to Psychological Therapies; training; Lime Trees Youth Committee; Friends and Family Test; eating disorders developments; hospital liaison (crisis and liaison and Intensive Home Based Treatment Team from September 2017); and learning from experience to date in other parts of the Trust's delivery.

MC sought clarification on performance measures in terms of the 'clock start time' noting that current information related to the second contact at nine weeks where performance was c57% against the 95% target. To understand the issues and the pathway the CCG needed to know when the waiting time started, how long waiting times were and how many children were waiting. RH explained that work was taking place nationally in respect of the 'clock start time' noting that comparative information between current performance and that of the same time in 2016/17 could be provided but it would not be like for like comparison due to the changes in IT systems and national counting methodologies. CR noted that performance against the nine week target had increased to 75% as at August.

EW referred to discussion at the Governing Body where GP members had reported they were not referring to child and adult mental health services because of the perception that there were long waiting times. RH and KD however reported that referrals were increasing and that young people were receiving a response within 24 to 72 hours of being referred. This contact may be direct with the young person or with their family but their GP would receive information in due course. EW highlighted the need to understand the increasing referrals in the context of GPs not referring and MC emphasised the need for a common understanding of both the number of children in the service and the issues.

MC explained reputational consequences resulting from the perception about long waiting times, including Individual Funding Requests and complaints and concerns received by the CCG. Local authority partners had also expressed concerns. In response RH advised that the Trust had attended a number of multi agency forums to raise awareness of the service changes and requested receipt of concerns received by the CCG. She recognised that autism waiting times continued to be an issue due to capacity, which was also a national issue, and highlighted that overall resources were limited. The Trust had invested an additional £380k into CAMHS services, in recognition of the need to bridge the historical under resourcing of the service. Any additional investment in this service would need to be considered through reallocation of the block contract into CAMHS and there would need to be greater understanding of the service impact across the wider contract. KD highlighted that a collaborative approach and further integrated working was key to providing effective services and continuous improvement. She sought the CCG's support for regular meetings with lead agencies to facilitate an ongoing collaborative approach to address the challenges.

KH sought and received assurance that potential child protection issues were taken into account at the initial telephone contact and that data about Looked After Children could be accessed.

Discussion ensued on referral mechanisms, the potential to strengthen the quality perspective and to eliminate inappropriate referrals through clear signposting. It was noted

Unconfirmed Minutes



in respect of self referrals that the response could be multi faceted and that information would only be shared with agencies within the confines of information governance. However, the young person would be advised that their GP would receive information about their referral. KH additionally noted that the Healthy Child Service was now the responsibility of the local authority and advised that she was following up the Care Quality Commission recommendation in this regard with the Safeguarding Lead.

DB highlighted that as the commissioner the CCG should know what service it was commissioning and reasons, such as resources, workforce or leadership, for any issues. RH responded that the pathways provided a framework for care needs and their fulfilment including any aspect of change required from referral through to discharge. EW emphasised that the CCG needed to understand issues as part of outcomes based commissioning and to be assured that the right service was being commissioned.

In respect of the Single Point of Access CR explained that, although the current response time was around 10 days with the aspiration of 24 hours, referrals were screened and prioritised immediately. She advised that internal monitoring, as well as system information, provided assurance that children were managed appropriately and not kept waiting if deemed to be in a 'crisis' situation. Discussion ensued on the need to share data at an early stage, with clarity about its status, to enhance collaborative working. The PARIS electronic data system for patient records was also discussed. RH referred to transition issues but advised that systems in use were being maximised to provide commissioners with the data required without impacting on clinical time.

In response to SdV's request for progress with the Data Quality Improvement Plan, CR advised that this information was available.

KD described workforce training in evidence based practice and the impact on waiting times due to courses being full time. Previous NHS England funding to support backfill was no longer ring fenced and had been transferred to CCG base budgets. This support had reduced over from 70% to 40% to 20% and would soon be zero. MC noted the need to clarify outstanding training requirements and associated costs and also to receive workforce information, including the impact caused by these issues.

CR referred to the Friends and Family Test real time feedback approach that was being developed in York following successful implementation in other areas covered by the Trust. This provided valuable feedback to enhance reporting.

CR described the development of the Enhanced Eating Disorders Team across York, Selby and North Yorkshire advising that analysis had identified a need for increased skills. She noted that capacity for the team in York and Selby was short of five whole time equivalent staff members due to funding when based on NHS England workforce guidance to achieve access and waiting times.

In response to EW enquiring about future funding for the NHS England New Models of Care pilot that aimed to reduce admissions to Tier 4 services, reduce the length of stay of any young people admitted to Tier 4 services and provide robust support packages for young people on discharge to reduce risk of readmission, RH advised that the Trust was working with NHS England Specialist Commissioning and partners to monitor the pilot and assess its impact. She noted that contract arrangements required consideration and advised that early findings were showing a reduction in the use of emergency beds. KD added that there was a national gap in provision of psychiatric intensive care units and

Unconfirmed Minutes

highlighted that savings achieved through the pilot had enabled establishment of a Crisis and Intensive Home Support Team in York and Selby from 1 September 2017. National evidence was that treatment in the community reduced hospital stays. CR confirmed that a stakeholder engagement plan would inform partners of the new service. EW highlighted the need to maintain such improvements but noted a potential risk in terms of affordability.

KH reported that a meeting between the Trust and Leeds and York NHS Partnership Foundation Trust had been arranged for the purpose of a table top learning discussion.

KH enquired about provision of child and adult mental health services, particularly in Selby, for children from a different originating CCG and the process and resource required for recharging. CR responded that these children usually moved out of area therefore there was little contact.

SdV referred to changes in autism data and expressed concern that the CCG did not have information on referrals or waiting times for the current financial year. PS responded that a scoping meeting was taking place week commencing 21 August. Further discussion in respect of the autism pathway and associated issues included confirmation from CR that information was entered on PARIS following telephone assessment and initial comprehensive assessment, however neither of these are a specialist Autism Spectrum Disorder (ASD) assessment which is required for NICE concordant diagnostic pathway. The current pathway requires the diagnostic assessment to be discussed at the York or Selby ASD Forum which adds up to 4 months wait on the diagnostic pathway due to the volume of assessments awaiting this discussion. KD also described increased demand due to numbers of young people associated with the need for specialist training to carry out the intensive assessment. She noted that the assessment service had been split with assessment of 5 to 18 year olds by the Trust and of 0 to 5 olds by York Teaching Hospital NHS Foundation Trust. If the diagnostic criteria were fulfilled parents would be offered support. Support for young people once diagnosed was not automatic but would be offered as appropriate to individual mental health need.

CR advised that a new service offer to support parents/carers of children with anxiety is currently being established.

Challenges identified by Tees, Esk and Wear Valleys NHS FoundationTrust that required consideration related to:

- Workforce in terms of capacity and skill mix. There were no significant vacancies other than psychiatry, which was a national issue, and staff sickness rates was low.
- Increasing demand which reflected the national position.
- Autism pathway in terms of referrals, skill mix and NICE compliance.
- Withdrawal of the City of York bespoke Looked After Children service due to funding requirements.
- Partnership arrangements and the impact of the serious incident action plan relating to the Paediatric Department.

### ***Healthwatch Report***

BD referred to a *York Inspirational Kids* survey which had focused on parent carers. He advised that a report of the results, currently being drafted, would be presented to the York Health and Wellbeing Board. BD described headline issues identified in respect of child and adolescent mental health services noting the expectation of fast access safe services.

Unconfirmed Minutes

He emphasised the key role of carers and their need for support in the event of delays to access.

### Next Steps


MC referred to the earlier discussion of a collaborative approach with all partners, which would include consideration of the trajectory for 2020, however there were specific areas for the CCG and Tees, Esk and Wear Valleys NHS Foundation Trust as set out below:

Action	Lead	Timescale
In terms of the Trust's request from the CCG: consideration of pathway redesign and investment; support at meetings with partners.		
Redefine and simplify data requirements; maximise use of data; only request data for added value. Specific information needed on numbers of children waiting, length of time and for which service.		
Strengthen Contract Management Board in terms of quality focus.		
MC to discuss with KH withdrawal of funding by City of York Council for bespoke Looked After Children service.		
Improve understanding of resource for children's homes in Selby.		
A system response to the Healthwatch report when published.		
Care Quality Commission <i>Local System Review of Health and Social Care in York</i> . MC reported on discussion with City of York Council on working together.		
CCG led clinical visits to provide a different aspect of assurance from the commissioner perspective.		
Trajectory for achievement of a 24 hr response in relation to the Single Point of Access.		
Options for support during the 10pm to 10am period when the Crisis and Intensive Home Treatment Team in York and Selby would not be available.		
Clarity about the improvement requirements needed to support the optimum pathway, including timeframes from referral through to full treatment.		
Clear communication and information for referrers, including GPs, regarding accessing services and signposting.		

EW referred to the areas of progress described but emphasised the requirement for basic performance information to provide assurance to parents, children and stakeholders. She also emphasised that the Governing Body required assurance through a robust recovery plan quantifying details of waiting times. The Trust highlighted that the CCG receives a similar level of reporting as other commissioners but acknowledge that this does not meet the CCG's needs. In this regard CR agreed to take CCG colleagues through the capacity and demand analysis which had a level of detail on the demand/numbers waiting and processes on the 16 August.

In response to SP seeking clarification about placement of children out of area, MC advised that this was considered through Safeguarding and noted that the CCG was aware of numbers and issues in this regard. KH additionally confirmed that specific care needs were subject to individual consideration and that discussion took place through strategic partnerships.

In conclusion MC highlighted that, although continuing concerns were expressed about service delivery, there was an improved understanding of the issues, some of which required a collaborative approach with all partners. The CCG would give further consideration to the required actions for the next steps identified.

<b>Item Number: 23</b>	
<b>Name of Presenter: Dr Shaun O'Connell</b>	
<b>Meeting of the Governing Body</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Date of meeting:</b> 7 September 2017	
<b>Medicines Commissioning Committee Recommendations July 2017</b>	
<b>Purpose of Report</b> <b>For Information</b>	
<b>Reason for Report</b> These are the latest recommendations from the Medicines Commissioning Committee (July 2017).	
<b>Strategic Priority Links</b>	
<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	
<b>Local Authority Area</b>	
<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	
<b>Impacts/ Key Risks</b>	<b>Covalent Risk Reference and Covalent Description</b>
<input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	
<b>Emerging Risks (not yet on Covalent)</b>	
<b>Recommendations</b>	
For information only  Clinical Executive has approved these recommendations.	

<b>Responsible Executive Director and Title</b>	<b>Report Author and Title</b>
Dr Shaun O'Connell Joint Medical Director GP Lead for Planned Care and Prescribing	Laura Angus Lead Pharmacist

### Recommendations from York and Scarborough Medicines Commissioning Committee July 2017

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
1	<a href="#">TA446</a> : Brentuximab vedotin for treating CD30-positive Hodgkin lymphoma		Recommended as an option for treating CD30-positive Hodgkin lymphoma under specified conditions as detailed in the TA.	Already listed as Red drug	No cost impact to CCGs as NHS England/CDF commissioned.
2	<a href="#">TA447</a> : Pembrolizumab for untreated PD-L1-positive metastatic non-small-cell lung cancer		Recommended for use within the Cancer Drugs Fund as an option for untreated PD-L1-positive metastatic non-small-cell lung cancer in adults under specified conditions as detailed in the TA.	Already listed as Red drug	No cost impact to CCGs as NHS England commissioned via CDF.
3	<a href="#">TA448</a> : Etelcalcetide for treating secondary hyperparathyroidism		Recommended as an option for treating secondary hyperparathyroidism in adults with chronic kidney disease on haemodialysis under specified conditions as detailed in the TA.	Red	No cost impact to CCGs as NHS England commissioned.
4	<a href="#">TA449</a> : Everolimus and sunitinib for treating unresectable or metastatic neuroendocrine tumours in people with progressive disease		Recommended as options for treating well- or moderately differentiated unresectable or metastatic neuroendocrine tumours (NETs) of pancreatic origin in adults with progressive disease.  Everolimus is recommended, within its marketing authorisation, as an option for treating well-differentiated (grade 1 or grade 2) non-functional unresectable or metastatic NETs of gastrointestinal or lung origin in adults with progressive disease.  Everolimus is recommended only when the company provides it with the discount agreed in the patient access scheme.	Both already listed as Red drugs	No cost impact to CCGs as NHS England commissioned.
5	<a href="#">TA450</a> : Blinatumomab for previously treated Philadelphia-chromosome-negative acute lymphoblastic leukaemia		Recommended as an option for treating Philadelphia-chromosome-negative relapsed or refractory precursor B-cell acute lymphoblastic leukaemia in adults, only if the company provides it with the discount agreed in the patient access scheme.	Red	No cost impact to CCGs as NHS England commissioned.
6	<a href="#">TA451</a> : Ponatinib for treating chronic myeloid leukaemia and acute lymphoblastic leukaemia		Recommended as an option for treating chronic-, accelerated- or blast-phase chronic myeloid leukaemia, and Philadelphia-chromosome-positive acute lymphoblastic leukaemia in adults under specified conditions as detailed in the TA.	Already listed as Red drug	No cost impact to CCGs as NHS England commissioned.

7	York and Scarborough Oral Nutritional Supplements (ONS) guidelines for adults in community and formulary medal ranking	MCC approved these guidelines which have been updated in consultation with Y&S dieticians to reflect price changes on some products, with re-ordering of the gold medal ranking to ensure use of the most cost-effective products.	N/A	Cost saving.
8	New methotrexate injectable device (Nordimet®)	Nordimet® prefilled pen was approved as a further option to Metoject® prefilled pen and Zlatal® prefilled syringe. Nordimet® is approximately 10% cheaper than Metoject® and the same price as Zlatal®. Prescribers should specify the brand to be dispensed. There is currently a significant amount of generic prescribing of methotrexate in primary care which could cause confusion between brands. A prompt on Optimise Rx for prescribers to prescribe by brand was suggested.	Amber Shared Care	Cost saving compared to Metoject®. Nordimet® costs around £1.50 to £1.80 less per device than Metoject®.
9	Methotrexate – addition of ophthalmology indications and further dermatology indications to the Shared Care Guideline (SCG)	The group approved inclusion of the additional indications <b>cutaneous sarcoidosis, uveitis and scleritis</b> to the SCG. There were limited data suggesting the successful use of methotrexate for these indications. The literature suggests methotrexate is used in practice to treat these conditions. Also, these indications were included in methotrexate SCGs from other areas.	Amber Shared Care	Low cost impact expected.
10	Updated methotrexate SCG	The group approved the updated SCG.	Amber Shared Care	Inclusion of Nordimet® will be cost saving compared to Metoject® (see above). No further significant cost impact is expected.
11	Liothyronine injection – RAG status for hypothyroid crisis.	The current RAG status for liothyronine tablets and injection is amber specialist recommendation. The group agreed that liothyronine injection used for hypothyroid crisis should have a red RAG status for this indication which is managed in critical care settings and does not involve primary care. The amber specialist recommendation remains for the tablets for hypothyroidism until the outcome of the NHS England review of low value items is published.	Red	No cost impact expected as confirmation of RAG status.
12	Lactose free infant formulae	The group agreed to assign black status to lactose free formulae on the basis that it is not a cost-effective use of NHS resources. Lactose free	Black	Cost saving. In 2016/17, VoY spent £3,100, while ScR spent £797 on lactose free formulae.



		<p>formulae are available at a similar cost to other regular infant formulae from the majority of retailers; and it has no role to play in the management of cow's milk protein allergy.</p>		
	<p>Adjuvant bisphosphonates to improve survival in post-menopausal women with breast cancer</p>	<p>MCC were asked to consider the introduction of adjuvant bisphosphonates (specifically oral ibandronate and IV zoledronate) to improve survival in post-menopausal women with breast cancer. The evidence supporting this use is from a large collaborative <a href="#">meta-analysis</a> (n &gt;18,000) which found that the absolute reduction with bisphosphonate use in post-menopausal women at 10 years was 3% for breast cancer recurrence, 3.4% for distant recurrence, 2.2% for bone recurrence and 3.3% for breast cancer mortality, with about 1 in 6 breast cancer deaths prevented.</p> <p>The proposed criteria for treatment includes post-menopausal women (&gt;50 yrs) with at least one of the following: tumour size 20mm or greater (T3-4); grade 2 or 3; node positive including those with micromets. The total duration of the treatment course is 36 months. Patients with chemotherapy planned as initial treatment would receive IV zoledronate for 3 cycles along with chemotherapy followed by oral ibandronate for the remaining 30 months. Those with no chemotherapy planned would receive oral ibandronate for the full 36 months. It is estimated that 20% of women will not tolerate oral ibandronate and will require IV zoledronate.</p> <p>Overall, MCC were in support of the use of adjuvant bisphosphonates based on the available evidence. However, implementation of treatment with IV zoledronate for those patients who can't tolerate oral ibandronate requires further consideration. Costings for IV zoledronate are currently only available for administration via the Medical Elective Suite (MES). However, CCGs would want to explore more cost effective ways of administering it, and put a system in place for those patients requiring IV zoledronate.</p>		<p>Costings below are based on the number of patients treated in the York breast cancer unit between May16 and April 17 (n=245, of which 195 would have met the criteria). Figures for Scarborough were not available but it was noted that there would be some Scarborough patients among those treated in the York breast unit.</p> <p>It is anticipated that costs of using adjuvant bisphosphonates will be offset by a reduction in the number of women within the cohort requiring DEXA scans by ~33% (estimated saving of around £8k per annum); and in the longer term, by a reduction in the number of women requiring treatment for metastatic disease.</p>

13	Oral ibandronate for improving breast cancer survival	Estimated 80% of eligible patients will be treated with oral ibandronate 50 mg daily either initially or following completion of chemotherapy.	Amber - Specialist initiation	<p>Drug acquisition cost = £6.26 per 28 days</p> <p>Total year on year primary care costs for 80% of 195 = 156 patients:</p> <p>Year 1 = £8,644</p> <p>Year 2 = £20,362</p> <p>Year 3 onwards = £32,080</p>
14	IV zoledronate for improving breast cancer survival	Estimated 20% of eligible patients who cannot tolerate oral ibandronate will be treated with IV zoledronate infusion (6 monthly). Implementation of this treatment option requires further consideration.	To be clarified	<p>Drug acquisition cost = ~£3 per dose in secondary care, but can be up to £350 per dose in primary care.</p> <p>Cost of IV zoledronate administered via MES = £410 per dose.</p> <p>Total year on year primary care costs for 20% of 195 = 39 patients (via MES):</p> <p>Year 1 = £31,980</p> <p>Year 2 = 63,960</p> <p>Year 3 onwards = £95,940</p>
				<p><b>Total year on year primary care costs for oral ibandronate AND IV zoledronate via MES:</b></p> <p>Year 1 = £40,624</p> <p>Year 2 = £84,322</p> <p>Year 3 onwards = £128,020</p>