

GOVERNING BODY MEETING

5 March 2020 9.30am to 12.45pm

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

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

The agenda and associated papers will be available at:

www.valeofyorkccg.nhs.uk

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Verbal	Staff Story	To Receive	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
4.	Pages 5-44	Minutes of the meeting held on 2 January 2020	To Approve	All
5.	Verbal	Matters arising from the minutes		All
6.	Pages 45-50	Accountable Officer's Report	To Receive	Phil Mettam Accountable Officer
7.1	Pages 51-72	Quality and Patient Experience Report incorporating Risk	For Decision	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
7.2	73-88	Board Assurance Framework	To Approve	Phil Mettam Accountable Officer

ASSURANCE – 11.10am				
8.	Pages 89-147	Committee Terms of Reference and Update to Detailed Scheme of Delegation	To Ratify	Phil Mettam Accountable Officer / Michael Ash-Mcahon Deputy Chief Finance Officer
9.	Pages 149-185	NHS Vale of York CCG Emergency/Business Continuity Plan	To Ratify	Phil Mettam Accountable Officer
10.	Pages 187-201	Primary Care Networks Update	To Receive	Dr Andrew Lee Executive Director of Primary Care and Population Health
11.	Pages 203-234	Safeguarding Adults Policy	To Ratify	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
FINANCE AND PERFORMANCE – 11.45am				
12.	Presentat ion	2020/21 Operational Plan	To Approve	Michael Ash-Mcahon Deputy Chief Finance Officer
13.	Pages 235-251	Financial Performance Report 2019/20 Month 10	To Receive	Michael Ash-Mcahon Deputy Chief Finance Officer
14.	Pages 253-277	Integrated Performance Report 2019/20 Month 9	To Receive	Caroline Alexander Assistant Director of Delivery and Performance
RECEIVED ITEMS – 12.35pm				
Committee minutes are published as separate documents				
15.	Page 279	Chair's Report Executive Committee: 18 December 2019 and 15 January 2020		
16.	Pages 281-282	Chair's Report Finance and Performance Committee: 19 December 2019 and 23 January 2020		
17.	Page 283	Chair's Report Primary Care Commissioning Committee: 30 January 2020		
18.	Page 284	Quality and Patient Experience Committee: 9 January 2020		
19.	Pages 285-289	Medicines Commissioning Committee: 11 December 2019		

NEXT MEETING

20.	Verbal	9.30am on 2 April 2020 at West Offices, Station Rise, York YO1 6GA	To Note	All
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CLOSE – 12.45pm**EXCLUSION OF PRESS AND PUBLIC**

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

A glossary of commonly used terms is available at

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

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

Present

Dr Nigel Wells (NW) (Chair)	Clinical Chair
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member, Chair of Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing / Chief Nurse
Dr Helena Ebbs (HE)	North Locality GP Representative
Julie Hastings (JH)	Lay Member, Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee
Dr Andrew Lee (AL)	Executive Director of Primary Care and Population Health
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

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

Apologies

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

There were two members of the public present.

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

Gwen Vardigans

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

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

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

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

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

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

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

Response

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

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

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

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

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

AGENDA

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

As noted above.

PM joined the meeting

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

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

3. Patient Story

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

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

AB joined the meeting

Detailed discussion and further clarification by MC included:

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

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

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

Members requested an update on progress at the next meeting.

4. Minutes of the Meeting held on 7 November 2019

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

The Governing Body:

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

5. Matters Arising from the Minutes

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

City of York Safeguarding Children Board Annual Report 2018/19 - Concerns to be fed back to the Lead GP for the Royal College of General Practitioners for the Safeguarding Children Guidelines, in particular understanding about children 'not brought' to appointments: NW reported that the CCG's practices were undertaking an audit of children 'was not brought'; the outcome would be presented on completion.

The other matters were confirmed as completed or agenda items.

The Governing Body:

Noted the updates and associated actions.

6. Accountable Officer's Report

PM referred to the report which provided an update on turnaround, local financial position and system recovery; operational planning; primary care protected learning time; Better Care Fund; emergency preparedness, resilience and response; Directions; and strategic and national issues.

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

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

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

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

The Governing Body:

Received the Accountable Officer's report.

STRATEGIC

LS joined the meeting

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

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

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

Support deprived areas - *North Yorkshire County Council, the Borough and District Councils should lead coordinated plans focused on areas of deprivation through collaboration with local communities and residents to reflect their priorities for reducing poverty and shaping healthy places.* LS noted potential via *Selby Health Matters*, a multi sector forum, in this regard. AL confirmed that the CCG was working with them, including in the context of a potential Integrated Care System.

Tackle rural poverty - *Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.* LS recommended that North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing. He noted the potential for contributing on the impact of rural deprivation to the North Yorkshire Rural Commission evidence review.

Reduce childhood inequalities - *All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child's full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.* LS proposed that, as part of the Joint Strategic Needs Assessment, North Yorkshire County Council and CCGs in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery. He emphasised the need for change, particularly in the face of reducing budgets, and highlighted opportunities provided through GPs' information about vulnerable groups.

Work with military families and veterans - *Military and related agencies should ensure that service and veteran-specific issues identified in the needs assessment are addressed.* LS proposed that all agencies should identify and train military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant. He noted work was taking place in terms of health needs assessment for groups with complex needs in Scarborough and City of York but highlighted that similar consideration was required for Selby.

Create safe environments for high-risk groups - *All agencies working with people with multiple health and social problems should consider a 'housing first' approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.*

Develop priorities to mitigate the impact of changes to the benefit system - *As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and CCGs in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.* LS noted potential opportunities via job centres.

Improve community engagement - *North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.* LS proposed that all agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations. He noted benefits of the statutory sector providing communities with access to small amounts of funding but emphasised the need for effective dialogue. JH additionally highlighted opportunities for the voluntary sector through support provided in terms of venues and refreshments.

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

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

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

The Governing Body:

Supported the recommendations detailed.

LS left the meeting

ASSURANCE

CP joined the meeting

9. Learning Disabilities Mortality Review Annual Report 2018/19

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

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

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

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

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

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

The Governing Body:

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

CP left the meeting

8. Quality and Patient Experience Report

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

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

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

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

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

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

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

The Governing Body:

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

FINANCE AND PERFORMANCE

CA joined the meeting

13. Integrated Performance Report Month 7

CA highlighted that NHS England and NHS Improvement had confirmed that there would no longer be a requirement for a separate assessment of CCG performance against the six 'Clinical Priority Areas': cancer, mental health, maternity, learning disabilities, diabetes and dementia. The focus would be on system reporting and providing assurance on delivery of the NHS Long Term Plan.

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

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

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

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

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

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

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

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

The Governing Body:

Received the month 7 Integrated Performance Report.

CA left the meeting; AC joined the meeting.

ASSURANCE Continued

11. Audit Committee Terms of Reference

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

The Governing Body:

Ratified the Audit Committee Terms of Reference.

10. Board Assurance Framework and Risk Management Policy and Strategy

Board Assurance Framework

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

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

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

Risk Management Policy and Strategy

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

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

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

The Governing Body:

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

AC left the meeting

FINANCE AND PERFORMANCE Continued

12. Financial Performance Report 2019/20 Month 8

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

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

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

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

The Governing Body:

Received the month 8 Financial Performance Report.

RECEIVED ITEMS

The Governing Body noted the following items as received:

14. Executive Committee chair's report and minutes of 16 October, 20 November and 4 December 2019.
15. Audit Committee chair's report and minutes of 28 November 2019.
16. Finance and Performance Committee chair's report and minutes of 24 October and 28 November 2019.
17. Primary Care Commissioning Committee chair's report and minutes of 21 November 2019.
18. Quality and Patient Experience Committee chair's report and minutes of 12 December 2019.
19. Medicines Commissioning Committee recommendations of September, October, November 2019.
20. **Next Meeting**

The Governing Body:

Noted that the next meeting would be held at 9.30am on 5 March 2020 at West Offices, Station Rise, York YO1 6GA.

Close of Meeting and Exclusion of Press and Public

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

A glossary of commonly used terms is available at:

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NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 2 JANUARY 2020 AND CARRIED FORWARD FROM PREVIOUS MEETING

<i>Meeting Date</i>	<i>Item</i>	<i>Description</i>	<i>Director/Person Responsible</i>	<i>Action completed due to be completed (as applicable)</i>
5 September 2019	Update on work relating to physical health checks for people with severe mental illness	<ul style="list-style-type: none"> • Further update to the next meeting 	DN	7 November 2019
7 November 2019		<ul style="list-style-type: none"> • Further discussion to take place outside the meeting 	DN	
2 January 2020		<ul style="list-style-type: none"> • Practice data on physical health checks for people with severe mental illness to be presented at the February Council of Representatives meeting 	AL	20 February 2020

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
2 January 2020	Patient Story	<ul style="list-style-type: none"> Update on establishing a local system approach for pertussis vaccination in pregnancy 	MC	5 March 2020
2 January 2020	Learning Disabilities Mortality Review	<ul style="list-style-type: none"> Update on potential proposals and a stocktake of progress 	MC	5 March 2020
2 January 2020	Board Assurance Framework and Risk Management Policy and Strategy	<ul style="list-style-type: none"> Risk Management Policy and Strategy to be presented for ratification 	AC	5 March or 2 April 2020

Theo and Debbie's Story

QSG 22nd November 2019

Clare Hedges & Debbie Smith



What Happened?

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



What has been learnt?

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

What actions are being taken?

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



Sharing

Debbie and Theo's story shared with:

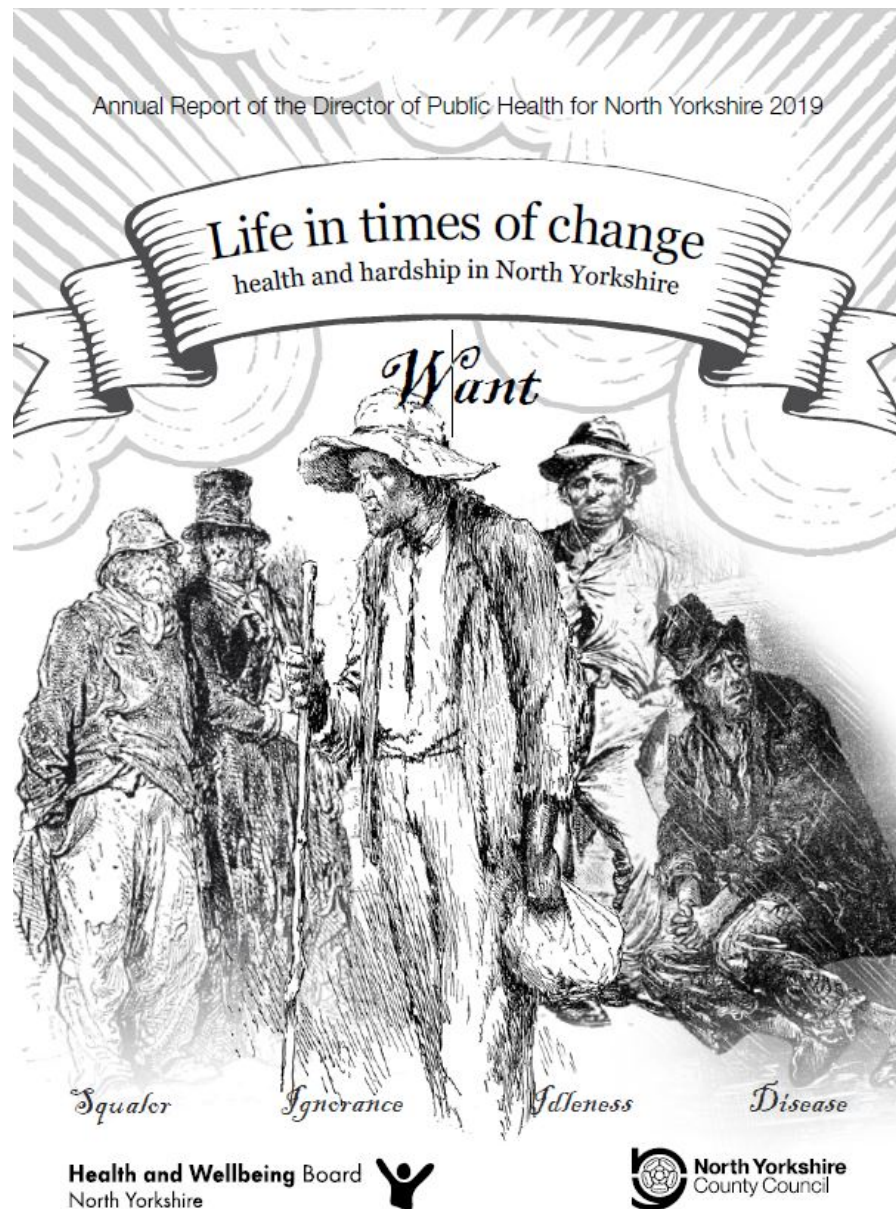
- GP Practices across North Yorkshire and York
- Quality Lead Managers NY&H and WY&H
- Child Death Overview Panel (CDOP)
- Perinatal Institute
- CORM at HDFT
- SI Panel at North Yorkshire & East Riding
- Midwives through Maternity Steering Group
- NHSE through Screening and Immunisation Manager



Thank you for listening

Any Questions?





Outline

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

Ripon workhouse in the 1850s

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

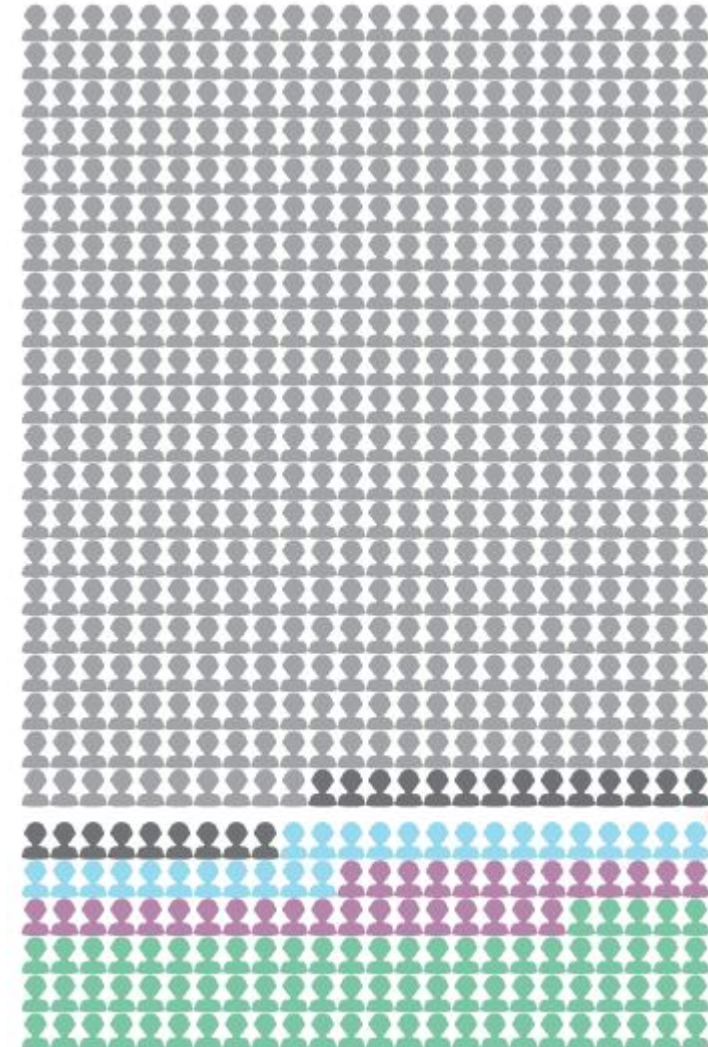


Poor UK

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



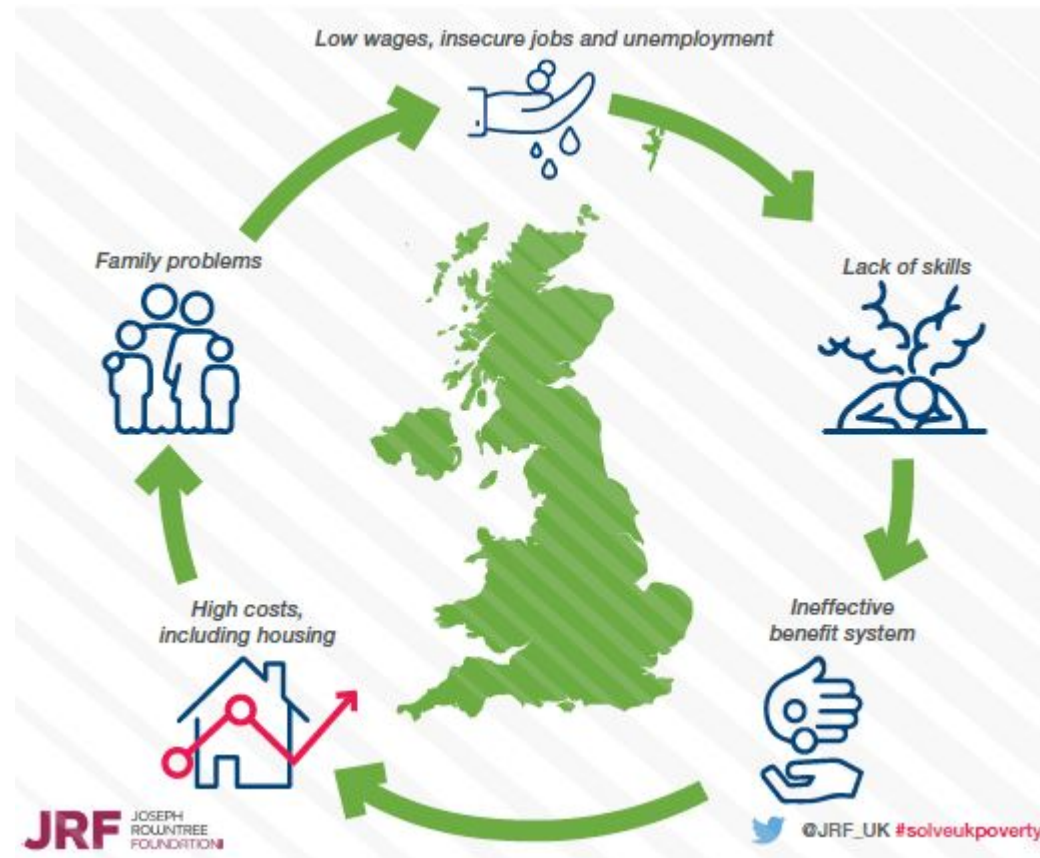
Total UK population 66.6m



Cycle of poverty

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

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



How does poverty affect health?

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

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

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

What makes us healthy?

Good health matters, to individuals and to society. But we don't all have the same opportunities to live healthy lives.

To understand why, we need to look at the bigger picture:

Good work

Our surroundings

Money and resources

Housing

The food we eat

Transport

Education and skills

Family, friends and communities

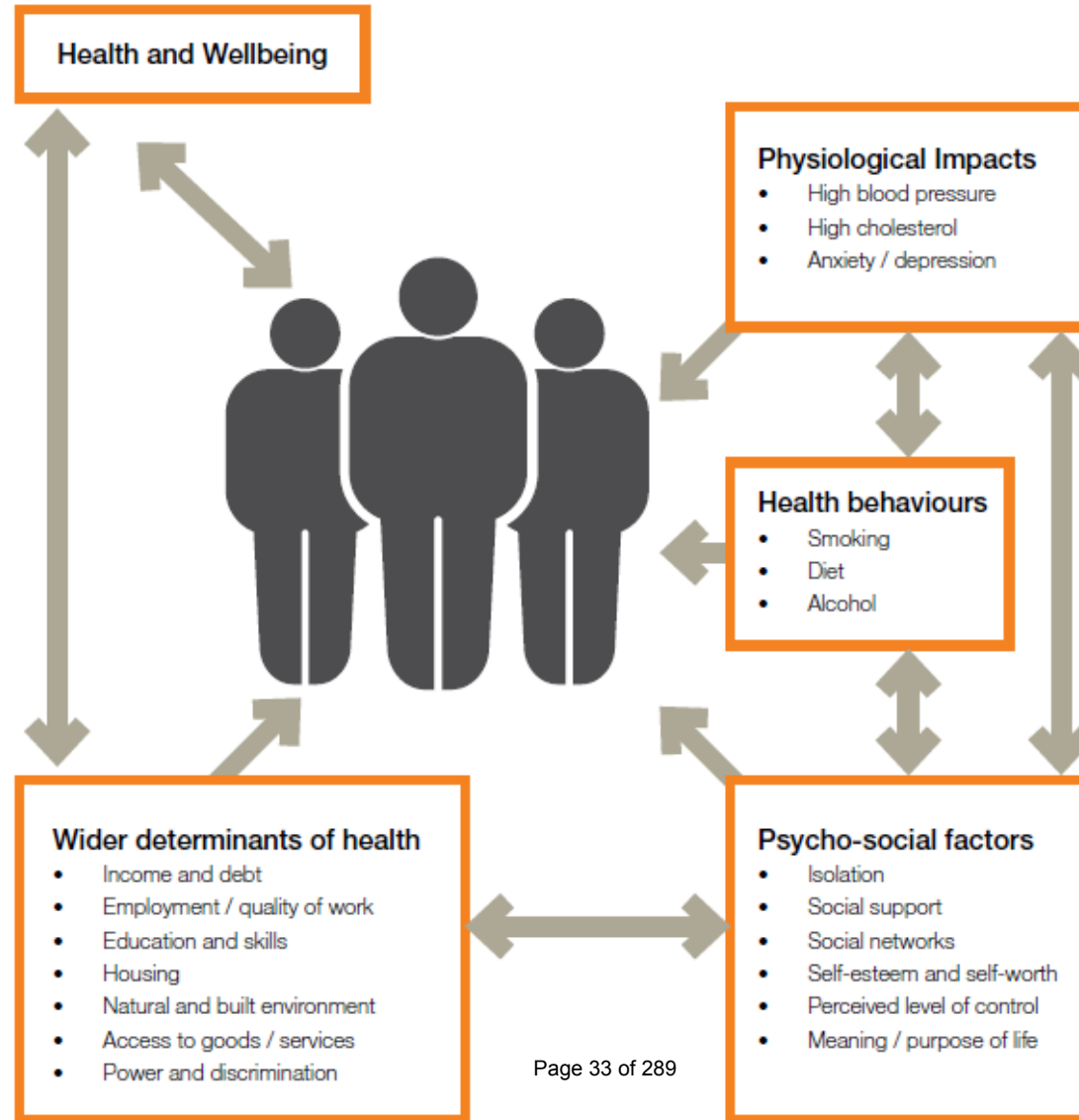
The healthy life expectancy gap between the most and least deprived areas in England is over **18** YEARS

Find out more: [health.org.uk/what-makes-us-healthy](https://www.health.org.uk/what-makes-us-healthy)

The Health Foundation

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System map of the causes of health inequalities



The Marmot Review

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

It outlined six policy objectives for reducing health inequalities:

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



Life expectancy in North Yorkshire

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

Scarborough continues to have the lowest life expectancy in North Yorkshire

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



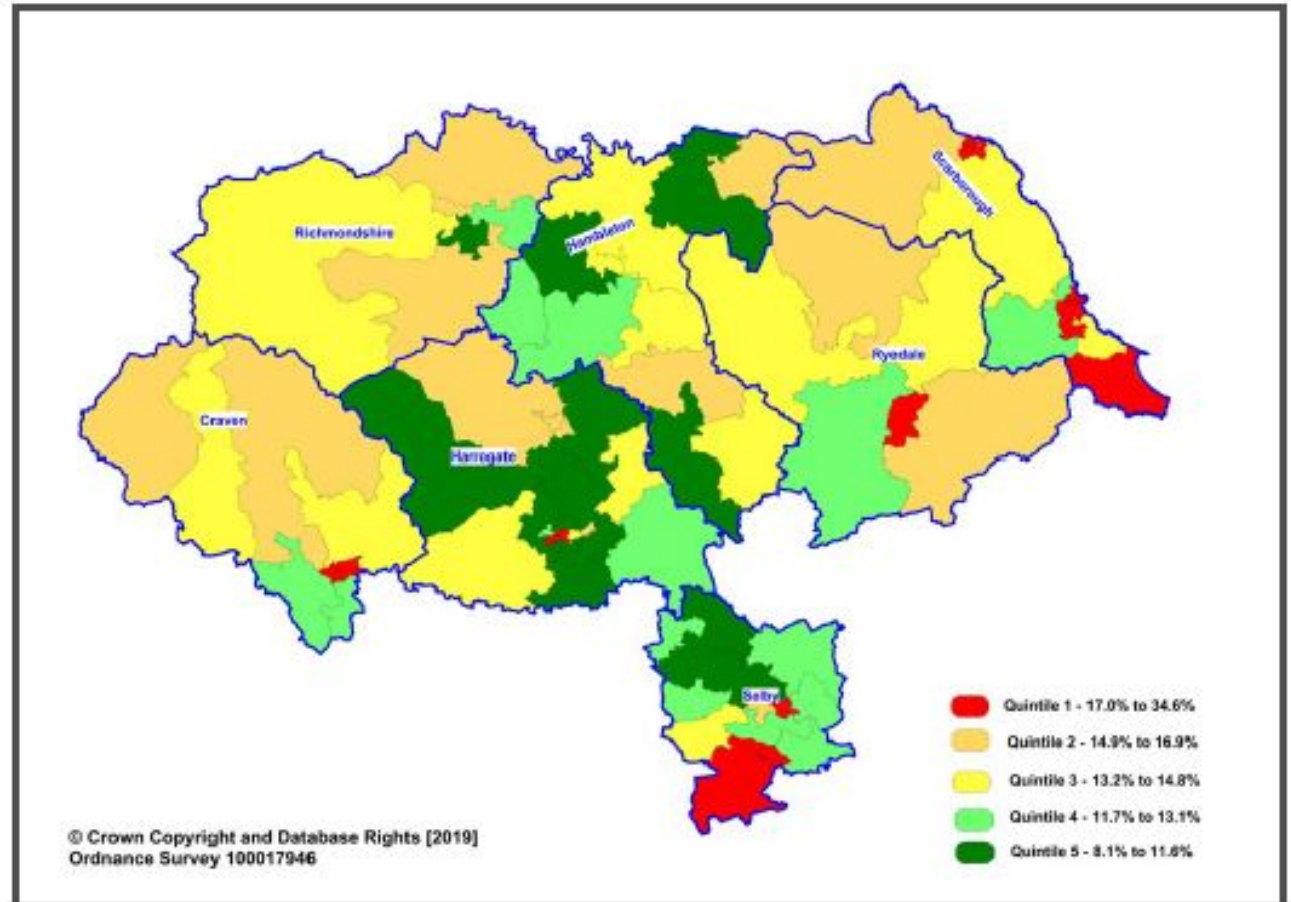
Poverty in North Yorkshire

Households in poverty

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

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

Households below 60% of median income (after housing costs), North Yorkshire MSOAs, 2013/14



The eleven most deprived neighbourhoods in North Yorkshire, 2015

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

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

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

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

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

LSOA Code	LSOA name (2011)	Ward containing LSOA	Rank of 42,844 LSOAs in England	Rank (NY)	Seven domains – national decile (1 is most deprived)						
					Employment	Income	Health Deprivation and Disability	Education, Skills and Training	Crime	Living Environment	Barriers to Housing and Services
E01027874	Scarborough 007D	Woodlands	313	1	1	1	1	1	3	8	3
E01027819	Scarborough 012E	Eastfield	318	2	1	1	1	1	1	7	3
E01027806	Scarborough 006E	Castle	319	3	1	1	1	1	1	1	5
E01027847	Scarborough 006D	North Bay	751	4	1	1	2	1	1	1	4
E01027804	Scarborough 010A	Castle	1,005	5	1	1	1	3	1	1	5
E01027817	Scarborough 012A	Eastfield	1,714	6	1	1	1	1	3	6	4
E01027907	Saibby 005C	Saibby West	2,057	7	1	1	2	1	4	9	5
E01027740	Harrogate 013F	Woodfield	2,283	8	1	1	1	3	4	7	6
E01027820	Scarborough 012C	Eastfield	2,515	9	1	1	2	1	5	6	6
E01027805	Scarborough 006A	Castle	2,561	10	1	2	2	2	1	1	8
E01027889	Scarborough 001C	Whitby West Cliff	2,792	11	1	2	1	4	2	1	5



Recommendation - support deprived areas

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

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

Recommendation

North Yorkshire County Council, the Borough and District Councils should lead coordinated plans focused on areas of deprivation through collaboration with local communities and residents to reflect their priorities for reducing poverty and shaping healthy places.



Recommendation - tackle rural poverty

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

Recommendation

Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.

North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing



Recommendation - reduce childhood inequalities

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

Recommendation

All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child's full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.

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

As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery.



Recommendation - work with military families and veterans

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

Recommendation

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

All agencies should identify and train military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant.



Recommendation - create safe environments for high-risk groups

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

Recommendation

All agencies working with people with multiple health and social problems should consider a 'housing first' approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.



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

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

Recommendation

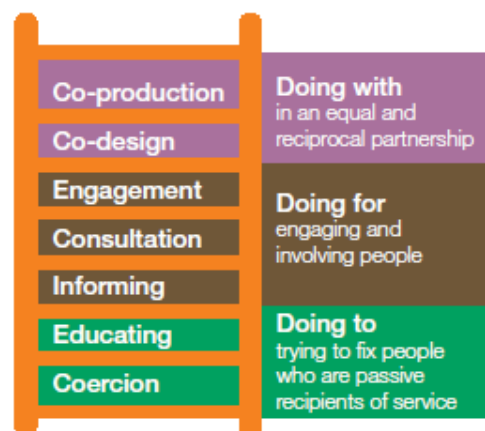
As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.



Recommendation - improve community engagement

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

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




Recommendation

North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.

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

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

Item Number: 6	
Name of Presenter: Phil Mettam	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Accountable Officer’s Report	
Purpose of Report <i>(Select from list)</i> To Receive	
Reason for Report To provide an update on a number of projects, initiatives and meetings that have taken place since the last Governing Body meeting along with an overview of relevant national issues.	
Strategic Priority Links <input checked="" type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks	
Impact Assessments Please confirm below that the impact assessments have been approved and outline any risks/issues identified. <input type="checkbox"/> Quality Impact Assessment <input type="checkbox"/> Data Protection Impact Assessment <input type="checkbox"/> Equality Impact Assessment <input type="checkbox"/> Sustainability Impact Assessment	

Risks/Issues identified from impact assessments: N/A
Recommendations The Governing Body is asked to note the report.
Decision Requested (for Decision Log)

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

GOVERNING BODY MEETING: 5 MARCH 2020

Accountable Officer's Report

1. Turnaround, local financial position and system recovery

- 1.1 The CCG is confident it will deliver its 2019-20 planned deficit of £18.8m based on the Month 10 forecast outturn position. The CCG has developed, implemented and delivered the plans to mitigate in full the in-year pressures we have seen in Prescribing from national issues and the shortfall in the System Recovery Schemes, all of which are detailed in the finance report. However, it is important to note that these mitigations are largely non-recurrent in nature whilst the pressures are recurrent and therefore the underlying position is deteriorating and increasing the financial challenge going into 2020-21.
- 1.2 QIPP delivery at Month 10 is £2.7m off plan. This largely relates to prescribing, which always had a stretching target, by £925k, as PIB2 (Prescribing Incentive Budget) was late starting and £1.9m from the System Recovery Schemes. However, we have delivered £9.8m of savings for the year in total, with the forecast premised on delivering £11.0m, which would be one of the highest amounts we have ever delivered as an organisation.
- 1.3 In terms of financial planning the CCG is actively part of the York and North Yorkshire system within the wider Humber, Coast and Vale STP footprint. The main aims of planning remain clinically led improvement and innovation, over a longer term planning horizon, alignment of plans between commissioner and provider, and working together as a system to deliver change at greater scale.
- 1.4 Initial planning demonstrates a requirement for significant savings across partners in York and North Yorkshire. Work continues to understand the implications of investments required as a result of national operational plan and regulatory requirements; the extent of savings plans developed to date; the requirement to improve operational performance; the need to respond to CQC report; and the need to achieve the financial recovery trajectory. It is expected that discussions with regulator and STP colleagues will continue beyond the draft submission made at the end of February and as such the risk in terms of agreeing a sustainable plan has been increased to reflect this.

2. Operational Planning

- 2.1 The CCG is working with all health and care partners across the local subsystem to confirm operational plans for 2020-21 and capture these for the Humber, Coast and Vale Health and Care Partnership's (HCVHCP) single plan. This planning now includes wider North Yorkshire partners further to the incorporation of Scarborough and Ryedale, Harrogate and District and Hambleton, Richmondshire and Whitby CCGs into recently formed single

North Yorkshire CCG. Activity plans have been refreshed and aligned across the subsystem based on actual delivery to Month 9 and performance trajectories are being developed to capture the impact of both demand and capacity plans and the impact of collective and collaborative work locally and with the HCVHCP.

- 2.2 The focus remains on exploring and developing all opportunities to integrate care and support for local people and staff across services, teams and in different care settings. This is supported by the now agreed allocations of transformational funding through the HCVHCP for 2020-21 and there is also an evaluation of schemes and actions undertaken during the winter to improve resilience.
- 2.3 The national operational planning guidance alongside the new GP contract and enhanced services have highlighted the focus on early cancer diagnosis, enhanced care in care homes, outpatient transformation, the reduction and stabilisation of waiting lists and the continued integration of end to end pathways of care to improve access and continuity of care for children, young people, people with LD and autism.

3. Primary Care Protected Learning Time

- 3.1 The latest protected learning time event for primary care took place on the 23 January 2020. More than 300 colleagues from primary care attended the event and once gain the post event feedback has been very positive. The next protected learning time event takes placed on the 30 April 2020.

4. Better Care Fund

- 4.1 Planning guidance for 2020-21 has been published for a further one year plan for each of the York, North Yorkshire and East Riding of Yorkshire areas. The CCG's draft financial plan submission has provided for the required contributions to all three Better Care Funds and the CCG is in discussions with partners in York and North Yorkshire in particular about how this can be used. The East Riding of Yorkshire element is largely expected to be a continuation of existing schemes.

5. Emergency, Preparedness, Resilience and Response update

- 5.1 Coronavirus (COVID-19)
 - 5.1.1 At the date of writing this report the UK has 13 confirmed cases of Coronavirus and 5000+ people have been tested to date.
 - 5.1.2 NHS111 and YAS are currently providing frontline triage for all UK patients, however, the potential for growth on screening demand on services is likely and the CCG has been asked to support the implementation of a Community Screening Team. This will involve mobilising 30 clinical staff to undertake

swabbing at the patients home, transporting the samples to local laboratories at York and Leeds and ensuring that test results are communicated to the patient and appropriate action taken. In addition to this work, the A&E Delivery Board has been asked to identify five clinicians who would be available to support clinical assessment and provide intervention to those identified as requiring a face to face assessment for those that would have normally been managed in Primary Care. The introduction of the Community Screening Team is to help protect frontline GP, Ambulance and Emergency Department services.

5.1.3 Keith Willett, NHS Strategic Commander and Medical Director for Acute Care and Emergency Preparedness is hosting weekly teleconference calls to update NHS organisations on the current situation and reporting requirements.

5.1.4 York Hospital is acting a 'receiving' unit for Coronavirus cases and has a designated assessment Pod to facilitate in an area separate from the Emergency Department.

5.1.5 Information for the public is available at gov.uk and NHS.uk.

5.2 Business continuity planning

5.2.1 The CCG's Emergency, Preparedness, Resilience and Response (EPRR) Manager and Head of Legal and Governance attended NHS England's Business Continuity Planning event on the 13 February 2020. The CCG's EPRR Manager attended Tees, Esk and Wear Valleys NHS Foundation Trust's business continuity on 16 January 2020 to test plans to tackle a period of adverse weather conditions and power cuts. The CCG's Primary Care Group undertook a table top exercise on 25 February 2020 to discuss the local impact on services due to Coronavirus.

5.3 Tour de Yorkshire

5.3.1 The dates for the Tour de Yorkshire 2020 event have been announced. This year's event does not take place in the Vale of York but goes through the surrounding areas.

30 April 2020	Stage 1 - Yorkshire Coast from Beverley to Redcar
1 May 2020	Stage 2 - Three Peaks from Skipton to Leyburn
2 May 2020	Stage 3 - Heritage Stage from Barnsley to Huddersfield
3 May 2020	Stage 4 – Yorkshire Classic from Halifax to Leeds

6. Strategic and national issues


6.1 NICE's latest impact report brings together its recommendations and real-world data to show that implementing its guidance is making a difference in priority areas of lung cancer care. Lung cancer is the third most common cancer and

the leading cause of cancer-related deaths. It is more important than ever to improve survival rates by recognising, staging and diagnosing more quickly and to provide clearer, easy to understand information to the public.

- 6.2 The Academy of Medical Royal Colleges has published the initial version of the first ever national patient safety syllabus for the NHS. This is a key programme commissioned by Health Education England and included in the NHS patient safety strategy. The syllabus will underpin the development of patient safety curricula for all NHS staff.
- 6.3 The new digital primary care maturity assurance dashboard contains data for CCGs and GP practices across 98 indicators, collected from 2015-16 to 2018-19. The data can be used as a measure of primary care organisations' digital maturity. The dashboard enables data filtration, comparisons and downloads.
- 6.4 NHS England and NHS Improvement have produced a brief video about personal health budgets. Recent legislation means up to 100,000 more people will benefit from personal health budgets in coming years.
- 6.5 NHS England and NHS Improvement are conducting a comprehensive review of non-emergency patient transport services to analyse how the current system works, and to work out how best to improve services within existing and future NHS resources. Evidence needs to be submitted by midday on Friday 13 March.

7. Recommendation

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

Item Number: 7.1	
Name of Presenter: Michelle Carrington	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Quality and Patient Experience Report incorporating Risk Report	
Purpose of Report <i>(Select from list)</i> For Decision	
Reason for Report	
<p>The Quality & Patient Experience Committee (QPEC) met on 13 February 2020 and reviewed the risk register.</p> <p>The following risks are being escalated straight to the Governing Body as a result of the scoring and the risk appetite. Those risks are set out in the report:-</p> <ul style="list-style-type: none"> • QN.03 - Quality of commissioned specialist nursing services • QN.04 - Increasing number of extended trolley waits in ED breaching 12 hours • QN.05 - Poor discharge standards from YTHFT • QN.06 - Infection control processes not adequate • QN.07 - Referral for initial health checks - timeliness of CYC referrals • QN.08 - Clinical risks associated with growing waiting list (planned care) • QN.10 - Potential unexpected closure of nursing beds • QN.12 – Missed pertussis vaccination for expectant mothers • QN.13 – Hep B vaccine in renal patients • QN.14 – Quality, safety and concerns at a GP Practice in Vale of York CCG area • QN.15 – CQC involvement in York Teaching Hospital NHS Foundation Trust <p>The Governing Body is asked to consider these risks and determine the actions required to manage them. The Governing Body should consider whether they wish to manage these risks themselves which will require the Governing Body to dictate mitigating actions and monitor the risks reported.</p> <p>QPEC also recognised that the Quality & Patient Experience Report on the whole had duplicate narrative on the risks and as such, for this time, the report has been combined with the risk register.</p>	
Events	
<p>There are two events which the Governing Body should be aware of. This means risks which have now materialised and therefore are no longer risks.</p>	

- QN.09 - Following the SEND Inspection in December 2019 confirmation was provided that the CCG and partners are failing to meet the Statutory Requirements of SEND children. It is accepted there will likely be risks from the SEND action which will need to be added to the risk register.
- ES.01 - The jointly agreed system financial recovery schemes will not deliver and will trigger the three way risk share arrangement and that this will exceed available contingency reserves in the CCG with the consequence that the CCG cannot deliver its accepted plan.

The Governing Body, in its progressive work to further develop its approach to managing risk has not yet considered a process for when a risk becomes an event. Therefore Governing Body is asked to consider whether a lesson's learned exercise and action plan for these two events should be submitted to the April 2020 workshop session of the Governing Body.

Strategic Priority Links

- | | |
|---|---|
| <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 | |

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

Risk Rating

Emerging Risks

Increasing cases of COVID-19 and a potential for immediate system response and effect on services

Risks emerging from the SEND action plan

Risks emerging from an intention to reconfigure the Healthy Child Service delivered by NYCC

Potential for risk associated with fragile provision of stroke services at Scarborough Hospital and a requirement to reconfigure services.

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

N/A

Recommendations

For Governing Body to accept this report for assurance and mitigation of key quality, safety and patient experience issues.

Decision Requested (for Decision Log)

Governing Body is requested to approve testing an approach to lessons learned from risks which become events.

To decide whether members are assured of the accuracy of risks and that appropriate mitigation is being taken to manage these risks.

To decide whether the risks identified are to continue to be managed by Governing Body

To identify any risks to be delegated back to QPEC.

To determine whether members are assured of the wider work being undertaken to ensure quality, safety and an underpinning approach to patient engagement.

Responsible Executive Director and Title

Michelle Carrington
Executive Director of Quality and Nursing

Report Author and Title

Michelle Carrington
Executive Director of Quality and Nursing

Quality and Patient Experience Report to Governing Body

– February 2020

1. PURPOSE OF THE REPORT

The purpose of this report is to provide the Governing Body with full detail on risks and mitigations associated with quality, safety and patient experience across our commissioned services. It also details by exception, progress and updates on quality, safety and patient experience that is not related to existing risks.

A more detailed report has been discussed at the Quality of Patient Experience Committee (QPEC) in February 2020.

INFECTION PREVENTION & CONTROL (IPC)

Novel Coronavirus – COVID-19

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV). A novel coronavirus (now named COVID-19) is a new strain that has not been previously identified in humans.

The first two cases in England were positively identified in patients within the VOY CCG.

They were appropriately triaged by NHS 111 and transferred to an Infectious Diseases unit to be cared for.

Public Health England (PHE) are leading and coordinating a system wide response. The CCG responded quickly by convening at least daily escalation meetings which included the local Director of Public Health, reviewing systems and processes including the Flu pandemic plan (which has transferable process management), developed a webpage for primary care with all the up to date and relevant information, agreed joint communications with partners and agreed funding for extra locum sessions to support potential affected practices.

It is noted that the CCG were assured by the robust plans operated by the Acute Trust which were enacted in a timely manner.

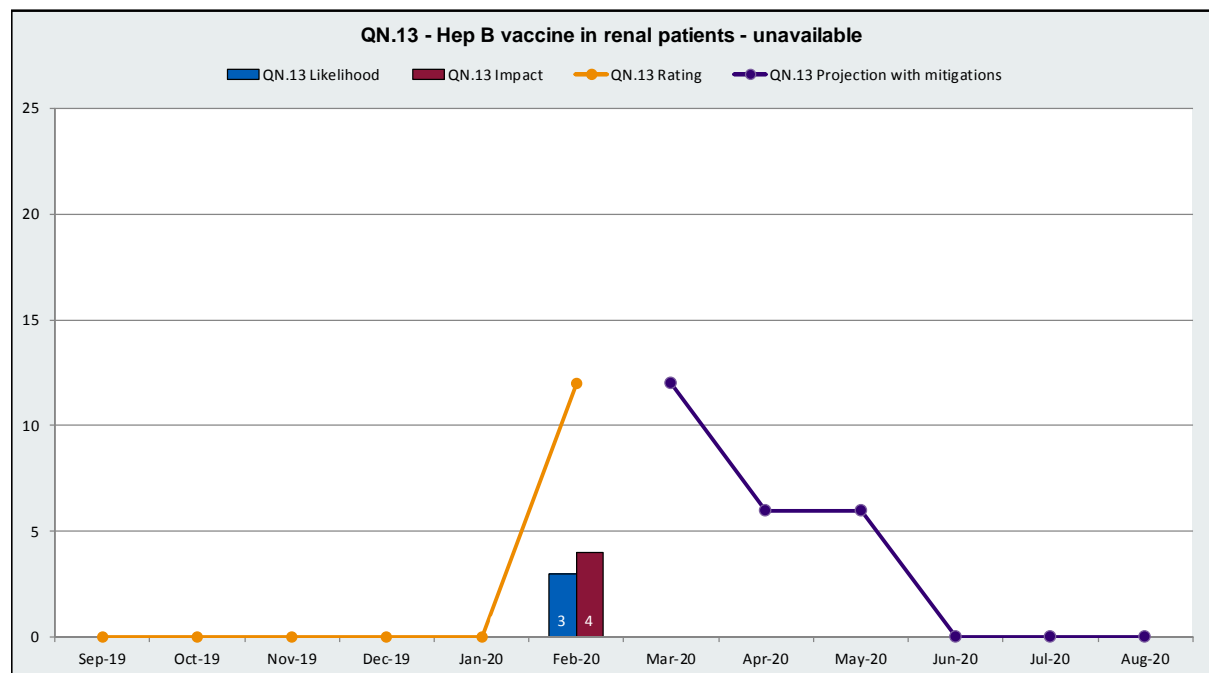
The CCG and system partners are continuing to report and take forward actions as guided by PHE in line with national and international developments.

Due to the increase in cases globally it is expected that there will need to be more local approaches to community testing and the CCG is working with partners to ensure readiness is required.

<p>There is a risk that services will be stretched affecting performance and safety as cases rise and a risk that a potential for a more local response to community testing will not be able to be initiated urgently due to logistics and resource issues.</p>
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Hepatitis B vaccine:

Risk Ref	QN.13
Title	Hep B vaccine in renal patients - unavailable
Operational Lead	Paula Middlebrook
Lead Director	Michelle Carrington
Description and Impact on Care	<p>Patients with chronic renal failure potentially remain at increased risk of hepatitis B virus (HBV) infection because of their need for long term haemodialysis. Due to impaired immune responses, HBV infection in haemodialysis patients may be subclinical, and such patients may become carriers of the virus.</p> <p>NHSE wrote to both Primary Care and Secondary Care Trusts informing them that the responsibility for provision of Hepatitis B vaccinations was transferring from Primary care to Secondary care renal services from July 2019. Prior to this there was an effective process in place for Primary care to deliver the vaccinations.</p> <p>Due to lack of advance notice, YTHFT have informed the CCG that they are unable to meet this need due to the additional resource that is required in clinic capacity and personnel to deliver the service.</p> <p>Local GPs have stopped providing the vaccinations due to the NHSE notification that they are no longer commissioned to provide it.</p> <p>There is a risk that patients requiring the vaccine are currently not receiving it.</p>

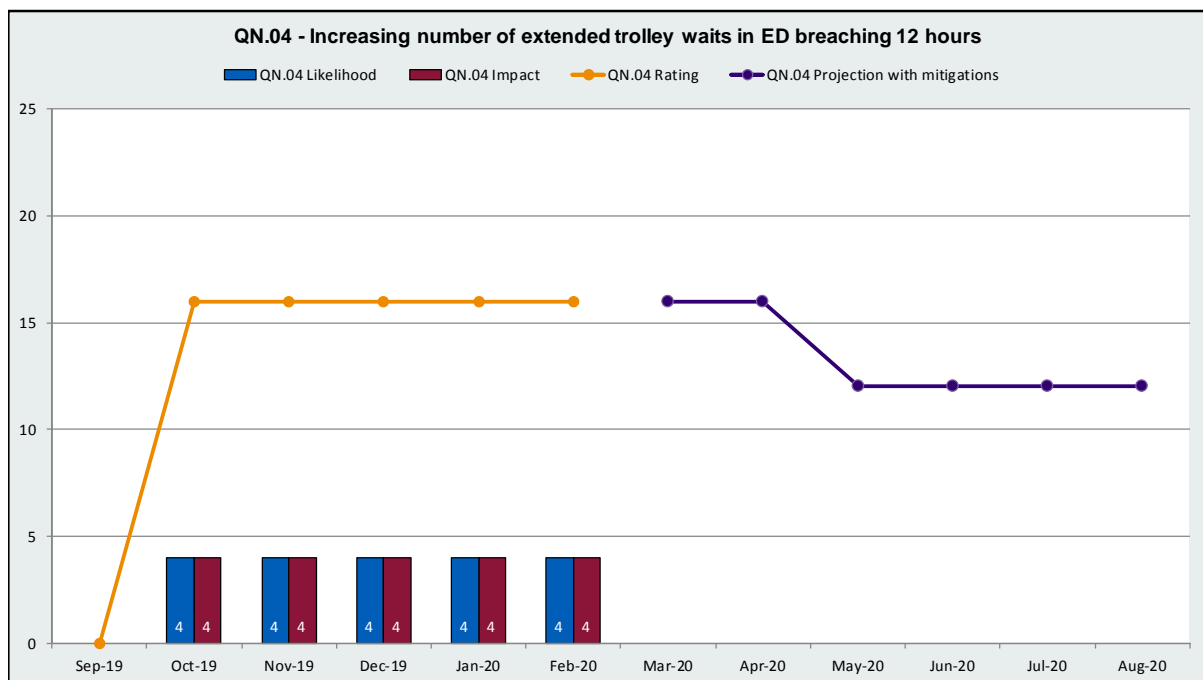


Mitigating Actions and Comments
<p>Date: 6 February 2020</p> <p>The CCG has met with YTHFT to fully understand the risk surrounding gaps in vaccinations and their plans to deliver the vaccination plan. The risk for patients are:</p> <ul style="list-style-type: none"> - Development of Hepatitis B which can increase their risk of chronic liver disease including cancer <p>The risk for the service is:</p> <ul style="list-style-type: none"> - If a patient develops Hepatitis B they would require isolation from other patients in order to prevent cross infection and an outbreak across the dialysis unit. <p>Patients are screened throughout dialysis for early detection and to ensure mitigation actions are put in place. YTHFT are developing an options appraisal for models to deliver vaccinations which they will submit to the CCG mid February. These will require further consideration and discussion with primary care.</p>

York Teaching Hospital NHS Foundation Trust (YHFT)

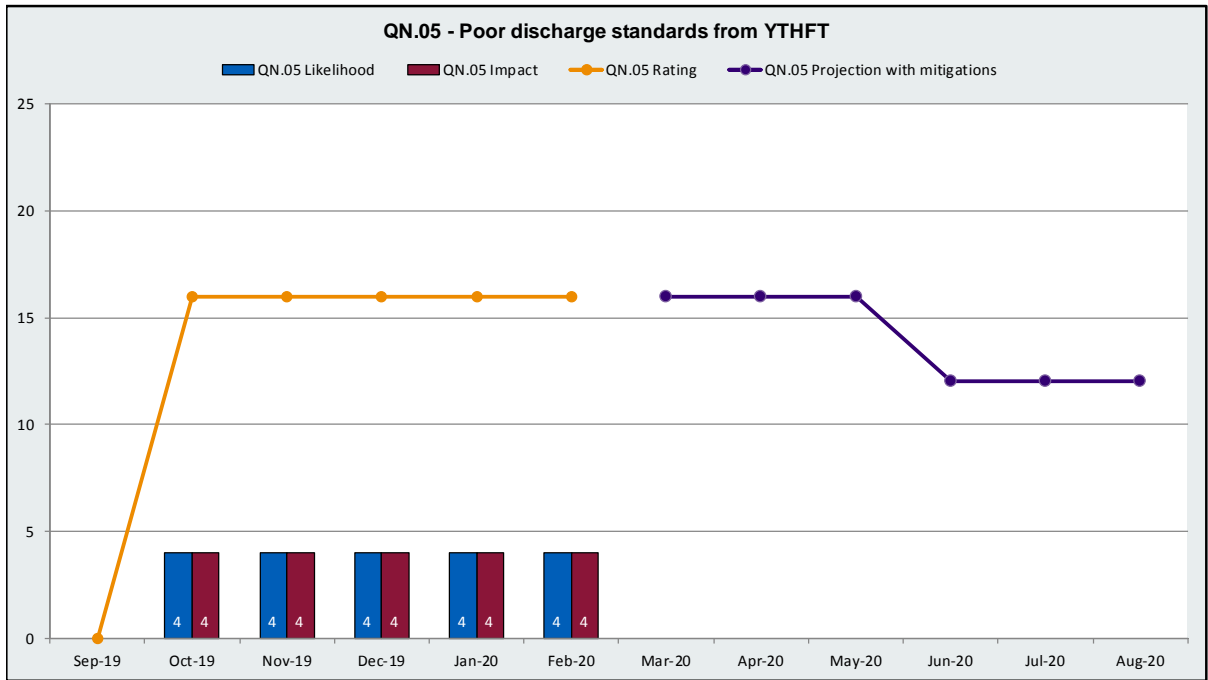
YHFT remains at Risk Summit level due to the nature of concerns around quality and safety and due to the regulatory notices imposed on them by the CQC. There is a newly convened Patient Safety Group chaired by NHSE/I the main aim being to support the resolution to the CQC 'must do's'. The governance of this is being worked through in terms of escalation and oversight across the system.

Risk Ref	QN.04
Title	Increasing number of extended trolley waits in ED breaching 12 hours
Operational Lead	Sarah Fiori
Lead Director	Executive Director for Nursing and Quality
Description and Impact on Care	Deterioration in achieving the 4hr ECS has resulted in extended trolley waits on both York and Scarborough sites posing potential risk to patient safety and quality of care both to those patients and those waiting in ED yet to be assessed or treated.



Mitigating Actions and Comments
<p>Date: 28 January 2020</p> <p>The majority of the breaches are on the Scarborough site and continue to rise.</p> <p>All 12 hour trolley waits are declared serious incidents and as such they are scrutinised and clinical site visits add to assurance processes and are continuing.</p> <p>Quality Improvement Board continues to focus on collaborative working to reduce the number and risk via the subgroup (12 hour trolley wait). The focus of the work is inevitably on the Scarborough site which affects a different CCG. Although a system approach is required and we are a part of that approach there are additional estate issues affecting Scarborough and the VoYCCG patients are less affected by these issues.</p>

Risk Ref	QN.05
Title	Poor discharge standards from YHFT
Operational Lead	Sarah Fiori
Lead Director	Executive Director of Nursing and Quality
Description and Impact on Care	There is a significant risk to patient safety that discharges are not reliably safe from YHFT to care homes and can result in poor patient experience.

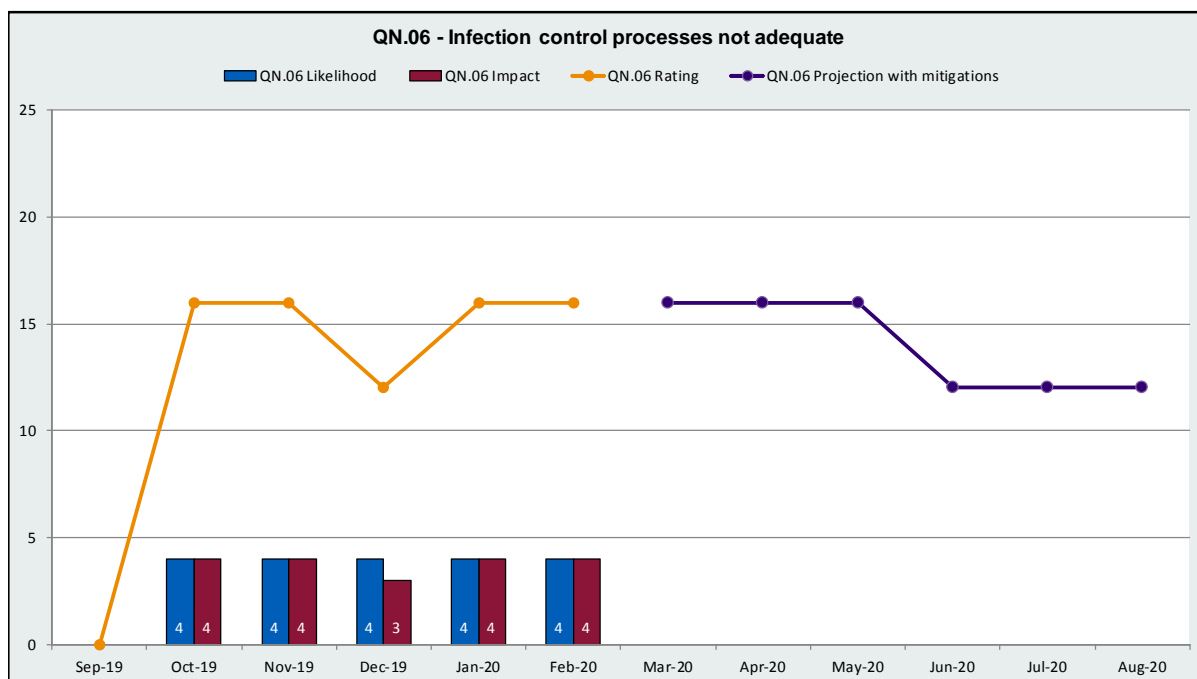


Mitigating Actions and Comments

Date: 6 February 2020

The CCG are supporting the Trust (both York and Scarborough sites) via a focussed piece of work to identify minimum discharge standards and to improve the quality and safety of the process to safeguard patients on transfer to another care facility or usual place of residence. This work will initially begin within Care Group 1, led by Head of Nursing on the elderly medical wards and Emergency Department but will eventually spread minimum discharge standards wider.

Risk Ref	QN.06
Title	Infection control processes not adequate
Operational Lead	Sarah Fiori
Lead Director	Executive Director for Nursing and Quality
Description and Impact on Care	Following previous infection outbreaks, there remain concerns about the robustness of the infection control processes at both YTHFT sites and estates issues at the Scarborough site. There is also an issue with the effectiveness of HPV equipment at both sites.



Mitigating Actions and Comments

Date: 3 December 2019

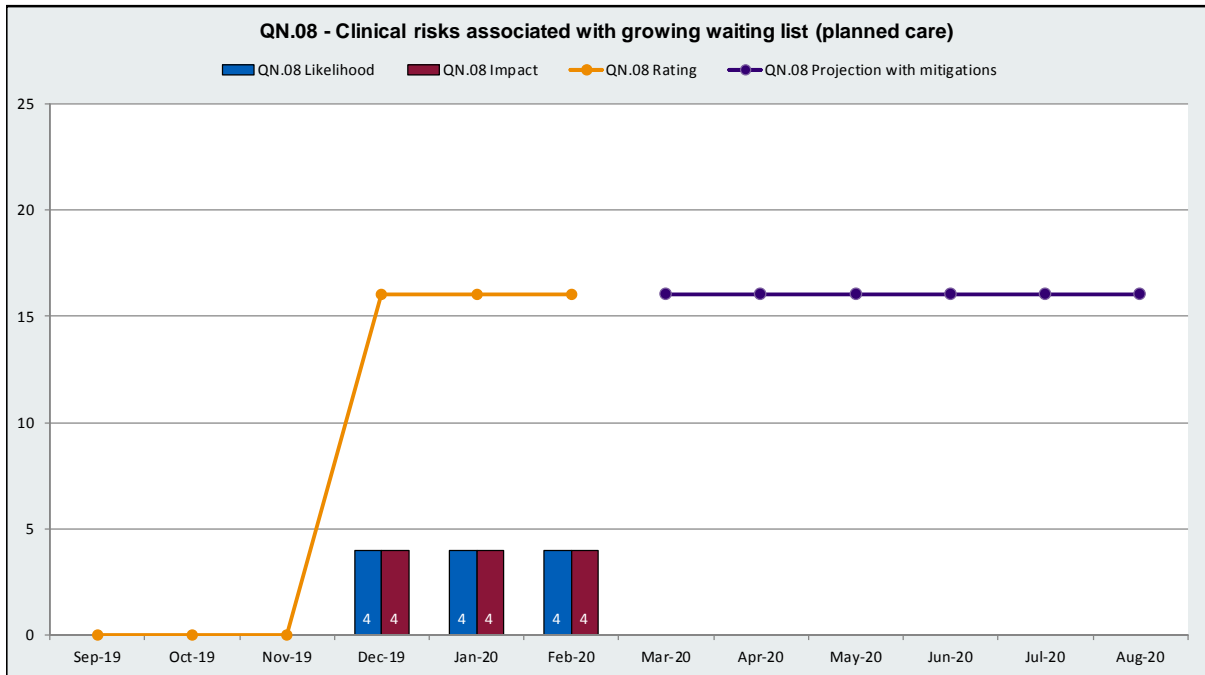
York Foundation Trust declared a further outbreak of Clostridium Difficile (C.Diff) cases on 7 January 2020, following increasing incidence of cases since October 2019. A number of Ribotypes have been identified of cases occurring within the same inpatient areas as the previous outbreak. The Trust has recommended fortnightly outbreak meetings and developed an action plan which incorporates outstanding issues from the previous outbreak. Issues identified include:

- Bed rail covers which are required to aid cleaning
- Replacement of the HPV machines and the business cases for staff
- Purchase of Microfiber mops on the Scarborough site
- Decant facility on the Scarborough site,
- Commode cleaning

The Infection Prevention and Control Microbiologist presented the Trust position at the Executive Board highlighting the Trust are currently 6th highest in the country for the number of C.Diff cases reported. This was a positive meeting with commitment to raise the leadership of IPC at Board level within the organisation as well as a request for action and funding to support capital build programme including a decant ward, the abolition of nightingale wards and the establishment of more side rooms.

Business case for HPV equipment approved December 2019. Further business case for staffing was due in January 2020 and we await the outcome. NHSE/I specialist in IPC completed review on behalf of YTHFT action plan to be shared with the CCG in February 2020.

Risk Ref	QN.08
Title	Clinical risks associated with growing waiting list (planned care)
Operational Lead	Caroline Alexander
Lead Director	Executive Director for Nursing and Quality
Description and Impact on Care	Growing waiting list for planned care at YTHFT increasing the clinical risk to patients while waiting for procedure. Some evidence of harm already.

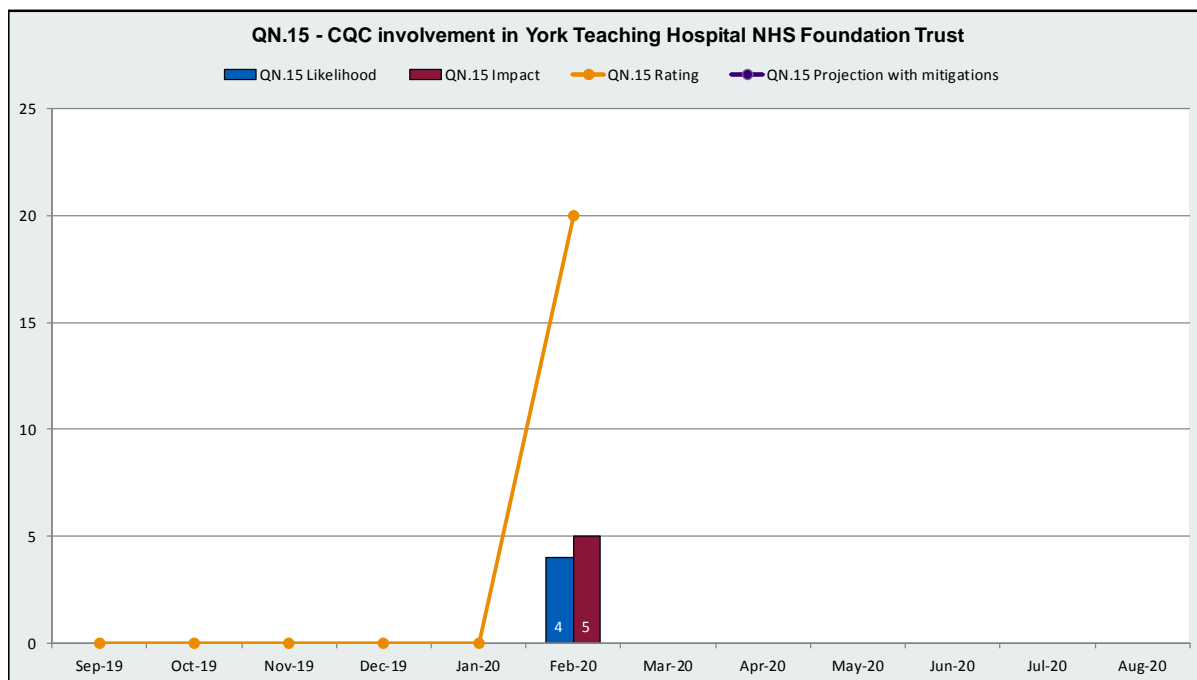


Mitigating Actions and Comments

Date: 6 February 2020

First assessment of the clinical risk of the backlogs undertaken by care groups has been received by the CCG. Monthly assessment and dashboard down to specialty level is being developed. Joint planned care board at the end of January agreed to mobilise joint secondary care and primary care clinical review of the backlog in the most pressurised specialties (respiratory, cardiology, pain, sleep). All patients overdue their surveillance appointments are being reviewed first but this will take 2-3 months to complete. It is anticipated that 60% of patients on surveillance list can be discharged under new guidelines which will significantly reduce the number of patients waiting.

Risk Ref	QN.15
Title	CQC involvement in York Teaching Hospital NHS Foundation Trust
Operational Lead	Michelle Carrington
Lead Director	Michelle Carrington
Description and Impact on Care	There is a risk that the current CQC involvement in services in the Acute Provider, on both sites, may result in CQC taking further regulatory action resulting in the potential closure of services significantly adversely affecting quality and safety of services across the system.



Mitigating Actions and Comments
Date: 7 February 2020
CQC have issued two regulation 31 notices and one regulation 29a and a regulation 64 notice in respect of services at York Teaching Hospitals NHS Foundation Trust. This may ultimately result in the closure of services and is impacting on the providers ability to deliver services where the focus is on responding to these notices. There is an existing Quality Improvement Board chaired by Chief Nurse CCG. From February 2020 there will be a patient safety group Chaired by the Chief Nurse North NHSE/I, concentrating on the 'must do' in the CQC action plan.
The main areas for concern are staffing in ED (paediatrics) and medical wards on both sites, mental health assessments ED both sites.

Stroke services on the Scarborough Hospital site are fragile due to specialist staffing issues and a potential for changes to pathways for patients is being considered. This may result in more patients being cared for at York Hospital. The issues are being worked through with the provider and the Stroke Strategic Clinical Network to ensure safe provision.

Tees, Esk and Wear Valleys Trust (TEWV)

There have been 17 incidents reported concerning VoY CCG patients as at 04/02/20 and a significant increase in the number of incidents reported by TEWV across the whole organisation.

This has significantly impacted on capacity and workforce issues within the Trust investigation team, resulting in an increased number of extensions requested to report deadlines.

The CCG has asked the organisations' plans to mitigate longer term impacts of this and a staffing update has been received. A Family Liaison Officer role has been developed by TEWV to support families through the investigation process and to keep them apprised of progress and timescales.

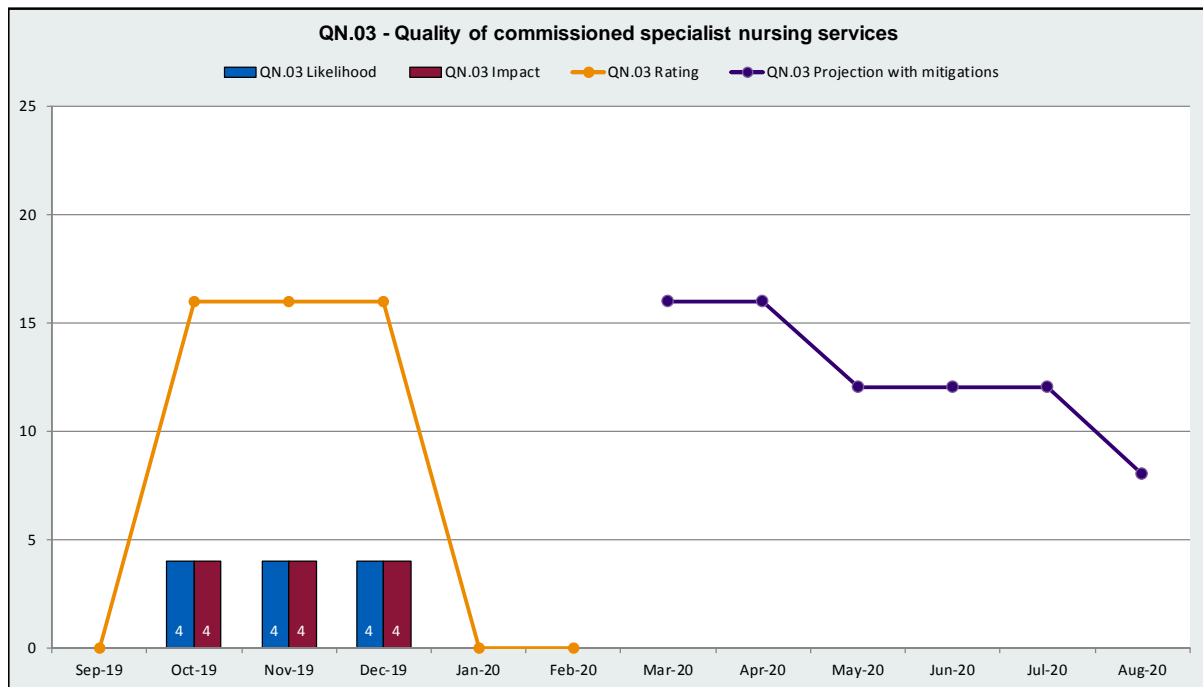
As a result of these issues provision of reports within the set timescale has not improved, with fewer than 25% of reports submitted achieving the set timescale.

Assurances had been requested concerning the mapping of learning from events and recurrent themes. TEWV clarified that across the organisation there isn't a system for identifying patterns and trends or to bring together the learning from each area. Improvement work to address this is on-going, with TEWV consulting with staff to ask what system, mechanism or processes can the Trust implement that will give a clear consistent approach to the learning to share, embed and monitor improvement across the Trust and the CCG has requested to be invited to future meetings.

Children's services:

1. Transformation of children's community services and special school nursing:

Risk Ref	QN.03
Title	Quality of commissioned specialist nursing services
Operational Lead	Karen McNicholas/Paula Middlebrook
Lead Director	Executive Director for Nursing and Quality
Description and Impact on Care	The quality of care provided to children is not of the standard expected and the model in which care is delivered is not transformational. This relates to special school nursing and generic school nursing, community paediatric nursing team. Providers are not fulfilling their required duties under the legislation and guidance.



Mitigating Actions and Comments

Date: February 2020

A childrens transformation plan is being developed which includes a detailed service specification. This will incorporate these services and enable them to be measured against quality. other activity includes

In response to these concerns the CCG has attempted to support YHFT on the development of a service transformation plan for special school nursing and community children's nursing. This transformation plan includes:

- the development of a detailed service specification to describe what the CCG needed to commission and expected standards
- leading on engagement with education and local authority partners on joint working practices
- Facilitating and leading discussions with our two special schools re reforms and improvements
- providing specialist advice to YHFT (including the need for a robust 'delegation of care' framework)
- Securing additional resources for a new paediatric tier 2 continence service
- The CCG itself hosting a Children's Community Nursing (CCN) and special school nursing forum to bring together services from across Yorkshire and Humber to review and share practice, benchmark against national standards and provide peer supervision and support. The first event was in June 19 with a resounding positive outcome (7 teams made up of 25 nurses attended including YHFT) and there was a huge appetite for this to continue

Progress so far and outstanding issues:

Engagement with YHFT has been fluctuating and there are a number of outstanding issues and concerns which are summarised as follows:

- No formal response/ comments to SLA continence service submitted to YHFT at the end of January 2019 (other than ad hoc comments & some finance issues despite asking numerous times) & recruitment has gone ahead. Financial agreement has however been ratified
- No formal or informal response to service specification submitted on April 16th 2019, despite a request for a 6 week timeframe
- No formal response to final audit report submitted in May 2019
- There is still no competency framework for 'delegation of care' in place despite YHFT advising they would go ahead with this at the end of January 2019
- On-going risks to the residential short breaks service
- Unclear and concerning governance arrangements for the support offered to community short breaks service (12.5 hours ring-fenced funding). Concerns re-record keeping raised internally prior to notification of CQC inspection in December 2018
- Potential risks to the developing strong and integrated relationship with CYC who have developed significant trust in the CCG to deliver assurance that health support will continue and improve in quality
- Recent concerns raised regarding joint policies within special schools e.g. medicines management. No response received
- Suspension by YHFT (by the Interim Chief Nurse) re the transformation plan until review of all above
- The CCG has had to manage very delicate communications with education and children social care as they are unclear what the service is delivering and will make the CCG and YHFT potentially non-compliant with the Children & Families Act 2014

Re the last two points, consultations with education, head teachers and YHFT staff had taken place re proposals to remodel the special school nursing service. Consultations were planned with parents in the summer term of 2019, with an implementation plan to begin in September 2019 (timescale 1 year to ensure all safeguards and risks were all considered).

Meeting held with Chief Nurse YHFT who has endorsed the transformation plan and meeting with the relevant YHFT to progress on 6 December 2019. Karen McNicholas and Michelle Carrington leading from the CCG.

2. Special Education Needs and Disabilities (SEND):

The joint area Ofsted and CQC SEND inspection took place during the week of 9th-13th December 2019. The inspection was anticipated as part of the national inspection schedule set out to measure compliance with the duties enacted by the Children & Families Act 2014. Essentially the inspection considers whether organisations and in this case VOY CCG and CYC carry out their duties and responsibilities to ensure children and young people up to the age of 25 years who have special educational needs and disabilities (SEND) receive timely and good quality support to improve outcomes regarding educational achievements, employment opportunities and inclusivity. For the CCG and health organisations this means ensuring the services they commission support the SEND strategy by promoting health in delivering outcomes based advice, support and interventions.

The inspection team notified the CCG and CYC that they are not compliant with the Children & Families Act (2014) and associated statutory SEND code of Practice (2015). A formal notification is expected at the end of January 2020. In response, a written statement of action is required to inform the inspectorate how the local area

will improve services to become compliant. Whilst CYC will lead on the written statement of action, the CCG is required to collaborate on the response in partnership with its health providers and other agencies. Reasons for non-compliance that directly relate to the CCG are captured under the following headings:

- How effectively does the local area identify children and young people with SEND?
- How effectively does the local area assess and meet the needs of children and young people with SEND?
- How effectively does the local area improve outcomes for children and young people with SEND?

Mitigating actions

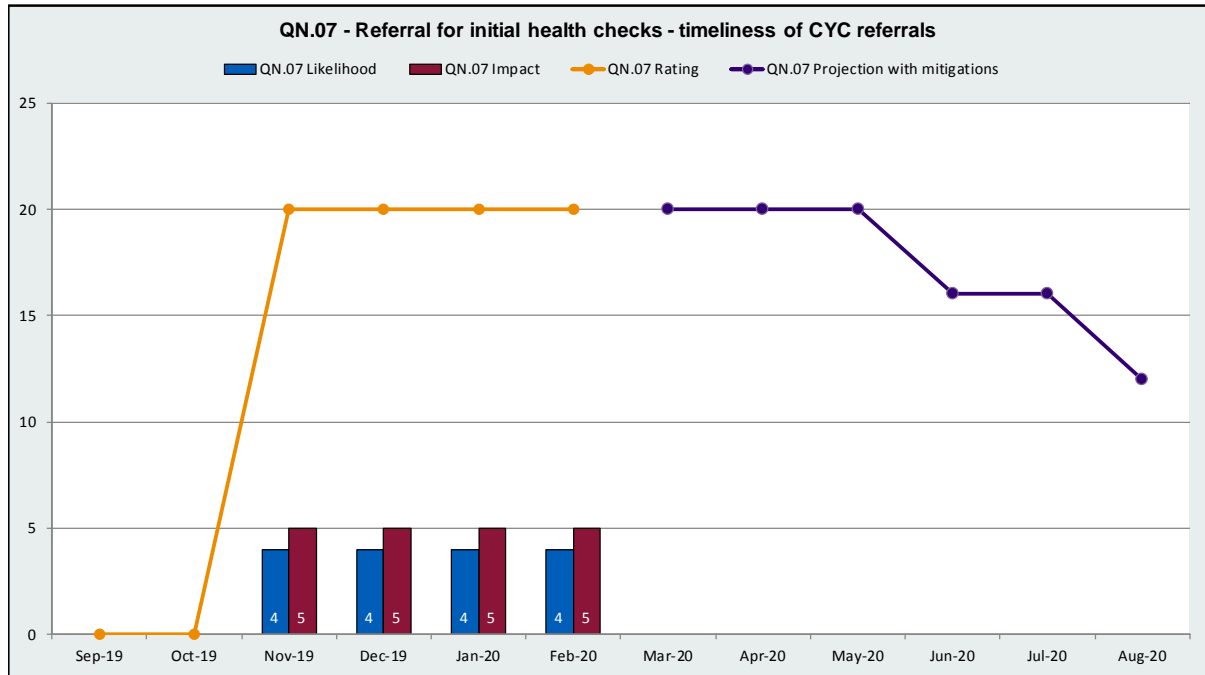
The formal letter from the inspectorate is expected early February 2020

- DfE and NHSE meeting with CCG executives on the 20th February 2020 followed by a meeting with children's commissioning and quality leads in the CCG to support the Written statement of Action with local authority colleagues and health partners.
- Children's Community Nursing & Special School nursing transformation plan in progress will address the service specification issue and will describe a more strengthened service offer in relation to SEND.
- Integration of short breaks and continuing care strategy in progress.
- High likelihood of more joint commissioning and integration will be required and probable further investment will be required
- CCG representation at a two weekly SEND Improvement Board which will agree the response strategy and lead into a number of sub groups to actions. This will include a health partner's sub group led by the CCG. More detail on specifics will be available then.

Timeline – once the formal letter is received CYC & the CCG will need to formulate a joint response in the written statement of action within 70 days setting out the plan. It is anticipated this will be approximately around April 2020. At this time we will have a clearer understanding of the short, medium and long term objectives. The inspection team will require periodic updates on progress and re inspect eighteen months following acceptance of the written statement of action and is estimated to be around October 2021. However if they are dissatisfied with progress reported they may visit sooner.

3. Children's health assessments:

Risk Ref	QN.07
Title	Referral for initial health checks - timeliness of CYC referrals
Operational Lead	Karen Hedgley
Lead Director	Michelle Carrington
Description and Impact on Care	The CCG has a statutory responsibility to work with the Local Authority to ensure children new to the care of the Local Authority are offered an initial health assessment within 20 working days of entering care. Analysis of the data, measuring timeliness of assessment has identified very poor performance in York. This fluctuates between 0-50% over the last year with no sustained improvements. The data also indicates the delays are primarily due to lack of notification/request from Local Authority.



Mitigating Actions and Comments
Date: 27 January 2020
LA Childrens Social Care have identified an administrative resource to support more timely notifications to health. The initial data for Q3 suggests a significant improvement in timeliness of notifications. It is expected that the issue of delays across the system will not be fully realised until Q4.

4. Healthy Child Program North Yorkshire

It is in the public domain that NYCC is developing a new Healthy Child Programme Service Model which may result in reduced provision when compared to the current service model. A risk based approach to support is being developed. An initial meeting with system partners and stakeholders has taken

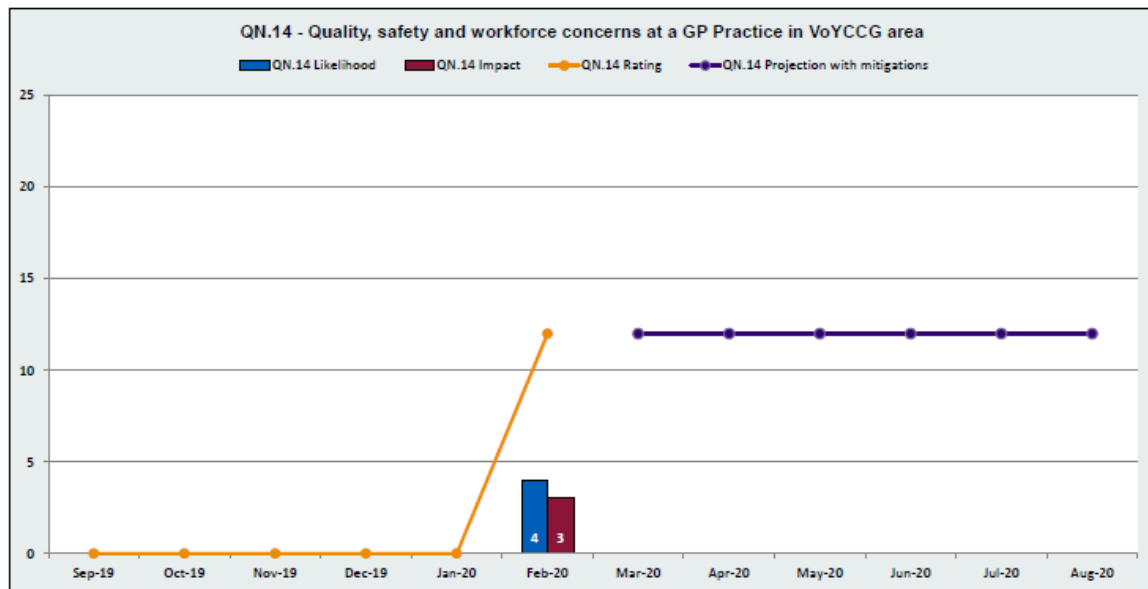
place and a timeline for development and engagement agreed. Public consultation will take place.

Primary Care:

In January the QPEC had a single quality item on Primary Care. A range of presentations and discussions took place. QPEC was assured that the CCG has a range of information and intelligence available to them to determine the quality and safety of services and that robust relationships and support to practices is key. The gap in key intelligence remains themes and issues from complaints and serious incidents (significant event audits). The minutes from that meeting are available to Governing Body.

One practice in particular is flagging concern.

Risk Ref	QN.14
Title	Quality, safety and workforce concerns at a GP Practice in VoYCCG area
Operational Lead	Stephanie Porter
Lead Director	Michelle Carrington/Andrew Lee
Description and Impact on Care	There are quality and safety risks emerging for one of the VoYCCG GP practices following the receipt of information from whistleblowing, soft intelligence information and complaints. The potential impact is on the safety and quality of services being maintained and a particular concern around the fragility of the workforce and clinical supervision.

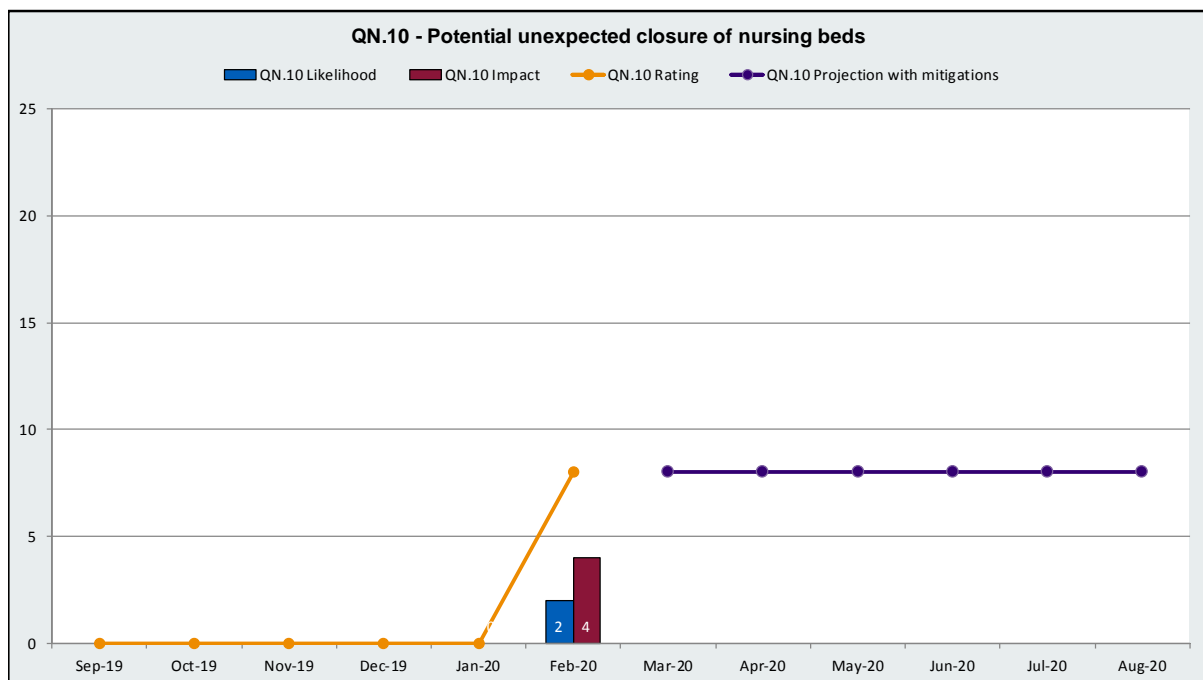


Mitigating Actions and Comments
Date: 27 February 2020
The CCG wrote to the practice outlining concerns and seeking assurance regarding management of complaints, serious incidents, workforce, raising concerns (whistleblowing), leadership and culture and access to appointments and requested a meeting. This meeting took place with the two remaining partners on 23 January 2020. Follow up actions have been agreed which include support to the practice for complaints and Freedom to Speak Up Guardianship. The CCG were also invited to go into the practice to undertake a more formal clinical site visit and speak to staff which is being planned.

Residential and Nursing Care:

A risk has been identified around change of registered use or loss of beds in the system. Work continues to support care homes, domiciliary care and supported living to be more resilient and provide high quality care including React to Red, React to Falls, trusted transfer pathways, digital connectivity and softer signs to detect and act on deterioration.

Risk Ref	QN.10
Title	Potential unexpected closure of nursing beds
Operational Lead	Sarah Fiori
Lead Director	Michelle Carrington
Description and Impact on Care	Recently a care home has changed their registration from nursing to residential resulting in the loss of nursing beds to the system. There is the potential for more homes to do this or for homes to cease to trade in the York area resulting in capacity issues. The CCG needs to develop ways of gaining soft intelligence about this to increase preparedness for the event of a closure.



Mitigating Actions and Comments

Date: 6 February 2020

The CCG became aware that a nursing home in the area would be changing its registration from nursing home to residential home which would cost the system a number of nursing home beds. The CCG found out after the decision had been made by the care home and it has given rise to concern about how the CCG obtain intelligence about whether homes are planning to close or change their registration status. As a result the CCG is going to consider whether there is a way intelligence can be gathered using the partners in care meeting or other forums to establish whether there is a risk of closure of other homes. The CCG Quality team hope to be able to report a plan for this intelligence gathering to the QPEC meeting in April 2020.

PATIENT EXPERIENCE UPDATE

Vale of York CCG Complaints

11 complaints were registered in the CCG during November and December 2019

100% of the complaints were acknowledged within 3 days (in accordance with the NHS complaint procedure).

100% of the closed complaints were responded to within allocated timescale. 1 CHC complaint has been extended for 2 weeks as additional records were requested to inform the investigation.

Specialty/Area	No. of complaints	Outcome after investigation
Continuing Healthcare	7	3 partially upheld 3 upheld 1 on-going
Patient Transport Service	3	3 not upheld
Independent Funding Request	1	Not upheld

Parliamentary & Health Service Ombudsman (PHSO)

The PHSO is the second and final stage of the NHS complaints procedure for complainants who remain unhappy with the NHS organisation's attempts to resolve their complaint.

1 complaint about Continuing Healthcare (CHC) has been referred to the PHSO. A copy of the complaint file has been provided and we are waiting to hear whether they are investigating further.

Vale of York CCG Concerns

109 concerns/enquiries were managed by the Patient Relations Team during September and October. These cover a wide ranging variety of topics, some of which are complex cases requiring investigation. This figure does not include the cases where straightforward information and advice was given, as these are not recorded.

Compliments

2 compliments were received – both for the Patient Relations Team by complainants who thanked the team for their help and support through the complaints process.

ENGAGEMENT UPDATE

CCG Improvement and Assessment Framework (IAF), Patient and Community Engagement Indicator

We submitted our evidence for the CCG IAF Patient and Community Engagement Indicator on 11 February 2020. This indicator assesses how well a CCG has involved the public and demonstrated a commitment to supporting continuous improvement in public participation.

In our submission we have illustrated how we have made improvements in the way that we assess engagement in relation to the Equality Delivery System (EDS2). We have been using the EDS2 to help us to review and improve our equality and engagement performance for people with characteristics protected by the Equality Act 2010.

[More information about EDS2 and engagement can be found on our website.](#)

We have also shown how we responded to feedback and created a public facing version and an EasyRead version of the Engagement Annual Report 2018-19. These [engagement reports can be found on our website.](#)

Healthwatch reports:

The CCG has received and responded to two Healthwatch reports:

- **Healthwatch Report on Changes to Repeat Prescriptions – March 2020**
This report was undertaken within a few months of the changes to the process for ordering repeat prescriptions. The changes introduced were to ensure an improved approach to prevention of inappropriate prescribing from both a clinical / patient safety and financial waste perspective.
The CCG has responded to the recommendations and learning from the implementation process
- **NY Healthwatch Report – Interpreting in Health and Social care services**
The report, [Policy Vs Reality: Interpreting In Health And Social Care Services](#), details research which found that some refugees seeking medical help were being denied access to interpreters or discouraged from using them, while health professionals often relied on Google Translate – which NHS guidelines say should be avoided due to its lack of accuracy.

Healthwatch commits to working with providers and commissioners to help improve the experience of accessing healthcare for North Yorkshire's refugees.

INVOLVING OUR COMMUNITIES:

In this section there is information to illustrate how we are developing, monitoring and improving services in partnership with our community. This includes the difference public involvement activity has made.

Date	The impact of engagement
29 January	<p>Engaging with young people with a disability: In January 2020, in partnership with the City of York Council, our leads for children and young people, and engagement spoke to a group of children aged between 15-16 years old about what health means to them. As part of the 'access for all' session we took along some nurses from the hospital and talked about what it is like to access healthcare from the point of view of a young person with a disability.</p> <p>Some of the feedback was as follows: 'we want quiet places', 'we get bored easily – it's good if there is internet', 'better food', 'staff are friendly - I like that', 'can people speak more slowly when they introduce themselves', 'sometimes I don't understand what they are saying', 'sometimes they talk to my mum instead of me'.</p> <p>As a result we will be working with health services to respond to this feedback and make improvements. This could include a hospital site walk around with young people, so they can show us what works well and what could be better.</p>
29 January 2020	<p>Access to services for deaf and hard of hearing people: In partnership with the local authority, Healthwatch and voluntary sector advocacy groups we reviewed feedback around the barriers to accessing services for deaf and hard of hearing people. The group will be hosting an event in April 2020 to look at collaborative solutions with services users.</p>
23 January	<p>Protected Learning Time: This session focused on understanding more about patients' needs and how community-based resources might help to improve their care outcomes. Over 275 delegates and 30 community facilitators attended. They were able to network and raise awareness of the wealth of resources from across health and wellbeing available to patients. The feedback has been overwhelmingly positive and has helped to connect primary care with resources available in the community to provide non-medical interventions.</p>
21 January 14 and 15 January	<p>Healthwatch Assembly: Giving feedback and letting people know how their views have made a difference is really important. We learnt how our main provide York Teaching Hospital Trust is improving its services for patients with a disability.</p> <p>Meeting with Healthwatch York and North Yorkshire to discuss the IAF community engagement indicator submission and to look at working together on future engagement projects.</p>
11 December 2019	<p>Student health campaign: We went into York College as part of their winter health and wellbeing day (December 2019) to talk to students about what would make a health campaign attractive. Many students said they would notice adverts and advice through social media. We will be using this feedback to deliver some targeted campaigns.</p>

RESEARCH AND DEVELOPMENT:

The following table provides an overview of research activity across the CCG.

CCG Name	No. Practices	No. Practices Recruiting	% Practices Recruiting	No. Studies	Recruitment	Population	Recruitment per Million
NHS Vale of York CCG	26	20	77%	13	615	359,602	1,710

The CCG Portfolio Research Activity recruitment figures have increased which is excellent progress.


Two non-research active GP's have signed up to the GLAD (Genetic Links to Anxiety and Depression) study and the Research and Development manager plans to encourage participation in more interventional research as it comes on line.

The figures mean that the CCG will be eligible to receive Research Capability Funding monies for 2021/2022.

RECOMMENDATIONS

Governing Body is requested to:

- Governing Body is requested to approve testing an approach to lessons learned from risks which become events.
- To decide whether members are assured of the accuracy of risks and that appropriate mitigation is being taken to manage these risks
- To decide whether the risks identified are to be continue to managed by Governing Body
- To identify any risks are to be delegated back to QPEC
- To determine whether members are assured of the wider work being undertaken to ensure quality , safety and an underpinning approach to patient engagement

Item Number: 7.2	
Name of Presenter: Phil Mettam	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Board Assurance Framework	
Purpose of Report <i>(Select from list)</i> For Approval	
Reason for Report The report is to highlight progress against specific strategic objectives and to outline the current risks related to the delivery of those objectives.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks	

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

Recommendations

Approval of the Board Assurance Framework

Decision Requested (for Decision Log)

Approval of the Board Assurance Framework

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

Responsible Executive Director and Title

Phil Mettam
Accountable Officer

Report Author and Title

Abigail Combes
Head of Legal and Governance

NHS Vale of York CCG
Board Assurance Framework




Introduction


NHS Vale of York CCG are required consider a Board Assurance Framework. The purpose of this document is so that the organisation can satisfy itself that it is monitoring its own performance against the strategic objectives which it has set itself.

NHS Vale of York CCG determined in 2019 that the current strategic objectives would be:

Strengthen	<ul style="list-style-type: none"> • GP services and support practices working closer together within their communities • Breaking down the barriers between community services at a local level • Clinical engagement focused on the patient pathway • Partnerships to support the transformation of hospital services
Improve	<ul style="list-style-type: none"> • Access and quality of mental health services for adults and children • Cancer outcomes and quality
Facilitate and influence	<ul style="list-style-type: none"> • Strategic partnerships with local government and providers • Greater focus on working locally • The creation of Integrated Care System or Partnership that provides safe, high quality services for the local population
Develop	<ul style="list-style-type: none"> • Leaders for the future
Deliver	<ul style="list-style-type: none"> • Financial sustainability of the local health and care system



Strengthen Primary Care to meet demand out of hospital and support with the development of partnership working focussed on the patient pathway


Current Priority	Exec Lead	Issue and current actions	Direction of risk travel
ConVid 19 Primary Care Response	Dr Andrew Lee	<ul style="list-style-type: none"> - System Partner Planning full engagement of the CCG with system partners in Place Based Planning and wider partnership planning. Responding to community testing request and development with partners. - CCG Business Continuity Planning detailed work up of local planning to support primary care if services were affected ie if Practice had to close and all staff self isolate. 	
PCN Development	Dr Andrew Lee	<ul style="list-style-type: none"> - Progressing discussions to establish a Selby Town & District health partnership group. Ambition to create a functional sub-ICS in the next 12 months. - Initiated discussions with Primary Care Home in York regarding them taking a role in facilitating the Ageing Well Programme, specifically around anticipatory care. - Set up joint CCG – PCN meetings to develop shared understanding re: DES contracts, additional roles. Scheduled meetings with Clinical Directors 	
Estates and Workforce	Dr Andrew Lee	<ul style="list-style-type: none"> - Progressing 3 month pilot of GP Locum service for City – to support Urgent on day need - Identified need to develop a public communications strategy regarding the new PCN Additional Roles to manage public expectations. - The CCG is jointly funding a YORLMC project looking at Practice Manager Resilience utilising GPFV monies which will be promoted in the new year - Work commenced to develop priority schemes to feasibility stage to complete the Primary Care Estates Strategy. - STP workforce groups developing future plans for training requirements being scoped. - Group Consultation Bursary Eols being developed. 	

Transforming Primary Care	Dr Andrew Lee	<ul style="list-style-type: none"> - Urgent Care Transformation – work initiated on this managed change process. Clinical reference groups to meet in January 2020, with report back to Council of Reps and Governing Body in February & March respectively. Target mobilisation before winter 2020. - Embedding Anticipatory Care – work initiated, to be delivered through Ageing Well Programme. Core multiagency working group set up. Exploring how AWP funding can be mobilised this year. Intelligence Analysis gap a priority in first year to identify target groups and priorities. - Transformation of Referral Services to provide support to primary care through Rapid Expert Input. REI key priority with aim to set up and deliver by April 2020 at least for 2-3 key specialties initially.. 	
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5				
4	PRC.12		PRC.11	
3		PRC.13;QN.14		
2			IG.01	
1	2	3	4	5

Improving Access and Quality of Mental Health Services for Adults and Children



Current Priority	Exec Lead	Issue and current actions	Direction of risk travel
Dementia Targets	Denise Nightingale	<ul style="list-style-type: none"> - Dementia targets are not being met. - Funded care co-ordinators in Ryedale PCN and Selby PCN to identify any at risk patients and to co-ordinate care around them and ensure they are on the dementia registers. - Identified funding to support dementia forward and a nurse working with the Acute Trust and York PCNs along the same lines as the PCN model (although clinically trained individual co-ordinating) - We are feeding back to the PCNs practice and PCN data on a monthly basis with business intelligence as to how many patients have been lost off the register either through death or movements. - Plans for a whole system dementia review led by TEWV around June. We have trained GP Practices and CHC nurses and PLT on the use of diadem tool. - Case finding in care homes continues through TEWV funding a trainee psychologist. This is highlighting a number of clients who are being referred into General Practice for consideration of a dementia diagnosis however this is not currently translating into new cases. We have asked the clinical network to outline pathways and information for us to send to General Practice to improve their confidence in using the tools available. There has been the recent recruitment of a band 7 post in the memory team which will increase capacity for diagnosis. TEWV have been asked to consider follow up for people who do not complete the assessment or Do Not Attend. - Referrals for the memory service continue with the average waiting time for assessment being 8 weeks. 	
Adult Autism Adult ADHD	Denise Nightingale	<ul style="list-style-type: none"> - <u>Adults Autism</u> - There are long waits for adult autism through a single provider, the Tuke Centre. In addition individuals diagnosed requiring support usually obtain this through a funding request to the CCG. Again to a service provided by the Tuke Centre. There is no differentiation between the level of support offered for patients and all patients under 	


		<p>IFR obtain CBT rather than a tiered offer of support.</p> <ul style="list-style-type: none"> - Unless a service user has a mental health problem not linked to their autism currently they are not able to access TEWV. We are the lead commissioner for North Yorkshire and York with the Tuke Centre. The Tuke Centre has had their long wait highlighted in a CQC report. - TEWV reviewed autism and looked at how they could integrate with their services and operate with support as a lead provider subcontracting to TUKE potentially. - TEWV speed of change may not be fast enough but they are working with the CCG - The Tuke Centre reviewed their model of operation last year and they adopted some online approaches which allowed more capacity. - <u>Adult ADHD</u> - When TEWV reviewed and indicated they would look to manage all autism they did not include ADHD. As a result we have long waiting lists with the Tuke Centre and issues regarding medication reviews. This is particularly with new service users to York through the University. - Whilst there are shared care arrangements with GPs but they still require an annual review by the specialist provider and anybody with escalating concerns needs to be seen. The Tuke Centre have again received a notification from CQC that their waiting lists have been a cause for concern. 	
CAMHS and children's autism diagnosis	Denise Nightingale	<ul style="list-style-type: none"> - There is investment into these services for the next four years as part of the mental health investment standard. This area is now under the whole Children's Commissioning pathway (provider collaborative with TEWV). There is a recognition that prevention is key. Under this model TEWV have invested in Kouth which is a schools based service. There are a range of other support and prevention models being implemented (trailblazer bids for school, art therapy etc). Although the waiting lists are long and not improving rapidly, the CCG is content that the lists are appropriately risk managed by the provider. Patients are risk assessed and signposted to the correct services and overseen throughout the waiting list. - There is now a 24 hour crisis service attached to CAMHS. 	

		<ul style="list-style-type: none"> - Children's Autism - This is a limb of CAMHS however TEWV are considering looking at a different model to deliver the children's autism diagnosis in the future. 	
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4		JC.26b	JC.26c; MH.01; MH.02; MH.03; MH.04	
3			JC.26a; JC.30	
2				
1	2	3	4	5


Facilitating and influencing partnership working to create high quality services for the population

Current Priority	Exec Lead	Issue and current actions	Direction of risk travel
Working with the Local Authority on Delayed Discharges to get the right care in the right place at the right time	Phil Mettam	<ul style="list-style-type: none"> - The Local Authority (CYC) have agreed to lead on the final phase of getting people out of hospital following the ECIST review. This will support and implement the agreed policy as well as trying to promote the market to support people leaving hospital. - There are a number of areas of work which the ADs from the Local Authorities are leading with input from Steve Spoerry on behalf of the NHS to promote swift responses to the discharge policy. - Joint training planning session planned for 6 March 2020 to be led by the NHS. - DTOC reporting now simpler and more reliable which is accepted by all parties. It may be that the recent rise in DTOCS is in part because of better, more accurate reporting. - In reality this is a culture shift in different parts of the system owning different parts of the pathway. It will take some time to establish whether the actions are improving the overall picture and is likely to expose more risks as time goes on however at this point the pace of change is increasing and collaboration is evident. 	
Supporting providers to ensure safe high quality services	Michelle Carrington	<ul style="list-style-type: none"> - . New Patient Safety Group chaired by NHSE/I established with CCGs, CQC & YHFT to monitor and mitigate the quality and safety risks associated with the CQC regulatory requirements. These in addition to other quality and safety concerns are as follows: - ECS performance - Actions: winter plan actions with daily reporting and improved escalation. Additional access to primary care. EDFD and streaming. Direct acceptance to downstream wards from ED. SDEC. Children's transformation plan. End to end review of harm and patient experience for 12 hour trolley waits which continue to rise on the Scarborough site. - Infection prevention and control at YHFT - primarily Scarborough site Actions: IPC specialist input from CCGs and NHSE/I, System wide Outbreak Plan now in place and approval of business case for new HPV equipment and staffing accepted. - CQC report – safe domain 'inadequate' 	

		<p>Scarborough and further inspection of both EDs and medical wards has resulted in further regulatory action around paediatric staffing and mental health assessments in ED. Actions: CQC action plan.</p> <ul style="list-style-type: none"> - RTT – potential for harm while waiting for elective care. Actions: Clinical risk assessments of the waiting lists being determined in each Care Group. Clinical harm reviews in place. - Quality of discharges from YHFT –Actions: escalation to Chief Nurse YHFT. Discharge standard group established and led by Heads of Nursing with CCG support. Part of CDSG. Agreement for regular membership of Partners in Care. Trusted Transfer processes. Discharge standards policy in development. 	
Sustainable Acute Fixed Contract Value	Simon Bell	<ul style="list-style-type: none"> - The CCG needs to shift focus of financial sustainability from just the acute contract. The Acute contract inevitably accounts for the vast proportion of CCG financial activity however there are a number of other contracts which can either deliver savings or pressures depending upon how they are managed. 	



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4			PLC.04; PLC.05; UPC.10; QN.03; QN.04; QN.05; QN.06; QN.08	QN.07; QN.15
3			ES.15; QN.13	
2			QN.12; QN.10	
1	2 QN.11	3 ES.38; ES.22	4	5

Improving access and quality of cancer services

Current Priority	Exec Lead	Issue and current actions	Direction of risk travel
62 Day Cancer Waits	Phil Mettam	<ul style="list-style-type: none"> - 62D performance improved in Month 8 & again in Month 9 reaching 77.6% in December 2019 and remains the highest performance in the HCV (although still below target). - Fast track (2WW) performance is at or above target for 5 consecutive months and 28 day diagnosis is almost at national target of 70% already in Month 9 with services planning capacity to deliver fast tracks in 7 days to ensure shorter pathways and earlier diagnosis, despite significant challenges around diagnostic capacity locally. - A full subsystem cancer delivery action plan is in place capturing the priority workstreams locally and linking to the Cancer Alliance collaborative work and transformational funding has been agreed to support these. - Both key NHS Long Term Plan ambitions around Rapid Diagnostics for vague symptoms and 28 day faster diagnosis standard being supported through the actions in the local and HCV plans. - Operational planning has supported the subsystem in understanding the demand and capacity required alongside transformational work to deliver performance improvement in the 62 day standard with a trajectory to return to target by April 2021. - A local subsystem timeout was held in February to bring all partners together to consider what the future vision for Cancer services in North Yorkshire might look like and to start to develop a Cancer Strategy. - The new GP contract incorporating enhanced services to support early cancer diagnosis will also start to develop additional screening and diagnosis support led by PCNs and should contribute towards improving access and faster diagnosis. 	

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4				
3			JC.19	
2				
1	2	3	4	5


Investing in and developing leaders for the future of the system

Current Priority	Exec Lead	Issue and current actions	Direction of risk travel
Improved staff well being and organisational development following restructure	Michelle Carrington	<ul style="list-style-type: none"> - Actions: 'Engaging for Success' whole CCG time-out October 2019. Paper on People to Governing Body November 2019 for assurance and involvement. Lay member roles firmed up and role of Remuneration Committee. First staff 'engaging for success' bulletin published December 2019. Workstreams established for renewed Staff Engagement Group, Organisational Development, Staff Benefits and office environment with staff involvement. Draft Health and Wellbeing framework (Staff Wellbeing Strategy) and development of the Organisations Coaching Offer. Draft Leadership Development Programme; Management to Leadership Programme and OD plan on a page. 	
Shared Organisational Development	Michelle Carrington	<ul style="list-style-type: none"> - We have also undertaken work to understand the Leadership programmes with the Regulators and the STP and see how they might align with our plans. The CCG has put forward names of 6 staff to undertake Improvement Academy Mary Seacole Course. 	

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4				
3	COR.01			
2				
1	2	3	4	5

Risk Reference	Title	Likelihood Score	Impact Score	Stable/Improving/Worsening
QN.15	CQC in YTHFT	4	5	Stable
QN.07	Initial health checks quality of service	4	5	Stable
QN.03	Commissioned specialist children's nursing provision	4	4	Stable
QN.04	12 hour trolley breaches, safety/quality concerns	4	4	Stable
QN.05	YTHFT Poor discharge standards	4	4	Stable
QN.06	Infection control processes YTHFT	4	4	Stable
QN.08	Planned care waiting list risk assessment YTHFT	4	4	Stable
QN.10	Unexpected closure of nursing beds in CCG area	2	4	Improving
QN.12	Failure to obtain pertussis vaccine in pregnancy	2	4	Stable
QN.13	Commissioning issues with Hep B vaccine	3	4	Stable
QN.14	Quality concerns surrounding a GP practice in VoYCCG area	4	3	Stable
JC.26a	CAMHs long waits	3	4	Stable
JC.26b	Children autism long waits diagnostics	4	3	Stable
JC.26c	Eating disorders waiting lists	4	4	Worsening
JC.30	Dementia diagnosis primary care	3	4	Stable
ES.15	Inability to deliver a sustainable financial plan	3	4	Stable
JC.19	Cancer 62 day waits	3	4	Improving
PLC.04	Planned care diagnostic target	4	4	Stable
IG.01	Transition to new CCG/Primary care IT provider	2	4	Worsening
UPC.10	4 hour A&E target	4	4	Stable
PLC.05	18 week RTT target	4	4	Stable
PRC.11	Estates and Technology Transformation Fund	4	4	Stable
MH.01	Physical health checks LD and severe mental health	4	4	Stable
MH.02	Waiting times adult ADHD/autism diagnosis	4	4	Stable
MH.03	ADHD prescribing and medication reviews	4	4	Stable
MH.04	Waits for autism and ADHD assessments	4	4	Stable
COR.01	Increased HR service cost (hosted)	3	2	Increasing

PRC.12	Evening and weekend GP cover	4	2	Stable
PRC.13	Statutory CCG Primary Care staff capacity	2	3	Stable
ES.38	CCG failure to deliver financial plan	1	3	Worsening
QN.11	Woodlands neuro-rehabilitation unit safety concerns	1	2	Improving

Item Number: 8	
Name of Presenter: Helena Nowell / Michael Ash-McMahon	
Meeting of the Governing Body	 Vale of York Clinical Commissioning Group
Date of meeting: 5 March 2020	
Committee Terms of Reference and Update to Detailed Scheme of Delegation	
Purpose of Report <i>(Select from list)</i> To Ratify	
Reason for Report	
<p>Committee Terms of Reference</p> <p>Further to ratification of the Audit Committee Terms of Reference at the January Governing Body meeting, Committee Terms of Reference are presented following their respective annual review and approval for the:</p> <ul style="list-style-type: none"> • Executive Committee • Finance and Performance Committee • Primary Care Commissioning Committee • Remuneration Committee 	
<p>Update to Detailed Scheme of Delegation</p> <p>The Detailed Scheme of Delegation (DSoD) was last approved in April 2018. Since then the organisation has gone through a restructure and it was felt necessary to update the DSoD to align job titles as well as other organisational changes and internal audit recommendations.</p> <p>The updated DSoD is shown at Annex 1. Amendments are shown in red. The DSoD as at April 2018 is shown for comparison at Annex 2.</p> <p>Summary of amendments:</p> <ul style="list-style-type: none"> • 'Senior Manager' has been removed. • 'Relevant Senior Manager' has been replaced by 'Assistant/Deputy Director'. • Where authority has been delegated to Directors, the specific job titles have been updated. • Reference documents have been updated as necessary. • Section 3. Non Pay Expenditure has been updated to clarify the approval process and add new specific items of expenditure, including Primary Care discretionary payments, which was a recommendation by internal audit. • Section 6. Capital Schemes has been amended to reflect capital schemes at the CCG. • Section 11. Condemning and Disposal and Section 12. Losses, Write-offs and Compensation have been simplified. • Section 13 has been updated to include credit card expenditure. • Primary Care Rebates has been added in Section 16. 	

Strategic Priority Links <ul style="list-style-type: none"> <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 	
Local Authority Area <ul style="list-style-type: none"> <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council 	
Impacts/ Key Risks <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities 	Risk Rating
Emerging Risks	
Impact Assessments <p>Please confirm below that the impact assessments have been approved and outline any risks/issues identified.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Quality Impact Assessment <input type="checkbox"/> Data Protection Impact Assessment <input type="checkbox"/> Equality Impact Assessment <input type="checkbox"/> Sustainability Impact Assessment <p>Risks/Issues identified from impact assessments:</p> <p>N/A</p>	
Recommendations <p>The Governing Body is asked to ratify the Terms of Reference of the Executive Committee, Finance and Performance Committee, Primary Care Commissioning Committee and Remuneration Committee.</p> <p>The Governing Body is asked to approve the updated Detailed Scheme of Delegation.</p>	

Decision Requested (for Decision Log)

The Governing Body:

Ratified the Terms of Reference of the Executive Committee, Finance and Performance Committee, Primary Care Commissioning Committee and Remuneration Committee.

Approved the updated Detailed Scheme of Delegation.

Responsible Executive Director and Title

Phil Mettam, Accountable Officer
Simon Bell, Chief Finance Officer

Report Author and Title

Abigail Combes, Head of Legal and Governance
Caroline Goldsmith, Deputy Head of Finance

EXECUTIVE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group (CCG) Governing Body resolves to establish an Executive Committee which has delegated decision making authority as set out in these Terms of Reference. The Executive Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires from any employee and all employees are directed to co-operate with any request made by the Executive Committee. The Executive Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference.

2 Purpose of the Committee

The Executive Committee is responsible for making decisions relating to restructuring the organisation or the removal or addition of organisational posts. The Executive Committee is also responsible for decisions relating to the delivery of services commissioned by the CCG where appropriate (for example where the value of the service is such that it falls outside the financial value of the scheme of delegation for an individual Director to approve or where it relates to more than one area of business).

In its role as Committee responsible for decisions relating to the delivery of services, the Executive Committee will have oversight of submissions to NHSEngland/Improvement and Quality/Equality Impact Assessments.

Guiding Principles

3 Remit

- To review processes are in place to deliver the Improvement and Assessment Framework expectations, including in-year targets, clinical, operational and financial.
- To implement, monitor and review the CCG's Strategic and Operational Plan under the direction of the Governing Body.
- Make recommendations about investment and de-commissioning proposals across the CCG and ensure appropriate resource allocation to the Governing Body (utilising the Quality/Equality Impact Assessment process).
- To approve commissioning plans, strategies and intentions to develop the CCG as an effective healthcare commissioner and local leader building strong relationships with stakeholders and patient and public groups where those plans are of a value which falls within the scheme of delegation (£500,000).

- Where commissioning plans exceed the scheme of delegation, the Executive Committee will make recommendations to the Governing Body for the approval of such plans.
- Approval of HR, IG and corporate policies.
- Equalities, diversity and human rights development and implementation of the action plan.
- Review service changes ensuring service developments and CCG processes and policies are compliant with national regulations and law, including equalities legislation.
- To ensure projects and plans are supported by adequate governance, i.e., QIAs, PIAs, EIAs, SIAs and Col.
- To be responsible for and review the organisation's service delivery risks as set out in the risk appetite statement.

4 Frequency

The Executive Committee will meet at least nine times a year.

5 Membership

Accountable Officer (Chair)
 Executive Director of Quality and Nursing
 Chief Finance Officer
 Executive Director of Transformation and Delivery
 Director of Primary Care and Population Health

In Attendance :

Executive Assistant to the Accountable Officer (to take minutes)

Anyone else at the invitation of the membership.

6 Quoracy

A minimum of three members will constitute a quorum and one of those members must be a clinician.

7 Accountability

The Executive Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Executive Committee minutes.

Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.

8 Decision Making

The decision making authority of the Executive Committee is defined in the scheme of delegation within the constitution.

When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote. **A Deputy nominated by a Member can vote on behalf of the Member.**

9 Effectiveness

The Executive Committee shall undertake an annual review of its effectiveness.

10 Secretary

The secretary will be responsible for supporting the Chair in the management of the Committee’s business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

11 Review of Terms of Reference

The Executive Committee shall review its terms of reference at least annually and sooner if changing circumstances dictate.

Author	Abigail Combes Head of Legal and Governance
Committee Approved and Date)	Executive Committee 15 January 2020
Ratification and Date	Governing Body
Issue Date	
Review Date	
Version Number	7

Author	Rachael Simmons Corporate Services Manager
Committee Approved and Date)	Executive Committee

Ratification and Date	Governing Body 05 July 2018
Issue Date	06 July 2018
Review Date	July 2019
Version Number	6

Author	Rachael Simmons Corporate Services Manager
Committee Approved and Date)	Executive Committee 19 July 2017 / 16 August 2017
Ratification and Date	Governing Body 07 September 2017
Issue Date	11 September 2017
Review Date	September 2018
Version Number	5

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Executive Committee
Approval Date	Governing Body – 02 March 2017
Issue Date	
Review Date	
Version Number	0.4

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group (CCG) resolves to establish a Committee of the Governing Body to be known as the Finance and Performance Committee (FPC) (the Committee). The Committee has delegated decision making authority as set out in these Terms of Reference. The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires, from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference. The Committee may not delegate executive powers delegated with these Terms of Reference (unless expressly authorised by the CCG) and remains accountable for the work of any such group.

2 Purpose of the Committee

The paramount role of the Finance and Performance Committee is to oversee the financial recovery and performance of the CCG.

The Committee shall undertake the scrutiny of all financial recovery plans on behalf of the Governing Body of NHS Vale of York CCG and provide assurance to the Governing Body that appropriate actions are being taken in relation to financial and performance recovery. This does not mean that detailed reports will be sent to every Committee meeting and scrutinised; the Committee is enabled to consider the content of the Risk Report in assessing whether performance and financial recovery is being appropriately managed and also the actions from System Delivery Board or equivalent.

The Committee may request detailed reports on performance, delivery and particular financial recovery plans as required and where there is a significant drop in performance or deviance from financial plan this will be reported by exception to the next committee, verbally if required.

The Committee shall advise and support the Governing Body in scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's Strategic and Operational Plans.

The Committee shall pro-actively challenge and review negative variance in delivery against the performance expectations for the CCG, the NHS Constitution, NHS mandate and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate

In particular, the Committee will receive, assess and challenge performance management and contract management information associated with:

- Main provider contracts
- Voluntary sector contracts
- Community Services
- Jointly commissioning services between the CCG and Local Authority
- The CCG's Quality, Innovation, Productivity and Prevent Plan (QIPP)
- The CCG's strategic work-streams
- Other areas of significant risk to the achievement of performance standards and financial balance
- Delivery of the RightCare programme

Either on a bi annual basis or by exception where there is a significant challenge with delivery and performance in these contracts.

The Committee will scrutinise the financial position of the CCG and monitor the delivery of the Commissioning Plan.

The Committee will receive and scrutinise performance delivery information against key performance trajectories ensuring delivery and where necessary corrective actions are followed up.

As part of its deliberations and recommendations, the Committee will take into account the CCG's statutory service responsibilities and service levels.

The Committee shall initiate reviews in its own right and undertake, as directed, reviews on behalf of the Governing Body. Work shall be progressed by co-option of other key individuals.

The Committee shall determine what reports they would wish to see on a regular basis.

The Committee will make decisions on behalf of the Governing Body regarding procurement exercises including determining what procurement process ought to be utilised for the commissioning of services by the CCG (including Direct Award, Competitive Dialogue or other processes). This does not include decisions relating to packages of care for individual patients as assessed by the Executive Director of Mental Health and Complex Care.

The Committee will also make decisions relating to the identity of the body or individual to be awarded contracts by the CCG where the total contract value is below £500,000. In making such a decision the Committee must consider conflicts of interest and where appropriate seek advice on how to manage and mitigate these. This does not include decisions relating to packages of care for individual patients as assessed by the Executive Director of Mental Health and Complex Care.

The Committee will assure itself, on behalf of the Governing Body, that the CCG has a process for managing business continuity and emergency planning. The Committee does not need determine the detail of the plans in place but will be required to ensure that there are appropriate policies in place relating to these matters.

The Committee will assure itself that Information Governance risks are appropriately managed within the CCG.

3 Remit

The Committee has remit over all areas of finance and performance, including, but not limited to, development and implementation of strategy, planning, reporting, delivery, recovery, management, governance and control.

- Review the Medium Term Financial Strategy, ensuring it is consistent with commissioning plans and is sustainable
- Review the Financial Plan, including ensuring all planning assumptions are within the guidelines set by NHS England and that there is clear accountability throughout the plan
- Review and scrutinise the organisation's in-year financial position
- Review and scrutinise all financial forecasts, including forecasting methodology
- Oversee the development of a medium term financial plan, in line with NHS England requirements, in order to support the delivery of an optimum underlying financial position for the CCG
- Ensure the CCG operates within its Detailed Financial Policies (Standing Financial Instructions)
- Review and monitor CCG performance and associated recovery plans, scrutinising additional detail where required
- Review performance information where there is a deviance from national performance targets
- Receive regular contract performance reports where required
- Review and scrutinise delivery of the organisation's QIPP programme, ensuring plans are appropriately phased and reflected in budgets. This may include reviewing for the purposes of lessons learned
- Challenge delivery of rectification plans produced to achieve targets or reduce deficit
- Make Quality and Patient Experience Committee aware of any safety or quality concerns arising from this Committee
- Oversee emergency planning (EPRR) and business continuity planning

4 Risk Management

The Committee will review the risk register and update the Governing Body on key risks.

Finance and Performance Committee will have oversight of risks referred to in the Risk Management Policy and Strategy as 'Finance Risks' and 'Compliance Risks'. These risks which score a total risk score of between 4 and 15 will be reported to the Committee.

Those risks with a total risk score of 16 or over will be reported to the Governing Body even where they relate to 'Finance Risks' or 'Compliance Risks'

5 Frequency

The Finance and Performance Committee will meet at a minimum 9 times per financial year.

6 Membership

Two Lay Members, one of whom shall be the Chair

Accountable Officer

Chief Finance Officer

Executive Director of Nursing and Quality

Executive Director of Transformation, Complex Care and Mental Health

Executive Director of Primary Care and Population Health

In attendance :

Lay Chair of Audit Committee

Director of Finance, NHS England North (or deputy)

Anyone else at the invitation of a member of the Finance and Performance Committee.

7 Quoracy

A minimum of three members are required for the meeting to be quorate to include a lay member, a clinical executive director (or nominated deputy) and the Chief Finance Officer (or nominated deputy).

8 Accountability

The Finance and Performance Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Finance and Performance Committee minutes and a Chair's report which will highlight the key risks discussed.

9 Decision Making

The Committee acts as an assurance and scrutiny group and provides the opportunity for discussions about financial and performance issues to enable policies to be shaped for approval by the CCG Governing Body. The Committee has specific delegated authority to:

- Develop the annual financial plan for approval by the Governing Body.
- Approval of disposals, condemnations, bad debts, losses and special payments to the value of £50,000 is enacted by the executive approval of the Chief Finance Officer (then taken to Audit Committee to note and review).
- Review the delivery of delivery partners' services and make recommendations to the Governing Body in respect of service delivery, quality, value for money and cost.
- Decisions regarding procurement up to a total contract value of £500,000.
- When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.
- Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.

10 Secretary

The secretary will be responsible for supporting the Chair in the management of the Committee's business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

11 Committee Effectiveness

The Committee shall review its effectiveness annually.

12 Review of Terms of Reference

The Committee shall review its terms of reference at least annually.

Update by :	Abigail Combes Head of Legal and Governance
Reviewing Committee (including date)	Finance and Performance Committee 19 December 2019
Approval Committee (including date)	Governing Body
Issue Date	
Review Date	December 2020
Version Number	1.0

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Finance and Performance Committee 23 February 2017
Approval Date	Governing Body – 02 March 2017
Issue Date	02 March 2017
Review Date	September 2017 - six month review
Version Number	0.6

PRIMARY CARE COMMISSIONING COMMITTEE

Terms of Reference

Introduction

1. Simon Stevens, the Chief Executive of NHS England, announced on 01 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.
2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the "NHS Act"), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Vale of York CCG. The delegation is set out in Schedule 1.
3. The CCG has established the NHS Vale of York CCG Primary Care Commissioning Committee (the "Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.
4. It is a committee comprising representatives of the following organisations :
 - NHS Vale of York CCG
 - NHS England
 - Healthwatch
 - Health and Wellbeing Board(s)
 - Director of Public Health

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.
6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.
7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
 - a) Management of conflicts of interest (section 14O);

- b) Duty to promote the NHS Constitution (section 14P);
 - c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - d) Duty as to improvement in quality of services (section 14R);
 - e) Duty in relation to quality of primary medical services (section 14S);
 - f) Duties as to reducing inequalities (section 14T);
 - g) Duty to promote the involvement of each patient (section 14U);
 - h) Duty as to patient choice (section 14V);
 - i) Duty as to promoting integration (section 14Z1);
 - j) Public involvement and consultation (section 14Z2).
8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act
- Duty to have regard to impact on services in certain areas (section 13O);
 - Duty as respects variation in provision of health services (section 13P).
9. The Committee is established as a committee of the Governing Body of NHS Vale of York CCG in accordance with Schedule 1A of the NHS Act.
10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the Vale of York area, under delegated authority from NHS England.
12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Vale of York CCG, which will sit alongside the delegation and terms of reference.
13. The functions of the Committee are undertaken in the context of commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.
14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.
15. This includes the following:
- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”);
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on ‘discretionary’ payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities :

- a) To plan, including needs assessment, primary care services in the Vale of York CCG area;
- b) To undertake reviews of primary care services in Vale of York CCG area;
- c) To co-ordinate a common approach to the commissioning of primary care services generally;
- d) To manage the budget for commissioning of primary care services in Vale of York CCG area.

Geographical Coverage

17. The Committee will comprise the NHS Vale of York CCG area.

Membership

18. The Committee shall consist of :

- Lay Chair of Quality and Patient Experience Committee (Chair)
- Lay Chair of Audit Committee
- Lay Chair of Finance and Performance Committee
- Accountable Officer
- Chief Finance Officer
- Director of Primary Care and Population Health
- Representative of NHS England
- (voting members)

19. The Chair of the Committee shall be the Lay Chair of the Quality and Patient Experience Committee.

20. The Vice Chair of the Committee shall be a Lay Member but not the Lay Chair of the Audit Committee.

21. The following standing attendees (non-voting) will be invited :

- A representative from each of the Primary Care Networks
- LMC representative
- Director of Public Health
- Assistant Director, Primary Care
- Healthwatch Representative

- Health and Wellbeing Board Representative
- Practice Manager

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Executive Support to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 5 working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.
23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

24. The committee shall be quorate with the following attendance :
- At least four members.

Frequency of meetings

25. The committee will meet six times a year with dates circulated to committee members in advance. Additional meetings may be convened at short notice if the Chair deems it necessary in accordance with paragraph 22 above.
26. Meetings of the Committee shall :
- a) be held in public, subject to the application of 26(b);
 - b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
27. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
28. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest. A

Primary Care Commissioning Delivery Group may be established to ensure the delivery of arrangements agreed by the Committee.

29. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
30. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.
31. The Committee will present its minutes to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 28 above.
32. The CCG will also comply with any reporting requirements set out in its constitution.
33. The Committee shall review its terms of reference at least annually. The Committee shall undertake a review of its effectiveness at least annually.

Links to other Committees and Groups

34. Due to the nature of integrated governance, the work of the Committee dovetails with some functions of the Audit Committee. Both Chairs will work collaboratively to ensure that where objectives align, their work will complement rather than duplicate effort, bringing their own perspectives to agenda items.

Accountability of the Committee

35. The Primary Care Commissioning Committee is a delegated committee of the Clinical Commissioning Group Governing Body, and its powers are set out in the CCG's Constitution, including revised Standing Financial Instructions and Standing Orders.
36. For the avoidance of doubt, in the event of any conflict between the provisions of these Terms of Reference and the CCG's Standing Orders or Standing Financial Instructions, the latter will prevail.

Procurement of Agreed Services

37. The detailed arrangements for procurement of agreed services will follow the Standing Financial Instructions and Standing Orders of the Clinical Commissioning Group. These reflect the arrangements within the CCG's constitution and the delegation agreement with NHS England. The Committee will adhere to these arrangements.

Decisions

38. The Committee will make decisions within the bounds of its remit.
39. The decisions of the Committee shall be binding on NHS England and NHS Vale of York CCG.

40. The Committee will produce an executive summary report which will be presented to the North (Yorkshire and Humber) area team of NHS England and the governing body of NHS Vale of York CCG each quarter for information.

Conflicts of Interest

- 41 Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.

Secretary

- 42 The secretary will be responsible for supporting the Chair in the management of the Committee's business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include :

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

[Signature provisions]

Schedule 1 : Delegation

[Delegation from NHS England attached separately]

Schedule 2 : Delegated Commissioning Functions

Delegated commissioning functions are as follows :

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

Delegated commissioning arrangements exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation).

QUALITY AND PATIENT EXPERIENCE COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group resolves to establish a Committee of the Governing Body to be known as the Quality and Patient Experience Committee (the Committee). The Committee has delegated decision making authority as set out in these Terms of Reference. The Committee is authorised by the Governing Body to investigate any activity within its Terms of Reference. It is authorised to seek and has full access to any information it requires, from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference. The Committee may not delegate executive powers delegated with these Terms of Reference (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

2 Purpose of the Committee

The overall objective of the Committee is to scrutinise the quality and safety of all of our commissioned services and those which affect the CCGs population. The Committee will seek assurance on the safety, quality and effectiveness of these services and where possible, seek to mitigate risks. The committee will also actively encourage service providers to seek to continually improve in line with the NHS Constitution (2011). The approach of the committee is underpinned by the CCG Quality Assurance Strategy. In line with the NHS Constitution, this also includes actively seeking patient feedback on health services and engaging with all sections of the population with the intention of improving services.

The Committee will also oversee staff experience within the CCG. This will include understanding the work of Staff Engagement Group and setting a workplan for this group.

3 Remit

3.1 The Committee will request assurance, monitor, report, provide information and share the learning, including mitigation and actions, on the following:

- Quality Assurance Strategy and progress against the Strategy and action plan.
- Patient 'insight' – primarily complaints, concerns, PALs and compliments on commissioned services and the CCG itself.

- Patient safety – which includes Health Care Associated Infections (HCAI) and Serious Incidents (SI) / Never Events (whether these are in primary care, mental health services or any other provider).
- Safeguarding Children and Adults.
- Monitor the strategic workplan of the Designated Professionals (Children and Adults)
- Quality concerns from commissioned services / affecting commissioned services including from contract management boards with providers.
- Regulatory / national reports regarding quality (e.g., CQC, National Enquiries, NHS England/Improvement reports and strategies).
- Information from and for NHS England Quality Surveillance Groups.
- Agree clear escalation processes, including appropriate trigger points, to enable appropriate engagement of external bodies on areas of concern.
- Agree escalation to the Governing Body.
- Agree commencement of enhanced surveillance or additional actions where triggers are met
- Have a forward work plan.
- Sustainability issues (including carbon reduction and climate change adaptation).

The Committee will receive and scrutinise :

- Independent investigation reports relating to patient safety issues and agree publication plans.

The Committee will agree and set a workplan for the work of Staff Engagement Group and receive quarterly updates from the Chair of the Staff Engagement Group as well as hear staff stories as and when there is an appropriate story to share.

- 3.2 The Committee shall review the establishment and maintenance of an effective system of quality assurance. This will mainly be through the Quality Assurance Strategy. Its work will dovetail with that of the Audit Committee.
- 3.3 The Committee shall pro-actively challenge and review the CCG's performance against the standards in the CCG Improvement and Assessment Framework (mainly the Better Care element), NHS Outcomes Framework (mainly domains 4 and 5 – 'ensuring people have a positive experience of care' and 'treating and caring for people in a safe environment and protecting them from avoidable harm') and against the strategic priorities of the CCG, agreeing any action plans or recommendations as appropriate.
- 3.4 In particular, the Committee will enquire, receive, assess and challenge quality and patient experience information associated with:

- Main provider contracts (including primary care).
 - Voluntary sector contracts.
 - Community Services.
 - Jointly commissioned services between the CCG and Local Authority.
 - Services which the CCG may not commission but which may impact on local people and services i.e. care homes.
 - Benchmarking information regarding quality.
 - Patient experience information relating to concerns, complaints, PALs and compliments from commissioned services and into the CCG.
 - Lessons learned and actions taken to improve patient experience.
 - Evidence from key clinicians and managers from commissioned services.
 - HCAI and SI information (including Never Events) relating to the CCG commissioned services.
 - The CCG's commissioning for Quality and Innovation schemes (CQUIN).
 - Reports and feedback on any clinical quality visits.
 - The CCG's strategic work-streams relating to quality.
 - The Quality Premium (QP).
 - Adult Safeguarding.
 - Children's Safeguarding.
 - Quality Impact Assessments (QIA) relating to commissioning plans and statements where the Assessment suggests an adverse impact on quality, choice or patient experience or where full public consultation is required.
- 3.5 The Committee will ensure that quality is embedded in the CCG processes for development of Commissioning Statements (Value Based Commissioning). This will be enacted through Clinical Evidence and Advisory Group
- 3.6 The Committee will ensure the CCG is listening to patients to learn from their experiences and use the feedback to identify and inform areas for service improvement.
- 3.7 The Committee shall initiate reviews in its own right and undertake, as directed, reviews on behalf of the Governing Body. Work shall be progressed by co-option of other key individuals.
- 3.8 The Committee shall determine what reports they would wish to see on a regular basis and what will form the discussion point on the single item agendas.
- 3.9 The Committee will maintain appropriate liaison with regulatory bodies especially the Care Quality Commission, NHS England/Improvement and any

relevant professional regulatory bodies in order to ensure appropriate information flows on matters within the committee's remit.

- 3.10 The Committee has delegated authority from the Governing Body to oversee the 'Choice' agenda and any quality implications for patients.

4 Risk Management

The Committee will review and manage the risk register on key risks relating to Quality, escalating to the Governing Body where appropriate.

5 Frequency

The Quality and Patient Experience Committee will meet at least 9 times per year and of these meetings at least 4 will relate to single item matters.

6 Membership

- Lay Member of the Governing Body (Chair)
- Clinical Chair of the Governing Body (Deputy Chair)
- Secondary Care Doctor
- Executive Director of Quality and Nursing (Director with responsibility for quality and patient experience)
- Executive Director of Primary Care and Population Health

In attendance :

- Deputy Chief Nurse
- Head of Legal Services and Governance
- Head of Quality Improvement and Research
- Head of Engagement
- Designated Professionals for Safeguarding – both adult and children
- Healthwatch representative
- Senior Quality Lead: Children and Young People
- Patient Experience Lead

The Chair of the Audit Committee may also be asked to attend as appropriate, where the roles of both committees are seeking assurance that robust clinical quality is in place.

Anyone else at the invitation of the membership.

7 Quoracy

A minimum of three members will constitute a quorum, so long as this includes the Chair or Deputy Chair and a clinician (Doctor or Nurse)

8 Decision Making

- 8.1 The Committee shall make decisions on any remedial action required as a result of quality issues.
- 8.2 The Committee shall make recommendations to the Accountable Officer and/or Executive team regarding the review of commissioned services and business cases for changes to commissioning in line with the CCG detailed scheme of delegation.
- 8.3 The Committee has delegated authority from the Governing Body with regard to all quality issues in line with the scheme of delegation (Accountable Officer level).
- 8.5 When a vote is required, each core member of the Committee has a single vote. A simple majority is necessary to confirm a decision. In the event of an equality of votes, the Chair of the meeting shall have the second and casting vote.
- 8.6 Conflicts of Interest, both actual and perceived, shall be managed in line with NHS Vale of York CCG Conflicts of Interest policy and recorded at the start of every meeting.
- 8.7 Where a member cannot attend the meeting they can nominate a Deputy to attend on their behalf provided that they have the appropriate delegation to make decisions on behalf of the member they are representing.

9 Accountability

- 9.1 The Quality and Patient Experience Committee will be accountable to the NHS Vale of York Clinical Commissioning Group Governing Body who will receive the Quality and Patient Experience Committee minutes. The Committee has delegated functions to manage and monitor issues in relation to quality in primary care.
- 9.2 The Committee will, by exception, escalate matters it considers should be brought to the attention at the full Governing Body.

10 Secretary

The secretary will be responsible for supporting the Chair in the management of the Committee's business.

The Committee will also be supported administratively by the secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes

- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

11 Committee Effectiveness

The Committee shall undertake an annual review of its effectiveness.

12 Review of Terms of Reference

The Committee shall review its terms of reference at least annually.

Author	Abigail Combes Head of Legal and Governance
Committee Approved (including date)	Quality and Patient Experience Committee 13 February 2020
Approval Date	Governing Body
Issue Date	
Review Date	January 2021
Version Number	1.1

Update	Rachael Simmons Corporate Services Manager
Reviewing Committee (including date)	Quality & Patient Experience Committee 14 June 2018
Approving Committee	Governing Body 05 July 2018
Issue Date	7 June 2018
Review Date	July 2019
Version Number	1.0

Update	Rachael Simmons Corporate Services Manager
Reviewing Committee (including date)	Quality & Patient Experience Committee 12 October 2017
Approving Committee	Governing Body 02 November 2017
Issue Date	01 December 2017
Review Date	November 2018
Version Number	0.6

Author	Rachael Simmons Corporate Services Manager
Committee Approved (including date)	Quality and Patient Experience Committee 08 February 2017
Approval Date	Governing Body - 02 March 2017

Issue Date	02 March 2017
Review Date	September 2017 - six month review
Version Number	0.5

REMUNERATION COMMITTEE

Terms of Reference

1 Constitution and Authority

NHS Vale of York Clinical Commissioning Group Governing Body resolves to establish a Remuneration Committee which has delegated decision making authority as set out in these Terms of Reference. The Remuneration Committee is authorised by the Governing Body to approve any activity within its Terms of Reference. The Remuneration Committee is authorised to create working groups as necessary to fulfil its responsibilities within these Terms of Reference.

2 Purpose of the Committee

The Remuneration Committee is responsible for determining the terms and conditions, remuneration and travelling or other allowances for staff who are members of the Governing Body. Those staff who are employed by the CCG and not members of the Governing Body will have their terms and conditions, remuneration and travelling or other allowances determined by the Executive Committee of the Governing Body. This includes those employees not currently working under the terms of Agenda for Change.

3 Remit

The Committee shall approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.

The Committee shall make recommendations to the Governing Body on:

- The terms and conditions of employment for all Governing Body members of the Clinical Commissioning Group (the Group).
- Pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the Group.
- Retention Premia.
- Annual salary awards [where applicable].
- Allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.
- The severance payments of NHS Vale of York Clinical Commissioning Group employees and contractors, seeking HM approval as appropriate in accordance with the guidance 'Managing Public Money'.
- Policies and instructions relating to remuneration.
- Any significant amendments to the terms and conditions of employment which affects all employees of the Clinical Commissioning Group generally (for example changes to the Agenda for Change terms and conditions)

- The CCG's Talent Management Processes including the provision of funding for training for staff.
- The CCG's approach to staff wellbeing
- The CCG's Freedom to Speak Up processes where this relates to staff.

4 Frequency

Meetings shall be held as and when required upon receipt of a request to the Chair or Vice Chair. The Committee will meet a minimum of twice per financial year. Seven calendar days' notice will be provided of the meeting and any documents to be considered / discussed at the meeting will be circulated to the Committee at least two calendar days prior to the meeting.

5 Membership

The Committee shall be appointed by the NHS Vale of York Clinical Commissioning Group from amongst its Governing Body members. The membership of the Committee shall comprise the following:

- Lay Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee (Vice-Chair)
- Lay Member and Chair of Audit Committee (Chair)
- Lay Member and Chair of Finance and Performance Committee

Other directors and external advisers such as Human Resources representatives may be invited to attend for all or part of any meeting as and when appropriate. The role of other individuals who attend and external advisors will be to draw the Committee's attention to best practice, national guidance and other relevant documents as appropriate.

Full time employees or individuals who claim a significant proportion of their income from the NHS Vale of York Clinical Commissioning Group are not permitted to be voting members of the Committee.

No individual should be in attendance for discussion about their own remuneration and terms of service.

6 Quoracy

The quorum shall be the Chair (or in his or her absence, the Vice Chair) plus one other member.

Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the Chair of the meeting shall consult with the Chair of the Audit Committee on the action to be taken. This may include:

- requiring another of the Group's committees or sub-committees, the Group's Governing Body or the Governing Body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible,

- inviting on a temporary basis one or more Governing Body members to make up the quorum so that the group can progress the item of business.

7 Accountability

The minutes of the Committee meetings will be submitted by the Committee Chair within seven calendar days of the meeting.

8 Decision Making

All Members of the Remuneration Committee will have voting rights. Each member will have one vote, and the Chair shall have the casting vote.

9 Administrative Support

A Secretary will be identified by the NHS Vale of York Clinical Commissioning Group. The Secretary will be responsible for supporting the Chair in the management of remuneration business. This will include arranging, formally minuting and archiving of all reports and documentation associated with the business of the Committee.

10 Committee Effectiveness

The Committee shall review its effectiveness annually.

11 Review of Terms of Reference

The Committee shall review its terms of reference at least annually.

Author	Abigail Combes Head of Legal and Governance
Committee Approved (including date)	Remuneration Committee 6 February 2020
Approval Date	Governing Body – 5 March 2020
Issue Date	March 2020
Review Date	March 2021
Version Number	4



Vale of York
Clinical Commissioning Group

Annex 1

Detailed Scheme of Delegation

Section A – Financial Issues

Section B – Human Resources Issues

Section C – Other

NHS Vale of York CCG - Detailed Scheme of Delegation

The delegations set out in the detailed scheme of delegation represent the lowest level to which authority for that specific issue has been delegated. All items concerning Finance must be carried out in accordance with Prime Financial Policies in Appendix E and Standing Orders (SO) in Appendix C of the NHS Vale of York Constitution and the Detailed Financial Policies. Where it is believed that the matter or decision being taken under these arrangements has far reaching implications then this must be reported to the Accountable Officer and / or Chief Finance Officer. The Deputy Chief Finance Officer may substitute for the Chief Finance Officer if necessary.

This detailed scheme of delegation refers only to services or activity for the corporate offices, equipment and employees, contractors and Lay Members of NHS Vale of York Clinical Commissioning Group and not for activity, offices, equipment or employees of any member practice.

SECTION A - FINANCIAL ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
1.	Management of Budgets		Detailed Financial Policies (DFP) Section 3
	Responsibility for maintaining expenditure within budget:		
	a) At individual budget level (Pay and Non Pay)	Head of Department	
	b) Department Budgets	Assistant/Deputy Director	
	c) Financial Reserves and Provisions	Deputy Chief Finance Officer	
	Where it is necessary for expenditure to be approved that is outside of an approved budget either in value or in terms of what the budget was originally intended for, this can only be done with approval of the Chief Finance Officer and will require an appropriate business case in line with the approval process.		
	Budget virement:		
	a) Approval of annual budget	Governing Body	
	b) Budget transfer within budget holders area - no limit	Head of Finance	
	c) Budget transfer between budget holders		
	• Up to £100,000	Head of Finance	
	• Up to £500,000	Deputy Chief Finance Officer	
	• No limit	Chief Finance Officer	
	d) Budget transfer from reserve codes – no limit	Head of Finance	
	e) Transfer of budget via RTF	Head of Finance	
2.	Maintenance / Operation of Bank Accounts		DFP Sections 3, 4 & 8
	a) Day to day operation of organisational bank accounts	Finance Manager (Financial	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
		Accounts) and Financial Controller of Shared Business Services	Financial Procedure Note (FPN) 3 – Cash Drawdown
	b) Authorisation for cash limit drawdown	Deputy Chief Finance Officer or Chief Finance Officer	
	c) Authorisation for cheque requests		FPN 4 – Accounts Payable
	• up to £10,000	Head of Finance	
	• up to £150,000	Deputy Chief Finance Officer	
	• over £150,000	Chief Finance Officer or Accountable Officer	
3.	Non Pay Expenditure		DFP Sections 3, 8, 9, 10 & 12
	Expenditure on existing budgeted expenditure (as per GB approved annual budget)		
	For most healthcare services, expenditure should be included on a contract, service level agreement (SLA) or memorandum of understanding (MoU)		Governing Body approved plan
	• Signing of contracts / SLAs / MoUs	Chief Finance Officer	
	Except for:		
	Specific Non Pay Expenditure Items		
	• Complex Care incl. Continuing Healthcare (up to £250,000 per annum and within overall complex care budget)	Executive Director of Transformation, Complex Care and Mental Health	
	• Complex Care incl. Continuing Healthcare (over £250,000 per annum and within overall complex care budget)	Executive Director of Transformation, Complex Care and Mental Health and Chief Finance Officer	
	• Authorisation of Primary Care monthly contract payments from Delegated funds (within Delegated funds budget)	Deputy Chief Finance Officer	
	• Community Equipment and Wheelchairs – where individual items have been supported through the relevant clinical review and approval processes and are the equivalent or less financial value (within community equipment and wheelchairs budget)	Relevant Contract Manager	
	• Non-contracted activity (purchase of healthcare - within budget)	NCA team at NECS to check VoY patient	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<ul style="list-style-type: none"> Agreement of new Primary Care Local Enhanced Services or GP incentive schemes (within LES budget) 	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> Primary Care discretionary payments (including Local incentive Schemes, returner/retainers and other ad-hoc payments not covered by Section 96) up to £10,000 (within Delegated funds budget) 	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> Primary Care discretionary payments (including Local incentive Schemes, returner/retainers and other ad-hoc payments not covered by Section 96) over £10,000 (within Delegated funds budget) 	Primary Care Commissioning Committee then Executive Committee	
	<ul style="list-style-type: none"> Actual/notional Primary Care rent changes under £5,000 (within Delegated funds budget) 	Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> Actual/notional Primary Care rent changes over £5,000 (within Delegated funds budget) 	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> Prescribing expenditure 	Primary Care Commissioning Committee	
	Before orders are placed for non-healthcare related goods and services the following conditions must be complied with:		DFP Section 10 NHS Vale of York CCG Procurement Policy
	a) Confirmation that budgetary provision is available and	All	
	b) Where competitive tendering or competitive quotations are not required e.g. below £5000 then in the first instance the NHS Supply Chain must be used. In the event that NHS Supply Chain are unable to supply the goods or services then the following procedure, for which documentary evidence must be kept, will be followed:		
	<ul style="list-style-type: none"> up to £4,999 a minimum of 2 verbal quotations have been sought 	Assistant/Deputy Director	
	<ul style="list-style-type: none"> between £5,000 and £25,000 a minimum of 3 written quotations have been sought 	Assistant/Deputy Director	
	<ul style="list-style-type: none"> between £25,001 and £49,999 a minimum of 5 written quotations have been sought 	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	<ul style="list-style-type: none"> for orders in excess of £50,000, competitive tendering will apply, 		

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	the form of which is dependent on the precise goods or services involved. Therefore for all orders above £50,000 the advice of the Chief Finance Officer must be sought.		
	Note that most non-healthcare services expenditure should be covered either via a contract, SLA or MoU.		
	<ul style="list-style-type: none"> Signing of contracts / SLAs / MoUs 	Chief Finance Officer	
	If the value is less than £25,000 this may be covered by a purchase order. Purchase orders must be approved as follows:		
	<ul style="list-style-type: none"> Up to £10,000 	Head of Department	
	<ul style="list-style-type: none"> £10,001 to £25,000 	Assistant/Deputy Director	
	The total value of requisitions that cover more than a 12 month period or that are open ended need to be considered as a total value, not just the cost for the 12 month period. E.g. a 2 year contract which has an annual value of £3,000 will require 3 written quotations. Where the number of years is not specified or open ended (from year to year) a 3 year period should be assumed for the purpose of this calculation.		
	New unbudgeted expenditure		
	Authority to approve business cases that commit the organisation to a new, unbudgeted level of investment or a change to an existing area / level of spend is as follows:		
	<ul style="list-style-type: none"> Up to £250,000 	Executive Committee – which must include the Chief Finance Officer or Deputy Chief Finance Officer – and reported to Finance and Performance Committee	
	<ul style="list-style-type: none"> Over £250,000 	Governing Body – which must include the Chief Finance Officer or Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> Up to £250,000 for Individual Funding Requests 	IFR Panel	
	<ul style="list-style-type: none"> Over £250,000 for Individual Funding Requests 	IFR Panel and Executive Committee	
4.	Tendering & Contract Procedures (including Leases)		DFP Section 9
	a) Waiving of requirement to obtain quotations and tenders subject	Audit Committee	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	to the Detailed Financial Policies		CCG Procurement Policy
	b) Opening of Tenders	Head of Department plus witness	
	c) Authorising annual procurements and individual procurement approach. Awarding, authorisation and responsibility for contracts for non-pay expenditure including purchase of healthcare services agreed in line with the Financial Plan and subsequent variations, extensions or rolling over.		
	<ul style="list-style-type: none"> Up to £500,000 	Finance and Performance Committee	
	<ul style="list-style-type: none"> Over £500,000 	Governing Body (must include the Chief Finance Officer or Deputy Chief Finance Officer and requires the signature of the Chief Finance Officer or Accountable Officer)	
	d) Awarding External Audit contracts	Governing Body (on advice from Audit Committee)	
	All contracts awarded should be reported to the Audit Committee and the Governing Body with a responsible officer delegated to manage each contract.		
5.	Authorisation for Payment		DFP Section 8
	Where non-healthcare related goods and services have been procured in line with the above procedures (Sections 3 and 4) then authorisation of invoices for payment will be as follows:		FPN 4 – Accounts Payable
	<ul style="list-style-type: none"> up to £10,000 	Head of Department	Oracle User Hierarchy
	<ul style="list-style-type: none"> up to £50,000 	Assistant/Deputy Director	
	<ul style="list-style-type: none"> up to £150,000 	Deputy Chief Finance Officer, Executive Director of Quality and Nursing (Chief Nurse), Executive Director of Transformation, Complex Care and Mental Health, Executive Director of Primary Care and Population Health	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<ul style="list-style-type: none"> over £150,000 	Chief Finance Officer or Accountable Officer	
	The above values represent the maximum permitted. Where appropriate, lesser values may be stipulated by the Head of Department / Assistant/Deputy Director / Executive Director / Chief Finance Officer / Accountable Officer. Where lesser values are sought this must be approved by the Finance Directorate.		
	For healthcare commissioned services on contract authorisation of invoices for payment within the approved budget will be as follows:		
	<ul style="list-style-type: none"> up to £25,000,000 	Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> over £25,000,000 	Chief Finance Officer or Accountable Officer	
6.	Capital Schemes		DFP Section 6
	Approval of Property Vacation Notices for void properties	Chief Finance Officer and Accountable Officer (and reported to Primary Care Commissioning Committee or Finance and Performance Committee)	
	Capital schemes in line with capital resource limit	Chief Finance Officer	
	Capital PIDs for NHSE funding	Chief Finance Officer	
7.	Setting of Fees and Charges		DFP Section 5
	a) Income Generation (Including recharges to other NHS bodies & Local Authorities)	Chief Finance Officer	
	b) Price of NHS Contracts. Charges for all NHS Contracts be they block, cost per case, cost and volume, spare capacity	Chief Finance Officer	
8.	Accounts Receivable Authorisation		DFP Section 5
	a) Invoices raised		
	<ul style="list-style-type: none"> Up to £500,000 	Head of Finance	
	<ul style="list-style-type: none"> Over £500,000 	Deputy Chief Finance Officer	
	b) Credit memos		
	<ul style="list-style-type: none"> Up to £500,000 	Head of Finance	
	<ul style="list-style-type: none"> Over £500,000 	Deputy Chief Finance Officer	
9.	Engagement of Staff Not on the Establishment		DFP Section 11

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	Managers must check with the Finance Department regarding HMRC implications where consultancy/agency staff are considered self-employed. Finance staff must then check the employment status for tax using the HMRC Employment Status Indicator so that the correct employment status is determined.		
	Booking of Consultancy, Bank or Agency Staff		
	a) Non-Medical Consultancy Staff		
	The delegated limits regarding non-medical consultancy are in line with current national NHS England guidelines which form the underlying guiding principle for these limits.		
	<ul style="list-style-type: none"> Below £600 per day 	Executive Committee	
	<ul style="list-style-type: none"> £600-£799 per day 	The relevant NHS England Director of Commissioning Operations and their Director of Finance	
	<ul style="list-style-type: none"> £800-£899 per day 	The relevant Regional Director and Regional Director of Finance	
	<ul style="list-style-type: none"> £900 and over per day 	The relevant Regional Director and Regional Director of Finance and NHS England Commercial Executive Committee	
	b) Medical Locums, Nursing, Admin and Clerical and other temporary staff	Executive Committee	
10.	Agreements / Licences		
	a) Extensions to existing leases	Chief Finance Officer	
	b) Approval of rent based on professional assessment (District Valuer rent assessments)	Primary Care Commissioning Committee	
11.	Condemning & Disposal		DFP Section 14
	<ul style="list-style-type: none"> Approval of disposals and condemnations up to £50,000 	Chief Finance Officer (reported to Audit Committee)	
	<ul style="list-style-type: none"> Approval of disposals and condemnations of £50,001 and above 	Chief Finance Officer and Accountable Officer (reported to Audit Committee)	
12.	Losses, Write-offs & Compensation		DFP Sections 13 and

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	a) Bad debts, losses and special payments up to £50,000	Chief Finance Officer (reported to Audit Committee)	14
	b) Bad debts, losses and special payments over £50,000	Chief Finance Officer and Accountable Officer (reported to Audit Committee)	
13.	Petty Cash Disbursements and Credit Card Expenditure		DFP Sections 8 and 10 CCG Credit Card Policy
	Petty Cash		
	a) Expenditure up to £75 per item	Head of Department	
	b) Expenditure over £75 per item	Chief Finance Officer or Deputy Chief Finance Officer	
	Credit Card	Deputy Chief Finance Officer or Chief Finance Officer or Accountable Officer (for expenditure requested by the Chief Finance Officer)	
	Credit card expenditure is limited to:		
	• Catering and catering supplies		
	• Clubs/Associations		
	• Training and Education		
	• Travel		
	• Hotels and Accommodation		
14.	Maintenance & Update of Financial Procedures		
	Maintenance and update of financial procedures	Deputy Chief Finance Officer	
15.	Implementation of Internal and External Audit Recommendations		
	Implementation of Internal and External Audit recommendations	All	
16.	Primary Care Rebates		NHS Vale of York CCG Policy on Primary Care Rebate Schemes
	Acceptance of primary care rebates	Chief Finance Officer	

SECTION B – HUMAN RESOURCE ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
17.	Personnel and Pay		
	a) Authority to fill funded post In line with establishment with permanent staff, subject to finance approval as part of the Organisational Procedure	Executive Committee or Remuneration Committee for VSM and Governing Body posts (or outside of committees – 2	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
		Executive Directors which is then ratified at the relevant committee)	
	b) Renewal of fixed term contract	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	c) Job Description Review All requests for Job Description Review shall be dealt with in accordance with Organisational Procedure and Agenda for Change Matching Process.	Line Manager and approved by A4C Matching Panel	
	d) Establishments Additional staff to the agreed establishment with specifically allocated finance in accordance with Organisational Procedures.	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	e) Pay		
	<ul style="list-style-type: none"> Authority to complete standing data forms affecting pay, new starters, variations and leavers 	Head of Department	
	<ul style="list-style-type: none"> Authority to authorise overtime 	Assistant/Deputy Director	
	<ul style="list-style-type: none"> Authority to authorise travel & subsistence expenses 	Head of Department (for Continuing Healthcare expenses only – CHC Clinical Team Leader)	CCG Travel and Expenses Policy
	f) Leave		CCG Annual Leave Policy
	<ul style="list-style-type: none"> Approval of annual leave 	Line Manager	CCG Other Leave Policy
	<ul style="list-style-type: none"> Annual Leave – in exceptional circumstances approval of carry forward up to maximum of 1 working week 	Line Manager	CCG Maternity, Maternity Support, Paternity, Adoption and Parental Leave Policy
	<ul style="list-style-type: none"> Compassionate leave up to 6 days 	Line Manager	
	<ul style="list-style-type: none"> Special leave arrangements 		
	<ul style="list-style-type: none"> Paternity leave – up to 10 days 	Line Manager	
	<ul style="list-style-type: none"> Carers leave – up to 5 days 	Line Manager	
	<ul style="list-style-type: none"> Parental leave – up to 4 working weeks pa 	Line Manager	
	<ul style="list-style-type: none"> Leave without pay 	Line Manager after consulting HR	
	<ul style="list-style-type: none"> Time off in lieu 	Line Manager	
	<ul style="list-style-type: none"> Shared Parental Leave – paid and unpaid 	Automatic approval with guidance from HR	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	g) Sick leave		CCG Management of Attendance Policy
	<ul style="list-style-type: none"> Extension of sick leave on half pay up to three months 	Assistant/Deputy Director in conjunction with HR	
	<ul style="list-style-type: none"> Return to work part-time on full pay to assist recovery on advice from Occupational Health in conjunction with HR 	Assistant/Deputy Director	
	<ul style="list-style-type: none"> Extension of sick leave on full pay 	Assistant/Deputy Director in conjunction with HR	
	h) Study leave		CCG Learning and Development Policy
	<ul style="list-style-type: none"> Study leave outside the UK 	Executive Committee	
	<ul style="list-style-type: none"> All other study leave (UK) 	Deputy Directors	
	i) Removal Expenses, Excess Rent and House Purchases		CCG Relocation Assistance Policy
	Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		
	<ul style="list-style-type: none"> up to £8,000 	Chief Finance Officer	
	<ul style="list-style-type: none"> over £8,000 	Remuneration Committee	
	j) Grievance Procedure		CCG Grievance Policy
	All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of HR	Assistant/Deputy Director in conjunction with HR	
	k) Mobile Phone Users		
	Requests for new posts to be authorised as mobile users	Head of Legal and Governance	
	l) Staff Retirement Policy		
	Authorisation of extensions of contract beyond normal retirement age	Assistant/Deputy Director and Remuneration Committee in conjunction with HR	
	m) Redundancy	Chief Finance Officer and Accountable Officer in conjunction with HR and as per CCG's policies	
	n) Ill Health Retirement	Chief Finance Officer and Accountable Officer in conjunction with HR	
	o) Dismissal	Accountable Officer in conjunction with HR	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	p) Salary Sacrifice Schemes (HMRC supported)	Executive Committee	
	q) Facilities for staff not employed by the Trust to gain practical experience		CCG Work Experience Policy
	• Professional Recognition, Honorary Contracts & Insurance of Medical Staff	Executive Director of Quality and Nursing	
	• Work experience students	Executive Director	

SECTION C – OTHER ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
18.	Authorisation of Sponsorship Deals	Accountable Officer and Chair of the Governing Body	CCG Sponsorship Policy
19.	Authorisation of Research Projects	Accountable Officer and Executive Director of Quality and Nursing	CCG Conflicts of Interest Policy
20.	Insurance Policies	Accountable Officer or Chief Finance Officer	NHS Resolution membership
21.	Reporting Incidents to the Police		CCG Anti-fraud, Bribery and Corruption Policy
	a) Where a criminal offence is suspected	On Call Manager or Assistant/Deputy Director	
	b) Where a fraud is involved	Chief Finance Officer and Local Counter Fraud Specialist (LCFS)	
22.	Receiving Hospitality and Gifts		CCG Conflicts of Interest Policy
	Applies to both individual and collective hospitality receipt items in excess of £25 per item received Gifts over £6, whether accepted or not	Declaration required in CCG's Register of Gifts and Hospitality	



Vale of York
Clinical Commissioning Group

Annex 2

Detailed Scheme of Delegation

Section A – Financial Issues

Section B – Human Resources Issues

Section C – Other

Updated: April 2018

NHS Vale of York CCG - Detailed Scheme of Delegation

The delegations set out in the detailed scheme of delegation represent the lowest level to which authority for that specific issue has been delegated. All items concerning Finance must be carried out in accordance with Prime Financial Policies in Appendix E and Standing Orders (SO) in Appendix C of the NHS Vale of York Constitution and the Detailed Financial Policies. Where it is believed that the matter or decision being taken under these arrangements has far reaching implications then this must be reported to the Accountable Officer and / or Chief Finance Officer. The Deputy Chief Finance Officer may substitute for the Chief Finance Officer if necessary.

This detailed scheme of delegation refers only to services or activity for the corporate offices, equipment and employees, contractors and Lay Members of NHS Vale of York Clinical Commissioning Group and not for activity, offices, equipment or employees of any member practice.

SECTION A - FINANCIAL ISSUES

Delegated Matter	Authority Delegated To	Reference Documents
<p>1. Management of Budgets</p> <p>Responsibility of maintaining expenditure within budget:</p> <ul style="list-style-type: none"> a) At individual budget level (Pay and Non Pay) b) Department Budgets c) Financial Reserves and Provisions d) Hosted Services <p>Where it is necessary for expenditure to be approved that is outside of an approved budget either in value or in terms of what the budget was originally intended, this can only be done with approval of the Chief Finance Officer and will require an appropriate business case in line with the approval process.</p>	<p>Senior Manager or Head of Department</p> <p>Relevant Senior Manager</p> <p>Deputy Chief Finance Officer</p> <p>Relevant Senior Manager</p>	<p>Budgetary Control Framework (TBD)</p> <p>DFP Section 3</p>

<p>Budget virement:</p> <p>Budget transfer within budget holders area -no limit</p> <p>Budget transfer between budget holders Up to £100,000 Up to £500,000 No limit</p> <p>Budget transfer from reserve codes-no limit</p>	<p>Head of Finance or Deputy Chief Finance Officer or Chief Finance Officer</p> <p>Head of Finance Deputy Chief Finance Officer Chief Finance Officer</p> <p>Head of Finance or Deputy Chief Finance Officer or Chief Finance Officer</p>	
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Delegated Matter	Authority Delegated To	Reference Documents
<p>2. Maintenance / Operation of Bank Accounts</p> <p>a) Day to day operation of organisational bank accounts</p> <p>b) Authorisation for cash limit drawdown</p> <p>c) Authorisation for cheque requests</p> <ul style="list-style-type: none"> • up to £10,000 • up to £50,000 • up to £150,000 • over £150,000 	<p>Finance Manager (Financial Accounts) and Financial Controller of Shared Services Agency</p> <p>Deputy Chief Finance Officer or Chief Finance Officer</p> <p>Head of Department Relevant Senior Manager Deputy Chief Finance Officer Chief Finance Officer or Accountable Officer</p>	<p>DFP Sections 4 & 12</p> <p>Local Financial Procedures (TBD) – Cash and Treasury Management & Payment of Accounts</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>3. Non Pay Expenditure</p> <p>Delegated authority to approve business cases or place orders and non-pay expenditure that commits the organisation to a new, anticipated level of investment or a change to an existing area / level of spend is as follows:</p> <ul style="list-style-type: none"> • Up to £25,000 and in line with existing budget • Up to £500,000 • Over £500,000 • Up to £250,000 for Individual Funding Requests <p>Specific Non-Pay Expenditure Items</p> <ul style="list-style-type: none"> • Consultancy 	<p>Budget Holder</p> <p>Executive Committee– Which must include the Chief Finance Officer or Deputy Chief Finance Officer</p> <p>Governing Body – Which must include the Chief Finance Officer or Deputy Chief Finance Officer</p> <p>IFR Service Provider</p> <p>Chief Finance Officer-in line with NHS guidelines for approval.</p>	<p>DFP sections 3, 8, 9, 10 & 12</p> <p>Budgetary Control Framework (TBD)</p> <p>Local Financial Procedures (TBD) - Procurement of goods and services & Contracting and Tendering</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>Before Orders are placed for goods and services the following conditions must be complied with;</p> <p>a) Confirmation that budgetary provision is available and</p> <p>b) Where competitive tendering or competitive quotations are not required e.g. below £5000 then in the first instance the NHS Supply Chain must be used. In the event that NHS Supply Chain are unable to supply the goods or services then the following procedure, for which documentary evidence must be kept, will be followed;</p> <ul style="list-style-type: none"> • up to £4,999 a minimum of 2 verbal quotations have been sought • between £5,000 and £25,000 a minimum of 3 written quotations have been sought. • between £25,001 and £49,999 a minimum of 5 written quotations have been sought. <p><u>For Requisitions that exceed a 12 Month Period</u> The total value of requisitions that cover more than a 12 month period or that are open ended need to be considered as a total value, not just the cost for the 12 month period. E.g. a 2 year contract which has an annual value of £3,000 will require 3 written quotations. Where the number of years is not specified or open ended (from year to year) a 3 year period should be assumed for the purpose of this calculation.</p> <p>For orders in excess of £50,000 competitive tendering will apply, the form of which is dependent on the precise goods or services involved. Therefore for all orders above £50,000 the advice of the Chief Finance Officer must be sought.</p>	<p>All</p> <p>Relevant Senior Manager Relevant Senior Manager</p> <p>Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)</p>	<p>Detailed Financial Policies sections 3 and section 9</p> <p>Local Financial Procedures (TBD) Contract and Tendering and Payment of Accounts</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>4. Tendering & Contract Procedures (including Leases)</p> <p>a) Waiving of requirement to obtain quotations and tenders subject to the Detailed Financial Policies</p> <p>b) Opening of Tenders</p> <p>c) Awarding, authorisation and responsibility for contracts for non-pay expenditure including purchase of healthcare services agreed in line with the Financial Plan and subsequent variations, extensions or rolling over.</p> <ul style="list-style-type: none"> • Up to £250,000 • Up to £500,000 • Over £500,000 <p>All contracts awarded should be reported to the Audit Committee and the Governing Body with a responsible officer delegated to manage each contract.</p> <p>5. Authorisation for Payment</p> <p>Where goods and services have been procured in line with the above procedures (Sections 3 and 4) then authorisation of invoices for payment within the approved budget will be as follows :</p> <ul style="list-style-type: none"> • up to £10,000 	<p>Chief Finance Officer (from Accountable Officer)</p> <p>Senior Manager plus a witness</p> <p>Chief Finance Officer and Accountable Officer or Chief Nurse Chief Finance Officer and Accountable Officer</p> <p>Governing Body (must include the Chief Finance Officer or Deputy Chief Finance Officer and requires the signature of the Chief Finance Officer or Accountable Officer)</p> <p>Head of Department</p>	

Delegated Matter	Authority Delegated To	Reference Documents
<ul style="list-style-type: none"> • up to £50,000 • up to £150,000 • over £150,000 <p>The above values represent the maximum permitted. Where appropriate, lesser values may be stipulated by the Budget Holder / Senior Manager / Accountable Officer. Where lesser values are sought this should be done in agreement with the Finance Directorate.</p> <p>Where commissioning contracts and services have been procured in line with the above procedures then authorisation of invoices for payment within the approved budget will be as follows;</p> <ul style="list-style-type: none"> • up to £15,000,000 • over £15,000,000 	<p>Relevant Senior Manager</p> <p>Deputy Chief Finance Officer, Accountable Officer, Chief Nurse or Director of Transformation and Delivery</p> <p>Chief Finance Officer and Accountable Officer</p> <p>Deputy Chief Finance Officer</p> <p>Chief Finance Officer and Accountable Officer</p>	
<p>6. Capital Schemes</p> <p>Responsibility for NHS Estate and associated capital schemes has passed to NHS Property Services.</p> <p>This delegated matter relates to the purchase of internal fixtures and fittings the approval limits for associated requisitions are as follows:</p> <p>All Expenditure</p>	<p>n/a</p> <p>Chief Finance Officer</p>	<p>Detailed Financial Policies section 6</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>7. Setting of Fees and Charges</p> <p>a) Private Patient, Overseas Visitors, Income Generation, Other Patient Related Service and Accommodation Charges (Including recharges to other NHS bodies & Local Authorities).</p> <p>b) Price of NHS Contracts:</p> <p>Charges for all NHS Contracts, be they block, cost per case, cost and volume, spare capacity.</p>	<p>Chief Finance Officer</p> <p>Chief Finance Officer</p>	<p>Detailed Financial Policies section 5</p>
<p>8. Accounts Receivable Authorisation</p> <p>a) Invoices raised Up to £500,000.00</p> <p>Over £500,000.00</p> <p>b) Credit Memos Up to £500,000.00</p> <p>Over £500,000.00</p>	<p>Head of Finance</p> <p>Deputy Chief Finance Officer</p> <p>Head of Finance</p> <p>Deputy Chief Finance Officer</p>	<p>Detailed Financial Policies section 5</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>9. Engagement of Staff Not on the Establishment</p> <p>a) Non-Medical Consultancy Staff</p> <p>The delegated limits regarding non-medical consultancy are in line with current national NHS England guidelines which form the underlying guiding principle for these limits.</p> <p>Below £600 per day</p> <p>£600-£799 per day</p> <p>£800-£899 per day</p> <p>£900 and over per day</p> <p>b) Senior Managers must check with the Finance Department regarding HMRC implications where consultancy staff are considered self-employed. Finance staff must then check the employment status for tax using the HMRC Employment Status Indicator so that the correct employment status is determined. Booking of Bank or Agency Staff</p> <ul style="list-style-type: none"> • Medical Locums • Nursing • Clerical 	<p>Authority Delegated to Executive Committee</p> <p>Authority Delegated to the relevant NHS England Director of Commissioning Operations and their Director of Finance.</p> <p>Authority Delegated to the relevant Regional Director and Regional Director of Finance.</p> <p>Authority Delegated to the relevant Regional Director and Regional Director of Finance and NHS England Commercial Executive Committee</p> <p>Within Budget-Budget Holder Not within budget –Executive Committee</p>	<p>Detailed Financial Policies section 3</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>10. Agreements / Licences</p> <p>a) Preparation and signature of all tenancy agreements / licences for all staff subject to CCG Policy on accommodation for staff</p> <p>b) Extensions to existing leases</p> <p>c) Letting of premises to outside organisations</p> <p>d) Approval of rent based on professional assessment</p>	<p>Chief Finance Officer</p> <p>Chief Finance Officer</p> <p>Chief Finance Officer and Accountable Officer</p> <p>Chief Finance Officer</p>	<p>Detailed Financial Policies section 3</p>
<p>11. Condemning & Disposal</p> <p>Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively;</p> <ul style="list-style-type: none"> • with current / estimated purchase price of less than £50 per item • with current purchase new price in excess of £50 per item • disposal of mechanical and engineering plant (subject to estimated income of less than £1,000 per sale) • disposal of mechanical and engineering plant (subject to estimated income exceeding £1,000 per sale) 	<p>Head of Department</p> <p>Relevant Senior Manager</p> <p>Deputy Chief Finance Officer</p> <p>Chief Finance Officer</p>	<p>Detailed Financial Policies section 6</p> <p>Local Financial Procedures (TBD)</p> <p>Security and disposal of fixed assets</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>12. Losses, Write-offs & Compensation</p> <p>Ex Gratia Payments</p> <p>a) Patients and staff for loss of personal belongings</p> <p>b) Write off of Non NHS debtors</p>	<p>Chief Finance Officer</p> <p>Chief Finance Officer Reported to Audit Committee for information</p>	<p>Detailed Financial Polices section 14</p> <p>Local Financial procedures (TBD) Losses and Special Payments</p>
<p>13. Petty Cash Disbursements</p> <p>a) Expenditure up to £75 per item</p> <p>Petty Cash disbursements over £75 per item are only allowed in exceptional circumstances</p>	<p>Budget Holder</p> <p>Chief Finance Officer or Deputy Chief Finance Officer</p>	<p>Detailed Financial Policies</p> <p>Local Financial Procedures (TBD) Payments to staff</p>
<p>14. Maintenance & Update of Trust Financial Procedures</p>	<p>Deputy Chief Finance Officer</p>	
<p>15. Implementation of Internal and External Audit Recommendations</p>	<p>All</p>	<p>Detailed Financial Procedures section 11</p>

SECTION B - HUMAN RESOURCE ISSUES

Delegated Matter	Authority Delegated To	Reference Documents
<p>16. Personnel and Pay</p> <p>a) Authority to fill funded post In line with establishment with permanent staff, subject to finance approval as part of the Organisational Procedure</p> <p>b) Job Description Review All requests for Job Description Review shall be dealt with in accordance with Organisational Procedure and Agenda for Change Matching Process.</p> <p>c) Establishments Additional staff to the agreed establishment with specifically allocated finance in accordance with Organisational Procedures.</p> <p>d) Pay</p> <p>i) Authority to complete standing data forms affecting pay, new starters, variations and leavers.</p> <p>ii) Authority to authorise overtime</p> <p>iii) Authority to authorise travel & subsistence expenses</p> <p>e) Leave</p> <p>i) Approval of annual leave</p> <p>ii) Annual Leave – In exceptional circumstances approval of carry forward up to maximum of 1 working week.</p> <p>iii) Annual Leave – In extreme cases approval of carry over in excess of 1 working week.</p>	<p>Accountable Officer or Remuneration Committee for VSM and Governing Body posts</p> <p>Line Manager</p> <p>Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)</p> <p>Senior Manager or Head of Department</p> <p>Relevant Senior Manager</p> <p>Senior Manager or Head of Department</p> <p>Line Manager</p> <p>Relevant Senior Manager</p> <p>Relevant Senior Manager</p>	<p>Detailed Financial Policies sections 3 and 7</p> <p>Agenda for Change Terms & Conditions.</p> <p>Detailed Financial Procedures section 5</p> <p>Establishment Control procedure</p> <p>CCG HR policy document</p>

Delegated Matter	Authority Delegated To	Reference Documents
<p>iv) Compassionate leave up to 6 days</p> <p>v) Special leave arrangements</p> <ul style="list-style-type: none"> • Paternity leave - up to 10 days • Carers leave - up to 5 days • Parental leave – up to 4 working weeks pa <p>vi) Leave without pay</p> <p>vii) Time off in lieu</p> <p>viii) Shared Parental Leave - paid and unpaid</p> <p>f) Sick Leave</p> <p>i) Extension of sick leave on half pay up to three months</p> <p>ii) Return to work part-time on full pay to assist recovery on advice from Occupational Health in conjunction with HR.</p> <p>iii) Extension of sick leave on full pay</p> <p>g) Study Leave</p> <p>i) Study leave outside the UK</p> <p>ii) All other study leave (UK)</p>	<p>Line Manager</p> <p>Line Manager Line Manager Line Manager</p> <p>Line Manager after consulting HR</p> <p>Line Manager</p> <p>Automatic approval with guidance from HR</p> <p>Relevant Senior Manager in conjunction with HR</p> <p>Relevant Senior Manager</p> <p>Relevant Senior Manager in conjunction with HR</p> <p>Chief Officer Level</p> <p>Budget Holder</p>	

Delegated Matter	Authority Delegated To	Reference Documents
<p>h) Removal Expenses, Excess Rent and House Purchases Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)</p> <p>i) up to £8,000</p> <p>ii) over £8,000</p> <p>i) Grievance Procedure All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of HR.</p> <p>j) Authorised Car and Mobile Phone Users Requests for new posts to be authorised as car users</p> <p>Requests for new posts to be authorised as mobile users</p> <p>k) Renewal of Fixed Term Contract</p> <p>l) Staff Retirement Policy Authorisation of extensions of contract beyond normal retirement age</p> <p>m) Redundancy</p> <p>n) Ill Health Retirement</p>	<p>Chief Finance Officer</p> <p>Accountable Officer</p> <p>Relevant Senior Manager in conjunction with HR</p> <p>Chief Finance Officer</p> <p>Chief Finance Officer</p> <p>Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)</p> <p>Relevant Senior Manager and Remuneration Committee in conjunction with HR</p> <p>Chief Finance Officer and Accountable Officer in conjunction with HR and as per CCG's policies</p> <p>Chief Finance Officer and Accountable officer in conjunction with HR</p>	


Delegated Matter	Authority Delegated To	Reference Documents
<p>o) Dismissal</p> <p>p) Facilities for staff not employed by the Trust to gain practical experience</p> <p>Professional Recognition, Honorary Contracts & Insurance of Medical Staff</p> <p>Work experience students</p>	<p>Accountable Officer in conjunction with HR</p> <p>Chief Nurse</p> <p>Relevant Senior Manager</p>	

SECTION C - OTHER ISSUES

Delegated Matter	Authority Delegated To	Reference Documents
<p>17. Authorisation of Sponsorship Deals</p>	<p>Accountable Officer and Chair of the Governing Body</p>	<p>Detailed Financial Procedures section 11 CCG Conflicts of Interest Policy</p>
<p>18. Authorisation of Research Projects</p>	<p>Accountable Officer and Chief Nurse</p>	<p>Detailed Financial Procedures section 11 CCG Conflicts of Interest Policy</p>
<p>19. Insurance Policies</p>	<p>Accountable Officer or Chief Finance Officer</p>	<p>NHSLA membership</p>
<p>20. Reporting Incidents to the Police</p> <p>a) Where a criminal offence is suspected</p> <p>b) Where a fraud is involved</p>	<p>On Call Manager or Relevant Senior Manager</p> <p>Chief Finance Officer or Local Counter Fraud Specialist (LCFS)</p>	
<p>21. Receiving Hospitality</p> <p>Applies to both individual and collective hospitality receipt items in excess of £25 per item received.</p>	<p>Declaration required in CCG's Hospitality Register</p>	<p>Detailed Financial Procedures section 11</p>

Delegated Matter	Authority Delegated To	Reference Documents
22. Partnership Commissioning Unit	Executive Director of Transformation and Delivery	Continuing Healthcare Contract approval and management of the Partnership Commissioning Unit Functions (SLA)

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Item Number: 9	
Name of Presenter: Helena Nowell	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – NHS Vale of York CCG Emergency/Business Continuity Plan	
Purpose of Report <i>(Select from list)</i> To Ratify	
Reason for Report <p>The Plan is a new document to NHS Vale of York CCG and is part of a review of the CCG's emergency and business continuity planning processes. It is hoped that rather than each team having individual plans we will be in a position to generate action cards for likely business continuity interveners and how these will be dealt with by the CCG not just teams.</p> <p>The responsibility for emergency and business continuity planning rests with the Finance and Performance Committee where this Plan was approved on 27 February 2020.</p> <p>Emergency contact details for partners have been deliberately left out of this document at this stage for confidentiality purposes (many personal mobile phone numbers and contact details).</p> <p>There would be reference to this Plan on the website however the Plan itself, because of the personal data included, would not be published on the website.</p>	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input 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 type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Risk Rating

Emerging Risks

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

Quality Impact Assessment Equality Impact Assessment
 Data Protection Impact Assessment Sustainability Impact Assessment

Risks/Issues identified from impact assessments:

Recommendations

Governing Body is asked to ratify the Emergency/Business Continuing Plan.

Decision Requested (for Decision Log)

Governing Body ratified Emergency/Business Continuing Plan and endorsed the approach for reference to be made to the Plan on the website without the publication of the full document as a result of the personal data included within it.

Responsible Executive Director and Title	Report Author and Title
Phil Mettam, Accountable Officer	Abigail Combes, Head of Legal and Governance

Business Continuity Plan

Version 10

Implemented:	March 2020
Revision due:	March 2021 (or in the event of any changes to information and guidance (whichever occurs first))
Authors:	Abigail Combes, Head of Legal and Governance
Version:	1
Authorised by:	Governing Body, NHS Vale of York CCG

A hard copy of this document can be found in the on-call file, however, the on-line version is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and should be checked that the version corresponds with the on-line version.

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REVISIONS / AMENDMENTS SINCE LAST VERSION

Date of Review	Amendment Details
11 February 2020	First draft

1. Introduction

This procedure covers the NHS Vale of York CCG (VoYCCG) 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). Vale of York CCG recognises the importance of thorough and robust planning for emergency preparedness, resilience and response. This includes planning to respond to both major incidents and those which may affect business continuity.

The Chief Officer of the CCG has the statutory responsibility for the Emergency Preparedness Resilience and Response arrangements of the CCG under the Civil Contingencies Act 2004 (CCA), Health and Social Care Act 2012, NHS England, Emergency Planning Framework and other central Government Guidance.

The CCG Accountable Emergency Officer (AEO) is responsible for '*ensuring that the organisation is properly prepared and resourced for dealing with a major incident or civil contingency event*' (Emergency Officers for Emergency Preparedness, Resilience and Response (EPRR) 2012). CCGs must assure their Board, NHS England and Local Health Resilience Partners that suitable arrangements are developed, tested and maintained.

The Accountable Emergency Office is the Accountable Officer.

Category of Responder

Category 1 Responders (main NHS providers and NHG England) have a legal obligation under the Civil Contingencies Act 2004 (CCA) to assess the risk of, plan, and exercise for emergencies, as well as undertaking Business Continuity Management. Category 1 Responders are also responsible for warning and informing the public in relation to emergencies.

CCGs are Category 2 Responders. This means that the CCG has a legal obligation under the Civil Contingencies Act 2004 (CCA) to support the Category 1 Responders. It also has a role in supporting NHS England and providers of NHS funded care in planning for and responding to an influenza pandemic. Please see Appendix A for further information

The CCG also has a statutory duty to deliver essential functions to meet its commissioning responsibilities for the CCG population. The purpose of this plan is to map these key functions and consider alternative ways of delivery in the short term until normal service is restored. Any long term disruption would need further discussion by the CCG's Governing Body.

For the NHS, Business Continuity (BC) management is defined as the management process that enables a NHS organisation:

- To identify those key services which, if interrupted for any reason, would have the greatest impact upon the community, the health economy and the organisation;
- To identify and reduce the risks and threats to the continuation of these key services;
- To develop plans which enable the organisation to recover and/or maintain core services in the shortest possible time.

This Policy has been developed to support the Major Incident Planning process, recognising that a BC scenario could provide the 'trigger' for a major incident response (such as loss of one or more Organisation HQ sites) or, alternatively, a major incident (such as widespread and prolonged flood affecting the ability of staff to travel and work) may require one or more departmental or service BC plan to be invoked.

The Head of Legal and Governance as the BC Manager is responsible for ensuring there is on-going dialogue and collaboration between the BC function and those teams with Major Incident Planning responsibilities.

2. Purpose of the Plan

This Business Continuity Plan is intended to help NHS Vale of York Clinical Commissioning Group (CCG) overcome any unexpected disaster to its premises at West Offices, Station Rise, York, YO1 6GA or 1st Floor, Building 2, Amy Johnson Way, Clifton Moor, York, YO30 4XT, key personnel, or to any important systems that it relies upon in its day to day operations.

In the event of service interruption, this policy sets out the framework for the CCG to:

- Manage and maintain the continuation of critical core functions and services
- Manage the recovery and restoration of normal functions and services

The plan holder (Accountable Emergency Officer) is responsible for coordinating any response under the plan. If the plan holder is unavailable, this duty will fall to the

Copies of this document, together with copies of the insurance policy and other relevant documents are to be kept by both the plan holder and deputy plan holder at all times, along with a readily accessible copy on site.

Revision of this document

Responsibility for maintenance of the plan lies with the Accountable Emergency Office. It should be reviewed annually and updated every time there is a change in suppliers, contracts or key staff.

3. Scope

3.1 Within Scope

This policy relates to the business continuity management of the business functions within the CCG. It addresses those services which are provided by the Teams of NHS Vale of York Clinical Commissioning Group:

- Legal and Governance
- Quality and Performance
- Commissioning (Mental Health, Planned, unplanned and Primary Care)
- Finance and Contracting (including analytics and BI)
- Continuing Healthcare
- Medicines Management
- Communications and Engagement

3.2 Out of Scope

This plan does not outline the arrangements for business continuity management of services and business functions carried out by the CCG's providers and service suppliers, such as:

- York Teaching Hospitals NHSFT
- North Yorkshire County Council
- City of York Council
- East Riding of Yorkshire Council
- eMBED
- North of England Commissioning Support
- Tees Esk and Wear Valley NHS Trust
- Other CCGs where Memorandum of Understandings are in place for the hosting of services
- NHS England (co-commissioning Primary Care Services)

The CCG is heavily reliant on the services provided by the above organisations. Contractually these organisations are required to ensure arrangements for business continuity are in place and assurance is given to the CCG that the processes are robust.

4. Senior Management Team - Key Contacts

In order to evoke the business continuity plan the following available members of the Senior Management Team (SMT) need to have agreed that the CCG has suffered a break to business continuity and will co-ordinate the CCGs response for their areas of responsibility.

Name	Role	Contact Details	On call rota (Y/N)
Executive Director Team			
Phil Mettam	Accountable Officer	p.mettam@nhs.net	Y
Michelle Carrington	Executive Director of Nursing and Quality	Michelle.carrington1@nhs.net	Y
Denise Nightingale	Executive Director for Mental Health and Complex Care	d.nightingale@nhs.net	Y
Simon Bell	Chief Finance Officer	Simon.bell@nhs.net	Y
Dr Andrew Lee	Executive Director for Primary Care and Population Health	Andrew.lee@nhs.net	Y
Deputy Team			
Abigail Combes	Head of Legal and Governance	Abigail.combes@nhs.net	N
Sharron Hegarty	Head of Communications and Engagement	Sharron.hegarty@nhs.net	N
Paula Middlebrook	Deputy Chief Nurse	Paula.middlebrook@nhs.net	N
Carl Donbovand	Programme Lead (Mental Health and Complex Care)	Carl.donbovand@nhs.net	N
Michael Ash-McMahon	Deputy Chief Finance Officer	m.ash-mcmahon@nhs.net	N

Stephanie Porter	Assistant Director of Primary Care	Stephanie.porter@nhs.net	N
Caroline Alexander	Assistant Director of Delivery and Performance	Caroline.alexander3@nhs.net	N

5. Threats to the CCG's Business Continuity

There are a number of potential threats that would impact on the CCG's ability to continue its day to day business functionality.

The table below should be used with Appendix B and C:

Appendix B – Staff contact list - should contact or re-directing of phones or auto- replies be required

Appendix C – Cascade System

Any initial communication with staff must include the following information:

1. What the incident is
2. What the cause of the Incident is or may have been (if known)
3. How long the incident is likely to last
4. How the incident is to affect their work and alternative working arrangements
5. What is expected of them during the course of the incident; and
6. Confirmation of how communication should be maintained between them and the Head of Service.

Functions within the CCG have been categorised as critical, essential and routine. The functions by category are described below in Section 6.

Not all services will be deemed critical. The framework will therefore help identify the high, medium and low risk factors so that effort can be applied where it will have most value.

6. Critical CCG Activities

CATEGORY 1 Critical - resume within 24 hours	Emergency Preparedness - Planning and Response
	Oversight, Management and Monitoring of communications and Engagement
CATEGORY 2 Essential- Resume within 24 – 48 hours	Authorisation of payments to NHS provider organisations
	Authorisation of payments to essential suppliers and independent contractors
	Authorisation of payments to non-essential suppliers and independent contractors
	Financial external returns to NHSE, including monthly finance information and financial plan returns etc.
	Quality and Performance - Statutory/external activity return
	Continuing Healthcare Decision making
	Safeguarding
	Serious Incidents
	Authorisation of payments to NHS provider organisations
	Authorisation of payments to essential suppliers and independent contractors
	Authorisation of payments to non-essential suppliers & independent contractors
	Individual Funding Requests
CATEGORY 3 Routine - Resume as soon as practical (ideally 2 weeks)	Complaints Management
	Freedom of Information request processing
	Maintenance of Assurance Framework and Risk Register
	Manage the business agendas for the CCG Governing Body, Executive Team and subcommittee meetings; minute taking process delivery and supervision
	Overseeing the delivery of the HR, corporate governance and information governance functions of the CSU.
	Corporate Health and Safety
	QIPPs relating to Primary Care
	Primary Care activity / quality
	Service Redesign - Primary Care Element
	Development of QP pathways and establishment of monitoring systems
	Support of Primary Care Contracting
	Financial and contract management function including, preparation of finance and contracting reports for CCG Governing Body etc.
	Key Provider Contract Management meetings Planning and Forecasting
	Ad hoc data analyses
	Management, development and ongoing monitoring of compliance and performance against the quality expectations within main provider contracts, assessment of performance on quality schedule
	KPIs and CQUIN delivery
	Management of the GP Feedback System
	Strategic Planning - coordinating the processes required to deliver strategic and operational plans
Organisational Development	
Equality and Diversity	

6.1 Staff safety

Staff safety remains high priority. If it is not safe for staff to be in West Offices, Station Rise, York, YO1 6GA

or 1st Floor, Building 2, Amy Johnson Way, Clifton Moor, York, YO30 4XT or travelling to and from West Offices, Station Rise, York, YO1 6GA or 1st Floor, Building 2, Amy Johnson Way, Clifton Moor, York, YO30 4XT or on CCG business then staff should remain at home. This decision will be taken by the Director on call or another Director.

In the unlikely event that some staff are not able to travel home due to disruption then they will stay with a colleague where possible or alternative accommodation will be sought.

7. Activating the Plan

Director on Call

Is responsible for activating and coordinating the plan. However, it should be noted that there may also be a major incident which they will be leading on behalf of the organisation. In this scenario it is possible to delegate the leadership of the business continuity plan to a senior manager or other suitable delegate. Senior Managers are not on the on call rota and therefore their own personal circumstances will need to be considered before agreeing to support the major incident response. If there is an incident that requires evacuation of West Offices, Station Rise, York, YO1 6GA or 1st Floor, Building 2, Amy Johnson Way, Clifton Moor, York, YO30 4XT and the Director on call is not on site they should delegate the responsibility to an individual who is in on site.

Business Continuity Manager

Is the key link with the Director on-call. They are responsible for ensuring that the business continuity plan is activated and that all staff are kept informed and updated. At NHS Vale of York CCG this is the **Head of Legal and Governance**.

Triggers for activation of plan

The Business Continuity Plan will also be activated by the Director on Call when the major incident plan has been activated or is on standby, and there is an incident that has the potential to cause business disruption and affect critical activities. Depending on the type of disruption, it is possible that not all teams will need to activate their business continuity plan.

Contact details of staff and key stakeholders are identified in Appendix B

Cascade details can be found in Appendix C

8. Action Cards

Action Cards should be used to initially address any potential threat to business continuity. They can be found in Appendix D and cover:

Contact details of staff and key stakeholders are identified in Appendix B

1. Partial loss of staff
2. Complete loss of staff (>40%)
3. Loss of access to West Offices or Amy Johnson Way for longer than the maximum acceptable downtime.
4. Loss of telephone communication
5. Loss of network connectivity for an anticipated prolonged period

6. Loss of email
7. Loss of electrical supply for longer than the maximum acceptable downtime
8. Loss of gas supply for longer than the maximum acceptable downtime
9. Loss of water supply for longer than the maximum acceptable downtime
10. Loss of security
11. Transportation issues
12. Fuel shortage
13. Adverse weather conditions

It should be borne in mind that these events may not be mutually exclusive, e.g. extreme weather leads to loss of electricity, disruption to transport, staff unable to get to work.

9. Incident Control Team

If the incident looks like it may be prolonged it may be necessary to set up an Incident Control Team (Directors and Heads of Service) and an Incident Co-ordination Centre to ensure the CCG critical activities are continued.

The team should meet in GO63, West Offices or communicate via teleconference. If GO63, West Offices is affected by the incident move to **York Teaching Hospitals NHS Foundation Trust Headquarters**.

Key individuals, or their deputies, involved would be:

- Accountable Officer
- Head of Legal and Governance
- Head of Communications and Engagement
- Additional Directors/Deputies as required
- Co-opted members may also include facility management from NHS Property Services and NECS IMT lead.

10. Communication

Each member of SMT will keep a copy of this business continuity plan so that it can be actioned as and when necessary from any location.

Communication to staff will be via the following means, as decided to be the most appropriate and effective:

- Emails (if available) to work nhs.net accounts
- Telephone (if available) to either their work, home or mobile numbers as appropriate
- Information and updates on the intranet website (if available)
- Team meetings
- Monthly staff briefing

Please see Appendix B for staff contact details. **Please note: Personal mobile numbers are only to be shared after discussion with a Director**

Cascade Notification

Notification of staff will operate in a cascade system where by notification is made via direct line management routes. Please see Appendix C.

Telephone Numbers

A telephone cascade list with work, home and mobile numbers for staff will be held by Senior Managers. A

central list of all staff will be held securely with the HR records and included in this plan. It will be the responsibility of the Admin Team Leader to ensure this is kept up to date.

11. Record Keeping

It is important that there is a clear record of decisions taken which should be recorded on the log pages in Appendix D

As a minimum this information will include:

- The time of the incident
- The nature of the decision;
- The reason for the decision;
- The date and time of the decision;
- Who has taken the decision;
- The extent of consultation and advice from external stakeholders;
- Who has been notified of decisions made;
- Any review dates of the decision.

12. Finance and resources

If necessary a separate cost centre will be set up with a budget in agreement with the Chief Finance Officer. The Scheme of Delegation will apply.

13. Recovery Process & Lessons Learned

Recovery from an incident or event is as equally important as the business continuity management process. It is important that recovery is a managed and coordinated process led by the Emergency Accountable Officer.

After the recovery process is complete a lessons learned session should be undertaken and the business continuity plan updated to reflect any lessons learned.

Appendix A – Flu Plan

NHS England Gateway: 06448 03 February 2017

Guidance on the roles and responsibilities of Clinical Commissioning Groups (CCGs) in preparing for and responding to an influenza pandemic

The Health and Social Care Act (2012) places a statutory duty on each Clinical Commissioning Group (CCG) to “*take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency*”. Similar duties are imposed on each NHS provider as a term of their contracts with the CCGs to provide NHS services.

In addition, the Civil Contingencies Act (CCA) 2004 places a statutory duty on emergency frontline responders to prepare, respond and recover from significant incidents and emergencies. There is also an expectation that CCGs, as Category Two responders under this legislation, will collaborate, coordinate and cooperate in planning for and responding during an incident. To this end, CCGs have a role in supporting NHS England and providers of NHS funded care in planning for and responding to an influenza pandemic.

The NHS England Emergency Preparedness Resilience and Response (EPRR) Framework (2015) requires each NHS funded organisation to have a nominated Accountable Emergency Officer (AEO) responsible for ‘ensuring that the organisation is properly prepared and resourced for dealing with an incident’. In conjunction with local A&E Delivery Boards, CCGs must assure their Governing Body, NHS England and Local Health Resilience Partnership (LHRP) that suitable arrangements are developed, tested and maintained for responding to an influenza pandemic.

Detailed below is guidance for CCG AEOs and EPRR leads on their role in influenza pandemic preparedness and response, and to support CCGs in identifying their high level priorities towards this. Wider multi-agency and health resilience partnership will also find this guidance useful. More detailed guidance will be developed and circulated as necessary, as part of health economy wide pandemic influenza documentation.

Before a pandemic, each CCG will:

- identify an executive lead (likely to be the AEO) to lead the CCG’s pandemic preparedness activities
- undertake business continuity planning for pandemic influenza
- participate in relevant groups to discuss, plan, share best practice and exercise
- have a robust communications plan for managing communications with all stakeholders during a pre-pandemic period
- work with commissioned service providers in planning for surge in relation to elective work and the possible financial implications if there is ongoing disruption to normal services during an influenza pandemic including the recovery phase
- participate in appropriate assurance processes to ensure commissioned services have adequate pandemic plans in place
- work with NHS England to support local preparedness activities

During a pandemic, each CCG will:

- support the national pandemic response arrangements as outlined in Department of Health (DH) and NHS England pandemic influenza guidance
- participate in discussions with NHS England, NHS Improvement and local providers regarding any proposed or actual changes to services, targets, tariffs, performance standards etc., whilst maintaining safe patient care at the forefront of any decisions
- maintain robust 24/7 on-call arrangements , particularly with respect to surge and responding to major incidents
- work with commissioning colleagues, providers and partners to lead the local health economy response, e.g. through proven surge capacity arrangements, appropriate mutual aid of staff and facilities, and supporting the management of local clinical queries
- activate the CCG pandemic influenza communications plan and participate in local communications activities
- participate in the multi-agency response to ensure a comprehensive local response
- enact business continuity arrangements as required to maintain critical activities
- maintain local data collection processes including completion and submission of situation reports and participation in teleconferences as required
- participate in timely and proportionate debriefs to ensure sharing and adoption of best practice
- implement a process to collate financial and contractual impact information from commissioned providers

After a pandemic, each CCG will:

- implement appropriate recovery arrangements to ensure the recovery of their own services and commissioned services as soon as appropriate
- maintain preparedness for a future wave of pandemic activity, or further significant system activity
- contribute to local, regional and national post-pandemic debriefs and implement the recommendations from subsequent reports
- acknowledge staff contributions
- review and update plans, contracts and other arrangements to assess the impact of the pandemic and reflect lessons identified
- provide recovery updates to the public and stakeholders through locally coordinated communications activity
- collate and review financial and contractual impact information from commissioned providers and respond accordingly

Practical support

A range of options are available to CCGs in undertaking the activity required to develop pandemic response arrangements. These include:

- the LHRP, a statutory group which oversees health economy-wide pandemic planning activities
- the Local Resilience Forum (LRF), a statutory multi-agency forum
- working across joint representative boards and through relationships with NHS England, local health partners, and members of the wider resilience partnership
- the Public Health England (PHE) pandemic influenza off-the-shelf-exercise available through exercises@phe.gov.uk to test local arrangements

For more information on pandemic influenza preparedness and response, please refer to www.england.nhs.uk/ourwork/eprr/pi/ and www.gov.uk/guidance/pandemic-flu.

2. Key Organisation Contact Numbers

3. Staff Contact List (Alphabetical by first name)

4. Staff Contact List (By Cascade Group)

5. Cascade System

6. GP Emergency Contact Details

Confidential – For Emergency Use Only - Do not distribute

Appendix D – Action Cards

Any actions taken should be documented on these forms and kept for reference and debriefing following the restoration of normal business.

1. Partial Loss of Staff

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Contact partner CCGs and neighbouring Trusts to inform them of issue.		
Secure cover for critical posts from remaining CCG staff		
Liaise with neighbouring CCGs to share resources/ agree secondment of staff		
Contact NECS to share resources/agree secondment of staff		
Contact staffing agencies to provide temporary staff		

To be continued until:

Staff return to work or formal appointment of successors

Agency staff recruited to fill gaps

Notes:

2. Complete or Near Complete (e.g. pandemic flu)

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
NHS England's Yorkshire and the Humber Area Team contacted to co-ordinate a response in co-ordination with the remaining most senior member of the CCG Governing Body and/or the Senior Management Team. Telephone 0333 0124267		
Contact partner CCGs and neighbouring Trusts to inform		
Secure cover for critical posts from remaining CCG staff		
Liaise with neighbouring CCGs to share resources/ agree secondment of staff		
Contact NECS to share resources/agree secondment of staff. Tel:		
Contact staffing agencies to provide temporary staff		

To be continued until:

Staff return to work or formal appointment of successors

Agency staff recruited to fill gaps

Notes:

3. Loss of Access - If the building becomes unavailable for use:

The address of the main premises of NHS Vale of York CCGt is:

West Offices, Station Rise, York YO1 6GA

If the building becomes unavailable for use for any reason:

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
All partners and staff who are already at work, together with visitors, should be evacuated in line with fire procedures		
Contact the building security team for emergency assistance. Tel: 01904 553 223 (Ext. 3223)		
Immediate arrangements must be made to occupy suitable alternative accommodation, sending staff to work from home as appropriate. Consider moving to Amy Johnson Way or York Teaching Hospitals NHS Foundation Trust		
All staff who are still due to come in to work must be contacted immediately to advise them: <ul style="list-style-type: none"> ▪ Whether they should proceed to VoY CCG or agreed temporary premises OR ▪ Whether they should remain at home – if so, any instructions regarding home working should be relayed Most staff have a work laptop and should be able to continue to work remotely.		
Inform staff that contact will be through the existing telephone cascade system		
Contact City of York Council to arrange the re-directing of telephone numbers (to other premises or staff work mobiles). Tel: 01904 552222 (for IT helpdesk who are first point of contact for landline phones)		
If offices are to be out of action for longer than a few hours staff should be advised whether they should; <ul style="list-style-type: none"> work from home work from other local CCG offices work from NHS England local offices 		
Inform staff that contact will be through the existing telephone cascade system (Appendix C)		
Circulate the staff contact list provided in Appendix B of work e-mail and work mobile telephone numbers telephone cascade		
Consideration should be given to arranging the re- direction of post to a temporary address where VoY CCG staff are available to receive it. Contact Royal Mail		

Longer term advice to staff on where to work will be dependent on the operational needs of the CCG & the necessity of teams to remain together

To be continued until:

Access to existing offices is restored, temporary offices sourced or alternative permanent offices are leased

Notes:

4. Loss of Telecommunications

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Issue logged with IT service desk requesting timeframe for restoration		
Forward the main CCG number to the on-call phone 0844 5895915 Use Mobile devices to call so that numbers calling or missed calls can be identified (Switchboards have no Caller ID)		
Depending on the expected outage time, consideration should be given to contacting key organisations (such as GP Practices and Providers) with the on-call phone number for use in emergencies. Give an estimated time for service restoration if this is known.		
Depending upon the timescales for restoring access, consideration should be given to staff working at alternative offices to field calls effectively		
Inform staff that contact will be through the existing telephone cascade system		
Contact City of York Council IT helpdesk to arrange the re-directing of telephone numbers (to other premises or staff work mobiles) Tel: 01904 552222		

To be continued until:

Telephone communications are restored or temporary offices are sourced

Notes:

5. Loss of Network Connectivity

NB this will affect e-mails and telephones

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Log issue with IT service desk requesting timeframe for restoration Tel: 0345 140 8000		
Use work mobiles as a personal hotspot to enable 4G access if possible		
Depending upon the timescales for restoring access, consideration should be given to staff working at alternative		

To be continued until:

Network connectivity is restored or temporary offices are sourced

Notes:

6. Loss of Email

NB: Information Governance rules still operate and as such consideration should be given before providing such alternative methods

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Issue logged with IT service desk requesting timeframe for restoration Tel: 0345 1408000		
Depending upon timescales for restoring, consideration should be given to contacting sources of regular communication to advise them of a loss of e-mail access and provide alternative methods of communication. Personal emails should NOT be used.		

To be continued until:

Network connectivity is restored or temporary offices are sourced

Notes:

7. Loss of Electrical Supply

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
The computers in the offices should be switched off at the sockets, to prevent damage when the power is restored,		
Contact the building manager for emergency assistance.		
Consider cancelling all meetings booked until power is restored		
Consider relocation of staff to other premises		

To be continued until:

Electrical supply is restored or temporary offices are sourced

Notes:

8. Loss of Water Supply

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Check if other buildings affected and ask to use their washroom facilities and water supply in the short term		
Contact North Yorkshire Water and establish the reason for the disruption in supply and the time period for outage.		
If required, obtain large bottles of water. 5L bottles available from Sainsbury's		
Consider relocation of staff to other premises or to work from home		

To be continued until:

Water supply is restored or temporary offices are sourced

Notes:

9. Loss of Security

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Report immediately to the Security office		
Discuss with Head of Finance next steps.		

To be continued until:

Notes:

10. Loss of Transportation

Due to the location of the CCG's offices, reliance on public transportation is minimal and so it is unlikely such an event will have a major impact.

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Work from home or alternative CCG offices closer to home		
Reduce or stop non-essential movement, such as attending meetings		
Car share with other colleagues		
Walk or cycle to work if able		
Use alternative services e.g. taxi (must be made in consultation with a member of SMT)		

To be continued until:

Public transportation is restored

Notes:

11. Fuel Shortages

Actions will be dependent upon the timescale, nature and severity of the situation.

See Appendix B for Contact Numbers

Contingency Measure	Actioned?	
	Sign	Time
Work from home or alternative CCG offices closer to home		
Reduce or stop non-essential movement, such as attending meetings		
Car share with other colleagues		
Use alternative modes of transport, such as trains and buses.		
Walk or cycle to work if able		

To be continued until:

Fuel shortage is over.

An impact assessment may be undertaken to determine critical travelling in line with any central government / NHS England guidance. Key staff required for front line working may be issued with permits for fuel.

Notes:

12. Adverse Weather Conditions

Particularly flooding and snow.

Actions will be dependent upon the timescale, nature and severity of the situation.

See Appendix B for Contact Numbers


Contingency Measure	Actioned?	
	Sign	Time
Work from home or alternative CCG offices closer to home		
Reduce or stop non- essential movement, such as attending meetings		
Car share with other colleagues who have vehicles designed to deal with the adverse weather		
Use alternative modes of transport, such as trains, buses and walking if able and safe to do so.		

To be continued until:

Normal travel conditions restored

Notes:

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Item Number: 10	
Name of Presenter: Dr Andrew Lee	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Primary Care Networks Update	
Purpose of Report <i>(Select from list)</i> For Information	
Reason for Report To provide a summary update of PCN plans and population health priorities for 2020/21 across the Vale of York.	
Strategic Priority Links <input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" 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	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks Capacity of primary care and the primary care networks to deliver the national service specifications, long term plan priorities and population health priorities over and above core primary care.	

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

Recommendations

For information

Decision Requested (for Decision Log)

Governing Body noted the update.

Responsible Executive Director and Title

Dr Andrew Lee
Executive Director of Primary Care and
Population Health

Report Author and Title

Fiona Bell, Lead Officer Primary Care
(Vale)
Gary Young, Lead Officer Primary Care
(City)

NHS Vale of York CCG Primary Care Network Update

Fiona Bell-Morrith, Lead Officer Primary Care – Vale

Gary Young, Lead Officer Primary Care – City

5th March 2020

Selby Town PCN

Our Place:

- 4 General practices in Selby Town **total population 50k.**
- **Co-terminous with Selby District Council**
- By 2025 there will be an additional 3,300 people aged 65 (19% increase from 2018)
- Higher number of population in 65+ age group than England Average.
- Highest number of care home beds in Vale of York
- **Second highest health inequality in North Yorkshire** - life expectancy varies by 9 years between wards
- two central Selby practices serve the **most deprived practice populations in VoY area**
- One LSOA area in the **Selby West ward in the 10% most deprived areas in England**
- 1/3 of children grow up in poverty in Selby South and North wards

Priorities

- Mental health - multi-morbidities
- reducing inequalities and improving access
- frailty

Population Health Needs

- Deaths from circulatory disease, CHD & stroke and cancer significantly higher than England
- Smoking the leading cause of preventable illness.
- Above expected winter deaths.
- High proportion of people dying in hospital
- Frailty and multimorbidity key issues
- High adult obesity rates

Challenges

- Life expectancy varies by 9 years between wards
- Fragmented services in an area of high inequalities

Vision

- Strong, sustainable and successful general practice able to co-ordinate
- The best health and well-being for all people in the Selby locality

Outcomes:

- A healthier, more equal, more resilient Selby

Priorities for 20/21

- **Selby Town:** Complete population health programme to confirm priorities.
- establish Dementia Co-Ordinator post and improve diagnosis and pathways
- Development of a care home frailty team to deliver enhanced health in care homes
- Review of integrated care teams
- Mental health link workers in practice
- Establishment of new additional roles: Care Co-ordinator; physiotherapists, clinical pharmacists, social prescribing link workers

Partnerships: working closely with community services, TEWV, NYCC and Selby District Council

Tadcaster and Rural Selby PCN

Our Place:

- 3 General practices in Tadcaster, Sherburn in Elmet, and South Milford, population 28,000
- District council services from Selby District Council,
- Wider social care support from West Yorkshire Council and North Yorkshire County Council
- Higher proportion of over 65's compared to England
- Low levels of deprivation vs wider Selby District
- Child development significantly better than England

Priorities

- Cardiovascular disease – particular focus on addressing adult obesity
- Smoking cessation
- Improving access to community services
- improving access to services across a wide geographical area

Population Health Needs

- Cardiovascular disease is the main disease priority
- Adult obesity and diabetes are higher than CCG average
- Smoking is the leading cause of preventable illness, but lower levels of smoking overall.
- All 3 practices have adult asthma prevalence above the CCG and England average
- Adult hypertension rates are significantly higher than England in 2 practices

Challenges

- Access to services across the wide geographical area.
- Fragmented services

Vision

Strong, sustainable and successful general practice able to co-ordinate and support the best health and well-being for all people in the locality.

Working with partners to improve access to co-ordinated and proactive services.

Priorities for 20/21

- reducing inequalities and improving access
- Reducing levels of obesity -part of CVD Program
- Implementing Social prescribing offer and clinical pharmacy offer across all practices
- Establishment of the First Contact Practitioner Physiotherapy role
- Improving links and pathways for community services and input into MDT's and care planning

Partnerships: working closely with community services, TEWV, NYCC and Selby District Council

South Hambleton and Ryedale PCN

Our Place:

- 6 General practices across wide geographical area. 35,000 patients.
- Significantly higher number of population in 54+ age group than England Average.
- High number of frail older people living at home (low number of care homes)
- Access to services due to geography is a challenge
- Ryedale has a high proportion of lone pensioner households, with above average fuel poverty.
- mainly rural locality with a very low overall population density

Priorities

- Dementia and frailty
- Multi-morbidities
- Cancer
- reducing inequalities and improving access

Population Health Needs

- Significantly higher rate of stroke & CHD & Cancer in some practices than England
- Smoking the leading cause of preventable illness.
- Above expected winter deaths. Frailty and multimorbidity key issues
- High levels of obesity in Tadcaster and Rural Selby

Challenges

- Access to services in a large rural area
- High proportion of frail, older people.
- Fragmented services
- lower levels of funding due to low population density

Vision

Building robust, responsive, effective and sustainable primary care using the PCN as a mechanism to enable. Shaping and co-ordinating services around our patients; collaborating with partners to share responsibility and to make doing the right thing for our patients and communities the right thing.

Priorities for 20/21

- Improving pathways of care and diagnosis rates for people with dementia
- Reducing variation and improving care co-ordination and care planning for our frail population
- Care co-ordination for patients with cancer
- Reducing unwarranted variation in practice where not supported by population need
- Working with partners to improve same day urgent care offer across the patch – particularly re UCP's
- Improving community support for our geographically disperse population

Partnerships: working closely with community services, Acute Trust, TEWV, NYCC and the third and voluntary sector - particularly around dementia and frailty and urgent care offer.

York Place

Our Place

- 3 PCNs comprising 5 PCN neighbourhoods covering almost 250,000 registered patients
- Central locality is co-terminus with City of York Council and there is some overlap to the east of the locality with East Riding of Yorkshire Council
- Relative wealth masks areas with higher than average deprivation: a recent multi-morbidity study shows correlation between poor health outcomes and multimorbidity/deprivation.

Partnership work underway

- York Better Care Fund has a successful track-record of partnership and integrated team working, some attracting national recognition.
- Primary Care Home (now York Health & Care Collaborative) is established as a commissioner provider forum representing health and social care including CVS at a senior operational level.
- York Hospital, Vocare, Harrogate NHS Trust, and Yorkshire Ambulance, together with GPs, are starting to collaborate to redesign Urgent Care.

Population Health

- **An increasing and ageing population will place a greater demand across all of health and social care**
- **10-year life expectancy gap between wealthiest and poorest wards in York central locality**

Challenges


- **The population shift will add pressure to services already operating at or near maximum capacity**
- **An historic culture of GPs and provider silo working**

Vision:

- **ICO**
- **Vanguard: fully integrated physical & mental health care**
- **ICS 'exemplar' for place**

Priorities for 2020/21

- In addition to high visitor and student numbers, the resident population of York is expected to grow 2% by 2025; 60-90 year olds will grow 10% in the same period placing an additional 3.5% demand on GP capacity, an 8% increase on community nursing teams and adult social care will coordinate 10% more care packages than at present. Beyond 2025, the city is forecast to continue growing and ageing.
- General Practice resilience: a national shortfall in GP workforce is being keenly felt with the risk of branch surgery closures and a lack of capacity now resulting in primary care patients inappropriately presenting at York Hospital Emergency Dept.
- Manage growing Care Home and Nursing Home population more effectively and collaboratively.
- PCN Clinical Directors working in partnership with each other, and also health/social care partners, to increasingly lead system-wide collaboration to find effective opportunities to improve care/outcomes.
- Align Primary Care Home, Better Care Fund and the 5x city PCNs to improve primary care integration.

Item Number: 10	
Name of Presenter: Dr Andrew Lee	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Primary Care Resilience and Capacity: Central York (Update)	
Purpose of Report <i>(Select from list)</i> For Information	
Reason for Report To provide the Governing Body with the update which had also been presented at the Primary Care Commissioning Committee on 30 January 2020.	
Strategic Priority Links <input checked="" 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	
Local Authority Area <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	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks	

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

Recommendations

N/A – For information

Decision Requested (for Decision Log)

The Governing Body noted the update.

Responsible Executive Director and Title

Dr Andrew Lee
Director of Primary Care and Population Health

Report Author and Title

Gary Young
Lead Officer Primary Care

GOVERNING BODY: 5 MARCH 2020

Primary Care Resilience and Capacity: Central York (Update)

In September 2019 our report to the Primary Care Commissioning Committee surmised “*not all practices in the City are at crisis point, but some are. The risk is that if one practice fails, General Practice in York does not have sufficient capacity to absorb the fall out and the impact will be felt across the whole health and care system*”. At the same time, analysis by Venn Group for the Better Care Fund concluded that, on an average day, the York system has capacity to function effectively but, on a bad day, the system is so stretched that when one part of the system comes under pressure the whole system becomes pressured.

With support from Vale of York CCG, previous issues at one practice had largely been resolved and the practice cleared a Care Quality Commission inspection. Another practice had been open and transparent about their capacity problems arising from difficulties recruiting medical and clinical staff and most practices reported operating at, or near, maximum capacity most days with some reflecting they feel they are, on some days, possibly operating beyond maximum capacity.

Since September these practices have coped but report that the pressures and causes of pressure remain. In addition, a large central practice reported Opel 4 three times in December 2019/January 2020 citing a lack of medical and clinical staff as the root cause.

The resilience and capacity report made several recommendations and, in addition, we visited Rochdale Health Alliance to look at the work they were doing to support practices.

The four recommendations of the report were:

1. GP Workforce

As part of the workforce review and strategy refresh, Vale of York CCG to work with GPs to establish the viability of establishing (1) Locum Bank, (2) Urgent Care Practitioners for Home Visits, and (3) review the ‘Scarborough model. Within this, support/facilitate all practices in the central locality to jointly review the Improving Access service with a view to improving equitability of access and efficiency of the service.

- A bid for GP Forward View funding (Retention/Resilience) for a Vale of York GP Locum Bank was made to Humber, Coast and Vale Partnership which was declined. Now funded by Vale of York CCG to support practices in readiness to respond to Coronavirus. Appendix 1.
- Liaison with Yorkshire Ambulance Service has taken place to focus more manpower into fewer hours in order to provide greater support to primary care and review how the service can work with GP home visits (ongoing).
- A desktop review of the Scarborough model resulted in a collaborative Better Care Fund funded bid (York Teaching Hospital NHS Foundation Trust with

Vocare and GPs (contracted through Nimbuscare) to provide additional sessions in the Emergency Department and GP Improving Access Hubs December 2019 – February 2020.

- As a result of this collaborative bid, a wide review of urgent care contracts (defined as 24/7 same/next day primary care) has led to the Urgent Care Transformation workstream. With meetings scheduled throughout January and February this is being led by frontline clinicians across all current urgent care providers, looking at reducing the number of inappropriate Emergency Department attenders while improving primary care resilience.
- Opel. Take up by practices has been piecemeal and, with a system review of Opel underway, there is an opportunity to review how primary care becomes an integral part of Opel (aligns with urgent care transformation). As one Clinical Director recently remarked, when one practice reports through Opel you get a snapshot view, if all practices report through Opel you get a full primary care picture.
- Data analysis by the Improving Access team at NimbusCare has reduced 'Did Not Attends' so improving access and equitability of access to the service.
- The visit to Rochdale Health Alliance was insightful: their work is focused supporting recruitment across the whole practice team along with education and development. Tameside 'urgent care village' was cited as a successful urgent care transformation.

2. Changes in Services, Specifications and Waiting Times

As local 'partnership boards' are created through the Primary Care Network contract, Commissioners and providers should find a mechanism to jointly consult with General Practice to establish workload impact before finalising changes to existing services, including a review of hospital waiting times. Where GPs are experiencing a clear increase in appointments and administration, they should, together with consultants, establish pathway specific working parties to review waiting list and follow-up management.

- Local partnership boards are embryonic: after urgent care pressure across the system, the impact on routine appointments due to hospital waiting times is cited by GPs as the next greatest cause of unnecessary workload pressure.

Vale of York CCG should review the feasibility of allowing the MSK Triage service to directly book patients for onward referral without referring back to the GP first.

- Now fully rolled out

A rapid review of resource available to the York Integrated Care Team (YICT) would establish if further investment would be a cost-effective intervention to help reduce GP workload and support more patients to navigate effectively through the system.

- This is outstanding and aligns with Ageing Well. In central York, Primary Care Home (provider collaborative steering group) is resetting to take on this piece of work with a population health perspective.

3. IT and Estates

A dedicated group, led by General Practice, should be created to refocus attention on the risk to patients and practitioners arising from the multiple and complex issues around IT and Estates. For example, any practice looking to reduce the number of surgery sites it operates from faces a huge amount of scrutiny and resistance. This is right and proper but presents a major barrier to practices looking for solutions to the complex pressures they face. A wide stakeholder group including public and patient representatives, other providers (including neighbouring practices), Shared Agenda (estates strategy), councillors, and commissioners would be a positive step forward.

- A report by City of York Council Public Health team analysed the demographic and health workload impact of York's increasing population and a focused piece of work with practices and City of York Council on the 'teardrop' development is ongoing with the four practices impacted working collaboratively agreeing to share a new GP surgery premise. Follow up is a Health and Wellbeing Board workshop on 5 March 2020.
- All city practices are fully engaged with the estates strategic review.
- Vale of York CCG have sharpened focus and resource supporting practices with the digital agenda and system interoperability

4. Individual Practice Support

The resilience funding offered to General Practice last year (December to January) was warmly welcomed as a solution that supported overstretched practices to add additional short-term capacity to their teams. This should be repeated this winter.

- The winter resilience bid, along with Improving Access service, fulfilled this aim.

Vale of York CCG to recognise increasing workload on practices close to surgeries that are themselves under pressure - working with groups of practices on a 'neighbourhood' basis should be part of the remit of the local estates stakeholder group/s.

- Vale of York CCG have offered support to practices under pressure including public engagement and liaising with councillors.

A review of specific needs identified should be carried out with the individual practices and GPs identified to create bespoke packages of support.

- Support for a practice to identify frequent ED attenders and clinical supervision for GPs managing a high mental health workload is in progress (multi-agency)
- Vale of York CCG is jointly funding a YOR Local Medical Committee project 'Practice Manager Resilience' to strengthen effective working relationships with key stakeholders who directly impact on the workload and resilience of Practice Managers.

Discussion

Welcomed by GPs, the findings of the resilience report have sharpened the focus on the needs of our primary care teams, not just in York but across the Vale. As GP workforce is the main cause of pressure (locally and nationally) this is where the main effort has been concentrated. The urgent care transformation workstream is an opportunity to relieve pressure across urgent care and create space for General Practice to focus on routine appointments, improve continuity of care, and successfully progress the Primary Care Network Directed Enhanced Service contract.

Appendix 1: Application for GPFV funding (Retention or Resilience) – Vale of York Locum Bank

Background

As being found nationally Vale of York is experiencing workforce recruitment and retention difficulties. There are a high number of GP vacancies across the locality particularly in the city. The knock-on effect of this and the impact it is having on primary care resilience is highlighted in the attached paper which was tabled at the Primary Care Commissioning Committee earlier this year. It demonstrates significant pressure across primary care leading to staff absences through sickness and difficulties retaining staff. Due to the number of vacancies being carried Practices are reporting back it's extremely difficult to secure a locum at short notice to provide cover due to sickness absence as the majority of locums are booked up in advance to essentially work as salaried GPs. The knock-on effect of this is that appointments are having to be cancelled at short notice which results in patient care and access being compromised as well as a reduction in patient satisfaction. Alternatively, the sessions are being covered by Partners or salaried GPs on their days off in addition to their regular workload which can attribute to work related stress and further absences.

Proposal

The Practices across Vale of York would like to trial the use of a locum bank over a 3-month period to provide primary care resilience. The locum(s) would be employed through a host Practice or Federation and be available for call off by any Practice who is notified of a staff absence at short notice ie, with less than 24 hours of the session starting. If on any day the locum is not required within GP Practices they would add capacity at ED front door or the urgent care centre. If successful, the Practices would be committed to funding this service ongoing. The overall proposal is for the locum bank to consist of a GP, an Advanced Nurse Practitioner and an Urgent Care Practitioner.

If funding is not available for all 3 clinicians, then please could a request for the locum GP to be funded*.

If the proposal is considered against the resilience programme it would meet the following criteria – 'Coordinated support to help practices struggling with workforce issues'

Costs

GP - 8 sessions of locum costs per week @£360 per session - £34,560 over a 12-week period*.

ANP - 8 sessions of locum costs per week @£160 per session - £15,360 over a 12-week period.

UCP - 8 sessions of locum costs per week @£160 per session - £15,360 over a 12-week period.


Total cost - £65,280

Benefits

The funding would provide short term resilience to primary care across the Vale of York whilst also trialling a system that could be deployed longer terms of found to be successful. It would also have the following benefits;

- Reduce the number of cancelled appointments
- Support the continuity of care, maintain access levels and reduce waiting times for appointments
- Reduce unnecessary demand on urgent and A&E services
- Increase patient satisfaction
- Increase workforce satisfaction
- Improve retention rates
- Provide flexibility within the primary care workforce
- Collaborative working between Practices

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Item Number: 11			
Name of Presenter: Michelle Carrington			
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group		
Report Title – Safeguarding Adults Policy			
Purpose of Report <i>(Select from list)</i> To Ratify			
Reason for Report The revised CCG Safeguarding Adults is presented for ratification by Governing Body following approval at the February Quality and Patient Experience Committee. Approval of the policy completes an action from the Safeguarding Adults Internal Audit 2019. The policy has undergone a refresh i.e. sections are more succinct with links where appropriate. Additions and updates have been highlighted in red.			
Strategic Priority Links <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" 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 </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability </td> </tr> </table>		<input checked="" 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 checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability
<input checked="" 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 checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability		
Local Authority Area <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> East Riding of Yorkshire Council <input checked="" type="checkbox"/> North Yorkshire County Council </td> </tr> </table>		<input checked="" type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council	<input checked="" type="checkbox"/> East Riding of Yorkshire Council <input checked="" type="checkbox"/> North Yorkshire County Council
<input checked="" type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council	<input checked="" type="checkbox"/> East Riding of Yorkshire Council <input checked="" type="checkbox"/> North Yorkshire County Council		
Impacts/ Key Risks <input type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Risk Rating		
Emerging Risks None			

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

N/A

Recommendations

Governing Body is asked to ratify the updated policy.

Decision Requested (for Decision Log)

Safeguarding Adults Policy ratified.

Responsible Executive Director and Title

Michelle Carrington – Chief Nurse

Report Author and Title

Christine Pearson
Designated Nurse Safeguarding Adults

Safeguarding Adults Policy

February 2020

Authorship :	Christine Pearson – Designated Professional Safeguarding Adults Olwen Fisher - Designated Professional Safeguarding Adults
Reviewing Committee :	Quality and Patient Experience
Date :	February 2020
Approval Body :	Governing Body
Approved Date :	
Review Date :	
Equality Impact Assessment :	
Sustainability Impact Assessment :	
Related Policies	<ul style="list-style-type: none"> ▪ Managing Allegations Against Staff ▪ Mental Capacity Act ▪ Recruitment Policy ▪ Safeguarding Children Policy ▪ Serious Incidents and Concerns Policy ▪ Whistleblowing Policy
Target Audience :	All employees, members, committee and sub-committee members of the group and members of the Governing Body and its committees.
Policy Reference No. :	[Unique Policy reference number]
Version Number :	[Version number]

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.

POLICY AMENDMENTS

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

New Version Number	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet

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

01904 555870 or valeofyork.contactus@nhs.net

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1. INTRODUCTION

1.1 This policy sets out the statutory requirements that apply to NHS Vale of York for the safeguarding of adults at risk of harm or abuse. In meeting its statutory arrangements for safeguarding adults the Vale of York CCG has joint contractual arrangements for Safeguarding Adults led by NHS Scarborough and Ryedale CCG (North Yorkshire CCG from April 2020).

1.2 Safeguarding is everyone's responsibility and aims to protect people's health, wellbeing and human rights, and enable them to live free from abuse and neglect.

1.3 The CCG has a statutory duty to ensure it makes arrangements to safeguard adults from abuse and neglect within its own organisation.

1.4 The CCG provides clear service standards against which healthcare providers (including independent and voluntary sector providers) will be monitored to safeguard adults from abuse and neglect from commissioned services.

1.5 The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect *and*
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

1.6 An adult is defined as a person aged 18 years and above. An adult experiencing, or at risk of abuse or neglect will hereafter be referred to as 'the adult' throughout the policy.

1.7 This policy demonstrates that the CCG recognises that safeguarding adults at risk of abuse or neglect is a shared responsibility with the need for effective joint working between agencies and professionals that have different roles and expertise if those individuals are to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- A commitment of senior managers and board members to seek continuous improvement with regards to safeguarding both within the work of the CCG and of services commissioned.
- Clear lines of accountability within the CCG for safeguarding.

- Clear policies setting out the commitment and approach to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with adults as appropriate.
- Service developments that take account of the need to safeguard all service users, and are informed, where appropriate, by the views of service users.
- Staff training and continuing professional development including appropriate supervision and support for staff in relation to safeguarding practice.
- Effective interagency working including effective information sharing.

1.8 In discharging these statutory duties account must be taken of the following:

- **Adult Safeguarding: Roles and Competencies for Health Care Staff 2018**
- Care Act 2014
- Care & Support Statutory Guidance- Section 14 Safeguarding
- Mental Capacity Act 2005
- **Mental Capacity (Amendment) Act 2019**
- Modern Slavery Act 2015
- **Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019**
- **Statutory Prevent Duty Guidance in Counter-Terrorism and Security Act 2015 revised 2019**
- Local Multi-Agency Safeguarding Adult Board Policies and Procedures

2 POLICY STATEMENT

2.1 The CCG requires its own employees and those from whom it contracts services to be fully aware of their duties and responsibilities for safeguarding adults.

2.2 The CCG is committed to delivery of care that is culturally and religiously sensitive to the needs of all individuals and groups.

2.3 All sections of this policy aim to ensure that no present or future patient, whether formal or informal, receives unfavourable treatment on the grounds of their protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; or sexual orientation (Equality Act 2010).

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.

Bribery Act 2010

3.3 The CCG follows good NHS business practice as outlined in the Business Conduct Policy and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the development (or review, as appropriate) of this policy document and no specific risks were identified.

4.0 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.

4.2 This policy covers all staff employed by the CCG while they are at work either within CCG premises or at any other location in pursuance of their normal work activities.

4.3 Staff working in CCG premises who are not CCG employees must follow the policy of their employer; however the results of risk assessments carried out in CCG premises that they work in must be shared with them and their risk assessments shared with CCG staff.

4.4 This policy covers all types of abuse of adults including: physical abuse; domestic violence and abuse; modern slavery and human trafficking; radicalisation; sexual abuse and exploitation; neglect and acts of omission; psychological abuse; financial or material abuse; discriminatory abuse; organisational abuse; and self-neglect, although this list is not exhaustive.

5.0 POLICY PURPOSE AND FAILURE TO COMPLY

5.1 The purpose of the policy is to ensure that no act of commission or omission on behalf of the CCG as a commissioning organisation or by a service it commissions puts a service user at risk of abuse or neglect and that robust systems are in place to safeguard and promote the welfare of adults at risk of abuse or neglect.

5.2 The policy reinforces the organisational philosophy that safeguarding is everybody's business and that all staff should respond and act to raise safeguarding awareness and address emerging issues.

5.3 The policy details the roles and responsibilities of the CCG as a commissioning organisation and of its employees, directly or indirectly employed.

5.4 To support the implementation of this policy an example set of contractual safeguarding quality standards have been included (see Appendix 3) for health care providers (including independent and voluntary sector providers). These standards form the basis for negotiating contractual arrangements with all commissioned services and will be audited as a minimum annually to ensure that all service users are protected from abuse and the risk of abuse. New safeguarding quality standards are currently being piloted by NHS England and these will be replace Appendix 3 when approved nationally.

5.5 Any failure to have systems and processes in place to protect adults in the commissioning process, or by providers of health care that the CCG commissions, would result in failure to meet statutory and non-statutory constitutional and governance requirements; potentially leaving adults at risk of abuse and neglect and the provision of services which are unsafe.

6.0 ROLES / RESPONSIBILITIES / DUTIES

6.1 Accountable Officer

The CCG Accountable Officer has ultimate accountability for safeguarding.

Robust arrangements must be in place to demonstrate compliance with safeguarding responsibilities including:

- A clear line of accountability for safeguarding reflected in governance arrangements.
- Establishing and maintaining good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and

responsibilities, as well as effectively commissioning services ensuring that all service users are protected from abuse and neglect.

- Having in place clear policies setting out the commitment and approach to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with adults as appropriate.
- Supporting improvements in the quality of safeguarding practice across primary medical care.
- Ensuring safeguarding plays an integral role in all parts of the commissioning cycle from procurement to quality assurance.
- Seeking assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure continuous improvement and to demonstrate compliance with statutory safeguarding duties.
- Ensuring staff are trained in recognising and reporting safeguarding issues, have access to appropriate supervision, and are competent to carry out their roles and responsibilities.
- Effective inter-agency working with the local authority, the police and third sector organisations which includes appropriate arrangements to co-operate with the relevant local authority in the operation of the Safeguarding Adult Board.
- Having a Designated Adult Safeguarding Lead, Prevent Lead and Mental Capacity Act Lead supported by relevant policies and training.
- Effective systems for responding to abuse and neglect.
- Effective arrangements for information sharing.
- Working with the relevant local authority to enable access to community resources that can reduce social and physical isolation for adults
- Supporting the development of a positive learning culture across partners for safeguarding adults to ensure that organisations are not unduly risk adverse.

6.2 Chief Nurse

The CCG Chief Nurse has delegated responsibility for safeguarding as the Executive Board Lead and as such:

- Ensures that the CCG has management and accountability structures that deliver safe and effective services in accordance with statutory duties and national and local guidance for safeguarding adults.
- Ensures that service plans/specifications/contracts/invitations to tender include reference to the quality standards expected for safeguarding adults at risk.
- Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding responsibilities are reflected in all job descriptions.

- Ensures that staff in contact with adults in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

6.3 CCG Safeguarding Adult Team

The Designated and Professional Leads for Safeguarding, Prevent and Mental Capacity Act together:

- Work across the local health system to support other professionals in their agencies on all aspects of adult safeguarding and Prevent.
- Ensure the CCG meet the requirements of the Mental Capacity Act 2005 (MCA), and Mental Capacity (Amendment) Act 2019 which include Deprivation of Liberty Safeguards (DoLS).
- Ensure that safeguarding adults is an integral part of the CCG quality and clinical governance framework.
- Promote, influence and develop safeguarding training and supervision – on a single and interagency basis - to meet the training and supervision needs of staff.
- Provide advice on the development and monitoring of the safeguarding aspects of contracts / service specifications.
- Provide a health perspective into single and multi-agency learning reviews
- **Fulfil the lead role for allegations against People in Positions of Trust (PIPOT) concerns, in accordance with the Local Safeguarding Adult Board (LSAB) guidance; resolving any interagency issues that may arise and liaising with the LSAB as necessary whilst adhering to the CCG Managing Allegations Against Staff Policy.**
- Provide advanced expert knowledge and advice on safeguarding adults to a wide range of professional groups and organisations/agencies and where necessary taking responsibility for the oversight of complex cases ensuring that recommendations from learning lesson review processes are reported to the CCG Quality and Governance Committee.
- Undertake statutory designated safeguarding functions as outlined in statutory guidance, and detailed in the Safeguarding Adults: Roles and competences for health care staff Intercollegiate Document (2018).
- Provide an annual report for assurance on adult safeguarding which is presented for approval to the CCG Governing Body.

6.4 Line Managers

Line Managers have a duty and responsibility:

- To understand the safeguarding policy and the commitment of the CCG to ensure all staff are supported to maintain safeguarding training and level of safeguarding competence commensurate with their role and responsibilities.
- To conduct regular reviews of the safeguarding roles and responsibilities required for each role in accordance with the current Intercollegiate Document. A full reassessment will be required if changes are made to the duties of a role which warrant a new and different level of employment check or training requirement (e.g. if the post holder takes on new duties involving adults at risk of harm or abuse).

6.5 Individual Staff Members

Each individual has a responsibility:

- To be alert to the potential indicators of abuse or neglect in adults, and know how to act on those concerns in line with the CCG Safeguarding Adult Policy and LSAB guidance.
- To undertake safeguarding training in accordance with their roles and responsibilities as outlined by the CCG Safeguarding Adult Training Strategy (2019) and Safeguarding Children Training Strategy.
- Understand the principles of confidentiality and information sharing in line with local and government guidance.
- To contribute, when requested to do so, to the multi-agency meetings and safeguarding enquiries held under Section 42 of the Care Act 2014, established to safeguard adults at risk.

7.0 ADULT SAFEGUARDING PRINCIPLES AND PROCEDURE

<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

7.1 Six Key Principles underpin all adult safeguarding work:

- Empowerment – People are supported and encouraged to make their own decisions and informed consent.
- Prevention – It is better to take action before harm occurs.
- Proportionality – The least intrusive response appropriate to the risk presented.
- Protection – Support and representation for those in greatest need.

- Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding.

7.2 Making Safeguarding Personal

Making Safeguarding Personal is the recommended approach to safeguarding adults which supports the principles of safeguarding listed above. Making Safeguarding Personal also means embracing the core statutory principles of the Human Rights Act 1988, the well-being principle detailed in the Care Act 2014, and the core principles of the Mental Capacity Act 2005. It is about having conversations with people about how a response in a safeguarding situation enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them

7.3 Managing Safeguarding Concerns

7.3.1 When there is a reasonable belief that an adult is experiencing, or at risk of experiencing abuse or neglect and is unable to protect themselves, a safeguarding adults concern should be raised with the relevant local authority where the abuse has taken place. Below are the SABs linked with the CCG area.

City of York:

<http://www.safeguardingadultsyork.org.uk/>

North Yorkshire:

<https://www.northyorks.gov.uk/safeguarding>

East Riding:

<http://ersab.eastriding.gov.uk/#>

Other local authority areas can be searched here: <https://www.gov.uk/find-local-council>

7.3.2 Abuse and neglect often involve the actions of one person towards another. However, self-neglect involves situations where a person is placing themselves at risk of harm. This could be due to their reluctance, or inability to accept the assistance they need with their care and support needs. A safeguarding concern may need to be considered where an adult appears to self-neglect.

7.3.3 All concerns should be raised on the day they are identified to ensure timely and appropriate actions can be taken to help safeguard the individual. A flow chart to illustrate the decision making process when deciding to raise a safeguarding concern is included in Appendix 1.

7.3.4 All safeguarding concerns must include the following information as a minimum:

- Information to confirm you believe the adult to have care and support needs;
- The specific nature of the abuse or neglect;
- The views of the person you are concerned about (where it is safe to gain these);
- The actions undertaken to date to safeguard the person from abuse or neglect.

7.3.5 It is necessary to ensure that safeguarding concerns are raised in accordance with the principles of the Mental Capacity Act 2005 and as a general rule no decisions should be made, or actions taken without the consent of the adult you are concerned about. How consent was gained should be recorded on the safeguarding adults concern form, and within the CCG records. For further information consult the Mental Capacity Act Policy.

7.3.6 There will however be occasions when it will be necessary to raise a concern without the adult's consent and this will include situations where:

- There is a risk of serious harm to the wellbeing and safety of the adult or others, for example concerns about organisational abuse or neglect within provider organisations.
- Other adults or children could be at risk from the person causing harm.
- It is necessary to prevent a serious crime or you are concerned a crime may have been committed.
- The person lacks mental capacity to consent.
- Gaining consent would put the adult at further risk.

7.3.7 If it is necessary to raise a concern against the wishes of the adult or without the persons consent, the person involved in making the decision where possible should inform the adult about the decision and the reasons for taking this action, unless telling them at the point of raising the concern would jeopardise their safety or the safety of others. This will ensure they understand why actions they have not consented to are being undertaken and what will happen next.

7.3.8 If any person is unsure whether they should raise a safeguarding concern, they should contact the Safeguarding Adult Team for advice or the relevant local authority - see Appendix 2 for contacts.

7.3.9 If the person raising a concern believes there is a medical emergency or other danger to life; risk of imminent injury or if a crime is in progress which requires an

immediate response then they should call 999 for the appropriate emergency response.

7.3.10 When reporting a crime that does not require an immediate response or there are concerns about a potential crime call 101 to report concerns. When a safeguarding concern is raised with the police it will also be necessary to ensure the relevant local authority is notified by completing the safeguarding adults' concern form on the relevant Local Authority safeguarding adult website and retain a copy within the CCG records.

7.3.11 Consideration of the safety and well-being of other adults or children should be made when safeguarding concerns are being raised. A safeguarding referral should be made to Children and Families Services where a child or children may be affected by the harm or abuse of an adult. Please see the CCG Safeguarding Children policy.

7.4 Information Sharing

7.4.1 Effective sharing of information between practitioners and local organisations and agencies is essential to keep adults at risk safe: Section 45 of the Care Act 2014 gives a safeguarding adults board (SAB) power to obtain information in support of its functions.

7.4.2 Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation 2018 (GDPR). http://www.legislation.gov.uk/ukpga/2018/12/pdfs/ukpga_20180012_en.pdf.

7.4.3 Practitioners looking to share information should consider which processing condition in the Data Protection Act 2018 is most appropriate for use in the particular circumstances of the case. This may be the safeguarding processing condition or another relevant provision. All practitioners should be confident of the processing conditions, which allow them to store, and share, the information that they need to carry out their safeguarding role.

7.4.4 Practitioners should ensure they have undertaken mandatory Information Governance training; this will clarify what information is appropriate to share. Attempts should be made to resolve any disputes with information-sharing through the responsible Safeguarding Leads in the relevant organisations.

7.5 Prevent and the NHS

7.5.1 The Health Service is a key partner in the Prevent agenda in accordance with the Statutory Prevent Duty Guidance in the Counter-Terrorism and Security Act 2015 revised 2019, and it applies to all parts of the NHS including charitable organisations and private sector bodies which deliver health services directly or indirectly to NHS patients. Locally this would apply to any services commissioned by the CCG.

7.5.2 All staff who work in Healthcare staff have a key role in Prevent. The strategy focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity.

7.6 Spotting the Signs

7.6.1 There is no single profile of a person likely to become involved in extremism and the process of radicalisation is different for every person. Radicalisers use normal social processes such as loyalty, self-perception, and fear of exclusion to influence others.

7.6.2 Some of the signs where a vulnerable person is being groomed or drawn into extremism can be linked to changes in behaviour and thought processes. The person may become withdrawn or stop participating in his / her usual activities. A person may express feelings of: Anger; grievance; injustice; going missing from their home, school or care setting; having a new group of friends who have an extremist ideology; using language that supports 'us and them' thinking.

7.7 Channel Process

The Channel process is a key element of the Contest strategy and is a multi-agency approach to receiving referrals from agencies to safeguard people at risk from radicalisation.

7.8 Information Sharing and Prevent

7.8.1 Effective information sharing is essential to the delivery of the Prevent agenda as it enables partner agencies to take informed action as appropriate. This will sometimes require the sharing of information between partner agencies, including the CCG; to ensure that the best support is provided to the individual at risk of radicalisation.

7.8.2 The decision to share information is on a case by case basis, and in addition to that of safeguarding the individual consideration should be given to:

- Is the public interest served by disclosure of personal information and does this outweigh the public interest served by protecting confidentiality?
- Could your action prevent a serious crime?

7.9 Notice, Check and Share

This is the process that staff can use to manage any Prevent concern and enables informed decisions to be made on actions required:

- Notice: signs that *may* indicate harmful extremist views or behaviours or you have a cause for concern about someone, perhaps their altered attitude or change in behaviour
- Check: discuss concern with line manager or safeguarding adult team

- Share: appropriate, proportionate information by completing raising a safeguarding concern

8.0 POLICY IMPLEMENTATION

Following approval of the policy, it will be published on the CCG website and reference will be made to the policy in staff and practice communications.

9.0 TRAINING AND AWARENESS

9.1 This policy will be published on the CCG website.

9.2 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 Policy and Assurance Manager.

10.0 MONITORING AND AUDIT

10.1 The policy and procedure will be reviewed periodically by the CCG in conjunction with Designated Professional Lead Safeguarding Adults. Where review is necessary due to legislative change, this will happen immediately.

10.2 The implementation of this policy will be audited at appropriate intervals and reported to the CCG Governing Body.

11.0 POLICY REVIEW

This policy will be reviewed annually. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation / guidance.

12.0 REFERENCES

Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
<https://www.rcn.org.uk/professional-development/publications/pub-007069>

Care Act 2014
<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

Care & Support Statutory Guidance- Section 14
Safeguarding <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

Mental Capacity Act 2005

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

Mental Capacity (Amendment) Act 2019

<http://www.legislation.gov.uk/ukpga/2019/18/enacted>

Modern Slavery Act 2015

<http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted>

Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019

<https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf-1.pdf>

Statutory Prevent Duty Guidance in Counter-Terrorism and Security Act 2015 revised 2019

<https://www.gov.uk/government/publications/prevent-duty-guidance/revised-prevent-duty-guidance-for-england-and-wales>

Local Multi-Agency Safeguarding Adult Board Policies and Procedures

City of York:

<https://www.safeguardingadultsyork.org.uk/the-board/policy-and-procedures/>

North Yorkshire:

<http://safeguardingadults.co.uk/>

East Riding:

<http://ersab.eastriding.gov.uk/policy-documents/>

13.0 ASSOCIATED POLICIES

Data Protection and Confidentiality

Local Anti-Fraud, Bribery and Corruption

Managing Allegations Against Staff

Mental Capacity Act

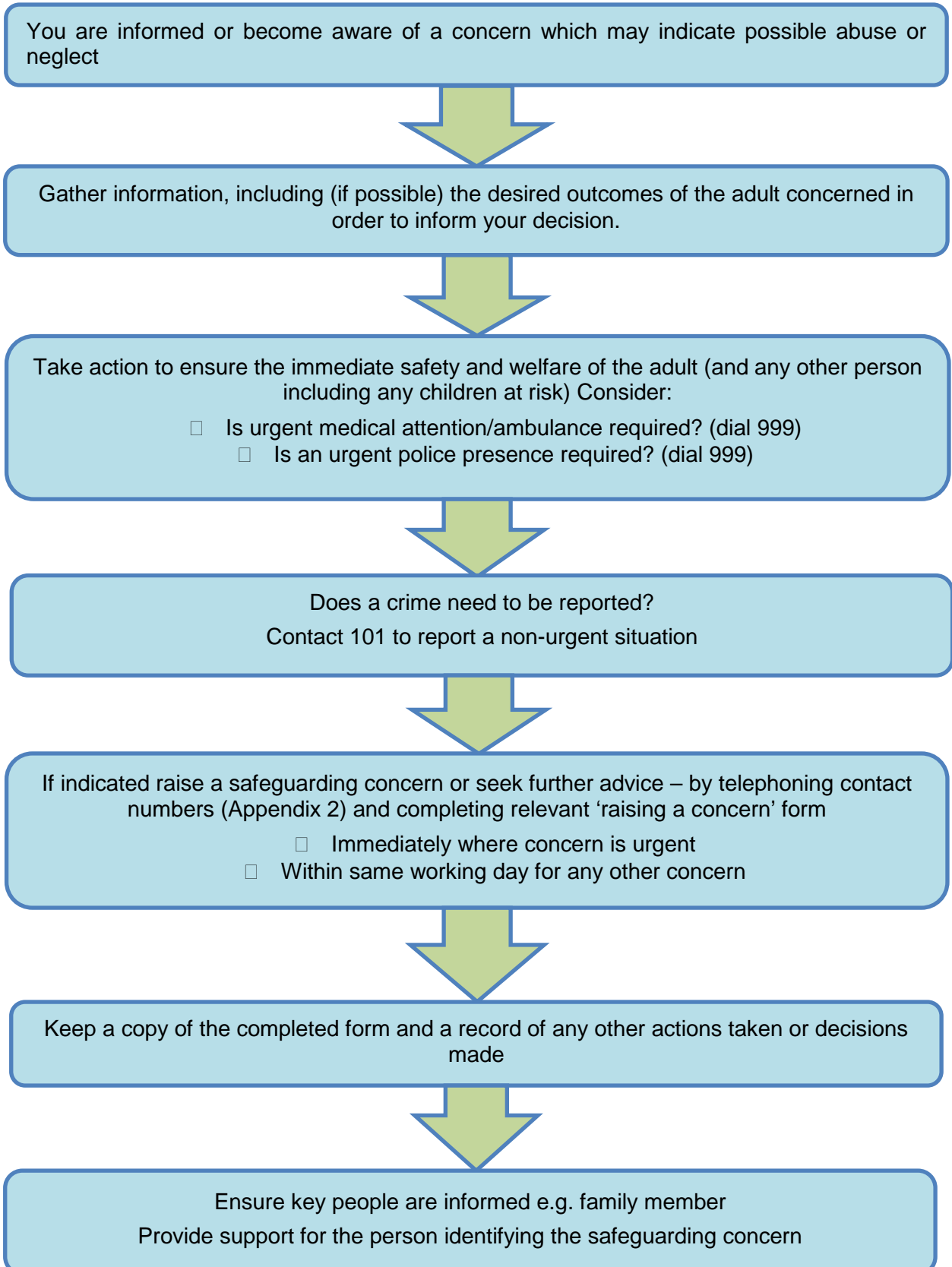
Recruitment Policy

Safeguarding Children Policy

Serious Incidents and Concerns Policy

Whistleblowing Policy

APPENDIX 1 **Raising a safeguarding concern flowchart**



APPENDIX 2

CONTACT SHEET

IT IS THE RESPONSIBILITY OF ALL STAFF TO TAKE APPROPRIATE ACTION WHEN THEY KNOW OR SUSPECT AN ADULT MAY BE AT RISK OF ABUSE OR NEGLECT

ADULT SAFEGUARDING CONCERNS

North Yorkshire:

Website and form to report abuse or concerns: www.safeguardingadults.co.uk/
Professional line 01609 536993
General and Out of Hours Emergency Duty Team (EDT) 01609 780780

City of York:

Website and form to report abuse or concerns:
www.safeguardingadultsyork.org.uk
Contact adults social care 01904 555111
Out of Hours Emergency Duty Team (EDT) 01609 780780

East Riding:

Website and form to report abuse or concerns
<http://www.ersab.org.uk/#>
Contact adults social care 01482 396940
Out of Hours Emergency Duty Team (EDT) 01377 241273

RAISING AN ADULT SAFEGUARDING CONCERN

1. If you suspect criminality or believe the individual to be at risk of immediate harm – dial 999 or 101 if non-urgent
2. Contact the relevant Local Authority using the contact details above informing them that you wish to raise an adult safeguarding concern
3. Ensure that you offer as much information as possible about the individual at risk as well as the person or persons alleged to be causing harm.
4. Follow all advice given to you by the relevant Local Authority – ensuring that you follow up your referral in writing and retain a copy of completed referral forms

For ADULT SAFEGUARDING ADVICE:

email SCRCCG.AdultSafeguarding@nhs.net or telephone 01904 694747

APPENDIX 3

NHS AND PRIVATE PROVIDER SELF DECLARATION AGAINST CCG STANDARDS:

SAFEGUARDING ADULTS

Provider

Completed by.....

Date

RED: Not Compliant. AMBER: Partially Compliant.

GREEN: Fully Compliant. BLUE: Not Applicable.

1	1. Policy and Procedures	RAG	Summary of evidence if compliant
1.1	The Provider will ensure that it has up to date organisational safeguarding adults' policies and procedures which reflect and adhere to the Local Safeguarding Adult Board policies and procedures.		
1.2	The Provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer adult safeguarding concerns and ensure that all staff have access to the guidance and know how to use it.		
1.3	The provider will ensure that all policies and procedures are consistent with and referenced to the Care Act 2014, the Care and		

	Support Statutory Guidance (2018) and the York and North Yorkshire Joint Multi-agency Safeguarding Adult Policy and Procedures and include safeguarding legislation, national policy and guidance.		
1.4	The Provider will ensure that all policies and procedures are consistent with legislation / guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.		
1.5	The Provider will have an up to date 'whistle-blowing'/ Raising Concerns procedure, which is referenced to local multiagency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The provider must have systems in place to demonstrate that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/Raising Concerns and that they will be supported to do so.		
1.6	The providers of care homes and hospitals will maintain an up to date policy and procedure covering the Deprivation of Liberty Safeguards, and when superseded the Liberty Protection Safeguards, and will ensure that staff practice in accordance with the legislation.		
1.7	NHS Trusts and all providers of hospitals and care homes will have an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to		

	contemporary best practice and legal standards.		
1.8	The Provider will ensure that there is a safeguarding supervision policy in place and that staff have access to appropriate supervision, commensurate to their role and function in accordance with the Intercollegiate Document (2018).		
1.9	All providers will ensure that they have relevant policies and procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These policies and procedures must adhere to contemporary best practice and legislation.		
1.10	The Provider must have a procedure which is accessible to all staff, consistent with the Prevent Duty Guidance (2019). The procedure must clearly set out how to escalate Prevent related concerns and how to make a referral.		
2	2. Governance		
2.1	The Provider will identify a person(s) with lead responsibility for safeguarding adults. For NHS Bodies / Trusts, this will be a Board-Level executive Director with lead responsibility for safeguarding adults Please name identified individual		

2.2	<p>The NHS Bodies / Trusts will also have in post a named health or social care professional (s) for adult safeguarding with sufficient capacity to effectively carry out the role</p> <p>Please name identified individual(s) and role(s)</p>		
	<p>This should include:</p> <p>A lead for the Mental Capacity Act and Deprivation of Liberty Safeguards/ Liberty Protection Safeguards</p> <p>Please name identified individual</p> <p>A lead for Prevent</p> <p>Please name identified individual</p> <p>A lead for managing adult safeguarding allegations against staff.</p> <p>Please name identified individual</p>		
2.3	<p>The Provider will review the effectiveness of the organisations safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.</p>		
2.4	<p>The Provider must ensure that there is a system for monitoring complaints, incidents and service user feedback, in order to identify and share any safeguarding concerns (including potential neglect),</p>		

	using multiagency safeguarding procedures.		
2.5	NHS Bodies / Trusts will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are referred appropriately according to multiagency safeguarding procedures.		
2.6	NHS Trusts should identify and analyse the number of complaints and PALs contacts that include concerns of abuse or neglect and include this information in their annual safeguarding or complaints report reviewed by their board		
2.7	The Provider must ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding and issues and inform constant service improvement.		
2.8	Providers of hospitals and care homes, will ensure that there are effective systems for recording and monitoring Deprivation of Liberty/ Liberty Protection Safeguard applications to the authorising body/Court of protection		
2.9	NHS bodies / Trusts must have in place robust annual audit programmes to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with the Mental Capacity Act (2005).		

2.10	All providers will have appropriate and effective systems in place to ensure that any care provided, is done so with due regard to all contemporary legislation. This includes, but is not restricted to, the Human Rights Act, Mental Capacity Act and Mental Health Act.		
2.11	The Provider will, where required by the local safeguarding board(s), consider the organisational implications of any Safeguarding Adult Reviews (statutory and non-statutory) and will devise and submit an action plan to the local responsible safeguarding adult board to ensure that any learning is implemented across the organisation.		
2.12	NHS Trusts and larger Independent Providers will ensure that Prevent data returns are shared quarterly with the CCG in addition to NHSE.		
2.13	The provider will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including: risk management systems; patient safety systems; complaints; PALS and human resources functions, and that these are referred appropriately according to multiagency safeguarding procedures		
3	3. Multiagency working		
3.1	The Provider will cooperate with any request from the Safeguarding Adult Boards to contribute to multi-agency audits,		

	evaluations, investigations and Safeguarding Adult Reviews (both statutory and non-statutory), including where required, the production of an individual management report.		
3.2	The Provider will, where required by the local safeguarding board(s), consider the organisational implications of any multiagency review(s) and will devise and submit an action plan to the responsible Safeguarding Adult Board or Partnership to ensure that any learning is implemented across the organisation.		
3.3	The Provider will ensure that any allegation, complaint or concern about abuse from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.		
3.4	The Provider will ensure that a root cause analysis is undertaken for all pressure ulcers of grade 3 or 4, and that a multi-agency referral is made for any stage of pressure ulcer where abuse or neglect are believed to be a contributory factor.		
3.5	The Provider will ensure that all allegations of neglect or abuse against members of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) are referred according to local multi-agency safeguarding procedures.		
3.6	The Provider will ensure that organisational representatives / practitioners make an effective contribution to safeguarding		

	meetings where required as part of multiagency procedures.		
3.7	The provider will where required, ensure senior representation on the Local Safeguarding Adults Board and contribution to their sub groups.		
4	4. Recruitment and employment		
4.1	The provider will ensure that it has a safe recruitment policy which refers to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which stipulates what information is required for people employed or appointed for the purpose of regulated activity, and adheres to the 'fit and proper persons' tests.		
4.2	The Provider must ensure safe recruitment policies and practice which meet contemporary NHS Employment Check Standards in relation to all staff including enhanced Disclosure and Barring Service (DBS) for appropriate staff, including those on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees, ensuring that Post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.		
4.3	The provider will ensure that all safeguarding concerns relating to a member of staff are effectively investigated, that any disciplinary processes are concluded irrespective of a person's resignation,		

	and that 'compromise agreements' are not be allowed in safeguarding cases.		
4.4	The Provider must ensure that their employment practices meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.		
4.5	The Provider should ensure that all contracts of employment (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) include an explicit reference to staffs responsibility for safeguarding adults.		
5	5. Training		
5.1	The provider will ensure that all staff and volunteers undertake safeguarding adults and Prevent training commensurate with their role and in accordance with the Intercollegiate Document 2018 and Prevent Duty Guidance 2019 and that this will be identified in an organisational training needs analysis and training plan which are reviewed regularly.		
5.2	The Provider will ensure that all staff, contractors and volunteers undertake safeguarding adult's awareness training on induction, including information about how to report concerns within the service or directly into the Local Authority in accordance with the		

	LSAB multi-agency policies and procedures.		
5.3	The Provider will ensure that all staff members (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) who provide care or treatment, have an understanding of the principles of the Mental Capacity Act 2005 and consent processes, appropriate to their role and level of responsibility, at the point of induction.		
5.4	The Provider will ensure that all staff and volunteers undertake Mental Capacity Act 2005 and consent training, including the Deprivation of Liberty Safeguards/ Liberty Protection Safeguards commensurate with their role and level of responsibility training in accordance with the Intercollegiate Document (2018), and that this will be identified in an organisational training needs analysis and training plan.		

Safeguarding Commissioners Standards: Remedial Action Plan				
Standard No.	Action(s) required to achieve standard	Person Responsible	Date Due	Comments / Progress


EXCEPTION REPORTING STANDARDS

The Provider is required to advise commissioners of the following changes or gaps in compliance – as soon as practicable – no later than 10 working days after changes/ issues are recognised.

On reporting on the following requirements, the Provider is required to identify any actions taken or required and timescale for completion.

Requirement	Change & any further Action Required
Any changes to the Executive or Professional leadership, including	

<ul style="list-style-type: none"> • Board/ Governing Body/ Senior Manager • Named Professional for Safeguarding • MCA/DoLS lead • PREVENT lead • Management of allegations against staff who work with adults with care and support needs 	
<p>Any challenges/ capacity issues in systems related to DoLS/ LPS applications.</p>	
<p>Any challenges/ capacity issues which affect the Provider's ability to maintain compliance with Safeguarding Standards</p>	

Item Number: 13	
Name of Presenter: Simon Bell	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Financial Performance Report 2019/20 Month 10	
Purpose of Report For Information	
Reason for Report To brief members on the financial performance of the CCG and achievement of key financial duties for 2019/20 as at the end of January 2020. To provide details and assurance around the actions being taken.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks	
Impact Assessments Please confirm below that the impact assessments have been approved and outline any	

risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

Recommendations

The Governing Body is asked to note the financial performance to date and the associated actions.

Decision Requested (for Decision Log)

The Governing Body note the report.

Responsible Executive Director and Title

Simon Bell, Chief Finance Officer

Report Author and Title

Caroline Goldsmith, Deputy Head of Finance

Annexes (please list)

Appendix 1 – Finance Dashboard

Appendix 2 – Running Cost Dashboard

Finance and Contracting Performance Report – Executive Summary



April 2019 to January 2020
Month 10 2019/20

Financial Performance Headlines

IMPROVEMENTS IN PERFORMANCE

Issue	Improvement	Action Required
Primary Care Prescribing	The Primary Care Prescribing forecast outturn has improved by £104k. Savings due to prescribing indicative budgets have increased significantly compared to previous months, with savings of £147k achieved in November as opposed to £79k forecast in Month 9.	Continue to work with Primary Care Networks to support and maximise the impact of Prescribing Indicative Budgets.
Nuffield Health	Activity in month 9 was significantly lower than previously forecast (£81k) which has resulted in a reduction in the forecast of £109k.	Continue to monitor the contract.
Financial Recovery - In-year Mitigations	The reserves forecast outturn position includes financial recovery actions now completed of £1.3m which is a reduced requirement from the £1.8m outstanding at Month 9.	
Non-Contracted Activity - Mental Health	Non-contracted activity for mental health has improved by £130k compared to Month 9. A review has been undertaken which identified a number of invoices which were incorrectly raised to the CCG instead of TEWV and have now been excluded.	Continue close monitoring of NCA invoices to ensure that invoices are correct.

Financial Performance Headlines

DETERIORATION IN PERFORMANCE

Issue	Deterioration	Action Required
System Recovery Schemes	Forecast delivery of system recovery schemes has reduced from £3.2m to £2.8m. This is due to the removal of the SRCCG prescribing scheme (£250k) and re-phasing of the second eye cataracts scheme. Both of these changes to forecast were agreed at January System Delivery Board. The impact for the CCG is a £111k reduction in its share of delivery.	Remaining 2019/20 schemes to continue to update SDB on progress. Ensure that schemes will a full year effect in 2020/21 deliver in line with forecast to ensure no detriment on 2020/21 financial plans.

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. In year mitigations – The CCG identified several risks to delivery of the financial plan earlier in the financial year, and currently anticipates a requirement for in-year mitigations of £1.3m to offset these pressures. The CCG has now agreed joint solutions with providers that would cover the current requirement for in-year mitigations.

2. Financial Planning for 2020/21 – Planning guidance and timescales for 2020/21 have now been issued, with a first detailed submission of draft financial plans to the Humber Coast & Vale (HCV) STP due on 28 February. Following initial review and feedback this will then form part of an HVC STP submission to NHSE/I the following week. The CCG is working with York Teaching Hospitals NHS FT and the North Yorkshire CCGs to agree a consistent and aligned plan, savings and investment requirements, and impacts on financial recovery trajectories. In turn, this will inform the approach to managing system financial risk in 2020/21. Although each organisation will complete and submit its own planning templates, these will be checked to ensure alignment, i.e. consistent assumptions between commissioner and provider organisations in terms of planned expenditure and income.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				2019-20 Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation					7.8	7.3	0.5	G
In-year total expenditure does not exceed total allocation (Programme and Running costs)					492.7	511.6	(18.8)	R
Better Payment Practice Code (Value)	95.00%	99.69%	4.69%	G	95.00%	>95.00%	0.00%	G
Better Payment Practice Code (Number)	95.00%	97.20%	2.20%	G	95.00%	>95.00%	0.00%	G
CCG cash draw down does not exceed maximum cash draw down					511.7	511.4	0.3	G

- 'In-year total expenditure does not exceed total allocation' – outturn expenditure is forecast to be £18.8m higher than the CCG's in-year allocation, but is in line with the CCG plan.

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				2019-20 Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	6.1	6.1	0.1	G	7.3	7.3	(0.0)	G
Programme spend within plan	421.4	421.5	(0.1)	G	504.2	504.2	0.0	G
Actual position is within plan (In-year)	(15.7)	(15.7)	0.0	G	(18.8)	(18.8)	0.0	G
Actual position is within plan (Cumulative)					(81.3)	(81.3)	0.0	G
Risk adjusted deficit					(18.8)	(18.8)	0.0	G
Cash balance at month end is within 1.25% of monthly draw down (£000)	500	128	372	G				
QIPP delivery	11.7	9.0	(2.7)	R	14.7	11.0	(3.6)	R

- 'QIPP delivery' Year to Date (YTD) and Forecast Outturn (FOT) – the shortfall relates to prescribing indicative budgets (YTD £925k, FOT £1.0m) and System Recovery Schemes (YTD £2.0m, FOT £2.8m). These variances are included in more detail in the financial performance report narrative.

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Detailed Narrative

Report produced: February 2020

Financial Period: April 2019 to January 2020 (Month 10)

1. Month 10 Supporting Narrative

The actual deficit at Month 10 was £15.7m which is in line with the plan. Within this figure there are several variances which are explained in further detail in the table below.

QIPP delivery at Month 10 is £9.0m against a year to date plan of £11.7m, representing a £2.7m shortfall against plan. The difference relates primarily to slippage on prescribing schemes and system recovery plans. The forecasts relating to these schemes have been updated to reflect anticipated in year shortfalls – see section 7 for more details.

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
Reserves	(£2.69m)	This relates wholly to the System Recovery Schemes. Year to date delivery of these schemes is now reflected on the relevant expenditure line.
Contingency	£1.70m	The 0.5% contingency built into plan has been released to offset the shortfall against System Recovery Schemes. The contingency has been profiled to offset the System Recovery shortfall evenly throughout the financial year.
Primary Care Prescribing	(£1.63m)	This variance includes slippage on QIPP schemes (£925k), Category M price increases from August (£498k) and additional costs from No Cheaper Stock Obtainable (NCSO) items (£396k).
Continuing Care	£1.21m	A £1.5m contingency has been provided in plan for high cost packages, and this has not been utilised in the year to date position resulting in a £1.25m underspend.
Other Acute Contracts	£1.04m	Several of the CCG's smaller acute contracts have had lower activity than plan including Nuffield (£393k), Harrogate (£228k) and Mid Yorkshire (£302k).
Ramsay	(£0.69m)	Activity at Ramsay continues to be higher than plan, however this is expected to reduce in February and March as Ramsay has reported a reduction in referrals to the Clifton Hospital.
York Teaching Hospital NHS Foundation Trust	£0.51m	The majority of the year to date delivery of System Recovery Schemes is now reflected on this line, as these schemes relate to reduced planned care costs

		at YTHFT and will be transacted through a contract variation at year end.
Other Mental Health	£0.51m	This variance is due to the current assessment of the Transforming Care Partnership risk share arrangement with the North Yorkshire CCGs.
Other Services	(£0.45m)	The majority of this overspend relates to the CCG's settlement with NHS Property Services for 2017/18 and 2018/19 invoices, as previously reported.
Out of Contract Placements	(£0.40m)	The reported position is based upon patient level information from the iQA system.
Other variances	£0.94m	
Total impact on YTD	£0.06m	

2. Forecast Outturn Supporting Narrative

The forecast outturn of £18.8m deficit is in line with plan, however within this position there are several variances which are explained in further detail in the following table.

The forecast outturn includes QIPP delivery of £11.0m, which is a shortfall of £3.7m against the CCG's plan of £14.7m. This variance relates to System Recovery Schemes (£2.8m) and Prescribing (£1.0m).

Forecast in-year financial position – variance analysis

Description	Value	Commentary / Actions
Reserves	(£2.50m)	This variance relates to the £3.7m planned System Recovery Schemes – forecast delivery of these schemes is now reflected on the relevant expenditure line. This is offset by in-year recovery actions of £1.25m.
Contingency	£2.44m	The CCG's contingency has now been released in full to offset the reduced delivery of the System Recovery Schemes.
Primary Care Prescribing	(£1.87m)	The Prescribing forecast now includes £1.0m slippage on QIPP schemes. It also includes £665k relating to the nationally notified Category M price adjustment and £475k of increased cost due to NCSO, which it is assumed will be managed by CCGs and therefore has been included in the forecast position.
Continuing Care	£0.93m	A £1.5m contingency has been provided in plan for high cost packages. There has been no expenditure incurred against this from April to November, and the forecast now assumes that there will be a £790k underspend against this contingency.
Other Acute Contracts	£0.69m	Several of the CCG's smaller acute contracts have had lower activity than plan so far in 2019/20 and this pattern is extrapolated in the CCG's forecast. This includes £347k with Mid Yorkshire and £276k with Harrogate.
York Teaching Hospital NHS Foundation Trust	£0.63m	The majority of the forecast delivery of System Recovery Schemes is now reflected on this line, as

		the majority of schemes relate to reduced planned care costs at YTHFT and will be transacted through a contract variation at year end.
Out of Contract Placements	(£0.47m)	The forecast position has now stabilised after deteriorating in month 8. The forecast overspend is due to an increased number of packages compared to 2018/19.
Nuffield Health	£0.47m	Activity year to date at Nuffield is less than planned which has then been reflected in the forecast outturn.
Other Services	(£0.46m)	The majority of this overspend relates to the CCG's settlement with NHS Property Services for 2017/18 and 2018/19 invoices, as previously reported.
Ramsay	(£0.40m)	Activity in April to December was higher than plan however this is expected to reduce in February and March as Ramsay has reported a reduction in referrals to the Clifton Hospital.
Other variances	£0.54m	
Total impact on forecast	£0.00m	

3. Gap and Key Delivery Challenges

In the Month 10 non-ISFE submission, the CCG did not report any additional risks to delivery of the forecast outturn.

4. Allocations

The allocation as at Month 10 is as follows:

Description	Recurrent / Non-recurrent	Category	Value
Total allocation at Month 9			£430.39m
Transfer to Scarborough for Winter Schemes	Non-recurrent	Core	(£0.54m)
HSCN Corporate Connection Costs	Non-recurrent	Admin	£0.01m
DWP Employment Advisors in IAPT	Non-recurrent	Core	£0.09m
Winter Pressure Volunteering Programme	Non-recurrent	Core	£0.03m
Pension uplift 19/20 6.3%	Non-recurrent	Admin	£0.28m
Total allocation at Month 10			£430.25m

5. Underlying position

The underlying position reported at Month 10 is a deficit of £23.53m; this is detailed in the table below.

Description	Value
Planned in-year deficit	(£18.84m)
Adjust for non-recurrent items in plan -	
Equipment and wheelchairs non-recurrent prior year payment	£0.20m
Deferred PIB payments	£0.60m
Repayment of 2016/17 system support	£0.33m
Primary Care slippage – non-recurrent QIPP	(£0.60m)
Other non-recurrent items in plan	£0.19m
Underlying position in financial plan	(£18.13m)
Recurrent impact of System Recovery Scheme under delivery	(£3.48m)
Recurrent impact of QIPP under delivery	(£1.00m)
Recurrent overspends in forecast outturn	(£1.32m)
FYE of QIPP and investments	£0.40m
Reported underlying position	(£23.53m)

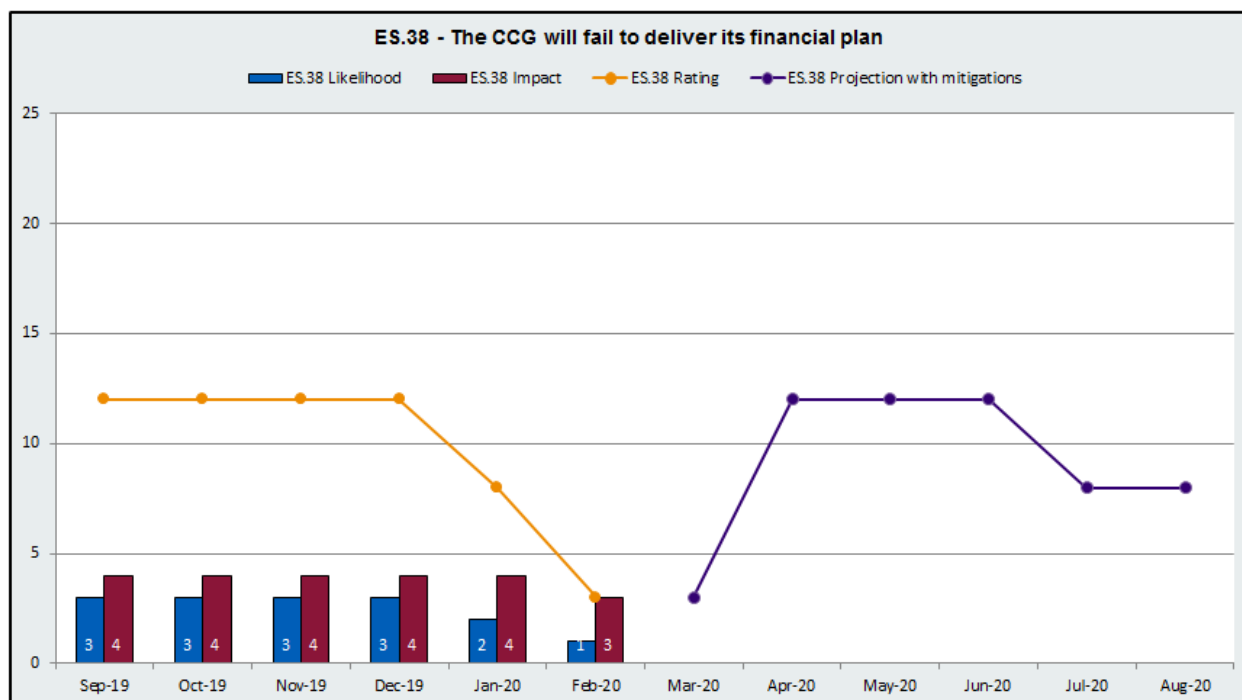
6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31 January 2020.

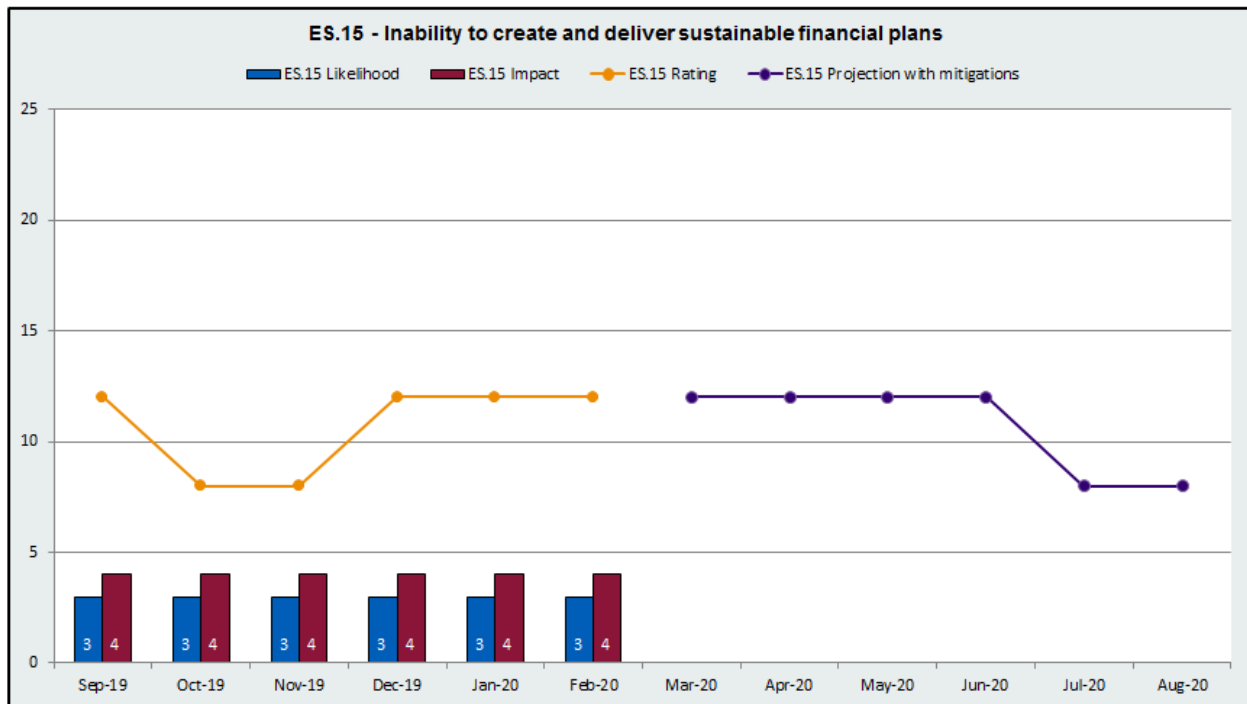
The CCG achieved the Better Payment Practice Code in terms of both the volume and value of invoices being paid above the 95% target year to date.

7. Key Financial Risks

ES.38 - The CCG will fail to deliver its financial plan



ES.15 – Inability to create and deliver sustainable financial plans



The CCG's Month 10 position remains a forecast in line with the approved plan with an anticipated deficit of £18.8m. Most of the additional and all of the material financial recovery actions to off-set the system savings slippage have been implemented and are delivering; there remain one or two smaller elements still under consideration. This has resulted in increased confidence in delivering the position and a reduction in both the likelihood and potential impact score in February.

The CCG is actively part of the York and North Yorkshire system planning as part of the wider Humber, Coast and Vale STP footprint. The main aims of planning remain clinically led improvement and innovation, over a longer term planning horizon, alignment of plans between commissioner and provider, and working together as a system to deliver change at greater scale.

Initial planning demonstrates a requirement for significant savings across partners in York and North Yorkshire. Work continues to understand the implications of investments required as a result of national operational plan and regulatory requirements (particularly around workforce); the extent of savings plans developed to date; the requirement to improve operational performance; the need to respond to CQC report; and the need to achieve the financial recovery trajectory.

It is expected that discussions with regulator and STP colleagues will continue beyond draft submission at the end of February and as such the risk in terms of agreeing a sustainable plan has been increased to reflect this.

8. QIPP programme

Area	Scheme	Year to Date			Forecast Outturn				Comments
		Plan	Actual	Variance	Plan	Delivered	Forecast	FOT Variance	
Acute Commissioning	Anti-Coagulation Monitoring - move to Primary Care	25	25	0	30	30	30	0	Full year effect, delivered in 2019-20
	Biosimilar drugs (FYE)	2,307	2,307	0	2,384	2,384	2,384	0	Delivered in full through acute contract
	Cost reductions in contract	2,252	2,252	0	2,970	2,970	2,970	0	Delivered in full through acute contract
Complex Care	CHC Packages (FYE)	1,348	1,421	73	1,401	1,443	1,443	42	Delivered in full
	MH Out of Contract Packages (FYE)	230	220	(9)	237	224	224	(13)	Delivered in full
	Review of CHC Packages	971	770	(200)	1,377	770	1,207	(170)	Forecast is based on a detailed package by package savings report and will continue to be monitored throughout the year.
	Fast track post (investment)	(40)	(40)	0	(48)	(40)	(48)	0	
	MH Out of Contract Packages	0	145	145	0	145	188	188	No specific line in plan relating to MH OOC but packages continue to be reviewed. This offsets the forecast shortfall in CHC to deliver the full level of planned savings across complex care.
Prescribing	Prescribing schemes	1,416	491	(925)	2,008	491	1,004	(1,004)	Prescribing Indicative Budgets 2 has been rolled out from September 2019 with Primary Care Networks. The forecast delivery of this scheme assumes delivery over the second half of the financial year and therefore £1.0m slippage against the plan value.
Primary Care	Primary Care investment slippage	500	690	190	600	701	700	100	The forecast delivery now includes an additional £100k slippage following Executive Committee approval of non recurrent mitigations to manage emerging in year pressures. £700k of slippage has been delivered, which includes £220k in relation to GP Framework additional roles.
System Recovery Schemes	Independent Sector	778	0	(778)	1,000	0	0	(1,000)	The forecast delivery of System Recovery schemes has been reviewed and agreed by system partners. The overall forecast delivery across the system is £2.8m against a plan value of £11.2m. This results in a £8.4m shortfall, of which £2.8m impacts the CCGs financial position.
	Cardiology prescribing - DOAC switch	544	0	(544)	700	0	0	(700)	
	Decommissioning non obstetric ultrasounds (YHS)	247	0	(247)	370	0	0	(370)	
	PTS - decommission saloon cars / tighten criteria	167	63	(103)	250	63	76	(174)	
	Management costs	140	0	(140)	180	0	0	(180)	
	Other acute cost reductions (YTHFT)	813	651	(162)	1,220	651	866	(354)	
		11,697	8,996	(2,701)	14,679	9,833	11,045	(3,634)	
			77%			67%	75%		

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Appendix 1 – Finance dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Commissioned Services																		
Acute Services																		
York Teaching Hospital NHS FT	182,113	181,603	510	163,622	163,231	391	18,491	18,372	119	218,092	217,464	629	217,607	216,892	716	485	572	(87)
Yorkshire Ambulance Service NHS Trust	11,889	11,889	(0)	10,700	10,700	(0)	1,189	1,189	(0)	14,267	14,267	(0)	14,267	14,267	(0)	0	0	0
Leeds Teaching Hospitals NHS Trust	7,095	7,046	49	6,365	6,274	91	730	772	(42)	8,497	8,438	58	8,497	8,376	120	0	62	(62)
Hull and East Yorkshire Hospitals NHS Trust	2,776	2,925	(149)	2,505	2,640	(135)	272	285	(13)	3,320	3,499	(179)	3,320	3,495	(176)	0	3	(3)
Harrogate and District NHS FT	2,125	1,896	228	1,899	1,720	180	225	177	49	2,552	2,276	276	2,552	2,308	244	0	(32)	32
Mid Yorkshire Hospitals NHS Trust	1,772	1,470	302	1,594	1,402	193	178	69	109	2,119	1,772	347	2,119	1,860	259	0	(88)	88
South Tees NHS FT	1,185	1,185	(0)	1,066	1,066	(0)	118	118	(0)	1,422	1,422	0	1,422	1,422	0	0	0	0
North Lincolnshire & Goole Hospitals NHS Trust	309	333	(24)	278	304	(26)	31	29	2	369	397	(28)	369	404	(35)	0	(7)	7
Sheffield Teaching Hospitals NHS FT	244	244	0	220	219	0	24	24	(0)	293	292	0	293	292	0	0	0	0
Non-Contracted Activity	4,498	4,681	(182)	4,049	4,273	(225)	450	407	43	5,398	5,625	(227)	5,398	5,698	(300)	0	(73)	73
Other Acute Commissioning	1,140	962	178	1,019	822	198	121	140	(19)	1,382	1,229	152	1,382	1,194	187	0	35	(35)
Ramsay	4,023	4,708	(685)	3,605	4,172	(566)	417	536	(119)	4,820	5,220	(401)	4,820	5,251	(432)	0	(31)	31
Nuffield Health	2,984	2,591	393	2,675	2,404	271	310	188	122	3,574	3,105	469	3,574	3,214	360	0	(109)	109
Other Private Providers	1,179	938	241	1,062	863	199	118	76	42	1,415	1,126	289	1,415	1,157	258	0	(31)	31
Sub Total	223,333	222,470	862	200,659	200,089	570	22,674	22,381	292	267,519	266,133	1,386	267,034	265,832	1,202	485	301	184
Mental Health Services																		
Tees, Esk and Wear Valleys NHS FT	36,726	36,702	24	33,046	33,056	(10)	3,680	3,647	33	44,113	44,090	24	44,028	44,038	(10)	85	52	33
Out of Contract Placements	6,127	6,531	(404)	5,514	5,832	(317)	613	699	(87)	7,353	7,823	(470)	7,353	7,835	(482)	0	(12)	12
SRBI	1,013	1,263	(250)	912	1,116	(204)	101	146	(45)	1,215	1,547	(331)	1,215	1,512	(296)	0	35	(35)
Non-Contracted Activity - MH	382	138	244	343	213	130	38	(75)	114	458	182	276	458	313	145	0	(130)	130
Other Mental Health	924	411	513	831	370	461	92	41	52	1,109	1,157	(49)	1,109	1,153	(45)	0	4	(4)
Sub Total	45,172	45,045	127	40,647	40,587	60	4,525	4,458	67	54,248	54,799	(551)	54,163	54,850	(687)	85	(52)	137
Community Services																		
York Teaching Hospital NHS FT - Community	15,937	15,937	0	14,344	14,344	0	1,594	1,594	0	19,125	19,125	0	19,125	19,125	0	0	0	0
York Teaching Hospital NHS FT - MSK	1,947	1,947	(0)	1,752	1,752	(0)	195	195	(0)	2,336	2,336	(0)	2,336	2,336	(0)	0	0	(0)
Harrogate and District NHS FT - Community	2,421	2,403	18	2,178	2,165	13	242	238	5	2,905	2,868	37	2,905	2,882	22	0	(14)	14
Humber NHS FT - Community	1,797	1,797	(1)	1,617	1,618	(1)	180	180	(0)	2,156	2,157	(1)	2,156	2,157	(1)	0	0	0
Hospices	1,247	1,212	35	1,123	1,091	32	125	121	3	1,497	1,455	42	1,497	1,455	42	0	(0)	0
Longer Term Conditions	235	225	10	212	212	(1)	24	13	11	282	271	11	282	285	(3)	0	(14)	14
Other Community	2,166	2,358	(192)	1,952	2,074	(122)	214	284	(70)	2,592	2,840	(248)	2,592	2,798	(206)	0	42	(42)
Sub total	25,750	25,880	(130)	23,177	23,256	(78)	2,572	2,624	(51)	30,893	31,052	(159)	30,893	31,039	(146)	0	13	(13)

NHS Vale of York Clinical Commissioning Group Financial Performance Report


	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn			FOT Previous Month			FOT 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
Other Services																		
Continuing Care	22,580	21,371	1,209	20,402	19,402	1,000	2,179	1,969	209	26,885	25,956	928	26,885	26,083	802	0	(127)	127
CHC Clinical Team	1,046	946	99	937	862	75	109	84	25	1,303	1,267	36	1,303	1,284	19	0	(17)	17
Funded Nursing Care	3,377	3,183	194	3,039	2,856	183	338	327	11	4,052	3,761	291	4,052	3,734	318	0	28	(28)
Patient Transport - Yorkshire	1,862	1,749	112	1,676	1,567	109	186	183	4	2,234	2,099	135	2,234	2,089	145	0	10	(10)
Voluntary Sector / Section 256	467	452	14	420	408	12	47	44	3	560	543	17	560	544	17	0	(1)	1
Non-NHS Treatment	518	529	(10)	467	468	(1)	52	61	(9)	622	633	(11)	622	623	(0)	0	10	(10)
NHS 111	884	881	4	796	793	3	88	88	0	1,061	1,059	3	1,061	1,057	4	0	1	(1)
Better Care Fund	9,405	9,409	(5)	8,469	8,471	(1)	935	939	(3)	11,275	11,281	(6)	11,275	11,281	(6)	0	0	0
Other Services	615	1,068	(453)	531	981	(450)	84	87	(3)	733	1,195	(462)	708	1,172	(464)	25	23	2
Sub total	40,754	39,588	1,165	36,736	35,807	930	4,017	3,782	236	48,726	47,795	931	48,701	47,867	834	25	(72)	97
Primary Care																		
Primary Care Prescribing	40,022	41,652	(1,630)	36,266	37,868	(1,602)	3,755	3,784	(29)	47,365	49,233	(1,867)	47,365	49,337	(1,972)	0	(104)	104
Other Prescribing	1,748	1,762	(14)	1,633	1,523	110	115	240	(125)	1,978	2,124	(146)	1,978	2,026	(48)	0	98	(98)
Local Enhanced Services	1,896	1,774	123	1,724	1,632	92	173	142	31	2,242	2,109	133	2,242	2,144	98	0	(35)	35
Oxygen	309	315	(6)	279	283	(5)	31	32	(1)	371	378	(7)	371	378	(6)	0	0	(0)
Primary Care IT	764	662	102	688	610	78	76	52	24	917	806	111	917	800	117	0	6	(6)
Out of Hours	2,706	2,777	(71)	2,435	2,508	(72)	271	270	1	3,247	3,328	(81)	3,247	3,372	(125)	0	(44)	44
Other Primary Care	2,261	2,382	(121)	2,035	2,112	(77)	226	270	(44)	2,713	2,948	(235)	2,713	2,946	(233)	0	1	(1)
Sub Total	49,706	51,324	(1,618)	45,060	46,535	(1,475)	4,647	4,789	(142)	58,833	60,925	(2,092)	58,833	61,003	(2,170)	0	(78)	78
Primary Care Commissioning	37,716	37,308	408	33,927	33,634	293	3,789	3,674	115	45,265	44,878	387	45,265	44,957	308	0	(79)	79
Trading Position	422,431	421,616	815	380,206	379,908	299	42,225	41,708	517	505,485	505,581	(97)	504,890	505,548	(659)	595	33	562
Prior Year Balances	0	(156)	156	0	(143)	143	0	(13)	13	0	(156)	156	0	(143)	143	0	(13)	13
Reserves	(2,691)	0	(2,691)	(2,175)	0	(2,175)	(516)	0	(516)	(3,697)	(1,195)	(2,502)	(2,674)	(746)	(1,928)	(1,023)	(449)	(574)
Contingency	1,659	0	1,659	1,268	0	1,268	392	0	392	2,443	0	2,443	2,443	0	2,443	0	0	0
Unallocated QIPP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reserves	(1,031)	(156)	(876)	(908)	(143)	(765)	(124)	(13)	(111)	(1,254)	(1,351)	97	(231)	(889)	659	(1,023)	(461)	(562)
Programme Financial Position	421,399	421,460	(60)	379,299	379,765	(466)	42,101	41,695	406	504,231	504,231	0	504,659	504,659	0	(428)	(428)	0
In Year Surplus / (Deficit)	(15,708)	0	(15,708)	(14,137)	0	(14,137)	(1,571)	0	(1,571)	(18,849)	0	(18,849)	(18,849)	0	(18,849)	0	0	0
In Year Programme Financial Position	405,692	421,460	(15,768)	365,162	379,765	(14,603)	40,530	41,695	(1,165)	485,382	504,231	(18,849)	485,810	504,659	(18,849)	(428)	(428)	0
Running Costs	6,142	6,076	66	5,324	5,272	51	819	804	15	7,334	7,334	(0)	7,052	7,052	(0)	282	282	0
Total In Year Financial Position	411,834	427,536	(15,702)	370,485	385,037	(14,552)	41,349	42,499	(1,150)	492,716	511,565	(18,849)	492,862	511,711	(18,849)	(146)	(146)	0
Brought Forward (Deficit)	(52,059)	0	(52,059)	(46,853)	0	(46,853)	(5,206)	0	(5,206)	(62,471)	0	(62,471)	(62,471)	0	(62,471)	0	0	0
Cumulative Financial Position	359,775	427,536	(67,761)	323,632	385,037	(61,405)	36,143	42,499	(6,356)	430,245	511,565	(81,320)	430,391	511,711	(81,320)	(146)	(146)	0

NHS Vale of York Clinical Commissioning Group
Financial Performance Report

Appendix 2 – Running costs dashboard

Directorate	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT 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
Joint Commissioning	192	131	61	165	113	52	27	18	9	247	179	68	247	188	59	0	(9)	9
Chief Executive / Board Office	969	852	117	872	769	103	97	83	14	1,162	1,013	149	1,162	1,009	153	0	4	(4)
Planned Care	804	779	24	732	703	29	71	76	(4)	947	918	29	947	910	37	0	8	(8)
Communication and Engagement	235	197	38	211	176	35	24	21	3	284	268	16	284	267	17	0	1	(1)
Contract Management	714	656	58	642	593	49	71	63	9	856	785	72	856	788	68	0	(3)	3
Corporate Governance	791	726	65	724	666	58	67	60	7	932	887	45	925	879	47	7	8	(1)
Finance	1,366	1,307	59	991	941	50	375	366	9	1,566	1,520	45	1,291	1,246	44	275	274	1
Medicines Management	105	99	6	95	90	5	11	9	2	126	116	10	126	115	11	0	1	(1)
Quality & Nursing	619	591	28	565	544	22	54	48	6	726	698	28	726	700	27	0	(2)	2
Risk (SI team)	26	25	1	24	23	1	3	2	0	31	31	1	31	31	1	0	0	(0)
RSS	267	281	(14)	240	249	(9)	27	32	(5)	320	338	(17)	320	333	(13)	0	4	(4)
Primary Care	534	431	102	494	405	89	40	26	13	711	645	66	711	652	59	0	(7)	7
Reserves	(479)	0	(479)	(431)	0	(431)	(48)	0	(48)	(575)	(63)	(512)	(575)	(64)	(511)	0	1	(1)
Overall Position	6,142	6,076	66	5,324	5,272	51	819	804	15	7,334	7,334	(0)	7,052	7,052	(0)	282	282	0

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Item Number: 14			
Name of Presenter: Caroline Alexander			
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group		
Report Title – Integrated Performance Report Month 9 2019/20 (December)			
Purpose of Report <i>(Select from list)</i> For Information			
Reason for Report <p>This document provides a triangulated overview of CCG performance across all NHS Constitutional targets which identifies the causes of current performance levels and the work being undertaken by CCG partners across a number of different forums and working groups in the local Vale and Scarborough and Ryedale (North Yorkshire) system and wider Humber, Coast and Vale Care Partnership to drive performance improvement.</p> <p>The report captures validated data for Month 9.</p>			
Strategic Priority Links <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <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 </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability </td> </tr> </table>		<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
<input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Reducing Demand on System <input checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract	<input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability		
Local Authority Area <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council </td> </tr> </table>		<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
<input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council	<input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council		
Impacts/ Key Risks <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	Risk Rating <p>All recommendations from risk assessment and changes to risk ratings are indicated in the headlines if required.</p>		
Emerging Risks			

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments: N/A

Recommendations

To note the draft performance trajectories for 2020/21.

Decision Requested (for Decision Log)

Integrated Performance Report Month 9 2019/20 and draft performance trajectories for 2020/21 noted.

Responsible Executive Director and Title

Phil Mettam, Accountable Officer

Report Author and Title

Caroline Alexander, Assistant Director of Performance and Delivery

Vale of York CCG Integrated Performance Report

Validated data to December 2019, Month 9 2019/20

Produced February 2020

Performance Headlines – At target or improving

1. Cancer fast track referrals (2WW)	Above target	RISK: remove this risk from risk register as achieved sustainable performance and further activity planning to deliver 7 day fast track referrals is incorporated into operational planning to support 28 day definitive diagnosis performance to 70% (target).
2. EIP	At target and stable	
3. IAPT	At target and stable	
4. Personal Health Budgets	Below target but improving and CQUIN plan supporting improvement.	
5. MRI delays/ breaches	MRI delays have much improved within the overarching diagnostics performance (below target).	
6. RTT – Total Waiting List	The YTHFT forecast out-turn position for the TWL is 30,000 which is inline with projected end of year trajectory.	The operational planning guidance for 2020/21 has changed for TWL and there will be a requirement to maintain or improve the January 2021 TWL position against January 2020 position. Operational planning performance trajectories (draft) will be presented to F&P Committee on 26/2/20.
7. CHC all targets	At or above target	

Performance Headlines – Not at target or deterioration

	On-going actions & improvement plans	Further escalations
<p>1. Diagnostics</p> <p>Further deterioration to 80.3% January 2020 (provisional)</p>	<p>1. Work completed on lower back/ lumbar and shoulder MRI; ultrasound groin.</p> <p>2. NHSE/I IST review and recovery plan in development.</p> <p>Review has been focused on:</p> <ul style="list-style-type: none"> - undertaking robust IMAS demand and capacity modelling (echo/ radiology/ endoscopy) - clinical validation and review of backlogs - pathway analyser tool to identify leaner processes - assessment against national KPIs - review against national access policies 	<p>1. Final recovery plan to be shared on 15th March 2020 – early recommendations have informed the performance trajectories for diagnostics at YFT for operational planning.</p> <p>2. Operational planning refresh has identified pressures on gastro and colonoscopy which will be further explored and support provided by the subsystem. A gastro workshop was held in February to start this and further discussion with primary care partners at CoR on 20th February.</p> <p>RISK: No change to risk assessment – remains high with long timeline for recovery to sustainable performance (2023/24)</p>
<p>2. ECS 4 hour</p> <p>Stable for past two months but below target</p>	<p>1. Wide range of schemes across MH crisis services, primary care access, in-hospital (SDEC/ SAFER/ extension of CRT) and additional care home capacity funded through winter funding</p> <p>2. Single workplan for Health & Care Resilience Board now established and constantly refreshed to identify and target work where most pressures.</p>	<p>1. Full review of all winter schemes and actions to evaluate impact over winter, and inform decisions around what to consider for maintaining throughout 2020/21 as part of NHSE/I ambition to achieve 92% occupancy rates throughout year and maintain acute bedbase as per winter capacity.</p> <p>RISK: No change to risk assessment – remains high and further escalation through HCRB & QIB</p>
<p>3. Dementia diagnosis</p>	<p>IST action plan progressing.</p>	<p>1. Winter funding used for establishing a specialist dementia nurse at York Hospital to support reducing avoidable hospital admissions.</p>

Performance Headlines – Not at target or deterioration

	On-going actions & improvement plans	Further escalations
4. Annual SMI health checks	Performance is improving and moving towards the local target of 30%.	1. Focus is on engaging with those practices who have not signed up to delivering the LES for health checks.
5. Cancer 62D	<p>Performance improved from 72.3% in November to 77.6% in December.</p> <p>The 28 day cancer diagnosis performance is close to target of 70% already and this is supported by delivery of fast track referrals in 7 days.</p>	<p>No further escalations but continued delivery of the jointly agreed cancer delivery plan and targeting of Cancer Alliance transformational funding and programme support to local workstreams.</p> <p>The new GP contract, network enhanced services and associated QOF includes early cancer diagnosis as an enhanced service.</p>

Suggested issues for discussion

1. Operational Planning 2020/21:

There will be a presentation of the draft activity and performance trajectories to Committee based on work in progress across all partners to support finalising operational plans for York and N Yorkshire with the HCV ICS in line with national guidance and HCV approach.

The Committee should note the ambitions for further improving mental health, LD and autism service access and quality of care and the focus on joining up all service and quality improvement work across C&YP.

The Committee should also note that the final GP contract and associated enhanced service specifications and QOF for primary care have been released and form a significant part of the work in 2020/21 to deliver operational plans and start addressing some of the pressures which contribute towards performance deterioration by developing the future model of enhanced out of hospital care. The focus is on enhanced care in care homes, structured medication reviews and early cancer diagnosis.

2. Cancer Alliance Transformational Funding

There has been a full partner review of all options for allocating transformational funding to support collaborative and local cancer priority programmes of work to target improvements in cancer outcomes and quality of care for local people including early diagnosis and staging.

3. Quality Improvement Board: ECS and Patient Safety

There will be a verbal update on the work with partners and CQC to agree the improvement actions across both EDs and hospitals related to the safety concerns arising from pressures experienced by urgent and emergency services in the York-Scarborough subsystem.

4. Single oversight and assurance framework for HCV ICS

There will be a verbal update on the emerging single oversight and assurance framework for partners working in the HCV ICS. The 20/21 Operational Planning and Contracting Guidance states that "NHS England and NHS Improvement will move to a combined System Oversight Framework for providers and CCGs, on which we will shortly consult."

Vale of York CCG Performance Summary Dashboard – Planned Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Previous 3 Quarters				Previous Financial Year 2018/19	Current Financial YTD 2019/20
																		2018/19 Q4	2019/20 Q1	2019/20 Q2	Current QTD 2019/20 Q3		
Planned Care																							
133a	E.B.4		Diagnostics	Diagnostics: % waiting >6 weeks	≤1%	11.1%	8.6%	8.2%	12.7%	13.7%	11.7%	12.2%	18.6%	17.4%	17.9%	15.4%	18.3%	9.4%	12.7%	16.0%	17.2%	6.5%	15.3%
129b		Y	RTT	RTT: Total incomplete pathways (waiting list)	<16,544 at March 2020	16,490	16,987	17,143	17,344	18,021	17,849	17,996	18,300	18,792	18,738	18,328	18,762	-	-	-	-	-	-
129a	E.B.3		RTT	RTT incomplete pathways: % within 18 weeks	≥92%	84.0%	84.3%	83.3%	81.6%	81.9%	80.5%	79.7%	79.1%	78.4%	77.7%	77.0%	76.7%	83.9%	81.3%	79.1%	77.1%	84.8%	79.1%
129c	E.B.18		RTT	RTT: incomplete pathways 52 week breaches	0	10	7	9	7	4	9	3	1	3	1	2	4	26	20	7	7	87	34
			RTT	RTT Completed Admitted pathways: % within 18 weeks	-	60.6%	63.3%	65.2%	65.1%	64.8%	63.7%	64.5%	64.5%	62.2%	58.5%	57.3%	58.9%	63.0%	64.5%	63.7%	58.1%	64.4%	61.9%
			RTT	RTT Completed Non-Admitted pathways: % within 18 weeks	-	89.5%	90.4%	90.5%	90.9%	89.4%	88.4%	87.7%	88.1%	87.4%	87.7%	86.1%	87.2%	90.1%	89.6%	87.7%	87.0%	90.5%	88.1%
	E.O.1		RTT	% of children waiting 18 weeks or less for a wheelchair	≥92%	Quarterly indicator												88.9%	81.8%	90.9%	88.2%	95.1%	85.2%
	E.B.6		Cancer	Cancer: 2WW	≥93%	86.5%	96.1%	90.7%	88.9%	84.9%	81.7%	88.8%	94.3%	93.6%	96.5%	95.7%	95.8%	91.0%	85.3%	92.1%	96.0%	91.6%	91.1%
	E.B.7		Cancer	Cancer: 2WW (breast symptoms)	≥93%	91.1%	93.1%	82.0%	81.3%	86.1%	92.8%	95.0%	97.3%	97.4%	98.0%	98.5%	97.6%	88.8%	86.2%	96.7%	98.0%	93.0%	93.5%
	E.B.8		Cancer	Cancer: 31 day first treatment	≥96%	94.9%	97.3%	95.4%	95.4%	96.3%	97.9%	96.1%	97.8%	95.5%	95.3%	94.9%	97.1%	95.8%	96.6%	96.4%	95.7%	96.8%	96.2%
	E.B.9		Cancer	Cancer: 31 day subsequent treatment - surgery	≥94%	88.6%	100.0%	90.2%	92.1%	88.6%	90.6%	89.7%	88.9%	96.9%	88.9%	95.0%	94.9%	92.0%	90.4%	91.6%	92.7%	93.6%	91.6%
	E.B.10		Cancer	Cancer: 31 day subsequent treatment - drug	≥98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.8%	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	99.7%
	E.B.11		Cancer	Cancer: 31 day subsequent treatment - radiotherapy	≥94%	98.0%	98.0%	96.7%	100.0%	98.1%	98.0%	100.0%	100.0%	92.3%	90.7%	100.0%	100.0%	97.5%	98.8%	97.5%	95.5%	98.8%	97.3%
122b	E.B.12	Y	Cancer	Cancer: 62 day GP referral	≥85%	83.2%	77.8%	82.8%	80.2%	77.9%	84.2%	82.1%	82.4%	76.0%	75.9%	72.3%	77.6%	81.4%	80.8%	80.1%	75.1%	78.3%	78.6%
	E.B.13		Cancer	Cancer: 62 day Screening referral	≥90%	100.0%	76.9%	80.0%	100.0%	88.9%	88.9%	100.0%	90.9%	94.1%	84.6%	100.0%	70.0%	86.2%	92.0%	93.9%	82.8%	87.7%	90.3%
	E.B.14		Cancer	Cancer: 62 day Status upgrade	-	100.0%	100.0%	33.3%	100.0%	100.0%	75.0%	60.0%	75.0%	100.0%	100.0%	100.0%	-	77.8%	88.9%	77.8%	100.0%	83.3%	85.7%

Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Diagnostics	<p>No –81.7% against >99% target</p> <p>Provisional data shows 80.3% in January with 848 breaches (134 YTHFT colonoscopy >13 weeks)</p>	<p>The highest number of breaches in December 2019 were in Colonoscopy (256) followed by Non-obstetric ultrasound (193), Echocardiography (116) and Gastroscopy (113).</p> <p>Endoscopy position has been impacted by the sustained increase in fast track demand on the service causing routine patients to be displaced to prioritise clinically urgent patients.</p>	<p>Additional funding secured from NHSE/I to reduce the Endoscopy backlog and number of patients waiting for MRI scans.</p> <p>Opening of 5th room in YTHFT's Endoscopy suite in February 2020 is expected to lead to an improvement against the diagnostic target.</p> <p>YTHFT is working with the National Elective Intensive Support Team (NEIST) specifically targeting diagnostic services with a programme of work started in January.</p>	<p>Recovery plans are in place for all modalities not achieving the 99% standard and progress against these is being monitored by Care Groups on a weekly basis.</p>

Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
RTT – Total Waiting List (TWL) and 92% target	No – 76.7% against 92% target and increase in waiting list	New operational planning guidance has outlined new requirement for the end January 2021 TWL position to be an improvement on the end January 2020 position. Vale of York CCG waiting list at end December was 18,762. The YTHFT target for year end 2019/20 is now 30,000 with improvement to 29,580 planned for 2020/21.	There are a range of mitigations which include: - Rapid Expert Input (REI) – early specialist input to augment advice & guidance. - Clinical validation of waiting lists - Clinical thresholds and commissioning statements supported by tracker tool (VBC)	The HCV Outpatients transformation programme will focus on every aspect of elective capacity optimisation including establishing the high impact digital enablers which could support delivering more non face to face attendances
RTT – 52 week breaches	No	There were 4 further breaches at LTHT in Trauma and Orthopaedics in December. The LTHT service is very stretched, with 1st OP waits currently standing at over 30 weeks and so any additional routine referrals from outside the area compromise their ability to treat more complex patients in a timely manner.	Since September 19th 2019, the LTHT Spinal Surgical Service has only accepted referrals made in line with the national back pain pathway guidance, which requires prior assessment by an appropriately trained spinal MSK practitioner. It has, therefore, removed GP access for non-urgent patients from their e-RS DOS. Access to this service is now restricted to providers of specialist spinal assessment services.	
Children's Wheelchair Waiting Times	No – 88.2% against 92% target	The latest Q3 2019/20 figures show 15 of a cohort of 17 were within 18 weeks, due to the small numbers involved this equates to a failure of the 92% target.		

Planned Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Cancer 2WW	Yes – 95.8% against 93% target	<p>Vale of York CCG met the 93% target for the fifth consecutive month with 95.8% in December. Skin was the only specialty that did not meet target in month.</p> <p>YTHFT also returned back above the 93% target in December with performance of 94.8%</p>	Recovery plans have been developed for any tumour sites not achieving the 14 day and/or 62 day standards and progress is monitored by Care Groups on a weekly basis.	
Cancer 62 day	No – 77.6% against 85% target	<p>Vale of York CCG performance saw an improvement in December 2019 to 77.6%, from 72.3% in November.</p> <p>YTHFT also saw an improvement from 75.9% in November to 76.5% in December.</p> <p>The 2020/21 target for 28 day faster diagnosis has now been set nationally at 70%. YTHFT are performing at or close to target and this is supported by delivery of fast track referrals in 7 days.</p>	<p>Weekly ‘Cancer Wall’ meeting implemented with scrutiny of every diagnosed cancer patient without a treatment plan, to reduce unnecessary delays and mitigate risk. Patients on a 62 day pathway without a diagnosis are also reviewed and plans agreed where required.</p> <p>Pathways have been reviewed for all the major tumour groups and work is ongoing to embed the timed pathways. Developing a Rapid Diagnostic Centre (RDC) for patients with vague symptoms and Upper GI referrals. NHSI Elect facilitating a rapid improvement project to reduce delays in Head and Neck pathway.</p> <p>Focused project on 28 day referral to diagnosis, overseen by Cancer Delivery Group, a subset of Cancer Board.</p>	<p>Full local cancer delivery plan is in place.</p> <p>All transformation funding from Cancer Alliance has now been agreed and aligned with local workstreams.</p>

Vale of York CCG Performance Summary Dashboard – Unplanned and Out of Hospital Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Previous 3 Quarters			Current QTD	Previous Financial Year	Current Financial YTD
																		2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2018/19	2019/20
Unplanned and Out of Hospital Care																							
127c	E.B.5	A&E*	A&E: % within 4 hours (YHFT)	≥95%	81.5%	81.5%	84.0%	80.5%	81.9%	83.2%	81.1%	81.3%	78.1%	80.4%	75.7%	75.1%	82.4%	81.9%	80.3%	77.1%	87.7%	79.3%	
		A&E*	A&E: 12 hour breaches (YHFT)	0	17	8	28	24	26	2	0	7	32	16	9	15	53	52	39	40	66	159	
		YAS	ARP: Category 1 (Life threatening) Mean	00:07:00	00:06:59	00:07:03	00:06:44	00:06:58	00:06:49	00:06:49	00:06:54	00:06:50	00:06:58	00:07:19	00:07:29	00:07:46	-	-	-	-	00:07:21	00:07:07	
		YAS	ARP: Category 2 (Emergency) Mean	00:18:00	00:19:49	00:20:02	00:17:40	00:19:40	00:18:38	00:18:46	00:18:17	00:17:04	00:18:26	00:21:50	00:23:10	00:27:12	-	-	-	-	00:20:26	00:20:30	
		YAS	ARP: Category 1 (Life threatening) 90th percentile	00:15:00	00:12:08	00:12:05	00:11:28	00:12:06	00:11:56	00:11:56	00:12:11	00:11:53	00:12:02	00:12:31	00:12:46	00:13:15	-	-	-	-	00:12:37	00:12:21	
		YAS	ARP: Category 2 (Emergency) 90th percentile	00:40:00	00:41:16	00:41:50	00:35:35	00:40:29	00:38:09	00:38:14	00:37:26	00:34:21	00:37:32	00:45:13	00:49:00	00:58:00	-	-	-	-	00:42:34	00:42:41	
		YAS	ARP: Category 3 (Urgent) 90th percentile	02:00:00	01:58:10	01:53:11	01:29:42	01:49:54	01:42:58	01:49:27	01:42:47	01:26:58	01:33:37	02:09:54	02:18:59	02:56:46	-	-	-	-	01:58:44	01:55:52	
		YAS	ARP: Category 4 (Less urgent) 90th percentile	03:00:00	03:52:38	03:25:18	03:00:09	03:36:53	03:51:12	04:33:48	04:01:23	02:47:17	02:41:57	02:40:55	02:38:08	03:18:01	-	-	-	-	03:51:57	03:16:33	
		NHS 111*	NHS 111: Calls abandoned after 30 seconds	≤5%	1.6%	1.7%	1.0%	1.2%	1.2%	1.3%	2.3%	1.2%	1.2%	1.5%	1.7%	1.3%	1.4%	1.2%	1.6%	1.5%	1.1%	1.4%	
		NHS 111*	NHS 111: Calls answered within 60 seconds	≥90%	81.6%	79.0%	86.1%	91.8%	90.9%	88.7%	84.1%	86.8%	89.0%	81.7%	75.8%	83.1%	82.3%	90.5%	86.6%	80.4%	88.1%	86.2%	
		GP OOH	GP OOH: Face to face within 2 hours	≥95%	88.5%	95.9%	94.9%	89.8%	91.8%	95.2%	93.3%	94.6%	93.4%	89.1%	92.0%	88.9%	92.8%	92.2%	93.8%	90.0%	95.9%	92.1%	
		GP OOH	GP OOH: Face to face within 6 hours	≥95%	97.4%	96.9%	98.4%	97.2%	96.7%	98.0%	97.0%	97.7%	98.5%	96.8%	96.7%	93.7%	97.6%	97.3%	97.7%	95.5%	98.3%	96.8%	
		GP OOH	GP OOH: Speak to clinician within 2 hours	≥95%	95.3%	91.3%	92.5%	88.6%	90.2%	89.2%	90.6%	91.3%	88.3%	90.1%	88.7%	81.1%	93.2%	89.3%	90.1%	85.9%	95.0%	88.3%	
		GP OOH	GP OOH: Speak to clinician within 2 to 6 hours	≥95%	97.5%	95.0%	96.1%	93.1%	95.6%	96.0%	94.7%	94.1%	96.5%	93.5%	92.4%	86.6%	96.2%	94.9%	95.1%	90.5%	97.7%	93.5%	
		GP OOH	GP OOH: Speak to clinician within 6+ hours	≥95%	99.2%	99.6%	99.6%	98.9%	99.0%	99.0%	98.7%	99.5%	99.5%	99.7%	98.1%	96.6%	99.4%	98.9%	99.2%	97.9%	99.6%	98.7%	
		GP OOH	GP OOH: Total calls	-	3,469	3,001	3,040	3,331	3,302	2,983	2,914	3,167	2,743	2,861	3,054	3,783	9,510	9,616	8,824	9,698	36,591	28,138	
		GP OOH	GP OOH: % of dispositions <2 hours	-	63.4%	62.7%	62.6%	61.5%	62.1%	61.5%	61.5%	60.5%	63.2%	63.4%	61.9%	62.6%	62.9%	61.7%	61.7%	62.6%	60.5%	62.0%	
	E.D.16	Primary Care Access	Proportion of the population with access to online consultations	≥75% by March 2020	Data to follow																		
	E.D.17	Primary Care Access	Extended Access appointment utilisation	≥75% by March 2020	Data to follow																		
	E.D.18	Primary Care Access	Proportion 111 can directly book appts into extended access	100% by March 2020	Data to follow																		
		DTOC	DTOC: YHFT - Acute bed days	-	1,093	1,067	1,178	1,456	1,529	1,486	1,346	1,325	1,355	1,215	1,054	1,183	3,338	4,471	4,026	3,452	13,693	11,949	
		DTOC	DTOC: YHFT - Non-acute bed days	-	385	295	377	277	303	352	235	362	335	342	182	249	1,057	932	932	773	4,182	2,637	
		DTOC	DTOC: YHFT - Total bed days	-	1,478	1,362	1,555	1,733	1,832	1,838	1,581	1,687	1,690	1,557	1,236	1,432	4,395	5,403	4,958	4,225	17,875	14,586	
		DTOC	DTOC: TEWW - Total bed days (All non-acute)	-	557	506	657	673	547	630	454	496	537	647	584	545	1,720	1,850	1,487	1,776	9,591	5,113	

*Note that A&E and NHS 111 data is available one month ahead of other data sources which will affect QTD and YTD calculations

Unplanned and Out of Hospital Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
ED 4 hour target	No – 75.2% in January against 95% target	Stable performance during November and December but significantly below 95% target and below the local trajectory.	Full range of winter schemes across the system funded through non-recurrent winter funding (including winter grant funding in BCF) and single workplan held by the Health & Care resilience board focusing on actions and schemes to improve resilience in response in primary care/ out of hospital, in-hospital focusing on SDEC and SAFER supported the national ECIST team and 'interface' with discharge teams and processes being refreshed and aligned around a single system approach to discharge and choice.	There have been monthly quality improvement board meetings which have focused on patient safety in ED on both hospital sites. There is an improvement plan in place to augment the work under winter schemes and the HCRB single workplan which focuses on CQC recommendations, particularly on the Scarborough site.
YAS	No – for Cat 2,3&4 but improved for Cat 1	None specific – winter and festive period		No
NHS 111	Yes calls < 30 mins and below target for <60 mins	None specific – winter and festive period		No
GP Out of Hours	No and deteriorated	Deterioration for all calls answered performance <6 hours. Capacity pressures over winter/ Festive period	Despite funding being available to fund additional Vocare capacity there have been issues with filling additional slots	OOH contract is part of the proposed transformation of urgent care services

Unplanned and Out of Hospital Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
<p>Primary Care Access</p>	<p>N/A – targets apply to year end</p>	<p>Proportion of the population with access to online consultations Priory Medical Group, Haxby Group, Jorvik Gillygate, Front Street and Tadcaster Medical Practices all have Online Consultations software installed and technically enabled. This represents 5 out of 26 Practices, with a combined list size of 129,050 out of a total Vale of York registered population of 361,626 (35.7%)</p> <p>Extended Access Appointment Utilisation Providers of Extended Access (evenings/weekends) appointments are required to report available appointments, number of appointments booked, DNAs, and utilisation on a daily basis.</p> <p>Utilisation is calculated as: (number of appointments booked - DNAs) / available appointments. For the quarter to end December 2019, the average Extended Access appointment utilisation was 67%.</p> <p>Proportion of the population that 111 can directly book appointments into the contracted extended access services For the month of December 2019, this figure is 0%.</p>	<p>The STP continues to fund a Project Manager to assist Practices in deploying the Online Consults software (Engage Consult) and has funded licenses to enable Practices to trial the system for 12 months The CCG plans further engagement with Practices to promote uptake in order to meet the GP Contract Reform target of all patients having access to Online Consults by April 2021.</p> <p>Workforce and GP workload continue to be the main challenges for this service. Providers are consistently meeting national targets in terms of hours offered, but the service may have a greater impact if the number of GP appointments (compared to nurse appointments) could be increased.</p> <p>GP Connect is now the agreed technical solution for delivery of this service and will be rolled out to Practices via the Yorkshire & Humber Care Record programme. Project resource has been secured and the plan is to meet the Apr 2020 deadline for go-live.</p>	<p>Comms planned to explain that if Practices choose not to access the STP-funded product, then they can self-fund an online consultations platform of their own choice to meet the contractual requirement.</p>

Unplanned and Out of Hospital Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Delayed Transfers of Care	Overall, No (Acute and Non acute NHS), Yes (mental health)	DTOC for York are monitored through daily and weekly meetings of the multi-disciplinary discharge hub. All individuals delayed in mental health are known individuals, enabling plans to developed to commission appropriate placements or services.	<ul style="list-style-type: none"> • Although December position was a deterioration from November, the system was closer to the target than it has been earlier in the year, and compared to the previous year the position was an improvement. • Out of hospital services have been under pressure in the period since Christmas, with January showing significant challenges, which have been carefully managed and monitored. 	Additional care packages in the community have been funded, including expansion of the option to receive live in care in one's own home to enable discharge from hospital in cases where a residential placement would otherwise be needed to support the patient to leave hospital once medically fit.

Vale of York CCG Performance Summary Dashboard – Mental Health

NHS OF: 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category	Indicator	2019/20 Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Previous 3 Quarters				Previous Financial Year: 2018/19	Current Financial YTD: 2019/20
																		2018/19 Q4	2019/20 Q1	2019/20 Q2	Current QTD: 2019/20 Q3		
Mental Health																							
123b	E.A.3		IAPT*	IAPT Access (rolling 3 months)	≥5.5% in Q4 (≥22% full year)	2.8%	3.8%	3.6%	3.5%	3.6%	3.5%	3.3%	3.6%	3.9%	4.4%	4.5%		3.6%	3.5%	3.9%	3.0%	14.6%	-
123a	E.A.S.2		IAPT	IAPT Recovery (rolling 3 months)	≥50%	39.1%	44.8%	47.4%	50.0%	48.6%	48.5%	51.4%	50.9%	52.7%	51.4%	53.8%		47.4%	48.5%	52.7%	54.1%	47.2%	51.6%
	E.H.1_A1		IAPT	IAPT: 6 weeks First Treatment	≥75%	95.1%	93.3%	94.3%	97.2%	93.0%	90.3%	91.1%	95.5%	100.0%	97.4%	97.6%		94.3%	93.6%	95.0%	97.5%	92.2%	95.1%
	E.H.2_A2		IAPT	IAPT: 18 weeks First Treatment	≥95%	100.0%	100.0%	100.0%	100.0%	97.7%	93.5%	93.3%	97.7%	100.0%	97.4%	100.0%		100.0%	97.3%	96.7%	98.7%	99.1%	97.4%
123c	E.H.4		EIP****	EIP: Within 2 weeks (rolling 3 months)	≥56%	48.0%	55.0%	47.0%	45.0%	44.0%	51.0%	67.0%	70.0%	80.0%	91.0%	91.0%		47.0%	51.0%	80.0%	-	-	-
126a	E.A.S.1		Dementia**	Dementia: Diagnosis Rate	≥66.7%	59.1%	58.7%	58.6%	58.0%	57.6%	57.3%	57.2%	57.5%	57.1%	57.4%	57.2%	56.9%	58.8%	57.7%	57.3%	57.2%	60.0%	57.3%
	E.H.9		CYPMH	Children and Young People's MH Access Rate (rolling 12 months)	34%	42.5%	42.7%	42.3%	43.5%	43.8%	44.8%	45.0%	45.5%	46.0%	45.7%							42.3%	-
			RTT***	% of patients starting treatment within 6 weeks of referral - CYP		47.6%	53.2%	56.5%	33.3%	43.6%	58.3%	73.4%	73.8%	68.5%	72.5%	84.5%	77.3%						
	E.H.10		CYPMH	CYP Eating Disorders: Routine cases % within 4 weeks	In year ≥60%, ≥95% by March 2021	Quarterly indicator (rolling 12 months)											66.7%	79.2%	86.8%	87.0%	66.7%	-	
	E.H.11		CYPMH	CYP Eating Disorders: Urgent cases % within 1 week	In year ≥75%, ≥95% by March 2021	Quarterly indicator (rolling 12 months)											71.4%	82.6%	85.7%	72.2%	71.4%	-	
			Autism Assessments	Total number of CYP waiting for a full specialist assessment		210	212	208	205	201	199	187	199	199	206	213	209						
				Of above, waiting up to 13 weeks		67	68	76	68	57	61	57	76	69	81	85	77						
				Of above, waiting 14 to 33 weeks		75	75	57	71	84	74	77	80	76	76	84	82						
				Of above, waiting 34 to 52 weeks		41	46	55	52	46	56	46	36	49	42	39	47						
				Of above, waiting 52+ weeks		27	23	20	14	14	8	7	7	5	7	5	3						
124b			LD AHCs	Annual health check for people on Learning Disability register	≥75%	Quarterly indicator											30.5%	18.0%	10.3%	-			
123g	E.H.13		SMI AHCs	Annual health check for people with Severe Mental Illness (SMI)	≥60%	Quarterly indicator (rolling 12 months)											17.6%	26.2%	26.1%	27.3%	17.6%	-	

*IAPT access is calculated differently to other mental health standards in that achievement is based only on Quarter 4 performance, multiplied by 4 to give the CCG's annual rate. There is a notional target of 4.75% in Quarters 1 to 3, however this is for monitoring purposes only and does not influence year-end achievement of this standard. The key target is achievement of 5.5% in Quarter 4, which is multiplied by 4 to give a 2019/20 annual target of 22%. The denominator for this indicator always remains the same at the annual level of need in the population. Monthly data against this target reflects a rolling 3 month position, i.e. April numerator will cover Feb+Mar+Apr. Quarterly data reflects only completed months within that quarter, i.e. in April, Q1 numerator would cover April only, in May it would cover Apr+May and so on. Annual data will be updated only at end Q4 when annual position is available for calculation.

**Dementia Diagnosis data can be at times be available one month ahead of other data sources which could affect QTD and YTD calculations

***TEWW definitions of treatment include self-help and wellbeing advice

****From October 2019 EIP waiting times are monitored using data from the Mental Health Services Data Set (MHSDS) instead of SDCS, so historic figures have been updated to reflect this change.

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalation required/ underway
IAPT	Yes	The access and recovery targets are currently stable.	<ul style="list-style-type: none"> • Proactive marketing of self-referral and raising awareness in primary care • Co-location and development of an IAPT Link worker aligned to a Primary Care Network • Co-location and integration of IAPT clinicians in 3 practices • 2 pilot perinatal and post-natal projects starting in February/March 2020 facilitated by IAPT clinicians and delivered from the new Women's Wellness Centre in York • IAPT-LTC service in development. This will be a distinct service delivered locally and integrated into current physical care provision 	
EIP	Yes	The access and waiting targets are currently stable	<p>The additional investment in 2019/20 has been utilised to meet the 2 week standard and high quality NICE interventions, moving the service towards achievement of level 2 status by the end of 2019/20.</p> <p>A service design event has evaluated progress and determined what is required to implement the At Risk Mental State (ARMS) pathway. Depending on workforce this pathway will reopen 01 April 2020.</p>	

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalation required/ underway
Dementia Diagnosis	No	Multiple causes including; GP awareness and understanding of benefits of a diagnosis; confidence of GPs to diagnose advance cases of dementia in care homes; high level of diagnosis of mild cognitive impairment following assessment at the Memory Service	<p>On-going implementation of IST action plan including</p> <ul style="list-style-type: none"> • Raising awareness with GPs, highlighting the pathway in terms of memory assessment and the range of post diagnostic support available • Targeted case finding now in most of VOY care homes and use of Diadem tool <p>Specialist dementia nurse commissioned to support work aimed at reducing avoidable hospital admissions which will include liaison with primary care to:</p> <ul style="list-style-type: none"> • identify patients and risk factors for avoidable hospital admissions • Identify patients with suspected dementia but no recorded diagnosis, and strategies /packages of care to support people to remain at home • liaise with GPs on strategies for case finding, screening for dementia and referrals for diagnostic assessment 	
CYP Access Rate	Yes	Data submitted by TEWV to NMHDS is consistently above the national target.	N/A	N/A

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
CAMHS Referral to Treatment (RTT)	No target currently set	Target for 2020/2021 is under discussion.	Target relates to initial advice and self directed support, and not to face to face or group interventions. Investment for 2020/2021 is directed at increasing access to direct therapeutic interventions.	N/A
CYP Eating Disorders	<p>Routine referrals: Yes</p> <p>Urgent referrals: No</p>	Performance has declined since October 2019, due to staff turnover and difficulties in assessing referrals as referrals may lack basic physical data such as weight, with delays in assessment whilst information is obtained	<p>TEWV is:</p> <ul style="list-style-type: none"> • Recruiting to vacant posts • Awaiting further investment into service via New Models of Care, although this may not be available until September 2020 • Working with primary care on protocols for physical health monitoring <p>TEWV has shared its recovery plan with the CCG through CMB.</p> <p>The CCG has issued a reminder through the Primary Care Bulletin to ensure that referrals for eating disorders contain the necessary physical health data.</p>	The position remains closely monitored via CMB and Performance and Quality Sub Group.

Mental Health

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
Autism Assessments	No target currently set: NICE guidance recommends 13 weeks	<p>Performance has improved slightly since additional investment was made into service in 2018/2019 and 2019/2020. However, referrals remain high and the number awaiting full assessment consistently remains at around 200.</p> <p>The conversion rate, at under 60% remains a cause for concern given the high numbers waiting.</p>	<p>The CCG monitors all cases waiting over 52 weeks at CMB. The CCG is working with TEWV and local authority colleagues to look at how support is provided in school and elsewhere to ensure that appropriate support is provided and reduce demand</p> <p>TEWV is reviewing its pathway for referrals and assessment. TEWV has drafted an action plan to improve administration of referrals and re-instate some clinics in Selby once staff are returned from maternity leave in March.</p>	The position remains closely monitored via CMB and Performance and Quality Sub Group
Annual SMI Health Checks	No	<p>The new reporting requirement was introduced in October 2018 and work has been undertaken since then with primary care to raise awareness. This has seen gradual improvements from 13.2% in October 2018 to the current position of 27.3%</p> <p>1 practice did not submit a Q3 return</p> <p>The CCG has agreed a local target of 30% for 2019/20.</p>	<p>16 practices have signed up to implement a Local Enhanced Service and a commitment to make improvements. Where practices do not demonstrate improvements the CCG will contact them to discuss any challenges and offer support. Links are being made with drug and alcohol services to establish potential crossover and opportunities for joint working</p>	

Vale of York CCG Performance Summary Dashboard – Complex Care

NHS OF 2019/20	Planning Guidance 2019/20	Quality Premium 2018/19	Category:	Indicator:	2019/20 Target:	Feb-19:	Mar-19:	Apr-19:	May-19:	Jun-19:	Jul-19:	Aug-19:	Sep-19:	Oct-19:	Nov-19:	Dec-19:	Jan-20:	Previous 3 Quarters				Previous Financial Year: 2018/19	Current Financial YTD: 2019/20
																		2019/20 Q1	2019/20 Q2	2019/20 Q3	Current QTD: 2019/20 Q4		
Complex Care																							
131a		Y	CHC	% DSTs undertaken in acute setting	≤15%	0.0%	2.1%	3.8%	13.6%	0.0%	6.7%	0.0%	9.5%	7.7%	0.0%	4.8%	0.0%	5.6%	5.1%	4.3%	0.0%	2.0%	4.6%
		Y	CHC	% of Standard CHC referrals with a decision on DST within 28 days	≥80%	96.9%	87.5%	82.1%	85.3%	89.7%	82.5%	86.7%	86.7%	92.5%	89.3%	71.4%	88.9%	85.7%	85.0%	85.6%	88.9%	74.8%	85.7%
105b	E.N.1		PHBs	Total Personal Health Budgets in place	330 by March 2020	Quarterly indicator												39	74	130	-	38	130

*Note - CHC data is generated internally within the CCG and therefore is available one month ahead of other data. Data is published nationally on a quarterly basis only.

Complex Care

Performance Area	Are targets being met	If yes are you assured this is sustainable, and if no what are the causes of adverse performance	What mitigating actions are underway and is there a trajectory for recovery/improvement	Further escalations required/underway
CHC – DST taking place in Acute Hospital	Yes	Due to process embedded within CHC regarding requests for DSTs undertaken in hospital we believe this target is currently sustainable.	The Discharge to Assess pathway works to reduce DST performed in an Acute setting although in some cases this activity is necessary.	Not Required
CHC – Decisions on DSTs within 28 days	Yes	The Target was met in January – reporting 88.9%. There were 3 breaches in month primarily relating to workforce issues and resultant reduction in process efficiency.	Workforce position has improved with further recruitment being undertaken. Additional tracking is in place and mitigating actions to increase throughput.	Not Required
CHC – Waiting Times	Yes	<p>There are 2 clients that have waited over the 28 day period. All are anticipated to have decisions in February.</p> <p>There were 0 people waiting beyond 85 days.</p>	<p>The DST booking process has improved it is anticipated that clients will be routinely seen within the required 28 day timeframe.</p> <p>A process is now in place to review any long waiters on a regular basis.</p>	Not Required
Personal Health Budgets	No	The position has improved since the introduction of Personal Wheelchair Budgets (PWBs). However, the current plan relies heavily on the Wheelchair service delivering the plan agreed in their CQUIN.	All new and existing fully funded CHC clients are considered for a PHB so PHBs are our default position. We have expanded our PHB offer to PWBs and working to expand these to people who are eligible for Section 117 aftercare. The wheelchair service has indicated it is unlikely to meet their planned trajectory so we are working to mitigate risk by ensuring PWB are offered as default for all newly eligible people at their face to face assessment as per our PWB model.	Not Required

Acronyms

Acronyms

2WW	Two week wait (urgent cancer referral)	DQIP	Data Quality Improvement Plan
A&E	Accident and Emergency	DTOC	Delayed Transfer of Care
AEDB	Accident and Emergency Delivery Board	ECS	Emergency Care Standard (4 hour target)
AHC	Annual Health Check	ED	Emergency Department
AIC	Aligned Incentive Contract	EDFD	Emergency Department Front Door
CAMHS	Child and Adolescent Mental Health Services	EMI	Elderly Mentally Infirm
CHC	Continuing Healthcare	ENT	Ear Nose and Throat
CIP	Cost Improvement Plan	F&P/F&PC	Finance and Performance Committee
CMB	Contract Management Board	FIT	Faecal Immunochemical Test
COPD	Chronic Obstructive Pulmonary Disease	FNC	Funded Nursing Care
CQC	Care Quality Commission	GA	General Anaesthetic
CQUIN	Commissioning for Quality and Innovation	GPSI	GP with Special Interest
CSF	Commissioner Sustainability Fund	HCV	Humber Coast and Vale
CT	Computerised Tomography Scan	IAF	Improvement and Assessment Framework
CYC	City of York Council	IAPT	Improving Access to Psychological Therapies
CYP	Children and Young People	ICS	Integrated Care System
DEXA	Dual Energy X-ray absorptiometry scan	IST	Intensive Support Team
DNA	Did not attend	LD	Learning Disabilities

Acronyms (cont.)

MDT	Multi Disciplinary Team	QP	Quality Premium
MHIS	Mental Health Investment Standard	RRV	Rapid Response Vehicle
MIU	Minor Injuries Unit	RSS	Referral Support Service
MMT	Medicines Management Team	RTT	Referral to Treatment
MRI	Magnetic Resonance Imaging	SOP	Standard Operating Procedure
MSK	Musculoskeletal	S&R/SRCCG	Scarborough and Ryedale CCG
NHS	National Health Service	STF	Sustainability and Transformation Fund
NHSE	NHS England	STP	Sustainability and Transformation Plan
NHSI	NHS Improvement	SUS	Secondary Uses Service
NYCC	North Yorkshire County Council	TEWV	Tees Esk and Wear Valleys NHS Foundation Trust
OOH	Out of Hours	T&O	Trauma and Orthopaedics
PCH	Primary Care Home	TIA	Transient Ischaemic Attack
POLCV	Procedures of Limited Clinical Value	ToR	Terms of Reference
PMO	Programme Management Office	VOY	Vale of York
POD	Point of Delivery	WLI	Waiting List Initiative
PSF	Provider Sustainability Funding	YAS	Yorkshire Ambulance Service
PTL	Patient Tracking List	Y&H	Yorkshire and Humber
QIPP	Quality Innovation Productivity and Prevention	YTHFT	York Teaching Hospital NHS Foundation Trust

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Chair's Report: Executive Committee

Date of Meeting	18 December 2019 and 15 January 2020
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee dedicated discussion time to delivery of the 2019/20 financial plan and preparing for the 2020/21 submission.

Additionally, the Committee reviewed the approach being taken by the Referral Support Service and also their approach applied to exceptional funding requests.

Commissioning discussions included cataract surgery and tier and obesity weight management services.

Areas of escalation

None

Urgent Decisions Required/ Changes to the Forward Plan

None

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Chair's Report: Finance and Performance Committee

Date of Meeting	19 December 2019 and 23 January 2020
Chair	David Booker

Areas of note from the Committee Discussion

19 December

The Committee:

- Noted that a reply was awaited from NHS England and NHS Improvement to the CCG's letter in response to the revised and refreshed legal Directions.
- Endorsed the move to focus, simplify and reduce detailed reporting, concentrating on exception reporting. In addition, thematic discussions at a deeper level would be programmed. SB would lead this work and provide an update at the February meeting.
- Approved the archiving of risks IG.02 *iQA system use of patient data for testing* (tolerated) and ES.14 *Failure to manage estate provision cost* (resolved) and the addition of PH.01 *Hepatitis C vaccine in renal patients – not available* accepting this may be reported at Quality and Patient Experience Committee on a later date.

23 January 2020

- The Committee confirmed its support for the movement to slimmer and more focused information sets across the CCG for executive decision making, assurance and governance purposes.
- The CCG noted the significant challenges presented both locally and regionally. It confirmed the commitment to achieving realistic targets and maintaining a leadership role within the wider system.
- The Committee accepted the requests to archive ES.39 *Procurement of alternative provider of GP IT and Corporate IT*, ES.40 *Procurement of an alternative provider of Business Intelligence*, ES.01 *Financial Recovery Schemes will not deliver*, JC.19 *Planned Care Constitutional Target for 62 day cancer waits* and IG.03 *Access to IT equipment and email*.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	30 January 2020
Chair (Interim)	Julie Hastings

Areas of note from the Committee Discussion

The Committee:

- Welcomed the developments on primary care quality.
- Noted that the CCG was now compliant with the improving access to General Practice at evenings and weekends requirements and that, related to this, a formally-designated Urgent Treatment Centre had been established in the New Selby War Memorial Hospital.
- Requested that the Governing Body receive an update on the Primary Care Networks.
- Recognised the need for awareness of expectations being placed on Primary Care Networks in the context of the draft contract specification.
- Commended the fact that all practices within the CCG had been rated as 'Good', with one rated as 'Outstanding', in the 2019 Care Quality Commission reviews.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	9 January 2020 – Primary Care Focused meeting
Chair	Julie Hastings

Areas of note from the Committee Discussion

The Committee:


- Commended the update on Theo and Debbie's Story.
- Agreed that the potential issues with a specific practice, lack of information reported back to the CCG about Serious Incidents from practices and potential for ongoing review of clinical pathways be added to the risk register.
- Noted the changing face of safeguarding commending the local developments.
- Noted the development of the primary care information resource.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Item Number: 19	
Name of Presenter: Dr Andrew Lee	
Meeting of the Governing Body Date of meeting: 5 March 2020	 Vale of York Clinical Commissioning Group
Report Title – Medicines Commissioning Committee Recommendations December 2019	
Purpose of Report <i>(Select from list)</i> For Information	
Reason for Report These are the latest recommendations from the Medicines Commissioning Committee – December 2019.	
Strategic Priority Links <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
Local Authority Area <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
Impacts/ Key Risks <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	Risk Rating
Emerging Risks	

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- | | |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment | <input type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

Risks/Issues identified from impact assessments:

Recommendations

For information only

CCG Executive Committee have approved these recommendations

Decision Requested (for Decision Log)

(For example, Decision to implement new system/ Decision to choose one of options a/b/c for new system)

Responsible Executive Director and Title

Dr Andrew Lee
Director of Primary Care and Population Health

Report Author and Title

Faisal Majothi – Senior Pharmacist
Callie Turner – Pharmacy Technician

Recommendations from York and Scarborough Medicines Commissioning Committee December 2019

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	TA610: Pentosan polysulfate sodium for treating bladder pain syndrome		<p>Pentosan polysulfate sodium is recommended as an option for treating bladder pain syndrome with glomerulations or Hunner's lesions in adults with urinary urgency and frequency, and moderate to severe pain, only if:</p> <p>their condition has not responded to an adequate trial of standard oral treatments</p> <ul style="list-style-type: none"> it is not offered in combination with bladder instillations any previous treatment with bladder instillations was not stopped because of lack of response it is used in secondary care and the company provides pentosan polysulfate sodium according to the commercial arrangement. 	RED	<p>Cost impact expected to be less than £9,000 per 100,000 population according to NICE</p> <p>The technology is a further treatment option after standard oral treatments have been unsuccessful. The overall cost of treatment is not deemed to be significant because there is a reduction in the number of patients requiring bladder instillations.</p>
2.	TA613: Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema in phakic eyes after an inadequate response to previous therapy		<p>Fluocinolone acetonide intravitreal implant is not recommended as an option for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies in an eye with a natural lens (phakic eye).</p>	BLACK for this indication	No cost impact to CCGs expected as not recommended by NICE for this indication.
NHSE commissioned Technology Appraisals – for noting					
3.	TA611: Rucaparib for maintenance treatment of relapsed platinum-sensitive ovarian, fallopian tube or peritoneal cancer		<p>Rucaparib is recommended for use within the Cancer Drugs Fund as an option for maintenance treatment of relapsed platinum-sensitive high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer that has responded to platinum-based chemotherapy in adults, only if the conditions in the managed access agreement for rucaparib are followed.</p>	RED	No cost impact to CCGs as NHS England commissioned.
4.	TA612: Neratinib for extended adjuvant treatment of hormone receptor-positive, HER2-positive early stage breast cancer after adjuvant		<p>Neratinib is recommended as an option for the extended adjuvant treatment of hormone receptor-positive HER2-positive early stage breast cancer in adults who completed adjuvant trastuzumab-based therapy less than 1 year ago only if:</p>	RED	No cost impact to CCGs as NHS England commissioned.

	trastuzumab	<ul style="list-style-type: none"> trastuzumab is the only HER2-directed adjuvant treatment they have had, and if they had neoadjuvant chemotherapy-based regimens, they still had residual invasive disease in the breast or axilla following the neoadjuvant treatment, and the company provides neratinib according to the commercial arrangement. 		
Formulary applications or amendments/pathways/guidelines				
5.	Oral Rifampicin – change in RAG status	Approved change from RED to AMBER Shared Care for use on recommendation of microbiologists. This is to improve ease of access for patients who require longer courses of treatment. Requires shared care due to monitoring requirements with long courses e.g. LFTs. IV to remain RED and to remain RED when used for TB.	AMBER SHARED CARE	Cost for 7 days of oral rifampicin = £17.34 to £34.69 Expect <10 patients per year.
6.	Insulin Toujeo Double Star	Approved. Note 1.5ml already on the formulary as a GREEN drug.	GREEN	No cost impact to CCGs as same price as 1.5ml pen already on the formulary.
7.	Nadolol	Approved Nadolol for Patients with Long QT syndrome as per Tertiary Centre position in Leeds	AMBER Specialist Initiation	Approx 5 patients year = £720 across VoY and ScR CCGs.
8.	Biologics Pathway for Crohn's disease and Ulcerative colitis	Approved. Reflects NICE TA guidance and most cost-effective agents used first.	n/a	No significant cost to CCGs expected.
9.	Lumacaftor/Ivacaftor; and Tezacaftor/Ivacaftor	Approved updating formulary to mirror NHSE Clinical Commissioning Urgent Policy Statement: Cystic Fibrosis Modulator Therapies NHS England URN: 190137P	RED	No cost impact to CCGs as NHS England commissioned.
10.	Testosterone Esters (Sustanon) for the treatment of delayed puberty	To mirror Leeds APC formulary decision from Oct 2019	AMBER Specialist Initiation	No significant cost impact to CCGs expected. Sustanon® 250, 250mg/mL solution for injection given monthly = £2.45
11.	Methotrexate (oral) for the treatment of non-oncology indications in paediatrics	To mirror Leeds APC formulary decision from Oct 2019	AMBER SHARED CARE	No significant cost impact to CCGs expected. 2.5mg tablets x 28 = £2.12
13.	Dolutegravir/ lamivudine 50mg/300mg F/C tablet (Dovato) for HIV-1 infection in	To mirror Leeds APC formulary decision from Oct 2019	RED	No cost impact to CCGs as NHS England commissioned.

	patients with no known or suspected resistance to integrase inhibitors or lamivudine.			
14.	Nicotinamide topical gel e.g. Freederm for mild to moderate acne (in line with NHSE Items available to purchase over the counter)	To mirror Leeds APC formulary decision from Oct 2019	BLACK	No cost impact expected.
15.	Aliskerin	To add as BLACK as use not recommended in NHSE guidance and to mirror Leeds APC formulary decision from Oct 2019.	BLACK	No cost impact expected.
16.	Methadone Injection	Agreed to change from RED to AMBER SR for use in substance misuse palliative care patients who cannot take oral methadone.	AMBER Specialist Recommendation	No cost impact expected. Not to exceed 2 patients per year.