Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

2 April 2020 9.30am to 10.45am

By teleconference due to Coronavirus COVID-19

0800 032 8069

Chair (Michèle) 135 857 55#

Participant 603 71 835#

AGENDA

STANDING ITEMS – 9.30am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 3-17	Minutes of the meeting held on 5 March 2020	To Approve	All
4.	Verbal	Matters arising from the minutes		All
STRATEGIC – 9.35am				
5.	Pages 18-35	Humber, Coast and Vale Health and Care Partnership - Integrated Care System Status Application	To Support and Approve	Phil Mettam

ASSURANCE – 9.40am				
6.	Verbal	2019/20 Annual Report and Accounts: Delegated Authority to Audit Committee on 21 May 2020	To Agree	Simon Bell
7.	Pages 36-40	Interim Measures – Governance and Committee Meetings	To Approve	Michelle Carrington
FINANCE – 9.45am				
8.	Pages 41-57	Financial Performance Report 2019/20 Month 11	To Receive	Simon Bell
CORONAVIRUS COVID-19 UPDATE – 9.50am				
9.	To Follow	Assessment of Current Position and Discussion of Risks	To Note	Andrew Lee
NEXT MEETING				
10.	Verbal	9.30am on 7 May 2020 by teleconference	To Note	All
CLOSE – 11.45am				

Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 5 March 2020 at West Offices, York YO1 6GA

Present

Dr Nigel Wells (NW) (Chair)	Clinical Chair
Michael Ash-McMahon (MA-M)	Deputy 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
Phil Goatley (PG)	Lay Member, Chair of Audit Committee and Remuneration Committee
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) - part	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Dr Chris Stanley (CS)	Central Locality GP Representative
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Fiona Bell-Morritt (FB-M) – item 10	Lead Officer Primary Care (Vale)
Helena Nowell (HN) – items 8 and 9	Planning and Assurance Manager
Michèle Saidman (MS)	Executive Assistant
Annette Wardman (AW) – item 3	MSK Lead

Apologies

Simon Bell (SB)	Chief Finance Officer
Dr Aaron Brown (AB)	Liaison Officer, YOR Local Medical Committee Vale of York Locality

There were four members of the public present.

There were no questions from members of the public.

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

AGENDA

STANDING ITEMS

1. Apologies

As noted above.

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

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

AW joined the meeting

3. Staff Story

In introducing AW MC noted that as part of the CCG's recent reorganisation it had been agreed to include staff as well as patient stories.

AW explained she had a physiotherapy background and had worked for the NHS for 22 years, 16 of these as a MSK (musculoskeletal) specialist. She had done a range of work with patients and had become interested in transformation. A chance conversation around two years ago had resulted in her joining the CCG where she found the same sense of purpose and values as her own. AW additionally referred to the CCG's restructure and commended the integrity of staff through this difficult time when the patient had remained central.

AW's work was in the main MSK related but had also included radiology projects, laboratory medicine and demand management. In respect of the latter AW noted support to primary care such as reduction in MRI reporting times from the previous 25 days. She noted work with first contact practitioners including additional roles to support primary care highlighting ongoing discussions with Primary Care Network Clinical Directors about their needs and closer working between primary and secondary care.

In response to NW enquiring whether AW had any suggestions where further support may be helpful she referred to the recently established Organisational Development Group which was reviewing the CCG's values and staff support such as wellbeing. In terms of personal development AW felt well supported.

Discussion ensued in the context of information being available both for support to primary care from the CCG and for contacts in primary care for CCG staff. MC advised that a staff structure with photographs and areas of specialist interest was being finalised for publication on the CCG website.

AL joined the meeting.

Members commended not only AW's work but also her passion and positivity.

AW left the meeting

4. Minutes of the Meeting held on 2 January 2020

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

The Governing Body:

Approved the minutes of the meeting held on 2 January 2020.

5. Matters Arising from the Minutes

Learning Disabilities Mortality Review – Update on potential proposals and a stocktake of progress: MC reported that, following discussion with Practice Nurses, they had committed to carrying out health checks for people with learning disabilities. The *Learning Disabilities Mortality Review* report was also being presented at the May Council of Representatives. HE added that learning disabilities was now included in the Quality and Outcomes Framework Quality Improvement Indicator noting this as an opportunity for the Primary Care Networks to work together to reduce unwarranted variance in the context of Learning Disability strategies.

The other matters were confirmed as completed, covered within agenda items or at the next meeting.

The Governing Body:

Noted the updates and associated actions.

6. Accountable Officer's Report

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

PM noted confidence in delivery of the 2019/20 £18.8m planned deficit based on the month 10 forecast outturn position and that the 2020/21 plan would be presented later in the meeting. He detailed the increased partnership working, both locally with NHS North Yorkshire CCG and York Teaching Hospital NHS Foundation Trust, and in the context of the Humber, Coast and Vale becoming an Integrated Care System from 1 April 2020.

PM explained that nationally the intention was for all parts of England to be covered by Integrated Care Systems within two years. NHS England and NHS Improvement were working with the government to change NHS financial resources allocation from the current organisations to Integrated Care Systems for such as new buildings, new equipment and maintenance. There was an emphasis nationally on partnership and collaboration, the approach the CCG had always tried to employ and would continue to do so.

PM also explained that Integrated Care Systems, as NHS commissioners, were adopting the approach of working closely with other NHS commissioners in the area

to avoid duplication; this included local government partners. He advised that the CCG was actively exploring opportunities with the three local authorities to work jointly in terms of financial resources and teams.

NW reported that the recent Protected Learning Time had been another successful event. Approximately 280 clinicians, had focused on health and wellbeing. HE additionally noted extremely positive feedback from nurses who had attended.

PM referred to the Better Care Fund update noting that partnership working was continuing but that the historic context and current financial constraints limited opportunities for transformation.

In relation to the COVID-19 update PM commended all involved for their discretionary effort, commitment and expertise.

The Governing Body:

Received the Accountable Officer's report.

7.1 Quality and Patient Experience Report incorporating Risk

MC noted this was the first iteration of the combined Quality and Patient Experience Report and Risk Register to avoid duplication; members supported this approach. MC also noted the need for the Governing Body to consider a process for when a risk becomes an event. The two detailed in the report were QN.09 following the outcome of the December 2019 SEND (Special Educational Needs and/or Disabilities) inspection and ES.01 due to the jointly agreed system financial recovery schemes not delivering and therefore triggering the three way risk share arrangement which would exceed available contingency reserves in the CCG with the consequence that the CCG could not deliver its accepted plan.

MC referred to the COVID-19 update noting this would be added to the Risk Register. She explained the position and requirements for testing and swabbing that were subject to ever changing national guidance. MC also reported that a further case had been identified in York the previous day.

MC explained the requirement for setting up NHS resourced co-ordination centres. In this regard she emphasised the context of pre-existing workforce pressures.

MC commended the responses from system partners, notably York Teaching Hospital NHS Foundation Trust who were providing various training aspects, and advised that a meeting with system partners had taken place the previous day to discuss such as transport requirements in terms of identification of drivers and vehicles. AL additionally commended and expressed appreciation to Haxby Group Practice for establishing, with 36 hours' notice, a seven day a week in-hours monitoring service.

In respect of business continuity in response to COVID-19 HE advised that the seven practices in the North Locality were considering an approach of memoranda of understanding for services. AL reported on an emergency planning exercise carried out by his team, noted that RW's practice's business continuity plan was being

shared and advised that he was meeting with Practice Managers to discuss worst case scenario planning.

Members noted concerns about care homes, carers, dispensing practices and the potential escalation of COVID-19. SS assured members that the Local Authorities were supporting the NHS noting she was working closely with both AL and the North Yorkshire Director of Public Health. In relation to care homes SS explained that the Local Authorities had established plans for closures but highlighted that it was unusual for a number of homes to close at the same time. She also referred historically to establishment of an Ethical Committee to safeguard frontline clinicians in terms of decision making at such a time. It was agreed that this approach be progressed.

AL emphasised that, while COVID-19 was highly infectious, the current position should be considered in the context of fatalities from other diseases such as seasonal 'flu and measles. In conclusion MC commended the partnership working and AL expressed appreciation to SS and her team for their support.

In presenting the risks MC requested members identify whether they wished each to continue to be managed at Governing Body level or delegated back to the Quality and Patient Experience Committee.

QN.13 – Hepatitis B vaccine in renal patients

MC explained that a pragmatic clinical solution was being sought for patients affected by the national decision to transfer responsibility for provision of Hepatitis B vaccinations for renal patients from primary care to secondary care. MC advised that the logistics were complex from the York Teaching Hospital NHS Foundation Trust perspective due to the importance of timing of the vaccination but they had provided a paper describing potential models for the CCG to consider and discuss with NHS England and NHS Improvement. The CCG was currently seeking views from primary care about the potential for them to resume this service.

Discussion ensued in the context of the increasing number of patients affected and therefore a growing backlog. MA-M additionally noted that if the CCG commissioned a separate clinic for these patients it would become the CCG's responsibility and only the cost of the vaccine would be reimbursed.

Members agreed that risk QN.13 continue to be managed by the Governing Body.

QN.04 - Increasing number of extended trolley waits in Emergency Department breaching 12 hours

MC referred to the context of York Teaching Hospital NHS Foundation Trust remaining at Risk Summit level, the regulatory notices imposed on them by the Care Quality Commission and the impact of 12 hour trolley breaches on performance indicators especially at the Scarborough site. She provided clarification and advised

that all 12 hour waits were declared Serious Incidents and were subject to the delogging process.

Members agreed that risk QN.04 continue to be managed by the Governing Body.

QN.05 - Poor discharge standards from York Teaching Hospital NHS Foundation Trust

MC highlighted a number of specific discharge processes that were a concern but advised that York Teaching Hospital NHS Foundation Trust was committed to resolving these issues. She advised that the Complex Discharge Group was a forum for discussion between senior nurses and care home managers. HE additionally noted ongoing concerns about drugs information.

Members agreed that risk QN.05 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

QN.06 - Infection control processes not adequate

MC explained that the main risks were in terms of day to day work as they related to estate and equipment, particularly at Scarborough Hospital. She emphasised the aspect of good levels of assurance in respect of COVID-19 infection control.

Members agreed that risk QN.06 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

QN.08 - Clinical risks associated with growing waiting list (planned care)

MC explained that, in the absence of national guidance, York Teaching Hospital NHS Foundation Trust was managing this area of clinical risk through the care group structure noting differing timescales for achievement and adding that further delays from COVID-19 impact were a concern. She noted positive working and advised that support was being provided by primary care and Rapid Expert Input. NW additionally noted gastroenterology discussion at the February Council of Representatives.

Members agreed that risk QN.08 continue to be managed by the Governing Body.

QN.15 – Care Quality Commission involvement in York Teaching Hospital NHS Foundation Trust

MC clarified the position in respect of the Care Quality Commission emphasising that the greatest issue was staffing particularly on the Scarborough site. In respect of the paediatric presence in A and E MC explained that York Teaching Hospital NHS

Foundation Trust, supported by NHS England and NHS Improvement and the Care Quality Commission, was working to develop an alternative, safe model. MC also noted that assurances were being sought from Tees, Esk and Wear Valleys NHS Foundation Trust on capacity and workforce issues.

Members agreed that risk QN.15 continue to be managed by the Governing Body.

QN.03 - Quality of commissioned specialist nursing services

MC explained that a transformation plan for children's services was being developed which included work with York Teaching Hospital NHS Foundation Trust for the community nursing aspect. Scrutiny and due diligence was taking place and additional funding was now available. PG advised that concern had also been raised about these services at the Audit Committee by Internal Audit

Members agreed that risk QN.03 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

MC additionally detailed the process and associated requirements relating to the SEND inspection, classed as an event as referred to above, noting that the report had been published and was available on line. She advised that a six month resource had been established for full time project management of this work.

PM left the meeting

QN.07 - Referral for initial health checks - timeliness of City of York Council referrals

MC explained that Harrogate District NHS Foundation Trust provided initial health checks for Looked After Children in City of York. Following identification of an administrative resource by the Local Authority, improved timeliness of notifications to health was expected.

Members agreed that risk QN.07 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

QN.14 – Quality, safety and concerns at a GP Practice in Vale of York CCG area

MC referred to the primary care focused Quality and Patient Experience Committee which had provided good levels of assurance in terms of quality and safety within the changing landscape. She noted that one of the CCG's big practices had recently had a Care Quality Commission inspection cancelled as, in view of COVID-19, only high risk practices were being inspected.

MC advised that the CCG was supporting one practice which had been of concern. She explained that at this point in time there did not appear to be any contract breaches and noted that they had provided some level of assurance.

In response to HE seeking advice about services for a vulnerable adult who was a temporary visitor, AL requested such concerns be reported to the Quality Team or to himself for consideration in the regular Soft Intelligence Meeting.

Members agreed that risk QN.14 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

QN.10 - Potential unexpected closure of nursing beds

MC explained that there were specific issues at the home which had changed its designation from nursing to residential. This was noted in the context of the fragile care home market.

Members agreed that risk QN.10 be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

QN.12 – Missed pertussis vaccination for expectant mothers

Members agreed that risk *QN.12* be delegated back to the Quality and Patient Experience Committee noting it would be included on the Committee Chair's report to Governing Body.

7.2 Board Assurance Framework

MC referred to the Board Assurance Framework which highlighted progress against specific strategic objectives and outlined the current risks related to the delivery of those objectives. She noted the aim of avoiding duplication of the risk registers.

The lay members commended the clarity of the document and expressed appreciation for the work in its development. PG additionally requested labelling of the axis on the impact charts. MA-M noted that financial information would be incorporated in the next iteration.

The Governing Body:

1. Approved testing an approach to lessons learned from risks which become events at the Part II meeting on 2 April 2020.
2. Confirmed assurance of the accuracy of risks and appropriate mitigation to manage these risks.
3. Agreed that the following risks continue to be managed by Governing Body:
    - QN.13 – Hepatitis B vaccine in renal patients
    - QN.04 - Increasing number of extended trolley waits in Emergency Department breaching 12 hours
    - QN.08 - Clinical risks associated with growing waiting list (planned care)
    - QN.15 – Care Quality Commission involvement in York Teaching Hospital NHS Foundation Trust

4. Agreed that the following risks be delegated back to the Quality and Patient Experience Committee and reported to Governing Body through the key messages on the Chair's Report:
    - QN.05 - Poor discharge standards from York Teaching Hospital NHS Foundation Trust
    - QN.06 - Infection control processes not adequate
    - QN.03 - Quality of commissioned specialist nursing services
    - QN.07 - Referral for initial health checks - timeliness of CYC referrals
    - QN.14 – Quality, safety and concerns at a GP Practice in Vale of York CCG area
    - QN.10 - Potential unexpected closure of nursing beds
5. Confirmed assurance regarding the wider work being undertaken to ensure quality, safety and an underpinning approach to patient engagement.
6. Requested that an Ethical Committee with partners be established.

ASSURANCE

HN joined the meeting.

8. Committee Terms of Reference and Update to Detailed Scheme of Delegation

HN advised that the terms of reference were presented following annual review by the respective committees. Changes had been agreed mainly to clarify remit.

MA-M highlighted that the Detailed Scheme of Delegation had been updated to take account of changes within the CCG including the restructure, introduction of a CCG credit card and in response to internal audit recommendations.

The Governing Body:

1. Ratified the Terms of Reference of the Executive Committee, Finance and Performance Committee, Primary Care Commissioning Committee and Remuneration Committee.
2. Approved the updated Detailed Scheme of Delegation.

Post meeting note for Scheme of Delegation: 'Under Section 3 Non Pay Expenditure':

- *'Expenditure on existing budgeted expenditure (as per GB approved annual budget)' to read 'Expenditure on existing budgeted expenditure (as per GB approved annual budget as amended)'*
- *'Before orders are placed for non healthcare related goods and services the following conditions must be complied with' to read 'Before orders are placed for non-NHS provided goods and services the following conditions must be complied with'.*

9. NHS Vale of York CCG Emergency/Business Continuity Plan

HN explained that the plan presented was a new document to NHS Vale of York CCG and was part of a review of the CCG's emergency and business continuity planning processes. This was a working document which aimed to establish a standard for the organisation as a whole rather than each team having individual plans. The final document would not be published for reasons of data protection as it would include contact names and numbers; senior managers would have the full information. It was agreed that further action cards would be presented for approval by the Finance and Performance Committee.

HN noted that she would feedback PG's concern that the action cards relating to loss of security required additional detail.

The Governing Body:

Ratified the 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.

*HN left the meeting; FB-M **j**oined the meeting.*

10. Primary Care Networks Update

FB-M presented the report that summarised the 2020/21 plans and population health priorities for the Primary Care Networks across the Vale of York noting this had been written by herself and Gary Young (GY), Lead Officer Primary Care (City), with Primary Care Network colleagues. FB-M highlighted the plans, each of which included 'Our Place' and 'Vision', had evolved in the context of sustaining and developing primary care and supporting populations at the 'place' level. She also commended the Primary Care Networks for achieving this in half a day a week and in addition to regular work.

FB-M explained that the Primary Care Networks were focusing on the additional roles to develop the workforce. She advised that an approach of sharing roles based on need was being adopted noting social prescribers and pharmacists currently in this regard; decision making was focusing on need and additionality for the biggest impact. Key challenges were in delivering the seven national service specifications and in recruiting the wider workforce. FB-M noted the CCG was reviewing potential support and the Primary Care Networks were working collaboratively across the system, for example with York Teaching Hospital NHS Foundation Trust, for physiotherapists (first contact practitioners). She emphasised the achievement in terms of partnership working since Primary Care Networks had been established.

In response to NW enquiring about CCG support in Primary Care Network development, discussion ensued in the context of considering core CCG roles spending more time at 'place' level to provide additional capacity; project management support; opportunities to influence system partners to support change; and support for recruitment.

AL highlighted aspects of assistance that the CCG was already providing, including FB-M and GY, which was recognised by the GP members. AL emphasised the magnitude of the national expectations from Primary Care Networks which the CCG would work to support. Members additionally noted the context of the CCG's statutory obligations and the fact that the CCG would not always have either the skill sets required or the solutions.

AL referred to the context of the former '1000 days', now '500 days Challenge' emphasising that the legacy would be based on working relationships therefore the Primary Care Networks required support in terms of strategic development as system partners. He reported that he and Sharon Stoltz, City of York Council Director of Public Health, were meeting with Simon Morritt, Chief Executive of York Teaching Hospital NHS Foundation Trust to discuss a system approach to population health prevention, noting that Tees, Esk and Wear Valleys NHS Foundation Trust were also supportive of this approach. MA-M added that the Clinical Directors and GY had started attending the City of York Better Care Fund group in the context of system partner forum.

FB-M left the meeting.

AL referred to the Primary Care Resilience and Capacity update on Central York. He highlighted work to address workforce issues including the CCG funded GP Locum Bank, liaison with Yorkshire Ambulance Service to focus services at times of greatest need and a review of the urgent care system. Additionally, Stephanie Porter, Assistant Director of Primary Care, was working with the Humber, Coast and Vale Sustainability and Transformation Partnership on potential international recruitment. A host practice was currently being sought.

The Governing Body:

1. Welcomed the Primary Care Networks update.
2. Requested a further update in approximately three months.

11. Safeguarding Adults Policy

MC referred to the revised CCG Safeguarding Adults Policy presented for ratification following approval by the Quality and Patient Experience Committee. This completed an action from the Safeguarding Adults Internal Audit 2019.The policy

The Governing Body:

Ratified the Safeguarding Adults Policy.

FINANCE AND PERFORMANCE

12. 2020/21 Financial Plan

MA-M presented the Planning Guidance 2020/21 to 2023/24 Financial Key Points; Financial Improvement Trajectories York and North Yorkshire System View, Multi Year Summary (2019/20 to 2023/24); Plan Comparison; Outturn to Exit Underlying Position (£24.3m) Bridge Chart; System Risk Assessment; 2020/21 Growth, Pressures and Investment Summary; Investments and Cost Pressures; Mental Health Investment Standard; QIPP; and 2020/21 Financial Plan Risk Assessment.

MA-M explained that the CCG share of the overall deterioration in the Sustainability and Transformation Partnership Financial Plan was £7.6m of which the CCG had previously accepted £2m of known risk as part of the first draft submission. The CCG's financial position was therefore £5.6m worse than in the November plan. Of this £1.3m was new and unforeseen in relation to the impact of the GP Contract; the rest was due to the deterioration in trading position and the non-recurrent actions to off-set these that needed accounting for in 2020/21.

MA-M also explained that the draft plan maintained the 2019/20 exit position of £24.3m deficit with an ambition of reducing this to £16.3m underlying deficit in 2020/21. In respect of the £10.0m system recovery requirement MA-M commended York Teaching Hospital NHS Foundation Trust for maintaining the aligned contract system approach.

MA-M provided clarification in relation to the investments and cost pressures including the Mental Health Investment Standard and the context of historic under investment in mental health services. Joint working was taking place with Tees, Esk and Wear Valleys NHS Foundation Trust to prioritise demand. MA-M also highlighted the £2.0m primary care prescribing QIPP emphasising the challenge in this regard in the context of previous efficiencies achieved. He referred to the c£1.0m of mitigations in the plan for prescribing and noted that other national cost pressures would have to be met from within this provision as well.

MA-M highlighted the impact of unidentified QIPP on the 2020/21 QIPP total of £19.9m. AL additionally expressed concern both in the context of support to the Primary Care Networks, including the additional roles, and reiterated the perspective of the challenge for primary care to contribute to the QIPP. A system approach would be sought for the additional roles.

MA-M emphasised that NHS England and NHS Improvement required assurance that all opportunities had been considered. Members agreed that transformation was the only remaining option but this would take time and investment; additionally staffing levels may have an impact on achieving this.

The Governing Body:

Approved the 2020/21 Financial Plan.

Post meeting note: Extracts from the York and North Yorkshire Subsystem Integrated Care Partnership Plan 2020/21 submission to the Humber Coast and Vale Health and Care Partnership were circulated to the Governing Body on 6 March.

13. Financial Performance Report Month 10

MA-M reiterated the increasing level of confidence in delivering the £18.8m deficit position noting that all financial recovery in year mitigations had been transacted and were reflected in the report. Forecast deterioration of the system recovery schemes remained unchanged.

MA-M explained that the key risk to the CCG related to delivery of the Prescribing Incentive Budget (PIB2) which was in the forecast position. This scheme had commenced late in the year and indications, based on Month 8 data due to the two month delay in prescribing reporting, were that it may not deliver.

MA-M reported that a Responsible Commissioner Continuing Healthcare case had been resolved within the contingency amount set aside for this purpose.

MA-M noted that the report now included financial risks and that the forecast delivery of £11.0m QIPP (Quality, Innovation, Productivity and Prevention) against the £14.7m target would be the highest level achieved in the CCG's history despite the current challenges.

The Governing Body:

Received the Month 10 Financial Performance Report.

14. Integrated Performance Report Month 9

MA-M reported that there were no material changes in performance and highlighted the continued improvement in mental health targets. With regard to cancer work was taking place to improve performance against the 62 day GP referral target, 77.6% against the 85% target, and cancer fast track referrals, two week waits, were above target.

MA-M explained that the forecast Referral to Treatment Total Waiting List position had changed from 30,000 to an expected 29,400 at the end of March due to challenges in specific specialties; focused work was taking place in these areas.

NW commended the improvement in MRI performance noting restrictions in place for some scans. MC reported that the Executive Committee had the previous day approved a primary care specific restriction on knee MRIs. HE expressed concern about rurality in respect of scanning noting the need for flexibility in pathways citing the example of public transport to clinics.

NW reported that discussions were continuing in respect of open access gastroscopy, noting that the Local Medical Committee was involved.

CS commented on the areas of good performance in the context of the current challenges and members commended the Vulnerable People's Team for the improvement in early intervention in psychosis.

The Governing Body:

Received the Month 9 Integrated Performance Report.

RECEIVED ITEMS

The Governing Body noted the following items as received:

15. Executive Committee chair's report and minutes of 18 December 2019 and 15 January 2020.

16. Finance and Performance Committee chair's report and minutes of 19 December 2019 and 23 January 2020

17. Primary Care Commissioning Committee chair's report and minutes of 30 January 2020.

18. Quality and Patient Experience Committee chair's report and minutes of 9 January 2020.

19. Medicines Commissioning Committee recommendations of 11 December 2019.

20. Next Meeting

The Governing Body:

Noted that the next meeting would be held at 9.30am on 2 April 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:

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

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 5 MARCH 2020 AND CARRIED FORWARD FROM PREVIOUS MEETING

Meeting Date	***Item***	***Description***	***Director/Person Responsible***	***Action completed due to be completed (as applicable)***
2 January 2020	Patient Story	• Update on establishing a local system approach for pertussis vaccination in pregnancy	MC	5 March 2020
2 January 2020	Learning Disabilities Mortality Review	• Update on potential proposals and a stocktake of progress	MC	5 March2020
2 January 2020	Board Assurance Framework and Risk Management Policy and Strategy	• Risk Management Policy and Strategy to be presented for ratification	AC	2 April 2020
5 March 2020	Quality and Patient Experience Report incorporating Risk	• Ethical Committee to be established with partners	AL	2 April 2020
5 March 2020	Primary Care Networks Update	• Further update in three months	AL	2 July 2020

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 2 April 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Humber, Coast and Vale Health and Care Partnership - Integrated Care System Status Application

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

Reason for Report

The attached report, circulated by email on 9 March 2020 for Governing Body support, is presented to seek formal approval for Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☐Legal
☐Primary Care
☐Equalities

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: N/A

Recommendations

That the Governing Body support and approve the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status.

Decision Requested (for Decision Log)

Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status approved.

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer	

Humber, Coast and Vale Health and Care Partnership - Integrated Care System Status Application

Purpose

The purpose of this paper is to seek support and approval from NHS Vale of York CCG Governing Body for the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status. This application is provided in the form of a Checkpoint Review Report and this is attached as appendix A.

Background

The NHS Long Term Plan, published in January 2019, set out a vision of an NHS focused on prevention and early intervention, working closely with local government and using population health insight to understand need and plan services and initiatives together.

As part of that vision it set out an aspiration for all Sustainability and Transformation Partnerships (STPs) to develop and be designated as Integrated Care Systems (ICSs) by April 2021.

In the "Designing Integrated Care Systems" document published by NHS England/Improvement (NHSE/i) in June 2019, the focus of an ICS is described as the mechanism through which all organisations in each health and care system can join forces, so they are better able to improve the health and wellbeing of their populations and offer well-coordinated efficient services to those who need them. The document sets out how collaborative activity might be undertaken at different scales within an ICS in pursuit of these objectives. It also sets out an expectation that, through the ICS, partner organisations will **coordinate the transformation of health and care across settings and collectively manage system performance**. This will include oversight and assurance of the operational and financial performance of NHS and NHS funded organisations, whilst recognising that individual organisations will retain individual (and statutory) accountabilities.

Taking into account the progress that had been made over the last three years, the Humber, Coast and Vale Partnership last year confirmed its ambition to achieve ICS status by Summer 2020.

Current Position

At the start of the current financial year, it was agreed with NHSE/I that the Partnership would receive support to continue its development, with a view to achieving ICS status within the identified timescales. This support was provided in the form of the ICS Accelerator Programme structured around an ICS maturity matrix, which is a tool used by the system development team within NHSE/I. It

supports Partnerships to measure the level of maturity of their relationships and collaborative working arrangements.

During the period between October 2019 and January 2020, partner organisations have been working together through a series of activities and events to facilitate the development of the Partnership. We have reaffirmed our purpose, agreed our priorities, strengthened our ways of working and agreed the principles that will underpin our operating and governance arrangements and our approach to financial and performance management. We have also recognised that we need to continue to develop as a Partnership. We have therefore agreed a Continual Development Plan that sets out the actions that we will take over the next 12 months as we seek to become a thriving ICS.

Following the progress made by the Partnership over the last three years and more recently through the ICS Accelerator Programme, we have been invited by NHS England and Improvement to submit an application to be considered for ICS status.

The application is made in the form of a Checkpoint Review Report which will be considered initially by the NHSE/I Regional Director for North East and Yorkshire and subsequently by the NHSE/I team at national level. A draft of the report is attached as appendix A.

In the report we have described the progress that we have made and the acceleration of our thinking in respect of partnership working. We have also demonstrated the commitment and ability of our Partnership to work collaboratively. We should be proud of the achievements we have made during the last three years and we are now well placed to develop further as a Partnership and achieve the ambitious objectives and outcomes that we have set out in our Long Term Plan.

Recommendation

NHS Vale of York CCG Governing Body is asked to:

- Consider the Checkpoint Review Report attached as appendix A that summarises the work that we have undertaken and the progress that we have made in strengthening the Partnership and in promoting collaboration within the Partnership to drive improvement; and
- Formally support the Humber, Coast and Vale Health and Care Partnership's application for Integrated Care System status.

Humber, Coast and Vale Health and Care Partnership

Integrated Care System Checkpoint Review

1. Introduction

This document sets out the formal expression of interest for the Humber, Coast and Vale Health and Care Partnership to achieve Integrated Care System (ICS) status.

The document describes the key strengths of our Partnership against the nationally set ICS criteria. It also summarises the successful work that we have undertaken and the progress we have made in strengthening the Partnership and in promoting collaboration within the Partnership to drive improvement.

2. Background / Context

The Humber, Coast and Vale Health and Care Partnership was established in 2016, to enable 28 organisations from the NHS, local authorities, other health and care providers and the voluntary and community sector (listed in appendix A) to work together more effectively, to address the challenges facing the NHS and the wider health and care sector.

From the outset there was extensive agreement across our Partnership that, in order to improve and sustain the health and wellbeing of our population of 1.4m people, we would need to adapt and change the way that we work and the way that health and care services are delivered. Specifically, it was recognised that we would need to take a more collaborative approach to delivering our shared goals. Our approach is therefore fundamentally based on the belief that we will be more successful if we work more closely together to drive improvement and integrate the health and care services that we provide.

In our 2019/20 Operating Plan, we set out our ambition to achieve ICS status by the summer of 2020. This aspiration was supported by NHS England and Improvement in May 2019 and it was agreed that the Partnership would receive support to continue its development, with a view to achieving ICS status within the identified timescales.

During the period between October 2019 and January 2020, partner organisations have been working together through a series of activities and events to facilitate the development of the Partnership. We have reaffirmed our purpose, agreed our collective priorities, strengthened our ways of working and agreed the principles that will underpin our operating and governance arrangements and our approach to financial and performance management with a view to supporting delivery of the Partnership's overarching ambition – to support our population to *start well, live well and age well*.

We are seeking to build on the momentum that has built up over the past four month to ensure that we continue to strengthen the Partnership. We have therefore agreed a Continual Development Plan that sets out the actions that we will take over the next 12 months as we seek to become a thriving ICS.

3. How will the Partnership discharge the roles of an Integrated Care System?

We welcome the clarity around the expected two core roles of an ICS and have put in place robust arrangements and plans to effectively discharge the following responsibilities:

- **Plan and coordinate the transformation of health and care across settings** of place and neighbourhood, including workforce planning, population health management and quality improvement; and
- **Collectively manage system performance** including health outcomes, quality of care, operational and financial performance.

Through the following sections we have described why, as a Partnership, we feel that we have reached the appropriate level of maturity to receive ICS status and have the arrangements in place to continue to mature and deliver against our ambitions and plans.

3.1. Does the Partnership have a clear shared vision and a credible strategy to support transformation of health and care in the system?

Our Partnership Long Term Plan clearly sets out a shared, person centred ambition in respect of health and wellbeing and, through the ICS Accelerator Programme, we have re-affirmed that the primary purpose of the partnership is ***improving and sustaining the health and wellbeing of the population in Humber, Coast and Vale.***

This provides the collective motivation and focus that will help us to deliver our vision of ***helping local people to: start well, live well and age well***. We want to become a health improving system rather than an ill-health treating system. This will require an increased emphasis on prevention and supporting larger numbers of people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

Our Partnership Long Term Plan has been co-produced by partner organisations and through proactive engagement with stakeholders, staff and local communities. It has been built up from our **local place plans** and our **collaborative programmes.** The plan is focused on the following four priorities:

- Helping people to look after themselves and to stay well
- Providing services that are joined-up across all aspects of health and care
- Improving the care we provide in key areas (e.g. cancer and mental health)
- Making the most of all our resources (e.g. people, technology, buildings and money)

To support us to achieve these ambitions, our senior leaders have agreed where it would make sense for them to focus their collective energy. This will be concentrated around the strategic plans and objectives for the following collaborative programmes that underpin the delivery of our priorities, as well as continuing to develop as a Partnership. These areas of focus are:

- Cancer
- Mental Health

- Population Health
- People/Workforce
- Estates and Capital Investment
- Digital

3.2. How will the Partnership ensure strong system leadership?

In Humber, Coast and Vale, we have had strong credible engagement from leaders across all sectors of our Partnership from the outset. We have been working together through a **distributed leadership model,** which complements and extends the existing responsibilities of the statutory organisations. The key elements are set out in appendix B and include:

- Collaboration at **Place** – centred on improving health and wider wellbeing of citizens; delivering the priorities for health, social care and addressing wider determinants of health for the population and neighbourhoods within a Place. This is undertaken through arrangements that bring together the local authorities, CCGs and health and care providers, working through the Health and Wellbeing Boards or similar governance arrangements.
- Collaboration at **'Sub System'** – focussed on convening either more than one Place and or sectors across Places including through:
    - commissioning arrangements across the Humber and North Yorkshire
    - well established Provider Alliances / partnerships between Community Interest Companies and NHS Providers
    - the recently established single Chair arrangements for Northern Lincolnshire and Goole Foundation Trust and Hull University Teaching NHS Trust
    - the Mental Health Provider Collaborative and Partnership Board
    - the proposed place based exemplar in York
    - specific pieces of work e.g. strategic acute service reviews and operational planning and financial management.
- Collaboration at **'Scale'** – formalised through arrangements such as the Humber, Coast and Vale Partnership Executive Group and the Collaborative Programme Boards, bringing together organisations from across the Partnership to work together where it makes sense to do things only once, to deliver better outcomes and make effective use of resources.

Our 'at scale' collaborative programmes have Chief Executive level sponsors, clinical and managerial leadership as well as clear links back into each Place to ensure strong alignment of plans and delivery of transformation. This is in addition, to the Partnership's System Lead/Independent Chair, the Partnership Executive Lead (who is also the Chief Executive of a Partner organisation), Partnership Director and Partnership Finance Lead who act as conveners of senior leaders to facilitate collaboration and deliver improvement. In accordance with the guidance on ICS leadership, the Independent Chair and System Leadership arrangements will be reviewed in summer 2020 and will be informed by a 360° exercise to be undertaken with the system leaders from all partner organisations.

The Clinical Advisory Group has been in place from the inception of the Partnership bringing together a range of clinical professions from partner organisations (including social care). Recognising the importance of our clinical leadership we have, through the ICS Accelerator Programme, focussed on improving our health and care professional engagement. This work has been clinically led and we will

continue this work with our Clinical Engagement Lead being supported by our newly appointed Partnership Clinical Lead.

We are proud of the engagement and effective working we have built with the Local Authorities in our Partnership. We have had strong representation from Local Authority Senior Officers, with regular attendance and contribution from them at the Partnership Executive and at a system level, as well as their critical leadership at Place. A number of the Senior Officers from our Local Authorities have also taken the Executive Lead / Senior Responsible Officer roles for our collaborative programmes, including Workforce and Digital.

In our Partnership Continual Development Plan we have acknowledged that we have more work to do over the coming year to ensure that the leadership of the Partnership is as effective as possible. This will include;

- Looking to our Local Authorities to take a lead on co-ordinating how the NHS and NHS funded organisations can play a more active role in the development and implementation of Health and Wellbeing Strategies at local level, with oversight being provided by the Health and Wellbeing Boards;
- Strengthening our engagement with the voluntary and community sector and ensuring their effective involvement in the Partnership;
- Supporting the development of Primary Care Networks, enabling them to maximise their involvement and contribution at Place;
- Continuing to explore the role of Non-Executives, Lay Members and Elected Members in the leadership and governance of the Partnership.

We are continuing to strengthen our leadership and collaborative working arrangements in the Humber and North Yorkshire sub-systems. The strategic direction is for Harrogate FT to join the Humber, Coast and Vale Partnership from April 2020. However, in recognition of the Trust's longstanding patient flows and clinical links into West Yorkshire, Harrogate FT will continue to be a key player in the West Yorkshire system.

3.3. How does the Partnership make collective and effective decisions for the system and hold each other to account for delivery?

We have discussed and agreed our operating arrangements and have committed to formalising these arrangements. To this end we are developing a Memorandum of Understanding that will set out a mutual accountability framework to ensure we have collective decision-making and ownership of delivery. Our established governance arrangements are set out in appendix C. The key groups are as follows:

- The **Partnership Executive Group** - responsible for setting and overseeing the strategic direction of the Partnership and building collective responsibility for delivery.
- A **Partnership Oversight and Assurance Group** – that takes an overview of system performance, allowing partners to hold each other to account for delivery.
- Quarterly **Partnership Assembly** – providing the opportunity for all executive and non-executive leaders to be informed, involved and engaged in the strategic direction and development of the Partnership.

3.4. How will the Partnership streamline its commissioning arrangements?

Our Clinical Commissioning Groups (CCGs) are currently developing a clear view of what streamlined commissioning functions would look like in the future, based around two geographical areas of Humber and North Yorkshire. This is being supported by other Partners across Humber, Coast and Vale and NHSEI as an alternative to a single strategic commissioner coterminous with the Partnership boundary.

We currently have a single Accountable Officer covering three of our CCGs (Hull, East Riding and North Lincolnshire) in the Humber and a merger of three North Yorkshire CCGs in Scarborough and Ryedale, Hambleton, Richmond and Whitby (currently in North East and Cumbria ICS) and Harrogate and Rural District (currently in West Yorkshire and Harrogate ICS) which will become the North Yorkshire CCG on 1 April 2020 with a single Accountable Officer.

Over recent weeks, work has been undertaken to draw up plans for the future development of commissioning arrangements across the Partnership. The four CCGs across the Humber have agreed to establish strategic commissioning arrangements with effective leadership and supporting resources. A Strategic Commissioning Board will be put in place from April 2020 which will be led and chaired by the Accountable Office for Hull, East Riding and North Lincolnshire. The Board will also have clearly delegated functions and authorities from all four CCGs in the Humber area. The North Yorkshire CCG and Vale of York CCG are working on the development of a joint commissioning committee to oversee delivery of a single set of priorities, a shared delivery model where appropriate and an aligned delivery plan.

For both the Humber and York & North Yorkshire commissioning plans are being developed which will also demonstrate how the proposed arrangements will:

- Tackle inequalities and improve outcomes for patients across the Humber
- Ensure resources and capacity are in the right place to support integrated place-based integration and consider the devolution of traditional commissioning functions to local partnerships/organisations
- Rapidly streamlining functions to reduce duplication of commissioning processes, governance arrangements and the use of staff time therefore being affordable, reducing running costs and supporting longer term financial sustainability
- Support a consistent approach to standards and outcomes
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Meet the well -led requirements of the commissioner assessment framework.

The new commissioning arrangements will be reviewed on a quarterly basis during 2020/21. It is anticipated that commissioning arrangements in the Humber and North Yorkshire areas will evolve further to meet national policy requirements. Our intention is to agree longer term arrangements from April 2021.

3.5. Does the Partnership have strong and collective financial and resource planning and management arrangements in place?

As a Partnership, we have developed a financial strategy for the next five years that will enable us to meet our financial improvement targets and deliver significant financial improvement towards financial balance by 2023/24.

We recognise that improving our financial performance at the required scale is a significant challenge, but it is an area in which we are currently delivering improvement. The efficiency gain requirements in the short term have and continue to exceed the levels set out in national guidance. We agreed a plan for 2019/20 to meet our financial targets and performance in the year to date has been in line with the agreed trajectories. We are working collaboratively to identify in-year financial risks and have taken actions to manage and mitigate these risks. This has involved flexible use of the financial resources available across the system, which has been possible because of the strong collaborative relationships within the Partnership. As a consequence our forecast financial outturn for 2019/20 is looking positive.

Although we are still dealing with significant financial challenges, we have reduced our overall deficit this year and plan to achieve a further reduction in 2020/21. Our planned deficit for 2020/21 is fully covered by our Financial Recovery Funding.

	18/19 Actual Deficit	19/20 Forecast Deficit	20/21 Planned Deficit
North Yorkshire and York	£46m	£46m	£43m
Humber	£75m	£52m	£40m
Partnership Total	**£121m**	**£98m**	**£83m**

Over the last two years we have strengthened our collaborative working through the operational and strategic planning rounds. This is demonstrated in the progress that we have made in:

- Agreeing and working to financial improvement targets and managing risk associated with our Financial Recovery Funding by grouping our organisations into the two geographies of the Humber and North Yorkshire;
- Continuing to establish alternative payment mechanisms that focus on managing activity levels and reducing cost;
- Developing and integrating out of hospital care with a focus on keeping demand for hospital services under control.

We are continuing to build on this way of working as we develop and finalise our 2020/21 Operational Plan.

We have been successful in securing capital funding through the Wave 3 and Wave 4 capital bidding exercises. Our bids for capital funding have been set in the context of the strong Estates Strategy that we have developed as a Partnership. Under Wave 3, funding of £8.2 million was secured to support the development of a new Tier 4 Children and Adolescent Mental Health inpatient facility in Hull. This scheme has now been completed and the facility is operational. Under Wave 4, funding of £88.5 million

was secured to support the development of urgent and emergency care and diagnostic facilities at four of our hospital sites. Strategic Outline Cases for the schemes supported by this funding have been submitted and should be formally approved before the end of March 2020. This programme of development is critical to the successful implementation of our plans to transform urgent and emergency care services and improve our performance against national cancer targets.

3.6. How is the Partnership redesigning and integrating care and introducing a system approach to population health?

The complexity of our health and care system can make it difficult for patients to navigate between different organisations and services. It frequently places responsibility on individual patients, their families and carers to coordinate between the different organisations and aspects of their care, often when they are least equipped to do so. We are working together, particularly at Place, to fundamentally reshape services so that they are properly joined up. This includes:

- Developing **primary care** – so that every neighbourhood has access to a single team of health and care professionals who can meet a wide range of their needs both locally and in a joined-up way; such as the South Hambleton and Ryedale Primary Care Elderly Care Services.
- Joining up **services outside of hospital** – so that care is designed around the needs of the person not the needs of the different organisations providing it. Integrated models have been developed to support the needs of key groups (e.g. frailty). Successful examples include the Jean Bishop Centre in Hull, Mental Health Services in North East Lincolnshire and Urgent Care Practitioners in York.
- Securing a long-term, **sustainable future for our hospital services** – so that our hospitals are working together more closely and more effectively to provide high quality care for our populations when they need to be in hospital. Plans for the future provision of hospital-based services are being developed through our Acute Service Reviews across the Humber and in Scarborough.

Across the Partnership, making better use of available data and local intelligence is key to improving health and wellbeing outcomes for our population and supporting integration of services. The Partnership has commenced the national Population Health Management (PHM) Development Programme supported by NHS England and Optum. Working with seven of our Primary Care Networks (PCNs) and covering each of our Places, we will apply advanced analytics and intelligence to design interventions that will improve the health of local populations, in particular, specific groups or cohorts of populations. This is an intensive 20 week programme following which each PCN/Place will produce a case study to demonstrate the impact of the programme.

As part of the programme we will agree how we will ensure that PHM becomes business as usual across the Partnership, in support of our ambition to improve and sustain the health and wellbeing of the Humber, Coast and Vale population.

3.7. How will the Partnership maintain and improve its track record of delivery?

In our Partnership Long Term Plan we have clearly set out our ambitions to integrate care and transform the lives of people in Humber, Coast and Vale. The Partnership has achieved much over the past three years through effective collaboration both at local level and at scale. Many of the service developments and transformations that have taken place across our region are set out as case studies

in the Partnership Long Term Plan (attached as Appendix D). The progress that we have has helped to strengthen relationships between partner organisations and strengthen our collective commitment to working collaboratively. We are confident that, by adopting this approach, we will continue to deliver improvements in service quality and performance across a range of service areas.

The collaborative work of the Partnership has achieved national recognition, with a number of projects being shortlisted for Health Service Journal (HSJ) Awards this year. These successes include:

- The Jean Bishop Integrated Care Centre gained recognition for partner organisations in Hull, winning the Community / Primary Care Service Redesign Award
- Vale of York CCG was highly commended for its React to Red campaign to reduce pressure sores among care home residents
- Our Mental Health Partnership was shortlisted for the Partnership Working award.

In November, the Partnership was privileged to have a visit from Professor Don Berwick, where we took the opportunity to share three video case studies which showcased the collaborative approaches to providing more holistic healthcare across our Partnership. These included the Jean Bishop Integrated Care Centre in Hull, NAViGO's Safe Space Café in Grimsby and the South Hambleton and Ryedale Primary Care Network's work with their frail population in North Yorkshire. Professor Berwick praised the work that we were undertaking to deliver integrated care, and offered his thoughts on the work the Partnership needed to continue to embed collaborative approaches and support us to achieve our aspiration of ICS status.

In addition, we have made good progress through our collaborative efforts in a number of other areas, including:

- Delivery of extended access and online consultations in primary care
- Collectively managing elective and non-elective demand for acute hospital services
- A significant reduction to almost zero in 2019/20 of 52 week waiters for planned care services from one of the most challenging positions nationally
- Managing Acute hospital lengths of stay, delayed transfers of care and stranded patients
- Maintaining cancer 2 week wait and 31 days to treatment at required levels
- Expanding screening services, including bowel screening and lung health checks with the latter successfully launched at the end of January 2020 in Hull
- Improving maternity services and compliance with Better Births, particularly in relation to continuity of carer
- Increasing personalised care including against personal health budgets where a number of our CCGs act as mentors to others nationally,

Our Partnership Long Term Plan also sets out our ambitions to achieve year on year improvement in performance against a wide range of metrics, including constitutional standards as we recognise that our performance against a number of key standards is still below the required levels.

In order to make best use of our skills and resources, we are adopting a collaborative approach to service improvement, transformation and performance management. Our collaborative Programmes are now the main vehicle through which we will drive service transformation and associated improvements in performance in key areas, including cancer, mental health, learning disabilities and

autism. In accordance with our agreed principle of mutual accountability, we will maintain a Partnership-wide focus on service and financial performance to ensure that planned improvements continue to be delivered.

4. Conclusion

In this document we have described the progress that we have made and the acceleration of our thinking in respect of partnership working. We have demonstrated the commitment and ability of our Partnership to work collaboratively and identified some of the ways in which this is making a tangible difference to peoples' lives. We are proud of the achievements we have made during the last three years and we are now well placed to develop further as a Partnership and achieve the ambitious objectives and outcomes that we have set out in our Partnership Long Term Plan.

Having completed the ICS Accelerator Programme, we have re-assessed the maturity of the Partnership against the five key domains of the ICS Maturity Matrix. The results of this re-assessment are very positive and are shown in the schedule attached as appendix D. Through the Accelerator Programme and the subsequent re-assessment we have identified where further work is required for us to continue to develop as a Partnership. The actions associated with this are set out in our Continual Development Plan and will be incorporated in our 2020/21 Operational Plan once finalised.

Appendices

Appendix A – Humber, Coast and Vale Health and Care Partnership - Partner Organisations

Local Authorities

- City of York Council
- East Riding of Yorkshire Council
- Hull City Council
- North Lincolnshire Council
- North East Lincolnshire Council
- North Yorkshire County Council

NHS Commissioners

- NHS East Riding of Yorkshire CCG
- NHS Hull CCG
- NHS North East Lincolnshire CCG
- NHS North Lincolnshire CCG
- NHS Scarborough and Ryedale CCG*
- NHS Vale of York CCG

(*as of 1 April 2020 will be merged with Harrogate and Hambleton, Richmond and Whitby CCGs to be NHS North Yorkshire CCG which will become part of Humber, Coast and Vale)

Health and Care Providers

- Care Plus Group
- City Healthcare Partnership CIC
- East Midlands Ambulance Service NHS Trust*
- Focus CIC (Independent Adult Social Work)
- Hull University Teaching Hospitals NHS Trust
- Humber Teaching NHS Foundation Trust
- NAViGO
- Northern Lincolnshire and Goole NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust*
- Tees, Esk and Wear Valleys NHS Foundation Trust*
- York Teaching Hospitals NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust*

(*These organisations are also members of neighbouring ICSs)

Health Regulator and Arms-Length Bodies

- NHS England and Improvement
- Health Education England
- Public Health England

Other Partners

- Healthwatch
- Yorkshire and Humber Academic Health Science Network
- Voluntary and Community Sector Organisations

Appendix B Humber, Coast and Vale Health and Care Partnership – Collaborative Approach to delivery

Neighbourhood
plans care around the individual

Local services are delivered and partners collaborate with primary care. The neighbourhood should be enabled to be a decision making member of the ICS, particularly at place

Place aggregates neighbourhoods to a scale for agreeing wider service changes

Building on existing arrangements, in particular local authority, the focus of place should be on agreeing delivery of services and transformation

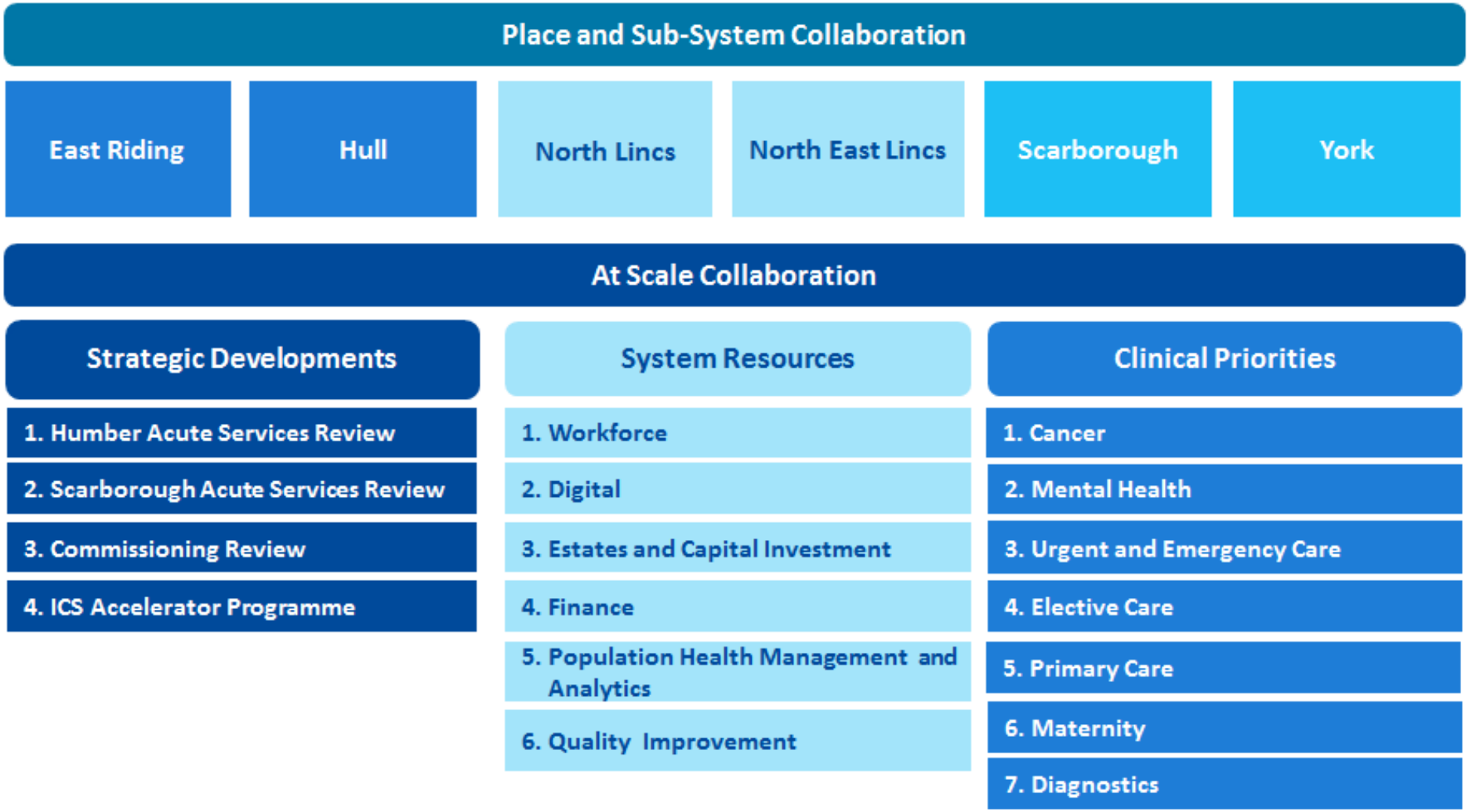
Sub-system
aggregates more than one Place to a scale for strategic changes

The sub-system acts as a convener, ensuring that delivery at place and neighbourhood is strategically and operationally aligned to meet the needs of the population.

System

The role of the system is to create the conditions that will improve and sustain health and wellbeing through collaboration

Appendix B continued



Appendix C – Humber, Coast and Vale Health and Care Partnership - Operating Framework

Partnership Executive Board (Monthly)

Attendees
Independent Chair, Executive Lead, Finance Lead and Clinical Lead
Representation from Sub-System Leaders (to be determined)

Focus
Partnership Strategy, priorities, plans and resources

Partnership Oversight and Assurance Group (Monthly)

Attendees
Independent Chair, Executive Lead, Finance Lead, Clinical Lead, Quality Lead, Locality Director and 3 representatives from each sub system (Commissioners from either CCG or Local Authority and two providers from either acute, community, mental health, primary care)

Focus
Service quality and performance and delivery of work programme objectives

Partnership Assembly (Quarterly)

Attendees
Representatives of from each place to include:

- Chairs/NEDS
- Wider Local Authority officers & members
- Wider public sector
- Third sector
- Voluntary sector
- Clinical leaders
- Academic Health Science Network
- Universities
- Healthwatch

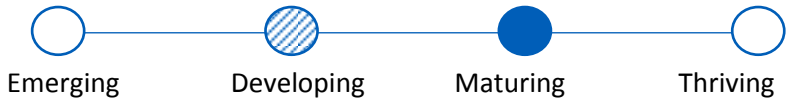
Focus

- Regular engagement with above members
- Shaping and influencing strategy
- Engaging with wider stakeholders to test strategy and big picture issues
- Information sharing and showcasing effective practice from across HCV

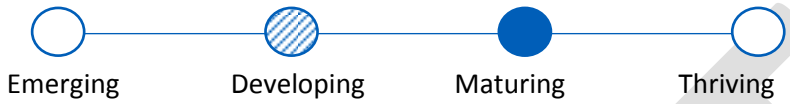
Appendix D – Humber, Coast and Vale Health and Care Partnership – Self Assessment Maturity Matrix

Below is the Partnership's re-assessment against the Maturity Matrix following the completion of the ICS Accelerator Programme.

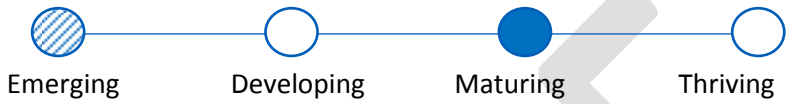
Domain one: System Leadership, Partnerships and Change Capability



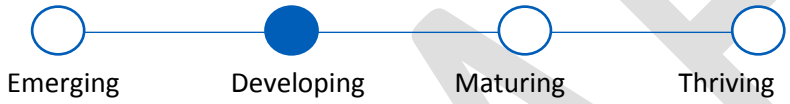
Domain two: System Architecture and Strong Financial Management and Planning



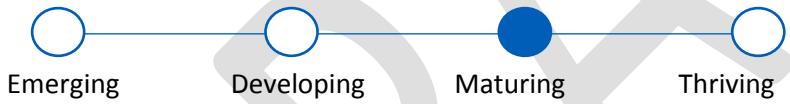
Domain three: Integrated Care Models



Domain four: Track Record of Delivery



Domain five: Coherent and Defined Population



Key Initial assessment Revised assessment

Item Number: 7

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 2 April 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Interim Measures – Governance and Committees

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

Reason for Report

The current measures needed in response to the global Covid-19 pandemic will have an impact on the CCG's governance processes, and in particular the conduct of meetings. The objective of the attached report is to free capacity for Governing Body members and CCG staff to support frontline healthcare colleagues.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☐Financial
☒Legal
☐Primary Care
☐Equalities

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:

N/A

Recommendations

Reduced agendas and shorter meetings

Remote meetings via online methods or conference call (with meetings in public on hold, for reasons of social distancing)

Reduced minuting, limited to action points and decisions

Suspension of current corporate policies on risk reporting, FOI and SAR requests, and the annual declarations of interest renewal – new declarations for new interests still required.

Chair has discretion to stand down meetings where necessary.

Decision Requested (for Decision Log)

Governing Body are requested to approve the recommendations of the report.

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

Annexes (please list)
Annex A Proposed Interim Measures April 2020

Interim Measures – Governance and Committee Meetings

Following the declaration of pandemic flu, Coronavirus Covid-19, as a major incident in line with national emergency planning provisions (under the Civil Contingencies Act 2004), and in order to maintain safety for staff and maximise available capacity, the following measures are proposed on an interim basis, initially for 3 months but on a renewable basis thereafter:

1. **Committee Meetings**
   Where meetings can be stood down safely, or reduced in number, the Chair of each committee has the discretion to do so, with information to be passed to the Head of Legal and Governance. The forward plan will be amended accordingly.
   At present, the Executive Committee are convening as a daily phone call and therefore formal committee sessions are not being held.

2. **Format of meetings**
   It is suggested that the agenda for each meeting be reduced to cover essential emergency planning updates and actions currently being taken, or to be taken, to address the issues raised. Other business is at the Chair's discretion. For example the Chair of QPEC has agreed the following:
   - Bi-monthly 'Deep Dives' scheduled will be paused until such a time as it is deemed appropriate to recommence.
   - The agenda will focus upon safeguarding and emerging quality and risks issues
   - Papers / reports can be brief in the format of a highlighted report, or the updated risks.

   Routine updates on normal CCG business can be circulated via email outside the meeting. Papers for each individual meeting should continue to be circulated in advance, in order that meeting attendees are fully briefed and to maintain focused discussions, and with any decisions requested to be clearly stated.
   Meetings in person should be reduced or suspended with telephone conference call (or such other remote access as may be available) being the preferred option in order to maintain social distancing and reduce unnecessary travel.
   The length of meetings should be reduced, with a suggested maximum of 90 minutes for Governing Body meetings, to free capacity.
   Meetings in public will be suspended, as will the publication of papers a week in advance for Governing Body, given the rapidly-changing nature of the current situation. Public updates can be given via the CCG website. See note below on the basis for this.

3. **Minuting of meetings**
   In order to free capacity for emergency planning support, detailed minutes will be reduced to action points and decisions only. These can then be circulated to meeting attendees with minimal delay. There are known difficulties with the conference call format, for example to know when attendees have left the meeting, so attendees at the start of the meeting will be recorded as well as subsequent joiners where they have introduced themselves.

4. **Governance-related issues**
   There are a number of standing items on committee agendas, in particular **risk**. Since the organisation's biggest risk at this point is the effect of Covid-19 on the organisation's work, it is suggested that risk monitoring focus on this, with any routine issues reported by exception only and circulated via email rather than forming part of a committee discussion. **Declarations of interest** should continue to be made at the start of meetings where these are not already captured on the standard form. However, the annual renewal of declarations will not take place in April as is normally the case, and it will be accepted that the 2019-20 declarations remain current into 2020-21 unless individuals declare otherwise. Individuals still have a responsibility to declare all interests, but the routine renewal of forms will be suspended until later in the year.

5. **Freedom Of Information Requests/ Subject Access Requests**
   The CCG will continue to process these, but given the other calls on staff time, the normal timescales may not be met, and requestors will be notified accordingly in the acknowledgement of receipt. It is suggested that the CCG's FOI policy be amended to include provision for emergency suspension or delay. Advice from the Information Commissioner's Office indicates that the ICO understands the issues that the NHS is currently facing.
   The latest advice from NHS Digital on information governance is here: https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance

6. **Remote working**
   Work is continuing with the CCG's new IT provider (NECS) to roll out Microsoft Teams in order to facilitate remote working, and it may be possible that further ways of enabling remote meetings are developed. These may require further changes to the way committee meetings are conducted which will be communicated as and when necessary.
   All Governing Body members (including lay members) and CCG employees are expected to work remotely (from home) to reduce rates of infection. This will continue until national government advice removes the current restrictions.

Note

The CCG's Constitution, at Annex C (page 63 of the current version 5), states that any portion of the standing orders may be suspended provided such suspension is recorded and the minutes made available to the Audit Committee for review. See also paragraph 7 of the Detailed Scheme of Delegation, which delegates decisions on suspension of standing orders to the Governing Body.

The Public Bodies (Admission to Meetings) Act 1960 includes provision for the discussion of confidential business in private sessions. Under the terms of this Act, a Board may:
" *. . . by resolution, exclude the public from a meeting (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 . . ."*

Given that the current nature of board and committee discussions will be focused on emergency planning arrangements, there is an argument that to hold such discussions in public would be prejudicial the public interest.

The majority of public bodies have now suspended meetings in public for reasons of public safety.

Item Number: 8

Name of Presenter: Simon Bell

Meeting of the Governing Body

Date of meeting: 2 April 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Financial Performance Report Month 11

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 February 2020.

To provide details and assurance around the actions being taken.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☐Primary Care
☐Equalities

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
☐ Data Protection Impact Assessment
☐ Equality Impact Assessment
☐ 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 notes the report.

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Natalie Fletcher, 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 February 2020

Month 11 2019/20

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

IMPROVEMENTS IN PERFORMANCE

Issue	Improvement	Action Required
Tees, Esk and Wear Valleys NHS FT	The forecast position now reflects an agreed reduction in contract value which has no implications for service delivery.	
Continuing Care	The final decision regarding arbitration on a high cost package has now been reached and is reflected in the forecast position, resulting in a £500k reduction in utilisation of the CHC high cost packages risk reserve.	

Financial Performance Headlines

DETERIORATION IN PERFORMANCE

Issue	Deterioration	Action Required
Prescribing	Prescribing QIPP delivery has been reviewed and revised in M11 to bring Q4 savings in line with those evidenced from Sep-Dec. Forecast delivery is now £254k compared to £1.0m in M10. Revising this forecast and maintaining the CCG's overall forecast position in line with plan represents a reduced risk to the final year-end position.	

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. In year mitigations – The CCG has now implemented the in year mitigations identified to offset known risks to the delivery of the financial plan. All areas of spend that were identified as being a risk to the delivery of the financial plan have been assessed, mitigated where possible, and included within the forecast outturn position.

2. Financial Planning for 2020/21 – The CCG submitted its draft financial plan on 5th March, following approval by Governing Body. The financial plan complies with the CCG's Financial Recovery Trajectory of a £16.3m in-year deficit. Risks and mitigations within the financial plan have been assessed resulting in a £7.6m net risk.
The equivalent gap across the York and North Yorkshire system has been assessed as £45.2m. The CCG is working with the STP and system partners to agree an approach to managing system financial risk in 2020/21.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date Target £m	Year to Date Actual £m	Year to Date Variance £m	Year to Date RAG rating	2019-20 Forecast Outturn Target £m	2019-20 Forecast Outturn Actual £m	2019-20 Forecast Outturn Variance £m	2019-20 Forecast Outturn 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)					493.6	512.4	(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%	97.17%	2.17%	G	95.00%	>95.00%	0.00%	G
CCG cash draw down does not exceed maximum cash draw down					511.7	512.2	(0.5)	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	6.7	6.6	0.1	G	7.3	7.3	0.0	G
Programme spend within plan	463.0	462.8	0.3	G	505.1	505.1	(0.0)	G
Actual position is within plan (In-year)	(17.3)	(17.0)	0.3	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)	467	107	360	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 £1.5m, FOT £1.8m) and System Recovery Schemes (YTD £2.5m, 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: March 2020

Financial Period: April 2019 to February 2020 (Month 11)

1. Month 11 Supporting Narrative

The actual deficit at Month 11 was £17.0m which represents a slight improvement on the plan of £17.3m. Within this figure there are several variances which are explained in further detail in the table below.

QIPP delivery at Month 11 is £9.4m against a year to date plan of £13.2m, representing a £3.8m shortfall against plan. The difference relates primarily to slippage on prescribing schemes and system recovery plans. Year to date and forecast delivery of QIPP schemes is shown in more detail in section 7.

Reported year to date financial position – variance analysis

Description	Value	Commentary / Actions
Reserves	(£3.21m)	This relates to the System Recovery Schemes. Year to date delivery of these schemes is now reflected on the relevant expenditure line.
Contingency	£2.05m	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	(£1.86m)	This variance includes slippage on QIPP schemes, Category M price increases from August (£582k) and additional costs from No Cheaper Stock Obtainable (NCSO) items (£438k).
Continuing Care	£1.37m	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 £1.4m underspend.
Other Acute Contracts	£1.12m	Several of the CCG's smaller acute contracts have had lower activity than plan including Nuffield (£464k), Harrogate (£288k) and Mid Yorkshire (£232k).
Other Mental Health	£0.83m	This variance is due to the Transforming Care Partnership risk share arrangement with the North Yorkshire CCGs which will be transacted in March, and is therefore not yet reflected in our year to date position.
Ramsay	(£0.56m)	Activity at Ramsay continues to be higher than plan.

York Teaching Hospital NHS Foundation Trust	£0.49m	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 variances	£0.08m	
Total impact on YTD	**£0.31m**	

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 £10.3m, which is a shortfall of £4.4m against the CCG's plan of £14.7m. This variance relates to System Recovery Schemes (£2.8m) and Prescribing (£1.8m).

Forecast in-year financial position – variance analysis

Description	Value	Commentary / Actions
Reserves	(£4.11m)	This variance mainly relates to the £3.7m planned System Recovery Schemes – forecast delivery of these schemes is now reflected on the relevant expenditure line. In addition, the reserves forecast includes a non-recurrent provision of £292k to offset any additional year-end pressures.
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	(£2.59m)	The Prescribing forecast now includes £1.8m slippage on QIPP schemes. It also includes £665k relating to the nationally notified Category M price adjustment and £478k of increased cost due to NCSO, which it is assumed will be managed by CCGs and therefore has been included in the forecast position.
Tees, Esk and Wear Valleys NHS FT	£2.02m	The variance to contract includes an agreed reduction in contract value which has no implications for service delivery.
Continuing Care	£1.23m	A £1.5m contingency has been provided in plan for high cost packages with £195k of this required in-year.
Other Acute Contracts	£1.07m	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 £506k with Nuffield, £256k with Mid Yorkshire and £320k with Harrogate.
York Teaching Hospital NHS Foundation Trust	£0.62m	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.

Other variances	(£0.68m)	
Total impact on forecast	**£0.00m**	

3. Gap and Key Delivery Challenges

In the Month 11 non-ISFE submission, the CCG did not report any additional risks to delivery of the forecast outturn.

4. Allocations

The allocation as at Month 11 is as follows:

Description	Recurrent / Non-recurrent	Category	Value
Total allocation at Month 10			£430.25m
Transforming Care Partnerships Resource Transfer	Non-recurrent	Core	£0.29m
Winter Pressures Funding	Non-recurrent	Core	£0.16m
Pharmacy Medicines Optimisation in Care Homes Q4 funding	Non-recurrent	Core	£0.20m
Digital First Primary Care Funding	Non-recurrent	Core	£0.10m
Clinical Waste cost pressure – pass through funding to YTHFT	Non-recurrent	Core	£0.06m
Leadership Training for General Practice Nurses	Non-recurrent	Core	£0.01m
GP Forward View – STP funding	Non-recurrent	Core	£0.02m
Total allocation at Month 11			**£431.09m**

5. Underlying position

The underlying position reported at Month 11 is a deficit of £24.50m; 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	(£1.75m)
Recurrent overspends in forecast outturn	(£1.54m)
FYE of QIPP and investments	£0.40m
Reported underlying position	**(£24.50m)**

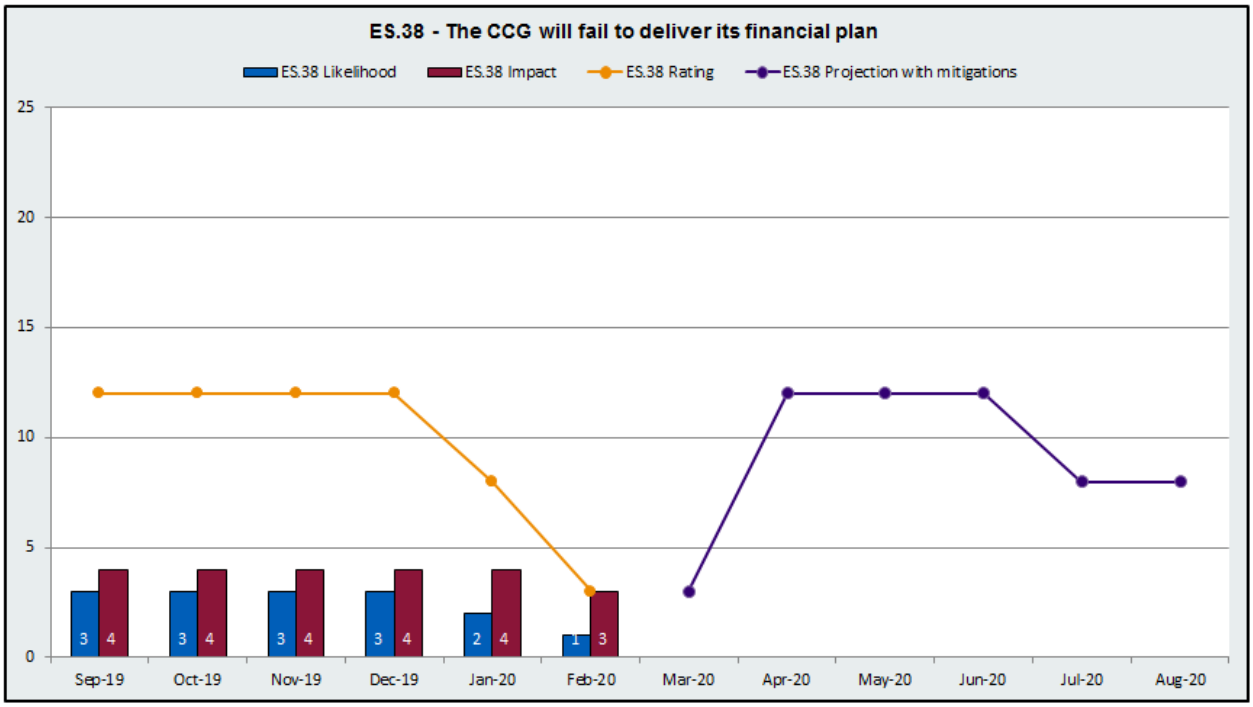
6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 29 February 2020.

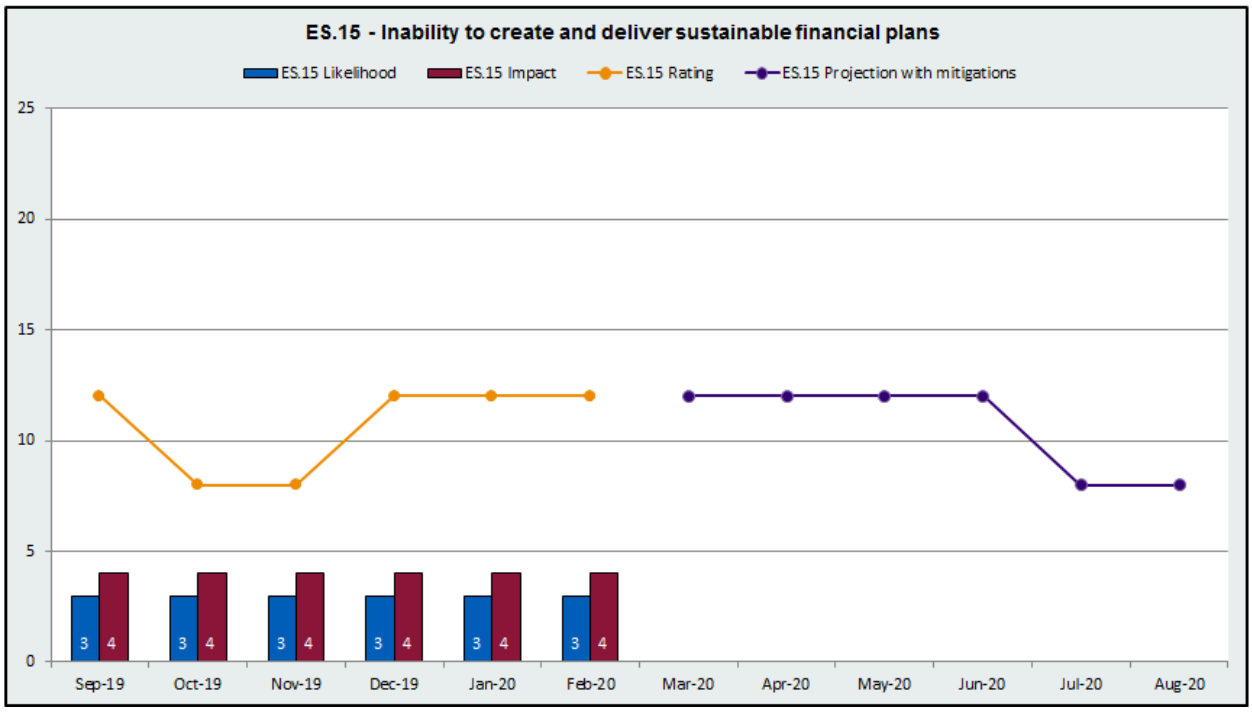
The CCG achieved the Better Payment Practice Code in terms of both the volume and value of invoices being paid above the 95% target year to date.

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



Due to the recent national development there has been no formal update to the risk register. The graphs above have therefore not been updated, but the actual ratings for March would have been in line with the projected scores.

The CCG's Month 11 position remains a forecast in line with the approved plan with an anticipated deficit of £18.8m. All of the financial recovery actions to off-set the system savings slippage have been implemented and delivering. This has further confirmed the holding of the risk rating as anticipated last month.

The planning process for 2020/21 has currently been paused due to the national focus on Covid19 work. However, prior to this it is clear that there is an increased financial challenge across the North Yorkshire and York system and indeed across the STP. Although the CCG submitted a control total compliant plan, this was with a significantly increased requirement for savings of which £7.6m was unidentified. This was in line with the approach taken by all organisations in the STP and will be subject to ongoing conversations in due course. Prior to the pause on operational planning it was clear that the CCG and North Yorkshire sub-system was not able to achieve a balanced financial position in 20/21 given the £45.2million assessed risk.

8. QIPP programme

		Year to Date			Forecast Outturn				
Area	Scheme	Plan	Actual	Variance	Plan	Delivered	Forecast	FOT Variance	Comments
Acute Commissioning	Anti-Coagulation Monitoring - move to Primary Care	28	28	0	30	30	30	0	Full year effect, delivered in 2019-20
	Biosimilar drugs (FYE)	2,353	2,353	0	2,384	2,384	2,384	0	Delivered in full through acute contract
	Cost reductions in contract	2,605	2,605	0	2,970	2,970	2,970	0	Delivered in full through acute contract
Complex Care	CHC Packages (FYE)	1,397	1,443	46	1,401	1,443	1,443	42	Delivered in full
	MH Out of Contract Packages (FYE)	236	223	(13)	237	224	224	(13)	Delivered in full
	Review of CHC Packages	1,165	970	(195)	1,377	970	1,186	(191)	Forecast is based on a detailed package by package savings report and will continue to be monitored throughout the year.
	Fast track post (investment)	(44)	(40)	4	(48)	(40)	(48)	0	
	MH Out of Contract Packages	0	167	167	0	167	189	189	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	1,699	218	(1,482)	2,008	218	254	(1,754)	The forecast delivery of Prescribing Indiciative Budgets has been reviewed and revised in M11 to bring Q4 savings in line with those evidenced from Sep-Dec.
Primary Care	Primary Care investment slippage	550	672	122	600	678	700	100	Slippage of £700k across Primary Care has now been identified.
System Recovery Schemes	Independent Sector	889	0	(889)	1,000	0	0	(1,000)	The in-year delivery of System Recovery schemes has been reviewed and agreed by system partners. The overall delivery across the system is £2.8m against a plan value of £11.2m. This results in a £8.3m shortfall, of which £2.8m impacts the CCGs financial position.
	Cardiology prescribing - DOAC switch	622	0	(622)	700	0	0	(700)	
	Decommissioning non obstetric ultrasounds (YHS)	308	0	(308)	370	0	0	(370)	
	PTS - decommission saloon cars / tighten criteria	208	70	(139)	250	70	76	(174)	
	Management costs	160	0	(160)	180	0	0	(180)	
	Other acute cost reductions (YTHFT)	1,017	645	(372)	1,220	645	866	(354)	
		13,193	**9,352**	**(3,840)**	**14,679**	**9,758**	**10,274**	**(4,404)**	
			71%			**66%**	**70%**		

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	200,268	199,783	486	182,113	181,603	510	18,155	18,180	(25)	218,252	217,637	616	218,092	217,464	629	160	173	(13)
Yorkshire Ambulance Service NHS Trust	13,078	13,078	(0)	11,889	11,889	(0)	1,189	1,189	(0)	14,267	14,267	(0)	14,267	14,267	(0)	0	0	0
Leeds Teaching Hospitals NHS Trust	7,767	7,796	(29)	7,095	7,046	49	672	750	(78)	8,497	8,529	(32)	8,497	8,438	58	0	91	(91)
Hull and East Yorkshire Hospitals NHS Trust	3,035	3,202	(167)	2,776	2,925	(149)	259	277	(18)	3,320	3,579	(259)	3,320	3,499	(179)	0	80	(80)
Harrogate and District NHS FT	2,330	2,042	288	2,125	1,896	228	206	146	60	2,552	2,232	320	2,552	2,276	276	0	(44)	44
Mid Yorkshire Hospitals NHS Trust	1,939	1,708	232	1,772	1,470	302	167	237	(70)	2,119	1,863	256	2,119	1,772	347	0	91	(91)
South Tees NHS FT	1,303	1,303	(0)	1,185	1,185	(0)	118	118	(0)	1,422	1,422	0	1,422	1,422	0	0	0	0
North Lincolnshire & Goole Hospitals NHS Trust	338	354	(16)	309	333	(24)	29	21	8	369	387	(17)	369	397	(28)	0	(10)	10
Sheffield Teaching Hospitals NHS FT	268	268	1	244	244	0	24	24	0	293	292	1	293	292	0	0	(0)	0
Non-Contracted Activity	4,948	5,045	(97)	4,498	4,681	(182)	450	365	85	5,398	5,541	(143)	5,398	5,625	(227)	0	(84)	84
Other Acute Commissioning	1,317	1,135	182	1,140	962	178	177	173	4	1,438	1,287	150	1,382	1,229	152	56	58	(2)
Ramsay	4,402	4,962	(560)	4,023	4,708	(685)	380	254	126	4,820	5,220	(400)	4,820	5,220	(401)	0	(1)	1
Nuffield Health	3,266	2,802	464	2,984	2,591	393	282	211	71	3,574	3,068	506	3,574	3,105	469	0	(37)	37
Other Private Providers	1,297	1,032	266	1,179	938	241	118	93	25	1,415	1,126	290	1,415	1,126	289	0	(0)	0
Sub Total	**245,558**	**244,508**	**1,049**	**223,333**	**222,470**	**862**	**22,225**	**22,038**	**187**	**267,735**	**266,449**	**1,286**	**267,519**	**266,133**	**1,386**	**216**	**316**	**(100)**
Mental Health Services																		
Tees, Esk and Wear Valleys NHS FT	40,399	40,377	22	36,726	36,702	24	3,673	3,675	(2)	44,113	42,090	2,024	44,113	44,090	24	0	(2,000)	2,000
Out of Contract Placements	6,740	7,102	(362)	6,127	6,531	(404)	613	570	42	7,353	7,768	(416)	7,353	7,823	(470)	0	(55)	55
SRBI	1,114	1,395	(281)	1,013	1,263	(250)	101	132	(31)	1,215	1,544	(328)	1,215	1,547	(331)	0	(3)	3
Non-Contracted Activity - MH	420	160	260	382	138	244	38	22	17	458	182	276	458	182	276	0	(0)	0
Other Mental Health	1,280	450	830	924	411	513	356	40	317	1,397	1,428	(31)	1,109	1,157	(49)	288	270	18
Sub Total	**49,953**	**49,483**	**469**	**45,172**	**45,045**	**127**	**4,781**	**4,438**	**343**	**54,536**	**53,011**	**1,525**	**54,248**	**54,799**	**(551)**	**288**	**(1,787)**	**2,075**
Community Services																		
York Teaching Hospital NHS FT - Community	17,531	17,531	0	15,937	15,937	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	2,142	2,142	(0)	1,947	1,947	(0)	195	195	(0)	2,336	2,336	(0)	2,336	2,336	(0)	0	0	(0)
Harrogate and District NHS FT - Community	2,663	2,637	25	2,421	2,403	18	242	234	8	2,905	2,868	37	2,905	2,868	37	0	(0)	0
Humber NHS FT - Community	1,976	1,977	(1)	1,797	1,797	(1)	180	180	(0)	2,156	2,157	(1)	2,156	2,157	(1)	0	0	0
Hospices	1,372	1,333	39	1,247	1,212	35	125	121	3	1,497	1,455	42	1,497	1,455	42	0	(0)	0
Longer Term Conditions	259	246	12	235	225	10	24	21	2	282	269	13	282	271	11	0	(2)	2
Other Community	2,380	2,606	(226)	2,166	2,358	(192)	213	248	(34)	2,592	2,847	(254)	2,592	2,840	(248)	0	7	(7)
Sub total	**28,322**	**28,472**	**(151)**	**25,750**	**25,880**	**(130)**	**2,572**	**2,593**	**(21)**	**30,893**	**31,056**	**(163)**	**30,893**	**31,052**	**(159)**	**0**	**4**	**(4)**

	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	24,741	23,376	1,365	22,580	21,371	1,209	2,161	2,005	156	26,885	25,654	1,231	26,885	25,956	928	0	(303)	303
CHC Clinical Team	1,154	1,032	122	1,046	946	99	109	86	22	1,303	1,267	36	1,303	1,267	36	0	0	(0)
Funded Nursing Care	3,715	3,491	223	3,377	3,183	194	338	308	29	4,052	3,784	268	4,052	3,761	291	0	22	(22)
Patient Transport - Yorkshire	2,048	1,916	132	1,862	1,749	112	186	167	19	2,234	2,090	144	2,234	2,099	135	0	(9)	9
Voluntary Sector / Section 256	513	494	19	467	452	14	47	42	5	560	539	21	560	543	17	0	(4)	4
Non-NHS Treatment	570	583	(13)	518	529	(10)	52	55	(3)	622	636	(14)	622	633	(11)	0	3	(3)
NHS 111	973	1,003	(30)	884	881	4	88	122	(34)	1,061	1,098	(36)	1,061	1,059	3	0	39	(39)
Better Care Fund	10,340	10,436	(96)	9,405	9,409	(5)	935	1,026	(91)	11,275	11,372	(96)	11,275	11,281	(6)	0	91	(91)
Other Services	674	1,091	(417)	615	1,068	(453)	59	24	35	733	1,152	(419)	733	1,195	(462)	0	(43)	43
Sub total	**44,729**	**43,424**	**1,305**	**40,754**	**39,588**	**1,165**	**3,975**	**3,835**	**140**	**48,726**	**47,592**	**1,135**	**48,726**	**47,795**	**931**	**0**	**(203)**	**203**
Primary Care																		
Primary Care Prescribing	43,559	45,422	(1,863)	40,022	41,652	(1,630)	3,538	3,770	(232)	47,365	49,954	(2,589)	47,365	49,233	(1,867)	0	722	(722)
Other Prescribing	1,863	1,873	(10)	1,748	1,762	(14)	115	111	4	2,180	2,247	(67)	1,978	2,124	(146)	202	123	79
Local Enhanced Services	2,069	1,892	177	1,896	1,774	123	173	118	54	2,242	2,058	184	2,242	2,109	133	0	(51)	51
Oxygen	340	346	(6)	309	315	(6)	31	31	(0)	371	378	(6)	371	378	(7)	0	(0)	0
Primary Care IT	841	712	128	764	662	102	76	50	26	917	788	129	917	806	111	0	(18)	18
Out of Hours	2,976	3,040	(63)	2,706	2,777	(71)	271	262	8	3,247	3,315	(68)	3,247	3,328	(81)	0	(13)	13
Other Primary Care	2,487	2,646	(159)	2,261	2,382	(121)	226	264	(38)	2,746	2,981	(235)	2,713	2,948	(235)	33	33	0
Sub Total	**54,136**	**55,931**	**(1,796)**	**49,706**	**51,324**	**(1,618)**	**4,429**	**4,607**	**(178)**	**59,068**	**61,720**	**(2,652)**	**58,833**	**60,925**	**(2,092)**	**235**	**795**	**(560)**
Primary Care Commissioning	**41,484**	**41,067**	**417**	**37,716**	**37,308**	**408**	**3,768**	**3,759**	**9**	**45,265**	**44,878**	**387**	**45,265**	**44,878**	**387**	**0**	**0**	**0**
Trading Position	**464,181**	**462,886**	**1,295**	**422,431**	**421,616**	**815**	**41,750**	**41,270**	**479**	**506,224**	**504,706**	**1,518**	**505,485**	**505,581**	**(97)**	**739**	**(876)**	**1,615**
Prior Year Balances	0	(117)	117	0	(156)	156	0	39	(39)	0	(117)	117	0	(156)	156	0	39	(39)
Reserves	(3,206)	0	(3,206)	(2,691)	0	(2,691)	(516)	0	(516)	(3,595)	519	(4,114)	(3,697)	(1,195)	(2,502)	102	1,714	(1,612)
Contingency	2,051	0	2,051	1,659	0	1,659	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	**(1,155)**	**(117)**	**(1,038)**	**(1,031)**	**(156)**	**(876)**	**(124)**	**39**	**(162)**	**(1,152)**	**402**	**(1,553)**	**(1,254)**	**(1,351)**	**97**	**102**	**1,752**	**(1,650)**
Programme Financial Position	**463,025**	**462,769**	**257**	**421,399**	**421,460**	**(60)**	**41,626**	**41,309**	**317**	**505,072**	**505,108**	**(36)**	**504,231**	**504,231**	**0**	**841**	**877**	**(36)**
In Year Surplus / (Deficit)	(17,279)	0	(17,279)	(15,708)	0	(15,708)	(1,571)	0	(1,571)	(18,849)	0	(18,849)	(18,849)	0	(18,849)	0	0	0
In Year Programme Financial Position	**445,747**	**462,769**	**(17,022)**	**405,692**	**421,460**	**(15,768)**	**40,055**	**41,309**	**(1,254)**	**486,223**	**505,108**	**(18,885)**	**485,382**	**504,231**	**(18,849)**	**841**	**877**	**(36)**
Running Costs	**6,686**	**6,634**	**51**	**6,142**	**6,076**	**66**	**544**	**558**	**(15)**	**7,334**	**7,299**	**36**	**7,334**	**7,334**	**(0)**	**0**	**(36)**	**36**
Total In Year Financial Position	**452,433**	**469,403**	**(16,970)**	**411,834**	**427,536**	**(15,702)**	**40,599**	**41,867**	**(1,268)**	**493,557**	**512,406**	**(18,849)**	**492,716**	**511,565**	**(18,849)**	**841**	**841**	**(0)**
Brought Forward (Deficit)	(57,265)	0	(57,265)	(52,059)	0	(52,059)	(5,206)	0	(5,206)	(62,471)	0	(62,471)	(62,471)	0	(62,471)	0	0	0
Cumulative Financial Position	**395,168**	**469,403**	**(74,236)**	**359,775**	**427,536**	**(67,761)**	**35,393**	**41,867**	**(6,474)**	**431,086**	**512,406**	**(81,320)**	**430,245**	**511,565**	**(81,320)**	**841**	**841**	**(0)**

Appendix 2 – Running costs dashboard

	YTD Position			YTD Previous Month			YTD Movement			Forecast Outturn (FOT)			FOT Previous Month			FOT Movement		
Directorate	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	220	139	80	165	113	52	55	26	29	247	162	86	247	188	59	0	(26)	26
Chief Executive / Board Office	1,065	927	138	872	769	103	194	158	36	1,162	1,007	155	1,162	1,009	153	0	(2)	2
Planned Care	875	836	40	732	703	29	143	132	11	947	906	41	947	910	37	0	(4)	4
Communication and Engagement	260	218	41	211	176	35	49	42	7	284	268	16	284	267	17	0	1	(1)
Contract Management	785	727	58	642	593	49	143	134	9	856	777	79	856	788	68	0	(11)	11
Corporate Governance	858	778	80	724	666	58	134	112	22	932	836	96	925	879	47	7	(42)	49
Finance	1,466	1,424	42	991	941	50	475	483	(8)	1,566	1,502	63	1,291	1,246	44	275	256	19
Medicines Management	116	107	8	95	90	5	21	17	4	126	108	18	126	115	11	0	(7)	7
Quality & Nursing	673	640	33	565	544	22	107	96	11	726	698	28	726	700	27	0	(2)	2
Risk (SI team)	29	28	1	24	23	1	5	5	0	31	31	1	31	31	1	0	0	(0)
RSS	294	308	(14)	240	249	(9)	53	59	(6)	320	342	(22)	320	333	(13)	0	9	(9)
Primary Care	573	502	71	494	405	89	80	97	(18)	711	662	49	711	652	59	0	10	(10)
Reserves	(527)	0	(527)	(431)	0	(431)	(96)	0	(96)	(575)	0	(575)	(575)	(64)	(511)	0	64	(64)
Overall Position	**6,686**	**6,634**	**51**	**5,324**	**5,272**	**51**	**1,362**	**1,362**	**0**	**7,334**	**7,299**	**36**	**7,052**	**7,052**	**(0)**	**282**	**246**	**36**