NHS
Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

5 November 2020 9.30am to 12.30pm

'Virtual' Meeting

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 4-17	Minutes of the meeting held on 3 September 2020	To Approve	All
4.	Verbal	Matters arising from the minutes		All
5.	Pages 5-23	Accountable Officer Update	To Receive	Phil Mettam Accountable Officer
6.	Pages 24-52	Quality and Patient Experience Report	For Decision	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
7.	Pages 53-59 To Follow	Risk Report Board Assurance Framework	To Receive	Helena Nowell Planning and Assurance Manager

ASSURANCE – 10.45am				
8.	Pages 60-73	Counter Fraud Guidance for Primary Care	To Receive	Steve Moss Head of Anti-Crime Services Audit Yorkshire
9.	Pages 74-99	Covid-19 and Staff Risk Assessment	To Receive	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
10.	Pages 100-112	Update on Work Relating to: Physical Health Checks for People with Severe Mental Illness and with Learning Disabilities	To Receive	Denise Nightingale Executive Director of Transformation, Complex Care and Mental Health
11.	Pages 113-115	Winter Resilience Planning 2020/21	To Receive	Caroline Alexander Assistant Director of Performance and Delivery
12.	Pages 116-121	Surge Escalation Planning	To Receive	Caroline Alexander Assistant Director of Performance and Delivery
FINANCE – 12 noon				
13.	Pages 122-133	Financial Performance Report 2020/21 Month 6	To Receive	Simon Bell Chief Finance Officer
CORONAVIRUS COVID-19 UPDATE – 12.10				
14.	Verbal	Update	To Note	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
RECEIVED ITEMS – 12.25pm **Committee minutes are published as separate documents**				
15.	Page 134	Chair's Report Executive Committee: 7 and 14 October 2020		
16.	Page 135	Chair's Report Quality and Patient Experience Committee: 8 October 2020		
17.	Pages 136-148	Medicines Commissioning Committee: June, July, September 2020		

NEXT MEETING				
18.	Verbal	9.30am on 7 January 2021	To Note	All
CLOSE – 12.30pm				

EXCLUSION OF PRESS AND PUBLIC

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

Vale of York
Clinical Commissioning Group

Item 3

Minutes of the Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 3 September 2020 by Microsoft Teams due to Coronavirus COVID-19

Present

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

In Attendance (Non Voting)

Sharron Hegarty (SH)	Head of Communications and Media Relations
Sarah Howey (SHo)	Senior Communications and Media Officer
Dr Andrew Moriarty (AM)	YOR Local Medical Committee Representative
Christine Pearson (CP) – item 9	Designated Nurse Safeguarding Adults
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS) – part	Director of Public Health, City of York Council

Apologies

Dr Chris Stanley (CS)	Central Locality GP Representative
Dr Nigel Wells (NW)	Clinical Chair

In welcoming everyone to the meeting PG noted that the CCG was proposing to 'live stream' the Annual General Meeting on 17 September and, subject to the successful application of technology, proposed to extend this facility to meetings in public of the Governing Body and Primary Care Commissioning Committee. PM advised that this was consistent with the approach adopted by Outbreak Management Boards and Local Authorities.

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. However RW declared an interest as a Member of Selby Town Primary Care Network during discussion of item 12 Financial Performance Report Month 4.

3. Minutes of the Meeting held on 2 July 2020

The minutes of the 2 July meeting were agreed.

The Governing Body:

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

4. Matters Arising from the Minutes

A number of matters arising were on the agenda, ongoing in the context of Coronavirus COVID-19 or had not reached their scheduled date. The Black, Asian and Minority Ethnic groups report to the Quality and Patient Experience Committee would be presented at the November Governing Body meeting.

Pertussis vaccination: MC referred to presentation of Theo and Debbie's story at the January meeting and the discussion about establishing a local system approach for pertussis vaccination in pregnancy. She commended the work undertaken by York Teaching Hospital NHS Foundation Trust to reconfigure the midwifery service noting particular progress on the Scarborough Hospital site. However, clarification was currently being sought following Trade Union advice that midwifery health care assistants should not give the pertussis vaccination. MC emphasised York Teaching Hospital Foundation Trust's commitment to progressing the local approach, noting the relevant documentation was being developed in the meantime.

The Governing Body

Noted the updates and ongoing work.

5. Accountable Officer Update

PM wished to record thanks to the CCG's staff on behalf of the Governing Body for their adaptability and discretionary effort in response to the Coronavirus COVID-19 pandemic. He explained that the approach of remote working continued to predominate but the position would be reassessed in the context of infection levels of both COVID-19 and 'flu in the coming weeks.

PM also wished to acknowledge the contribution of the CCG's Practices, acknowledge the pressures experienced and commend the provision of services in different ways to that prior to the pandemic.

PM described a number of areas of change relating to local government and the NHS both regionally and nationally. In respect of the former two devolution approaches were being developed: North Yorkshire County Council's proposals were across North Yorkshire and York with two unitary councils; the current District Councils were proposing devolution on the basis of an East / West split. PM noted the potential for a decision in early 2021 with implementation of the new model from April 2022.

PM explained that statutory organisations would prepare to respond as required to forthcoming change but noted NHS alignment would be influenced by national decisions on NHS financial flows and allocations. In this regard indications since month 7 had been that allocations would start to flow through Integrated Care Systems rather than CCGs with this model potentially being beyond 2021/22. In this event the CCG would need to consider governance arrangements and operating models working with partner CCGs and providers to deliver services, quality and outcomes differently. This had potential for the CCG to no longer control its allocation and for establishment of joint committees with other CCGs and Local Authorities.

The Governing Body:

Noted the potential for organisational change at pace and the associated consequences for statutory responsibilities.

ASSURANCE

6. Quality and Patient Experience Report including Risk

MC presented the report which provided an update on an exception basis on risks and mitigations associated with quality, safety and patient experience across the CCG's commissioned services. It summarised by exception, progress and updates on quality, safety and patient experience not related to existing risks and provided an update on actions to mitigate the risks aligned to Governing Body.

MC highlighted the forecast capacity for Phase 3 'recovery' of acute services compared to 2020/21 planned levels pre COVID-19 but noted that this did not account for a potential second wave of the pandemic, winter pressures, the reduced capacity due to social distancing requirements and that the current backlogs in some specialties were very large. She explained that York Teaching Hospital NHS Foundation Trust had systems and processes in place for clinical prioritisation but noted the expectation for primary care to be impacted by enquiries from patients about delays and also the context of deteriorating patients. MC assured members that the CCG, and NW in particular, was involved in this work.

MC referred to the review of childhood vaccinations during the pandemic

following discussion at the Quality and Patient Experience Committee. The outcome of the review had been assurance that vaccinations during the pandemic appeared to be in line with delivery in 2019.

MC reported on the continuing work to increase support to care homes. As per the Local Enhanced Service a clinical lead had been identified for each care home, patient registrations were moving across to their new Practices and each care home had a named Community Nurse. Additionally, Tees, Esk and Wear Valleys NHS Foundation Trust had identified leads for homes for people with learning disability. MC also highlighted the key trends and themes identified from initial use in seven care homes of an exploratory tool to understand contributory factors to a COVID-19 outbreak. Good practice and lessons learnt from this were being shared.

MC referred to the significant quality concerns in a Vale of York care home which she had reported verbally to the August Quality and Patient Experience Committee. She explained that the CCG had worked with partners to provide a collaborative response to the issues in an attempt to support the provider. However, this had been unsuccessful and the Care Quality Commission had now placed a Notice of Decision to Remove Location on the home from which all 47 residents had been moved. The provider had 28 days to appeal the decision after which time the Care Quality Commission would publish contemporaneous reports. MC noted that once the Care Quality Commission had issued the Notice of Decision the Local Authority became responsible for the care of the individuals.

MC commended Sarah Fiori, Head of Quality Improvement and Research, for her clinical expertise in supporting the work with both the care home and the Care Quality Commission and also advised that a multi disciplinary review would be undertaken. She confirmed the December 2020 timescale for this risk to be removed from the risk register noting that further discussion would take place at the private Governing Body meeting later in the day. JH expressed appreciation to MC and her team for the rapid response to the concerns emphasising the aspect of progressing lessons learnt.

MC referred to the adult mental health services information. In respect of perinatal mental health during the pandemic, a continuing area of concern in terms of impact from COVID-19, she highlighted the priorities of resuming face to face consultation and home visits as far as possible and resuming integration and training to ensure early recognition and appropriate referral. In respect of Garrow House in York, commissioned by NHS England and NHS Improvement, MC reported that the significant quality and safety concerns had been multi-factorial advising that the women had all been moved and the unit had been closed since publication of the meeting papers. She noted there had been no CCG residents there at the time.

MC highlighted the ‘flu planning both at a local and regional level noting that, with the exception of school children, vaccination of eligible groups was the responsibility of GPs. She also noted the need for innovative ways to deliver the programme. In respect of personal protective equipment MC explained that national guidance was for use of masks only, not routine use of gloves and

gowns, when administering the vaccination but adherence to good hand washing techniques was critical.

SS joined the meeting.

In response to concerns about availability of the vaccine for the 50 to 64 age group and the expectation that they would be required to travel to a drive through 'flu vaccination facility, SS advised that she was not aware of any supply issues. She noted that Directors of Public Health had sought and received assurance at a regional level in this regard and that if she was informed of any issues this would be where they were raised.

AM referred to the "light touch" personal protective equipment guidance for 'flu vaccination expressing concern about providing confidence and assurance to nursing teams. MC responded that this was for individual determination but emphasised the context of potential supply issues, noted that it did not replace handwashing and that vaccination was not akin to a blood taking procedure or a procedure where skin may not be intact such as a wound dressing.

MC advised that York Teaching Hospital NHS Foundation Trust had made significant progress in response to the Care Quality Commission involvement and potential for further regulatory action. She noted that the Care Quality Commission had been invited them to request removal of these notices but that they were undertaking final assurance, including in relation to estate and the model of paediatric services, prior to doing so.

MC reported that since publication of the papers the CCG had been notified of the requirement to identify a Patient Safety Specialist as part of the NHS Patient Safety Strategy. The Executive Team had identified Sarah Fiori as the most appropriate nomination and consideration was being given to her Head of Quality Improvement and Research role prior to putting her name forward.

MC provided an update on the Tees, Esk and Wear Valleys NHS Foundation Trust outstanding Serious Incident investigations. The Quality Group had received a report that this was due to capacity but progress was now being made with the timescales. MC explained that the Chief Nurse, the Director of Governance and the Serious Incident Lead were now involved in addressing the backlog and had additionally requested an independent review of their processes. The CCG had requested receipt of the outcome of this review. DN added that Tees, Esk and Wear Valley NHS Foundation Trust were looking to national models to prioritise incidents which had the most opportunity for learning from both the patient and system perspectives.

MC referred to the Patient Experience section of the report and noted that a question had been received from a member of the public about the GP Patient Survey 2020:

Overall the satisfaction of experience reported for the "GP practice associated with York University" was a rating of 50% good. This is a significant outlier in the chart showing a much better performance amongst all other York practices. It is

noted that the survey outcomes will be shared with the Primary Care Team. However, given previous failures in performances and previous failures in CCG actions to improve the situation, will the Governing Body please treat this specific problem with urgency and report back on findings and solutions.

MC explained that IPSOS MORI was commissioned nationally to undertake the GP Patient Survey. In the local context 7,053 questionnaires were sent out to Vale of York patients and 3,206 were returned completed, a response rate of 45%. MC noted that a regular criticism of this survey by Practices was the sample size, which this year represented approximately 3,200 returns from a registered population of 360,000, i.e. less than 1% of the total Vale of York registered population; 70 of Unity Health's registered patient list was represented in these returns.

MC advised that discussions had been taking place with Unity Health about the survey results. Prior to this the CCG had been working with the Practice since their assessment by the Care Quality Commission and resulting 'Special Measures' from which they had progressed to an assessment of 'Good' within six months. MC also noted: the Practice had invested in key posts to address staffing issues; the Care Quality Commission was of the view that they were making good progress; and the CCG would continue to meet with Unity Health to seek assurance. With specific reference to the survey results the CCG would be following up with all Practices any concerns raised.

AL added that, in response to poor results in the 2019 GP Patient Survey, Unity Health had undertaken their own survey. This had been completed by almost 900 patients and had received better results. The Practice had engaged actively with patients and had attended the York Health Overview and Scrutiny Committee which had resulted in an offer from a local councillor to support their engagement.

AL also referred to the fact that Unity Health's telephone system had previously been an issue. This had been updated and, although the work had been delayed due to COVID-19, like all the CCG Practices, Unity Health had successfully implemented a telephone triage first model.

AL reported that the CCG was in regular discussion with the Care Quality Commission about Unity Health and that there had been no issues that would trigger performance monitoring or management. He emphasised that the CCG was actively engaged with the Practice and this would continue behind closed doors as such work was not undertaken in public.

AL referred to negative publicity which resulted in the perception that General Practice was closed. Discussion ensued on the mismatch between this and the reality, including emphasis that face to face contact was taking place if appropriate and the impact on primary care from the backlogs in secondary care. SH advised that the CCG Communications Team was taking a proactive approach including working with the Primary Care Networks and local radio. PM added that the Primary Care Network Clinical Directors were contacting their local MPs in this regard and AL noted the need to manage patient expectations in the context of the ongoing restrictions and challenges.

MC referred to the two new risks in the report: Significant quality and safety concerns at a care home in Vale of York boundary and Potential changes to the North Yorkshire County Council commissioned Healthy Child Programme These would be discussed in detail at the private meeting later in the day.

In response to PG enquiring about the urgent care review MC noted the engagement activities in this regard. She also highlighted that demand for urgent care had reduced during the pandemic and that learning from this was being taken into account in the service reconfiguration. AL added that the urgent care review was at an advanced stage highlighting achievement of progress through clinical workshops. Further work, including patient engagement, was now taking place. AL advised that the Finance and Performance Committee and Governing Body would receive progress reports.

The Governing Body:

Received the Quality and Patient Experience Report confirming, in the context of the separate strategic and operational work streams which manage the response and risks associated with Coronavirus COVID-19, that it:

- provided assurance of the work being undertaken to understand and support the quality and safety of commissioned services;
- provided assurance of the actions to manage the risks aligned to Governing Body;
- cited members on the new risks identified which should be aligned to Governing Body, namely:

  - QN 17 - Significant quality and safety concerns at a care home in Vale of York boundary
  - QN 18 - Potential changes to the North Yorkshire County Council commissioned Healthy Child Programme

7. Audit Committee Annual Report 2019/20

PG highlighted the positive messages from both Internal and External Audit in the Audit Committee Annual Report. He commended the fact that all areas of work undertaken by Internal Audit had received either of its two highest levels of assurance.

PG expressed appreciation to SB and the Finance Team and to Abigail Combes, Head of Legal and Governance, for their work.

The Governing Body:

Ratified the Audit Committee Annual Report 2019/20.

SS left the meeting

8. External Auditors' Annual Audit Letter 2019/20

SB referred to the Annual Audit Letter which had not been available for inclusion with the Annual Accounts presented at the July Governing Body meeting. He noted the unqualified opinion of the audit of financial statements and explained that the qualified opinion for the Value for Money conclusion was due to the fact that the CCG did not have a plan to return to financial balance over the five year period although the position was as anticipated by NHS England and NHS Improvement recovery trajectories.

The Governing Body

Received the External Auditors' Annual Audit Letter 2019/20.

CP joined the meeting

9. Learning Disability Mortality Review Programme Annual Report 2019/20

CP gave a presentation highlighting aspects of the Annual Report circulated with the meeting papers. This included background and purpose of the programme; key achievements; information on age at and place of death; reported deaths per CCG area across North Yorkshire and York; causes of death; quality of care; local learning of best practice; reasonable adjustments; family and carer involvement; STOMP (Stop Over Medicating People); recommendations made by reviewers; key performance indicators from the NHS Operational Planning and Contracting Guidance 2019/20; challenges for 2020/21; and reference sources for further information.

Members sought and received clarification on aspects of the presentation including in relation to STOMP which DN explained was part of the North Yorkshire and York Transforming Care Programme. CP noted she would request information relating to review of people on antipsychotic drugs via this route.

The Governing Body

Received the Learning Disability Mortality Review Programme Annual Report 2019/20.

CP left the meeting

10. Proposal for a North Yorkshire and York Medicines Commissioning and Formulary Committee

AL presented the report which sought ratification, following approval in principle by the Executive Committee on 8 July 2020, to maintain the current three Area Prescribing Committees but to introduce a North Yorkshire and York Medicines Commissioning and Formulary Committee as a joint sub-committee of NHS North Yorkshire and NHS Vale of York CCGs. He highlighted the delegation decision levels noting the potential efficiencies through a standardised approach.

PM referred to the earlier discussion about organisational change and proposed

support in principle in the context of the requirement for further changes to the CCG's Constitution. MC additionally explained that this would be a decision for the Council of Representatives, not the Governing Body, but in any event the CCG's Constitution did not currently permit any delegation of powers. The arrangements could however be implemented in Shadow Form without any delegated powers.

The Governing Body

Supported in principle the proposal for a North Yorkshire and York Medicines Commissioning and Formulary Committee noting that at the present time implementation could only be in Shadow Form without any delegated powers.

11. Medicines Commissioning Committee Recommendations

AL noted that the recommendations presented had no projected impact on the CCG at the present time.

The Governing Body:

Received the Medicines Commissioning Committee Recommendations of March and May 2020.

FINANCE

12. Financial Performance Report 2020/21 Month 4

In presenting this report SB noted that it had been discussed in detail at the August meeting of the Finance and Performance Committee. He explained that, in line with the current COVID-19 financial arrangements, the CCG expected to break-even to month 4 and to continue to receive allocations to offset overspends and reasonable expenditure associated with the pandemic to month 6. The forecast financial position remained achievement of the £16.3m deficit plan based on the expectation of return to normal operational arrangements from October.

SB reported that national discussions were still taking place with HM Treasury therefore allocations from October were not yet known for the second planning phase. However, a number of changes to the interim financial arrangements had been notified, including: change to arrangements for continuing healthcare assessments from 1 September; hospices no longer receiving additional support from 1 August; changes to funding for GP Practices from 1 August; and significantly the return to fixed budgets from October.

SB additionally referred to PM's update at item 5 regarding system change noting that one CCG would receive the allocation on behalf of Humber, Coast and Vale partner organisations. He explained that work was taking place on the detail currently available but the move to a system approach for all CCG and NHS England and NHS Improvement monies, including for winter, was expected to be implemented at pace.

DB and PG referred to discussion at the Finance and Performance Committee where it had been noted that the focus on integrity and maintaining oversight would continue.

RW declared a conflict of interest as a member of Selby Town Primary Care Network prior to seeking clarification about the CCG's commitment to funding the Primary Care Network Additional Roles as per the GP Contract. SB confirmed this was the national position but noted the context of the Integrated Care System approach.

The Governing Body:

Received the 2020/21 month 4 Financial Performance Report.

COVID-19 UPDATE

12. Update

AL explained that, although levels of COVID-19 infection were currently comparatively low across the CCG area, there were sporadic outbreaks in both City of York Council and North Yorkshire County Council areas. He noted increasing concern around the re-opening of schools, universities and colleges but advised that outbreak management arrangements were in place.

AL also reported concern in the context of potential mass testing both in terms of implications for primary care to be able to support this and in respect of infrastructure and laboratory processing.

AL emphasised that recovery planning was taking place but highlighted potential impact from both 'flu and a COVID-19 surge. He noted that the Finance and Performance Committee would receive winter planning updates. Additionally work was taking place on the North Yorkshire and York footprint via the Health and Care Resilience Board and a number of interface groups. The frequency of Silver Command calls had been reduced but could be increased again if required.

MC reported that the CCG was working with City of York Council in respect of the pseudo-satellite unit in York for both symptomatic and surveillance testing. She explained that the site run by the CCG in Easingwold for testing NHS GP Practice and York Teaching Hospital NHS Foundation Trust staff had been closed due to low numbers making it no longer viable. These staff could now be tested at the Poppleton site or a ward identified on the York Hospital site. Additionally, discussions were taking place with the University of York to establish a local testing facility.

MC explained that antibody testing for NHS staff and contractors, which remained unfunded, was generally not taking place but GP Practices had agreed to test their own staff and use the laboratory facilities at York Teaching Hospital NHS Foundation Trust. Antibody testing for social care staff was funded from 22 July and acute trusts had been asked to lead on this. MC noted that locally additional phlebotomists had been recruited due to capacity concerns and agreement had

been reached that other NHS staff could also be tested for antibodies. This service was due to commence on 8 September at Peppermill Court. MC emphasised that an antibody test result did not change the need for vigilance and hand hygiene.

MC reported that the only change relating to personal protective equipment was in respect of 'flu. She noted concern about differential practice in this regard by Practice Nurses and Community Nurses and also differences between organisations in respect of aerosol generated procedures; work was taking place with the Local Authority regarding the latter for special schools. AL added that the Local Authority had established a cell for school related matters. MC noted she had requested guidance from the Local Authority for GPs on where to direct concerns of schools and parents.

Members discussed a number of aspects of testing and interpretation of results. AL additionally noted escalation for purposes of seeking clarity about care home workers who had tested positive for COVID-19 but were well and residents who were well but continued to test positive long after their initial diagnosis.

The Governing Body:

Noted the update.

Additional Discussion – Learning Disability Concerns

Prior to the close of the meeting further detailed discussion ensued on concerns expressed by HE and RW in respect of people with a learning disability. This included:

- Aspects of diagnosis and accuracy of Practice learning disability coding records, especially for mild learning disability. HE suggested establishment of a methodology to improve coding with a system to implement the change.

- The need to understand reasons why annual health checks for learning disability patients were not being undertaken across the CCG. DN emphasised that the national position was that anyone over 14 years of age with a learning disability should have an annual health check. Discussion in this regard included levels of funding for Practices, recognition of loss of income through not undertaking annual health checks, the need for education, opportunities through Care Coordinators for wrap around care which also supported avoiding hospital admissions, and the need to share expertise within Primary Care Networks. HE suggested development of an approach at Practice level to ensure understanding of the reasons why annual health checks did not take place for some learning disability patients.

- Concern about inequity and emphasis on the person centred care approach.

- Opportunities to learn from models in other areas.

- Recognition of the complexity and multi-factorial nature of the concerns relating to why practices found the processes for health checks with learning disability patients currently a challenge.

13. Next Meeting

The Governing Body:

Noted that the next meeting would take place on 5 November 2020.

EXCLUSION OF PRESS AND PUBLIC

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

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 3 SEPTEMBER 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 2 April 2020	Patient Story	• Update on establishing a local system approach for pertussis vaccination in pregnancy • Ongoing in context of the Coronavirus COVID-19 pandemic	MC	5 March 2020 Ongoing
2 January 2020 2 April 2020	Board Assurance Framework and Risk Management Policy and Strategy	• Risk Management Policy and Strategy to be presented for ratification	AC	2 April 2020 Deferred until "business as usual" resumed
2 April 2020	COVID-19 update	• Review learning on the part of both teams and organisations	All	Ongoing

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
2 July 2020	Annual Health Checks for People with Learning Disabilities or Serious Mental Illness – Update	• Update report	DN	1 October 2020 / 5 November 2020
2 July 2020 3 September 2020	Additional Item	• Quality and Patient Experience Committee to consider inequity and inequalities relating to Black, Asian and Minority Ethnic groups and report back to the Governing Body • Black, Asian and Minority Ethnic groups report to be included for the next meeting	JH / MC	3 September 2020 5 November 2020

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Accountable Officer's Report

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

Reason for Report

To provide an update on a number of projects, initiatives and meetings that have taken place since the last Governing Body meeting along with an overview of relevant national issues.

Strategic Priority Links

- ☒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: N/A
Recommendations The Governing Body is asked to note the report.
Decision Requested (for Decision Log)

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

GOVERNING BODY MEETING: 5 NOVEMBER 2020

Accountable Officer's Report

1. Local and system financial position

1.1 The financial planning and financial management arrangements so far and for the remainder of this year have been amongst the most changeable the CCG has faced. National guidance has been emerging and changing frequently and the CCG and our system partners across health and social care have had to adapt and respond to these quickly to ensure that, above all, services are supported to deliver effectively to our population. It is the strength of these relationships and the CCG finance, contracting and analytics team that means the CCG has been well placed to respond in the current climate and to whatever the future arrangements are.

1.2 The CCG's year to date position to September is breakeven as we continue to have the costs of responding to Covid-19 reimbursed and other reasonable budget variances "trued-up" retrospectively. We are also planning for this to be the position for the remainder of the year, although this will now need to be delivered within a system fixed funding envelope. For October to March the CCG remains within its financial envelope and is able to under commit by £1.5m on its allocation of the overall North Yorkshire and York (NY&Y) funding. Overall the NY&Y sub-system plan is for a breakeven position, after adjusting for known national issues, as partner organisations have agreed to an adjustment so that each will deliver a breakeven position.

1.3 There remain financial challenges across the rest of the Humber Coast and Vale Integrated Care System and it is not yet clear that the Humber part of the system will be planning to deliver a breakeven position.

2. System restoration and recovery in the era of COVID

2.1 The CCG has responded alongside all its partners to the COVID pandemic since March 2020. CCG teams and lead officers have supported services, local people and staff in delivering care for COVID patients and continuing non-COVID care to others. We have provided workforce capacity, system leadership, financial investment and communications to local people and politicians throughout.

2.2 The range of escalation and transformation across all organisations and collectively as a local system, as well as part of the wider HCV ICS partnership has been phenomenal in scale and scope. There has been rapid adoption of innovative ways of working across almost every team and between sectors, underpinned by digital remote working and a strong silver and gold command structure.

2.3 Since May health partners have worked to restore the full range of diagnostic and care pathways for non-COVID care ensuring they are segregated from COVID pathways across a range of hot and cold sites to keep our patients and staff safe. The physical reconfiguration and adaptation of our local care pathways to meet the national NHS England asks to restore the NHS demonstrates the strength and resilience of our local workforce to respond to large scale change after managing crisis.

2.4 Our joint recovery plans for this restoration through to March 2021 have now been approved by our Governing Body and the HCV ICS Partnership Board. Our delivery of these plans during September and October is strong, despite the challenge of a workforce navigating absence and self-isolation as it enters a second wave of COVID-19 and our winter period.

2.5 In March we updated Governing Body on financial turnaround and recovery. In November we find it hard to capture and reflect in a briefing like this the incredible response and recovery that our patients, partners, the local community and volunteers have made in the previous seven months.

3. Primary Care Protected Learning Time

3.1 The latest protected learning time session for primary care took place as an virtual event on the 15 October 2020. More than 300 colleagues from primary care attended the event and once gain the post event feedback has been very positive.

4. Emergency, Preparedness, Resilience and Response update

4.1 Coronavirus (Covid-19)

4.1.1 The CCG is working closely with North Yorkshire and York LRF and have found creative solutions to try to offer the most effective testing solutions that we have available as well as a safe supply of PPE. Guidance from the public health teams in North Yorkshire and York has been timely and the relationships formed during the pandemic response have been positive and constructive relationships. The CCG is an active partner in the response although remains a supporting partner as a category 2 responder rather than a category 1 responder in emergency planning terms.

4.1.2 The CCG covers three geographical areas; two of which (North Yorkshire County Council and East Riding of Yorkshire Council) remain in tier one and the third (City of York) has been moved into tier two in the National Covid-19 tier system.

4.1.3 The CCG has been actively involved in supporting primary care in any outbreak scenario, supporting remote working and trying to support with business continuity planning and information sharing as we move into the

winter season. The CCG has also been actively involved in supporting care home providers with access to technology and IPC/PPE guidance.

4.2 Business continuity planning

4.2.1 There has been a further business continuity planning exercise run by the NHSE/I team since March 2020. The CCG is also actively engaged in surge planning and flu and mass vaccination planning. The CCG has a role in bringing partners together to try and support business continuity to be business specific whilst understanding the impact on the system.

4.3 The York and North Yorkshire LRF are currently considering the next round of events that they will run to test business continuity and to understand the effectiveness of the current emergency arrangements. The CCG will have a role in these events however this will be as a category two responder.

5. Strategic and national issues

5.1 The Care Quality Commission released their annual State of Care report on the 16 October. The report looks at care people in England received in 2019-20. The report provides examples of good and outstanding care, trends in health care, and areas that require improvement - and this year the impact of COVID-19 is factored in. Overall, the report highlighted the vital role of CCGs particularly in working collaboratively with other bodies such as community groups, voluntary sector, NHS Trusts, and local bodies to deliver joined-up care and medicines management, particularly during the height of the pandemic. The report is available at CQC State of Care report - October 2020.

5.2 A new briefing from the NHS Confederation's Mental Health Network, NHS Clinical Commissioners and PCN Network, explores the importance of creating supportive pathways to employment for people with mental ill health. 'Ensuring Appropriate Employment Support for People with Mental Health Problems' recommends four 'R's: Raise, Respond, Recommend, and Refer to help systems ensure people with mental health challenges can gain and retain employment. The report is available at Ensuring Appropriate Employment Support for People with Mental Health Problems.

5.3 The Health Foundation's REAL Centre published its first report on the 15 October looking at how NHS care in England has changed over the last 20 years. Findings show that between 2000-01 and 2017-18 NHS-funded care increased by 114%. However, growth varied significantly across different services. The report aims to identify factors that have led to a significant shift away from primary and community services and towards hospital-based care, despite this being contrary to national policy aims. The report stresses the importance of good long-term planning and decision-making as the key to having a strong NHS. The report is available at REAL centre report.

6. Recommendation

6.1 The Governing Body is asked to note the report.

Item Number: 6

Name of Presenter: Michelle Carrington

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Quality and Patient Experience Report

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

Reason for Report – The purpose of this report is to provide the Governing Body with an update on an exception basis on risks and mitigations associated with quality, safety and patient experience across our commissioned services. It summarises by exception, progress and updates on quality, safety and patient experience that is not related to existing risks and provides an update on actions to mitigate the risks aligned to Governing Body.

Content of this report has been discussed in detail in the Quality and Patient Experience Committee in September and October respectively.

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 Risks to quality and safety across all commissioned services due to the impact of Covid-19 and anticipated 'surges' or 'waves' of demand across services and potential harm to people being able to or not accessing access services.

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

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

Decision Requested (for Decision Log)

In the context of the separate strategic and operational work streams which manage the response and risks associated with Covid-19, Governing Body is requested:

- determine whether members are assured of the work being undertaken to understand and support the quality and safety of commissioned services
- determine whether members are assured of the actions to manage the risks aligned to Governing Body
- review the new risk identified, determine whether members agree for continued management through the Quality and Patient Experience Committee

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington, Executive Director of Quality & Nursing	Michelle Carrington, Executive Director of Quality & Nursing Paula Middlebrook , Deputy Chief Nurse

1. INTRODUCTION

The purpose of this report is to provide the Governing Body with an exception report upon commissioned services and a full update regarding risks aligned to the committee.

The content of this report has been discussed at Quality and Patient Experience Committee in September and October respectively.

The exception report will focus upon:

- Covid-19 impact and changes to commissioned services with particular focus upon
    - Phase 3 recovery and 'readiness for Wave 2'
    - Support to care homes
- Preparing for Winter – Flu Planning
- End of Life Care and Marie Curie night sitting service
- Mental Health
- Continuing Healthcare
- New discharge guidance
- Children and Young People's Services Update
- Infection Prevention and Control (non covid)
- Serious Incidents
- Patient Experience – PHSO development of new Complaints Standards Framework
- Communications and Engagement update
- Risks to Quality and Safety

2. COVID-19 AND CHANGES TO COMMISSIONED SERVICES

A detailed account of the CCG and system partner organisational response and transition to 'Phase 3' was provided to Governing Body in August 2020. Since then we have seen the emergence of increased infections as anticipated moving into a winter season.

The HCV Partnership Clinical and Professional group have developed a set of principles with aligned actions to support prioritisation and validation across programmes of work and throughout all organisations and places across HCV. The message as a HCV leadership group is that 'we're in it together, so let's do the right thing at the right time'

PRINCIPLES

We will:

Be **open and transparent** with our Patients, the Public and All Staff about the challenges we are facing and provide clear communications

Work together and embed shared ownership of care, treatment and risk across Humber, Coast and Vale, the health and care sectors and with the Patients

Share patient health and care demand lists across Humber, Coast and Vale to ensure our people have fairer and easier access to services, starting with hospital services including Cancer and Diagnostics and continue into other sectors as soon as possible e.g. Mental Health

Ensure equity of access to advice and guidance, specialist healthcare services, diagnostics and treatments across patient cohorts

Review and prioritise health and care needs of patients based on clinical risk and vulnerability ensuring the process is transparent and takes into account the holistic needs of the patient

Ensure integrated health and care pathways are deployed throughout Humber, Coast and Vale, that make effective use of resources available across the system, embed best practice and create optimum and alternative pathways to meet the needs of the patient whenever possible

Enable patients to manage their own health conditions and promote prevention over cure by improving existing arrangements and where required developing and implementing new models and support tools

Ensure alignment of resources to support the needs of the patient, with a particular emphasis on investment in the primary and community sector and services

Actions

We will:

PHASE 2 – May 2020 to August 2020	PHASE 3 – from August 2020	From April 2021
Secure Covid care **Protect** urgent care capacity **Enable** cancer referrals and appropriate diagnostics	**Develop** shared waiting lists and share review and prioritisation **Embed** active referral, triage with appropriate care navigation and expert input **Embed** digital first across the patient pathway **Implement** system pathways **Publish** regular transparent, comparable metrics and data **Progress** population health management approach	**Embed** and encourage Place / PCN population health priorities / work plans **Invest** in community assets and community facing workforce **Communicate** widely prevention strategies.

Anticipated Impact

PRINCIPLES:	ANTICIPATED IMPACT:		
	Enhanced Patient Experience	**Improved Quality and Safety**	**Risk Reduced**
Shared Ownership of Care	Care about me, agreed with me	Progression flagged earlier	Shared clinical risk across clinical communities ensured
Improved self-management of Conditions	Personalised prevention embedded	Increased Health Awareness	Earlier flagging of issues
Prioritised health and care needs	Equitable and early access to care delivered	More holistic approach to managing health and care demand and addressing health inequalities	Reduced risk or progressed disease complications Shared clinical risk across clinical communities ensured
Equity of access to expert input	Early care input secured	Early disease intervention	Reduced disease progression and late presentation
Integrated health and care pathways	Appropriate care guaranteed	Standardised care accepted	Appropriate care given in all sectors
Appropriate aligned resources	Care at home or nearer to home offered	Appropriate input made	Better compliance and attendance

The report can be found at the following link:
https://humbercoastandvale.org.uk/2020/08/24/its-a-big-challenge-were-in-it-together-so-lets-do-the-right-thing-at-the-right-time/

Place plans have been resubmitted to the HCV to detail the progress and plans for Phase 3 recovery and Covid-19 Wave 2 readiness.

Support to Care Homes

Support to care homes continues. A multiagency review is in progress to understand what happened when a local care home was closed by the CQC. It will also identify any good practice and any lessons learnt which will be shared widely and used to prioritise the CCG care home work. Following this the NHS VOY CCG Care Home Team and NYCC QIT are collaborating to perform joint supportive visits to ensure there is assurance on how settings are coping and intervention provided, if required this is provided 'in the moment'. This visit aims to also gain insight and learning to share good practice and innovation.

The care home team is currently supporting the ongoing priorities surrounding training e.g. Infection Prevention and control (IPC), early identification of deterioration and nutrition/ hydration andfallsprevention.. The team are also supporting Covid testing in a range of community settings including domiciliary care, supported living and homeless accommodation settings.

It is important, in order to implement the national discharge guidance that we have the full support of our care home colleagues. This includes the potential for taking short term residents in order to enact 'D2A' (discharge to assess) and admissions at

weekends. We understand this is not always possible and we are working with our partners to make progress where we can.

The Partners in care forum continues with mutual support from the ECHO project.

We are also supporting the roll out and use of pulse oximetry into care homes and primary care as equipment becomes available and are working with the regional Chief Nurse Team to ensure best practice is instigated where possible i.e. the pilot of pulse oximetry across another CCG is demonstrating improved outcomes and reduction in hospital admissions.

3. FLU PLANNING

All practices have developed plans for delivery of the extended Flu program with significant progress being made. One practice has already reported they have vaccinated over 75% of their over 65 year olds. (National target is 75%) Vaccination rates for the CCG as a whole is above that delivered at the same time the previous year.

Nimbus Mass Vaccination site
The Mass Vaccination site at Askham Bar hosted by Nimbuscare on behalf of the city practices became operational w/c 5th October. Nimbus are liaising with any practices across the CCG footprint who wish for them to undertake any vaccinations to release capacity within General Practice. This will be supported contractually through SLAs.

Foundation Year Dentists
Nimbus are hosting Foundation Year Dentists who have been made available free of charge from across the Yorkshire and Humber region. Nimbus are hosting as honorary contracts for services across the HCV, ensuring all employment checks, training completion and competency sign off are in place before they work as vaccinators 1 – 2 days per week across practices. Any practice within the CCG or HCV footprint can access as required. In the periods where they are not required at Practice level, they are supporting the mass drive through at Askham Bar.

Flu Vaccine Supply

The key concern to delivery of the program at pace for the extended eligibility is vaccine supply. The national team are assured that there are sufficient supplies available for the season and practices have been informed how to request additional supplies with further delivery dates scheduled throughout November and December.

Whilst there is the public campaign to encourage as many people to have their vaccination, there is careful messaging needed in order to manage expectations around timescales to deliver.

HCV Flu Board
The HCV Flu Board continues to meet fortnightly. Vaccination rates will be reported into the Flu Board.

CCG Flu Leads took part in a 'stress test' of CCG plans on 30th September. Key areas where additional consideration is needed were highlighted as :

- Communications – the need to adapt to manage public expectations and to ensure in the case of local lockdowns that public know attending for a Flu vaccine would be considered 'essential' travel.
- Preparing for workforce loss due to local outbreaks
- Ensuring people from underprivileged areas / backgrounds have equal access including BAME.

4. END OF LIFE CARE – Marie Curie night care

The CCG has agreed to increase the night sitting service provided by Marie Curie. There is significant evidence that increase in capacity is required.

The CCG is working with YTHFT Palliative Care service and St Leonard's Hospice to determine the most appropriate pathway in line with the established single point of access hosted by the hospice.

5. MENTAL HEALTH

Adult Mental Health

Crisis teams are seeing a significant increase in referrals with more people accessing the team and home based treatment than pre-covid. A significant number of people have been previously unknown to services. This trend is also repeated in inpatient admissions. Overall there is an upward trajectory in Early Intervention in Psychosis (EIP) referrals. Both adult mental health (AMH) and mental health services for older people (MHSOP) have undertaken deep dives into recent admissions, with specific focus on those patients who have been previously unknown to services. Within MHSOP it appears that people have hit crisis point before seeking support from their GP. Within AMH the majority of the admissions from unknown patients have been under the Mental Health Act, which also links to the increased levels of first episodes of psychosis. The York At Risk Mental State (ARMS) pathway in EIP went live mid September. All services are operating a digital first approach and reviewing face to face contact to ensure that patient needs and risks are being met.

The York Safe Haven re-opened in September. Until re-opening the provider, Mental Health Matters, continued to offer a telephone support service. There has not been a significant growth in service activity at the Safe Haven during the pandemic.

Mental Health Matters is working with Converge to provide an enhanced weekend service and has already demonstrated it can support recovery through online activity.

A Voluntary care sector (VCS) provider is offering on-call mental health first aid in Selby.

- **IAPT**

Referrals and access into the service started to increase in June. Non face-to –face assessments continue.

An IAPT long term condition service (LTC) is being piloted at Scott Road practice in Selby.

A respiratory rehab LTC pathway is being developed to be co-located with the acute community service.

- **Physical health checks for people with severe mental illness**

In quarter four of 2019/20, the CCG met the locally agreed standard of 30% of people on GP severe mental illness registers who received the recommended annual health checks. In quarter one this rate was 24.7% due to the covid response. A local enhanced service has been offered to primary care to undertake the health checks.

- **Dementia**

There has been a drop nationally in dementia diagnosis rates due to Covid and social distancing that has changed the way that people are presenting for assessment, diagnosis and support. Remote consultations have been offered either by video or telephone. Face to face assessments have resumed, however people are facing waits of over 10 weeks. The CCG has commissioned a specialist dementia nurse who is taking referrals from primary care for people needing support. The memory service is working to clear these waits and ensure there is capacity to meet the needs of people referred. Work is on-going with primary care to raise awareness of dementia, for earlier identification and improved dementia support. A protected learning event for GPs and practice staff on dementia took place on 15th October which included people living with and supporting those living with dementia and a highly regarded national speaker. QPEC will be undertaking a single item agenda in November on dementia which will report back to Governing Body

- **Adult autism/ADHD**

The Retreat has resumed face-to face assessments but continues to offer virtual consultations where possible and if patients choose this approach. Both autism and ADHD pathways have been revised with the aim of addressing long waits which now exceed 20 months. A working group has been established to develop a long-term sustainable model integrated with mental health services.

Children And Young People's Mental Health

- **Specialist CAMHS services:**

Referral numbers dropped in April, but are now increasing.

Contacts with patients or children referred have increased significantly since Covid, with overall 16,007 around double for previous years during the same period. At the outset of lockdown, TEWV reviewed all cases, assigning risk ratings and implementing a system of routine check ins via phone or Attend Anytime. Therapeutic sessions are offered through virtual means subject to risk assessment, with face to face assessments and therapy at clinics reserved for those with highest risk. However, waiting lists for therapy have increased, as it has not been possible to deliver all therapies through digital means nor has it been appropriate in all cases.

Eating disorder referrals have been high. A higher level than usual are presenting as very poorly, and a higher level are requiring admission to acute wards for stabilisation. Staff are meeting the national target for assessment, but are struggling with the level of support needed in the early stages of treatment.

TEWV has developed the virtual offer to address some long standing problems around access:

- ASCEND: this is the course run for parents of children with a positive diagnosis of autism. The course has previously been run in conjunction with City of York Council staff, and resources have led to a lengthy waiting time. The course is now being transferred to a digital platform through the Recovery College Online

- Positive behaviour support: this is a systemic therapeutic approach for children with learning disabilities or autism: staff have developed webinars and training modules for schools and community settings

- Systemic family therapy: some very experienced staff have been brought in on retire and return to work solely on this pathway

- Low-mood groups are now running through AttendAnytime in Selby and York

- The Mental Health Support Team (MHST) in Selby has been amalgamated for the time being with the low mood group

- Support groups for parents of children and young people with eating disorders: previous face to face groups were fairly poorly attended, but video provision has proven very popular

The autism waiting list has grown during Covid: TEWV had to suspend face to face assessments, and could not use the approved assessment tools virtually. TEWV is implementing a fast track diagnosis for those for whom their initial assessment

indicates it is safe to do so, which will reduce numbers waiting. The parental screening form is proposed for use at assessment stage, which will reduce appointment time later.

TEWV anticipated a significant increase in referrals once schools resumed in September and October, and are working hard to manage waiting lists.

TEWV has surveyed staff and patients to gauge their experience of specialist CAMHS during Covid, and is starting to draw some conclusions regarding approaches to future service delivery:

- All are becoming more comfortable with digital delivery, provided risk management is effective

- Patients are generally content with digital provision: young people are generally quite comfortable with digital technology, travel time and costs are reduced, and has been possible to engage both parents more directly in care.

- Children and young people with autism have preferred telephone calls, probably due to finding the intensity of face to face online discussions stressful

TEWV is relocating the Lime Trees clinic to Osbaldwick in spring 2021, and is now considering afresh the ways in which the building may be used in light of the anticipated new ways of working with children and young people.

Crisis team contacts have also reduced, although the crisis team is now operating 24/7 since 1 June: although the contacts are down, TEWV has advised that a higher proportion are from children and young people previously not known to the service. This in fact suggests that some patients previously using the service have been better able to cope during the lockdown period, which resonate with comments from colleagues in local authority services that children with high anxiety around school have fared better than expected.

Other commissioned support

- The City of York school well-being service has continued to work virtually with pupils, but has focused on advising school staff in developing whole school approaches and in relation to specific children.

- Compass BUZZ has continued to offer web based advice and signposting information through the Compass website. Its BUZZ US texting service has seen a reduction in numbers accessing it: possibly children and young people are using more websites for general advice and information.

- Kooth: commissioned by TEWV. This is a national web based advice and counselling service: nationally it has seen a significant increase in access during Covid, but North Yorkshire and York has in fact seen a reduction in access.

Maternity Mental Health Service (MMHS)

The Humber Coast and Vale ICS has submitted a bid for transformation funding to support the development of a new Maternity Mental Health Service (MMHS). This is to complement the existing Perinatal mental health services, but with a focus upon women who have Post Traumatic Stress Disorder (PTSD) associated with a previous pregnancy. This distress may be associated with The PTSD arisen through birth trauma, or perinatal loss - including early or recurrent miscarriage, stillbirth, neonatal death, termination of pregnancy and tokophobia (fear of childbirth).

The proposal is for Hull, East Riding, North and North East Lincolnshire apply as Early Implementers to provide a suitable and effective service, with North Yorkshire and York to follow in the next phase as Fast Followers.

Funding is available for 18 months with subsequent funding included within the maternity baselines.

Future QPEC mental health deep dives

The PLT event in October focussed upon Dementia. Following this the November QPEC meeting will be a deep dive into dementia. The subsequent scheduled deep dive for QPEC will focus upon Eating Disorders.

No other exceptions to report this month

6. CONTINUING HEALTHCARE (CHC)

As part of the preparation in response to Covid–19, NHS England advised all CHC teams nationally, to suspend the usual assessment work for the eligibility of Continuing Healthcare (CHC).

Plans were quickly put in place for staff to work remotely, with daily virtual team meetings to ensure all staff knew what work they should complete and also to ensure staff remained well and engaged with each other and their managers.

Six new members of staff commenced their employment with the CHC team at this time, and remote induction and training was completed.

The CHC team undertook welfare calls to those living in the Vale of York CCG catchment area, who had previously been found eligible for NHS Funding via CHC, 327 such calls were made between March and July 2020. During these calls access to PPE was established and orders made through the CCG.

The CHC team also completed virtual reviews on those who had been referred to the team for assessment, but whose assessment could not take place due to the measures in place due to Covid-19.

Clients who had an increase in need or new clients with complex long term health needs, were provided with enhanced, or new packages of care to meet their needs, with new providers sought and engaged, where possible delivered via Personal Health Budgets (PHBs)

As part of the national response, the CHC team supported discharges from York Foundation Trust, participating in three command centre calls a day, 7 days per week. The national standard was for discharge within 3 hours and same day for complex needs clients. In addition to taking responsibility for those clients, CHC team members provided clinical expertise to other members of the command centre team.

The CHC team developed closer ways of working with the palliative care team and local hospices. A new pathway/process was developed and implemented, drawing this into the working of the acute trust discharge command centre.

This work carried on throughout the summer, and in the last week in August, NHS England confirmed it expected CHC teams nationally to resume their assessment work.

The CHC team had kept a register of those waiting for an eligibility assessment, and those clients were rated using a traffic light system, so they are now been assessed in order of priority.

Clients who are now newly referred will also be assessed within the six week time frame.

Planning for the resumption of assessments took place and ways of working are in place, with monitoring of progress planned into the system.

7. New Discharge Guidance

The Government has produced a new Hospital Discharge Service: Policy and Operating Model. This document sets out the Hospital Discharge Service operating model for all NHS trusts, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England. It replaces the Hospital Discharge Service Requirements.

The Government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and re-ablement care for up to six weeks following discharge from hospital.

It states that the discharge to assess model will be fully implemented across England as a sustainable model.

'Criteria to Reside' is a new term which replaces phrases such as 'medically fit for discharge' and details a set of criteria which patients are best cared for in hospital. Where appropriate, all other patients will be discharged under the discharge to assess guidance and pathways.

Discharge to Assess model – pathways:

Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.

Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.

Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.

Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

Health and social care systems should have an identified executive lead to provide strategic oversight of the discharge to assess process ensuring that there are no delays to discharge and that a "home first" approach is being adopted.

They should be supported by a single coordinator who should be appointed on behalf of all system partners to secure timely discharge on the appropriate pathway. They can be employed by any partner in the system to lead the implementation and delivery of the discharge to assess model in the acute hospitals in their area.

Local systems should ensure that data and intelligence about the sufficiency, suitability and sustainability of care and health services are shared, so as to maximise the effectiveness of services, outcomes for individuals and populations and the overall use of resources. This should include supporting data reporting from care providers, as outlined in the Support for Care Homes letter issued by the Government on 14 May 2020.

CCGs supported by Integrated Care Systems (ICSs) or System Transformation Partnerships (STPs) need to support the coordination of activities set out in this framework. As such the CCG is working with partners to implement the guidance.

The full guidance can be found here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912199/Hospital_Discharge_Policy_1.pdf

8. CHILDREN AND YOUNG PEOPLE

Special School Nursing and Community Children's Nursing

The transformation of community children's and special school nursing is now making progress with the service specification now fully agreed by YTHFT with a contract variation in place.

A service improvement plan will be formulated between the CCG and YTHFT to deliver the transformation to improve quality and standards across an implementation time line. Some of the work has already begun.

The transformation plan includes changes to special school nursing which proposes to move from a task orientated health provision to a health promotion and complex care management model. This will involve training teaching assistants to undertake delegated health procedures and also includes them administering prescribed medications as per Department of Education guidance. YTHFT have purchased and are already implementing a high quality delegation of care competency tool/framework in children's short break settings which will also be used in the schools. As this proposal requires changes to job descriptions, staff consultations are taking place. There are understandable anxieties regarding this change amongst educational staff. The CCG and YTHFT are supporting education services with this.

Health plan to host a series of coffee morning engagement events for parents, to facilitate explanation of the proposals and discuss any concerns they may have as the current system of school nursing has been in place for many years without change. These will be virtual due to the ongoing pandemic.

Special Educational Needs & Disabilities (SEND)

The SEND Improvement Board continues to oversee and monitor the progress against the Written Statement of Action (WSOA). Updated RAG rating for this has been undertaken (which can be viewed on the local offer). Whilst there are some minor delays in two areas, improvements are progressing.

The CCG has undertaken a significant piece of work with CYC and a range of stakeholders and service users to develop:

- A model of coproduction – re named Joint partnership at parents request
- A multi-agency quality assurance framework which will include standards that encompass support for individual children and young people and also strategic service development and improvements.
- A Communication and engagement strategy
- An Integrated data dashboard

- Joint partnership working arrangements
- SEND JSNA - Phase 1 scheduled for completion mid-October

These improvements will become an embedded work stream for the CCG and its partners. The CCG website has been updated and will include relevant attachments and links to CYC in relation to SEND.

The CCG has agreed additional resources to support delivery of the improvements required across the health and multi-agency system. This includes an Associate Designated Clinical Officer and business support officer, both of which will support the CCG in discharging its statutory functions in relation to the Children and Family Act 2014 and further improve joint partnership working with CYC, YTHFT and TEWV. Additional resources within children's nursing and therapy services at YTHFT have also been agreed to meet the demands of SEND related functions and provision.

The data work stream is being supported by the CCG business intelligence analytics' team and work is progressing in partnership with CYC, NYCC and North Yorkshire CCG to examine and determine how health data can be collected and shared to support the local area in understanding the SEND population which may take some time to embed. This work will subsequently inform future joint commissioning.

The first post inspection monitoring visit by the Department for Education and NHSE took place on the 25th September 2020. In summary the monitoring team reported they were assured by the progress being made against the WSOA and specifically noted the achievements around our engagement with children, young people and families under the Covid pandemic restrictions, an area where many other regions had not made progress. The next monitoring visit is the 17th November 2020. The inspection team have advised they will expect to see the beginnings of 'evidence of the impact' in response to the improvements

Audit Yorkshire has also commenced its review of the CCG's response to the WSOA and engagement with its partners in relation to SEND.

The CCG is working with the audit team and the initial draft report is expected at the end of October 2020

SEND – COVID Pandemic

In addition to the WSOA work, the DfE and NHSE met with CYC and the CCG on the 29th September 2020 in relation to the impact of the pandemic and how services have and continue to support children, young people with SEND and their families. This is occurring in all regions. The best endeavours caveat agreed by government in relation to the statutory functions of the Children and Families Act (2014) was

rescinded in September 2020. They team were interested in how the area is now meeting its obligations including how children were being supported in their return to school. The local area reported that it was slightly above the national average for children going back to school.

In the initial phases of lockdown, some clinicians at YTHFT were redeployed to meet covid in-patient requirements which had impacted on resources and subsequent SEND provision. However all children and young people underwent individual risk assessment by clinical services and in collaboration with families a graduated response in terms of risk was developed. Most consultations were virtual in nature, however face to face interventions, usually nursing, continued with the correct use of PPE if required. It is too early to say what impact this may have had but is being reviewed through the restoration and recovery work.

Waiting lists have also been lengthened as in most areas and the CCG will be reviewing the impact of this, particularly in relation to autism assessments.

Nationally, Aerosol Generating Procedures (AGP's) in schools are causing considerable challenges and debate due to interpretation of the guidance. Nationally many children have not been able to return to school, although this is not the situation in York. Risk assessments and care planning by our community children's nursing team have supported those children who require AGP's to return, although there are a few children who have not returned due to their extreme vulnerability, clinical advice and parental choice to continue shielding. Alternative arrangements re-education have been made in these circumstances. NHSE and PHE have been lobbied by all regions to resolve this and we are advised this is now with SAGE for consideration.

Children's End of Life and Palliative Care

Following the success of the CCG's match funding bid to NHSE, the CCG have now arranged a tripartite agreement between Martin House Children's Hospice and YTHFT to improve choice, standards and quality of health provision for those children, young people and their families who may wish to receive end of life care at home. The arrangement includes:

- A learning needs analysis of the community children's nursing team (at the start of funding, to inform topics/focus of teachings)
- Delivery of engagement sessions with the CCN team and hospice community team to increase cohesion and opportunities for joint working
- Delivery of training sessions on topics identified through the LNA and in discussion with the team
- Development of a care pathway that ensures choice in the place of care of families of children who require end of life care across York and Selby

- Evaluation of the development of knowledge and confidence of CCNs at the end of the funding term, to measure impact.

Children's Short Breaks

The CCG continues to work with CYC in supporting short beaks for children with complex health needs. The new nursing support offer is now embedded and the multi-agency pathway is in development. The move from the current residential short breaks provision 'The Glenn' to the new purpose built site 'The Beehive' has been delayed due to delays in building inspections however it is hoped this will take place at the end of October .

Healthy Child Service (HCS) in North Yorkshire

North Yorkshire County Council have formally launched their consultation on changes to the HCS in NYCC boundary which was paused during covid.

The proposals are to carry on with the universal service for children under 5, but will focus on more tailored support for children and young people aged 5-19 and target support for families most in need.

The Healthy Child Programme is a child and family health promotion programme for children aged 0-19 years. Some of the services within it are for all children, such as health visiting, and some are targeted to those most in need, such as vulnerable families and children and young people with emotional health and drug and alcohol problems.

The Council and partners have needed to find new ways of delivering the Healthy Child Service in the face of a national reduction in public health funding.

The proposals for consultation include:

- Mandatory visits to families with children under five at key child development stages will be co-ordinated by a qualified health visitor.
- At-risk under 5s and their families will continue to be prioritised, as they are now, with face to face visits where needed;
- Learning from how services have operated under Covid-19 restrictions, introducing a blended approach of face to face and online contact for families, based on robust assessment of the child and family's needs;
- More integrated support from agencies across the health, education, social care and voluntary sector for children to be ready to learn and to address developmental concerns in children and young people;
- More prevention and early intervention activities to reduce childhood obesity focused on infant feeding and family diet and nutrition including breastfeeding and healthy weaning;
- A partnership approach to the prevention and management of risky adolescent behaviour including prioritising and improving emotional health and resilience

- Effective identification and management of the safeguarding of children and vulnerable parents or family members.

The consultation can be found here:

https://www.northyorks.gov.uk/healthy-child-programme-north-yorkshire

This will be a 10-week consultation beginning on Monday 26 October 2020 and ending on Monday 4 January 2021 The feedback received will be presented to NYCC and HDFT Executives, and subject to the outcome of the consultation it is anticipated the new service will be in place on 1 April 2021

The CCG has requested to join the work streams associated with developing the new model especially any aspects which impact on health, quality and safety and will be responding formally to the consultation.

9. INFECTION PREVENTION AND CONTROL (IPC)

The focus for infection prevention and control (IPC) over the last 6 months has been upon the pandemic.

During 2020 a new HCV IPC group has been established which is chaired by the Chief Nurse for NYCCG. This group provides oversight and assurance of the whole system and provides support to individual organisations.

Infection rates of C.Diff at YTHFT have significantly reduced from March 2020 onwards, however there continues to be a consistent small number of infections each month. The maximum number the Trust is permitted is 65, with 25 infections (as of Aug 2020). This is a significantly improved position form 12 months ago when the Trust had reached their maximum number of cases by August 2019.

C.Diff Infection rates for the CCG as a whole follow the same pattern.

Further work is required to understand the E-Coli and MSSA bacteraemia rates and associated work required in order to reduce their occurrence.

YTHFT does not appear to be an outlier compared to other ‘similar’ sized organisations within the Yorkshire and Humber footprint.

YHFT continue a programme of work to deep clean areas of their estate and reconfiguration of old nightingale wards at Scarborough. They are prioritising the backlog maintenance and have enhanced their C-Diff action plan.

10. SERIOUS INCIDENTS (SIs)

A detailed progress update regarding approaches to Serious Incident management and investigation for both YTHFT and TEWV will be provided to QPEC in November as both organisations are making progress to improve their processes. The Chief Nurse of the CCG attended the YTFT internal SI panel which was really productive and gave valuable insight into internal challenge and scrutiny. The CCG will be joining YTHFT SI improvement workstreams and the CCG, as host for the SI service will be looking to make improvements too to improve processes and relationships with our providers. The CCG will also receive a quarterly assurance report.

Patient Safety Specialists

NHS England has now written to all NHS trusts, foundation trusts and CCGs asking them to begin the process of identifying their Patient Safety Specialists, who will lead on patient safety across their organisation. Trusts and CCGs have been sent details of how to register their specialists with the NHS England and NHS Improvement national patient safety team by a deadline of 30 November 2020. The CCG is on track to confirming our arrangements for this role and how it will be operationalised across the CCG.

11. PATIENT EXPERIENCE

Parliamentary & Health Service Ombudsman Update – new Complaints Standards Framework

The Parliamentary & Health Service Ombudsman (second stage of the NHS Complaints Procedure) have been working with the NHS and other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling, which is referred to as the 'Complaint Standards Framework'.

Public consultation on the Framework has now closed and the PHSO aim to publish the final version of the Framework in early 2021 (along with next steps for how it will be embedded – expected to be piloted in 20 organisations, hopefully a mix of acute trusts and primary care).

The Framework sets out a single set of standards for staff to follow and provides standards for leaders to help them capture and act on the learning from complaints.

'Mind the Gap' – NHSE/I Commitment to Carers Program

On the 7th September, the CCG Patient Experience Lead attended a workshop to explore the health inequalities for patients and their carers.

The workshop shared a number of experts by experience and carer stories. The carer stories demonstrated the challenges they experience, particularly when the person they are caring for has poorer patient experience, hidden stigma and the range of 'hidden' carers of both adult and young people.

A key emphasis of the workshop illustrated the additional impact of Covid-19 which is having a disproportionate impact on communities most likely to suffer from health inequalities, and that as a result of COVID-19, carers have provided on average an additional ten hours of care a week.

NHS E/I are launching *Mind the Gap*, a programme which aims to help Integrated Care Systems to identify and support carers from vulnerable communities through co-production and carer-led innovation. As such, in 2020/21 NHS E/I is offering up to £10,000 per project aimed at scoping how to best identify and support carers from vulnerable communities, subject to successful bidding.

NHS E/I carers team are looking to secure additional funds for 2021/22 to implement recommendations, subject to successful bidding. The CCG did not submit a bid at this stage, however there is the potential to submit a bid in 2021 to aid the implementation of 'action' projects moving forward.

Outputs from the presentation are also included within the Phase 3 recovery plans and organisational People Plans.

No other exceptions to report to update at this time.

12. COMMUNICATIONS AND ENGAGEMENT

Engaging with our public

During September we held a number of patient and public forums via online platforms.

- **NHS Vale of York CCG AGM** – 17 September. This was the first YouTube live stream meeting from the CCG. Viewers could listen to an update from each of the exec members and their reflections of the 2019-20 year. The session can be viewed here: https://www.youtube.com/watch?v=bYtcxCJgo-E

- **Wheelchair service user forum** – 22 September: The group had attendees from the provider (NRS Healthcare), the CCG and wheelchair users. The discussion focused around eligibility criteria, annual reviews, services during covid, patient survey, personalised budget case studies and a contract update. This forum acts as part of the feedback mechanism, hearing the voices of service users and sharing with the providers to encourage improvements. This gives NRS and the CCG the opportunity to get direct

feedback and be held to account.

Urgent care communications and engagement forum – 23 September. The review of urgent care is aimed at improving the way that patients are able to access care for an urgent medical need. However we need to make sure that this sits well with our communities. The meeting focused on the engagement carried out so far as part of the project and we asked the group to feedback their thoughts on the process and ensuring that we have the views of a representative proportion of our population. We used an interactive whiteboard to facilitate a really in depth discussion about urgent care. There were patient reps from PPGs, Healthwatch, local community voluntary sector and carers.

Special Educational Needs and Disability engagement

On 17 September and 5 October, in partnership with CYC, we facilitated two more training sessions with social workers to explore the understanding and perception of co-production and to understand how it could be embedded in everyday practice.

We know that we need to communicate better with the families, children and young people we are working with. In August 2020, we created a joint 'Communications and Engagement Strategy' which sets out how we want to communicate, who with and when. https://www.valeofyorkccg.nhs.uk/your-health-and-local-services/disabilities1/special-educational-needs-and-disability-send/

Urgent care engagement review 2020

The engagement continues as part of the urgent care reviews.

In September 2020 the CCG set up and held an engagement and communications forum with patient and voluntary sector representatives from across the patch. The forum provided the opportunity for attendees to review the CCG's engagement process and work together to reach out to seldom heard communities. A really valuable discussion ensued, focusing on making pathways clear and simple to access, communications and involving communities. It will continue to act as a critical friend to the engagement process.

As part of the formal process the CCG had meetings with the Health Scrutiny Committees on 2 October (City of York Council), 6 October (East Riding) and 21 October (North Yorkshire County Council)

Our finalised the engagement report can be found here.
https://www.valeofyorkccg.nhs.uk/seecmsfile/?id=4297

More information on the engagement can be found here: https://www.valeofyorkccg.nhs.uk/get-involved1/engagement-surveys-and-consultations/current-surveys-and-consultations/

Raising awareness of the flu jab with carers

On 23 September the Deputy Chief Nurse and Communications and Engagement Team presented at the York Carers' Action Group to raise awareness of the flu vaccination and that carers are entitled to a free vaccination. This is part of a bigger communications piece encouraging people to take up the flu vaccination this year.

Supporting Primary Care: GP practices are open

The team is now successfully rolling out phase 2 of 'our GP practices are open' campaign with a range of press releases, media interviews, dedicate webspace and a roll out of key social media messaging. The campaign will next start to focus on key health issues such as smear tests, cancer and diabetes as well as reminding patients and the public to get help if something isn't right.

This will lead into our winter messaging which will be a joint project with NYCCG.

Protected Learning Time – 15 October 2020

The protected learning event centred around the knowledge and resources needed to support GPs and fellow primary healthcare professionals to recognise dementia and improve the quality of life and care of people who are concerned about their memory, people with dementia and their family and carers. The event focussed upon opportunities for improving care, maximise spread of what is going well, share learning and building relationships. It enabled participants to gain a unique insight into dementia through the stories of people with dementia and their carers.

The CCG was delighted to welcome as the key note speaker, Nicci Gerard. Nicci Gerrard is a journalist and campaigner. She won the 2016 Orwell prize for her reporting on the care of dementia patients in the UK and also co-founded John's Campaign, named after her late father to encourage the NHS to collaborate more with families in the care of dementia patients.

One of the keynote sessions involved stories from people living with dementia. The Minds and Voice group meets once a month and talk about life beyond dementia, and offers a powerful insight from the patient perspective.

Outpatient transformation engagement audit

As part of a piece of work across the Humber Coast and Vale, the Engagement team at the CCG is leading on an audit and gap analysis on how providers attain patient feedback. The project will look at how providers across the system are gathering patient feedback about the move to non face-to-face appointments – either by email, phone or video, and how the feedback is being reviewed.

New blog

The CCG is hosting a blog on our website open to healthcare professionals across the Vale of York who want to write an article about their work, professional experiences or a health related subject they are passionate about. Dr Rumina Önaç, GP and Green Impact for Health lead at The Old School Medical Practice in York has shared her detailed experience of caring for patients during the coronavirus pandemic. In a blog article posted on the NHS Vale of York Clinical Commissioning Group (CCG) website, Dr Önaç gives an open account of the challenges, irritations and positive outcomes which have impacted on how the primary care environment works. https://www.valeofyorkccg.nhs.uk/after-the-apocalypse/

Other communication campaigns:

Working closely with our PCNs we are launching 'What is a PCN' this is an internal campaign aimed at bringing together those working within PCNs to share values and priorities whilst creating a feeling of belonging to those in individual practices and surgeries.

13. RISKS TO QUALITY AND SAFETY

QPEC agreed in September a new risk to be owned and managed by QPEC. Governing Body is requested to approve continued management of this risk within QPEC

> Following the significant concerns at the care home closed (previous risk QN17) and entering into a second wave of Covid-19 and winter, there is a risk to quality and safety in other homes where usual oversight and assurance frameworks cannot be enacted

The following section provides an update to the identified risks to quality and safety for the CCG commissioned services aligned to Governing Body.

Risks being managed by Governing Body are:	
Risk No	**Risk Description**
QN 04	Increasing number of extended trolley waits in ED breaching 12 hours
QN 08	Clinical risks associated with growing waiting list (planned care) – Reported through Board Assurance Framework, therefore not updated in this report.
QN 13	Hep B vaccine in renal patients
QN 15	CQC involvement in York Teaching Hospital NHS Foundation Trust
QN 17	Significant quality and safety concerns at a care home in Vale of York CCG boundary. Now closed as the home closed at end of August 2020.
QN 18	Potential changes to NYCC commissioned Healthy Child program

Covid-19 risks

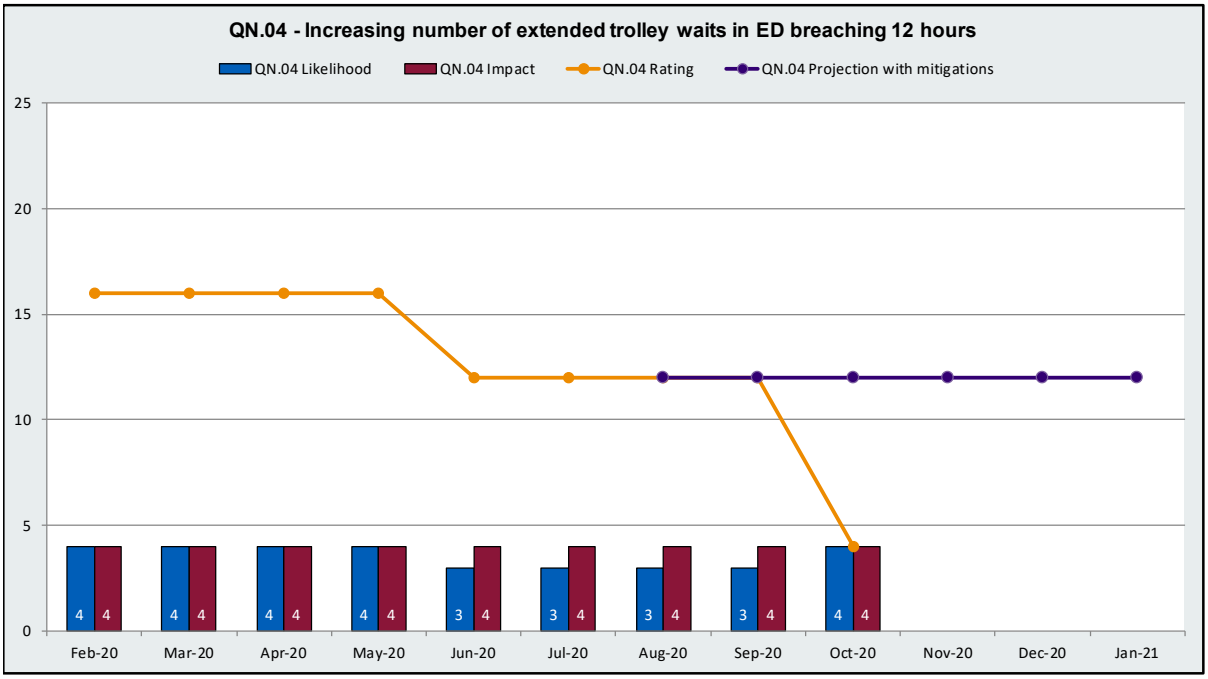
Whilst it is recognised that all services and risks are likely to be impacted by the pandemic, there are some risks that are being managed separately. Governing Body has received a specific risk register for covid-19 related risks. Therefore to avoid duplication those risks which were previously being managed by QPEC but are now specific to the Covid-19 response are transferred to the separate Covid Board Assurance Framework managed by Governing Body.

QN04 – Increased Number of extended trolley waits in ED breaching 12 hrs

GOVERNING BODY RISK

In anticipation of increased ED attendances as we move towards the winter period, risk score has been increased in line with the previous winter.

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

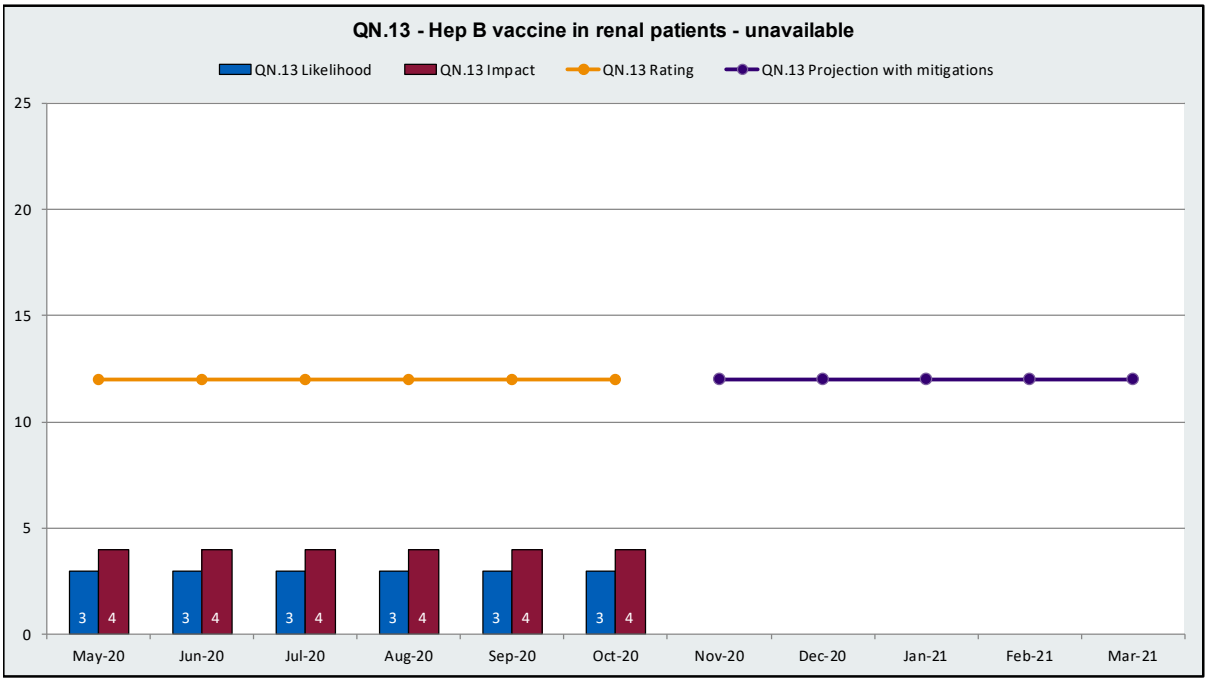


Mitigating Actions and Comments
Date: 02 Oct 2020
ED waiting standards are now being impacted on as ED activity is increasing. The risk needs to be closely monitored as the patients start to access emergency treatment during the tradiotional more busy 'winter season' alongside a surge in Covid cases. The risk remains that some patients attend with worsening conditions due to a delay in seeking help and admission flow is impaired due to a reduction in bed capacity to meet covid segregation requirements.

QN 13 – Hepatitis B vaccinations for renal patients

GOVERNING BODY RISK

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



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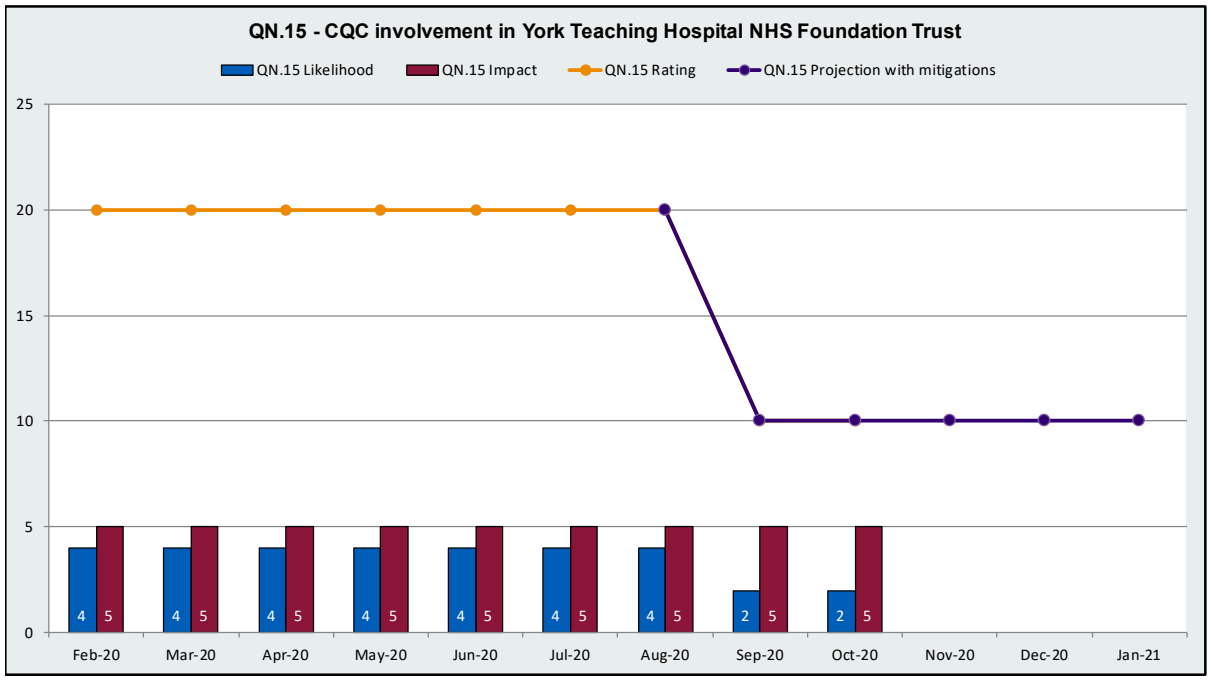
A costing model for Primary care to deliver throughout phase 3 recovery has been approved by CCG Exec committee and supported at LMC. Engagement will continue with practices to deliver through phase 3 whilst engaging with the renal services and across NY to develop a North Yorkshire model.

QN 15 – CQC Involvement in York Teaching Hospitals NHS FT

GOVERNING BODY RISK

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

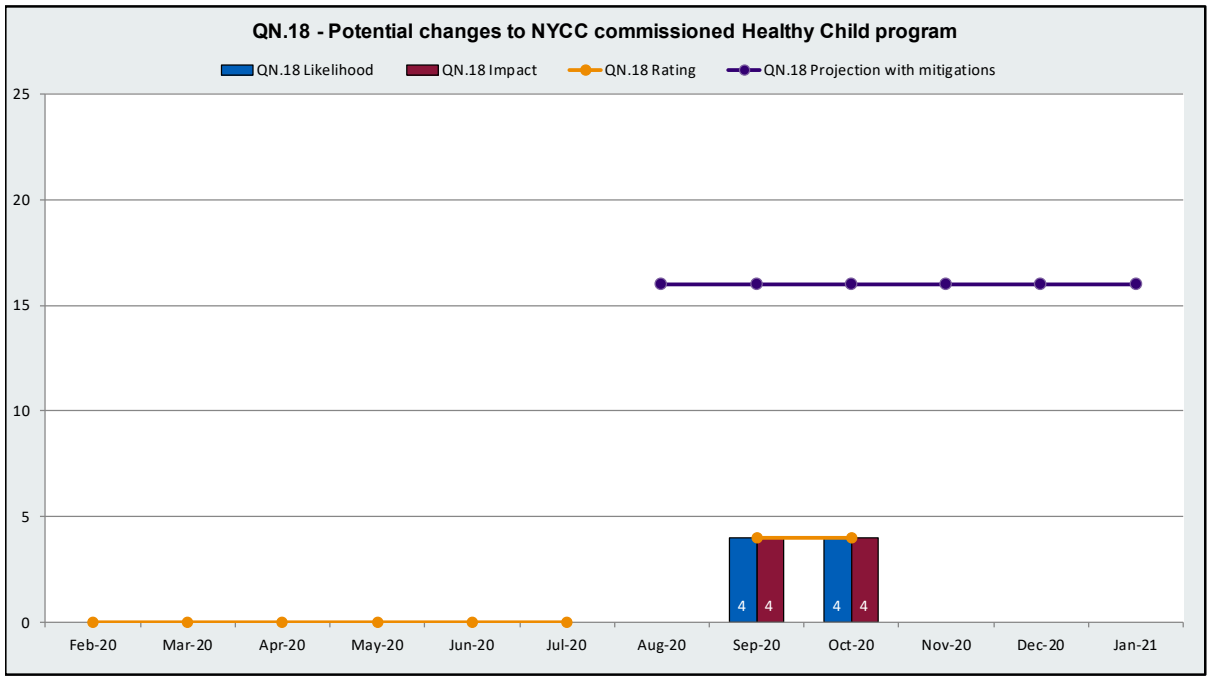


Mitigating Actions and Comments
Date: 5 October 2020
Interim governance arrangements are in place during Covid-19 with NHSE chairing the monthly meeting. Significant progress has been made against the actions resulting in the CQC advising the trust to apply for removal of the regulation notices placed on them however the Trust has opted to delay this application until all significant components of the action plan have been resolved.. The interim governance arrangements are being stood down and replaced with the re-established NHSE/I Patient Safety Board. Quality and safety issues which fall out of that remit will be picked up by a smaller group of commissioning and provider nurses. This group is being established and agreement between the respective Chief Nurses has agreed will agenda in the first instance: • Safe discharges • IPC • Serious incidents • Maternity survey actions • Care homes • Fragility of Scarborough hospital services and • Sharing best practice. First meeting of the new format is scheduled for October 16th In meantime the Patient Safety Group led by NHSE/I continues to meet monthly with improving levels of assurance.

QN 18 Potential changes to NYCC commissioned Healthy Child program

GOVERNING BODY RISK

Risk Ref	**QN.18**
Title	**Potential changes to NYCC commissioned Healthy Child program**
Operational Lead	Karen McNicholas
Lead Director	Michelle Carrington
Description and Impact on Care	The Healthy Child Programme (HCP) is a national public health programme. Commissioning responsibility for the programme sits with the Local Authority. It aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.



Mitigating Actions and Comments
06-Oct-20
In North Yorkshire, the HCP delivery is currently managed through a contractual relationship between North Yorkshire County Council (NYCC) and Harrogate and District Foundation Trust (HDFT). In order to achieve the NYCCC savings plan (necessary due to a reduction in Public Health Grant), changes and reduction in budget to the Health Child program are being proposed. These are currently being consulted with relevant stakeholders with changes expected to take place from April 2022 The new HCP model will create gaps in service delivery within the system, particularly for 5 – 19year olds which will impact upon health services. All impacted services are being consulted with to fully understand the resulting gaps in meeting children's needs and required mitigation. Latest proposals now received and being worked through. discussed at Governing Body with a request to formally write to NYCC outlining our concerns.

14. RECOMMENDATIONS

In the context of the separate strategic and operational work streams which manage the response and risks associated with Covid-19, Governing Body is requested:

- determine whether members are assured of the work being undertaken to understand and support the quality and safety of commissioned services
- determine whether members are assured of the actions to manage the risks aligned to Governing Body
- to be cited on the new risk identified and determine whether they require alignment to Governing Body or QPEC :

Item Number: 7

Name of Presenter: Helena Nowell

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Risk and Board Assurance

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

Reason for Report

The Governing Body are required to review a number of risks which, in line with the Risk Strategy and Policy require escalation to the Governing Body.

The Governing Body is also asked to receive and review the refreshed strategic objectives and associated Board Assurance Framework to comment upon for finalising at the next Governing Body meeting. It is to be acknowledged that the refreshed strategic objectives are likely to be interim and are simply to reflect the changing position of the NHS following the first wave of the Covid-19 pandemic.

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 is asked to confirm approval of the mitigating actions for the risks identified from the Quality and Patient Experience Committee and confirm whether the Governing Body wishes to retain the oversight of these risks or simply receive a report by update and return to Quality and Patient Experience Committee for oversight.

The Governing Body is asked to comment upon and where necessary suggest amendments to the suggested objectives contained within the refreshed Board Assurance Framework.

The Governing Body is asked to approve the direction of travel of risk and assurance process that the risk register will endeavour to only contain risks that the CCG controls and can mitigate; the Board Assurance will reflect system wide risks where the CCG is a party to the risk but can do little to mitigate it.

Decision Requested (for Decision Log)

Governing Body is asked to approve the mitigations for risks QN.04, QN.13, QN.15 and QN.18.

The Governing Body is asked to confirm whether they wish to retain oversight of these risks or return them to Quality and Patient Experience Committee.

The Governing Body is asked to approve; or comment on and amend the Board Assurance Framework and Strategic Objectives.

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

Annexes (please list)
Risk Paper
Board Assurance Framework (to follow)

Risk

The CCG has returned to use of the Risk Policy and Strategy from 5 November 2020. For that reason the following risks need to be reported to the Governing Body and the Governing Body is asked to approve the suggested mitigating actions and confirm whether the risk should remain at Governing Body or whether the mitigation is sufficient to return to Quality and Patient Experience Committee. The Committee are sighted on these risks however they exceed the threshold for reporting to Governing Body.

There are no risks from other committees which have reached the escalation point for Governing Body.

Strategic Objectives and Board Assurance Framework

The CCG has a series of strategic objectives which has formed the basis for the Board Assurance Framework prior to the changes brought about by the pandemic. During the pandemic the CCG received assurance through a Covid BAF which covered signficiant issues during the pandemic.

The Governing Body on the last occasion recognised that there was an opportunity to take the good practice from the Covid BAF and apply that to the BAF going forward and review the strategic objectives albeit early.

The draft of the strategic objectives along with the refreshed Board Assurance Framework will follow this paper to ensure that it is as up to date as possible.

Risks to Governing Body

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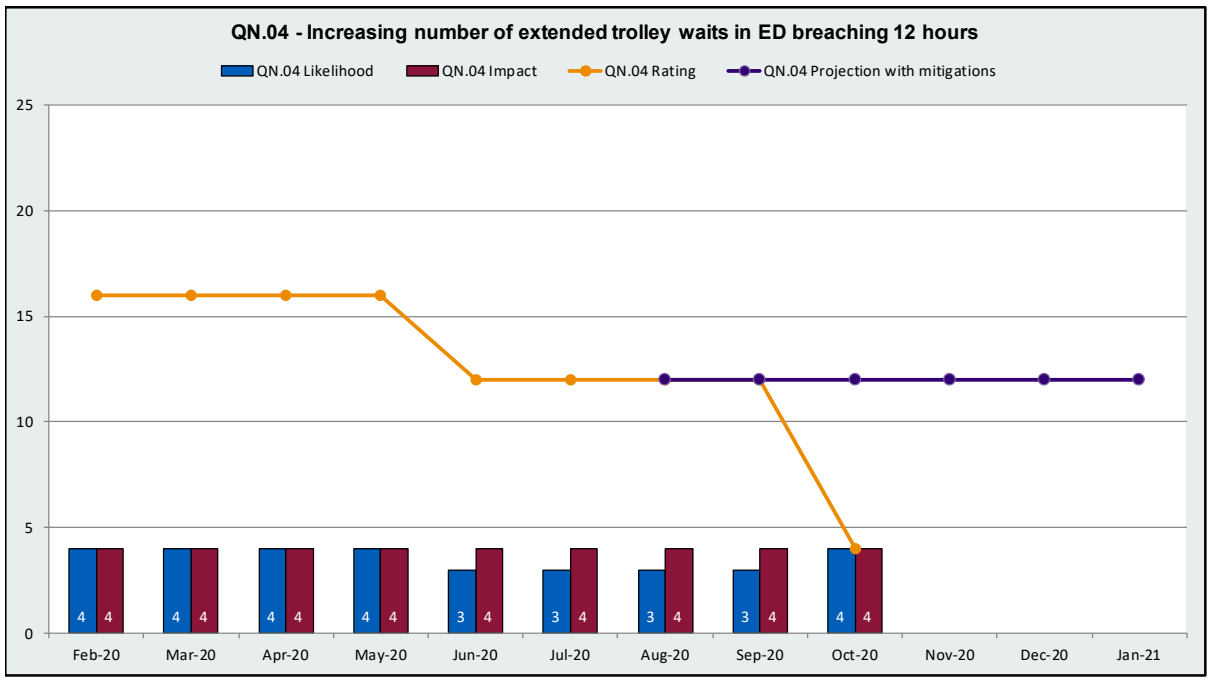

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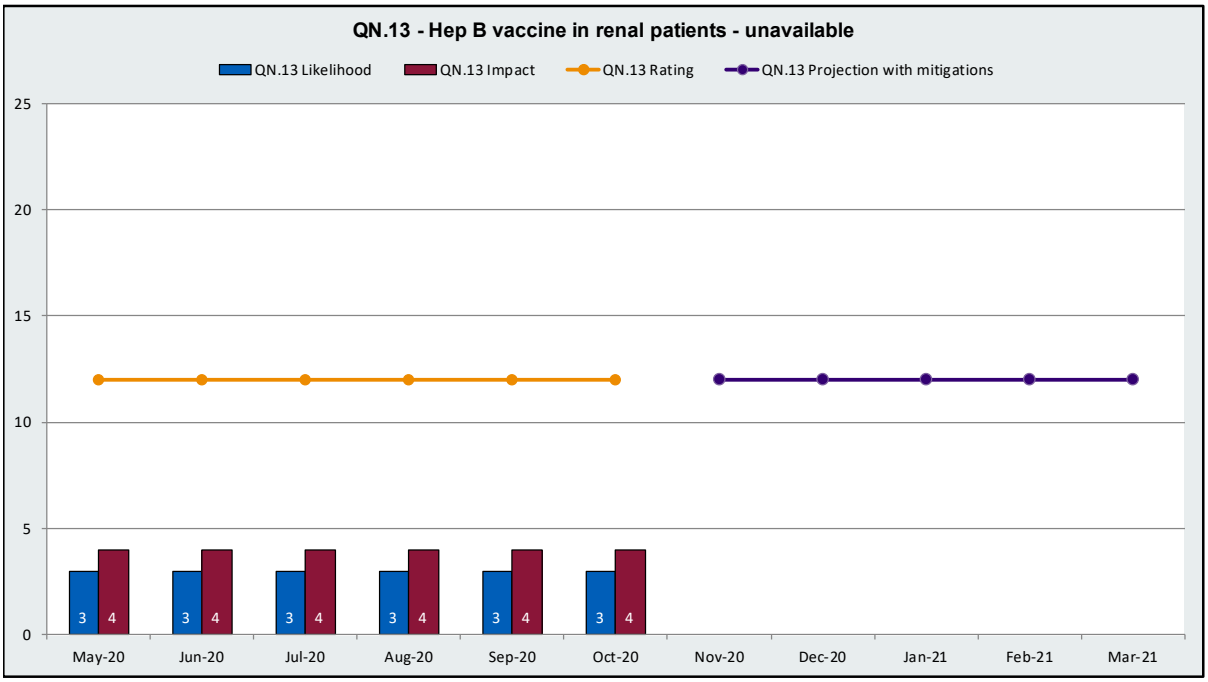

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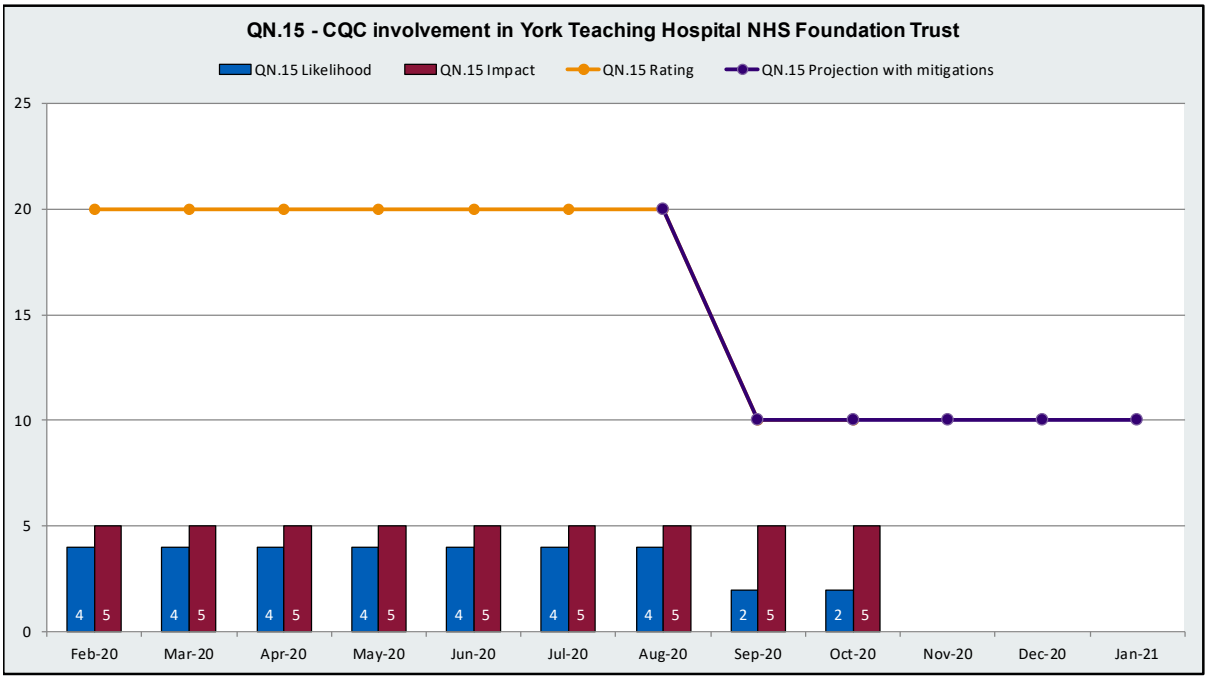

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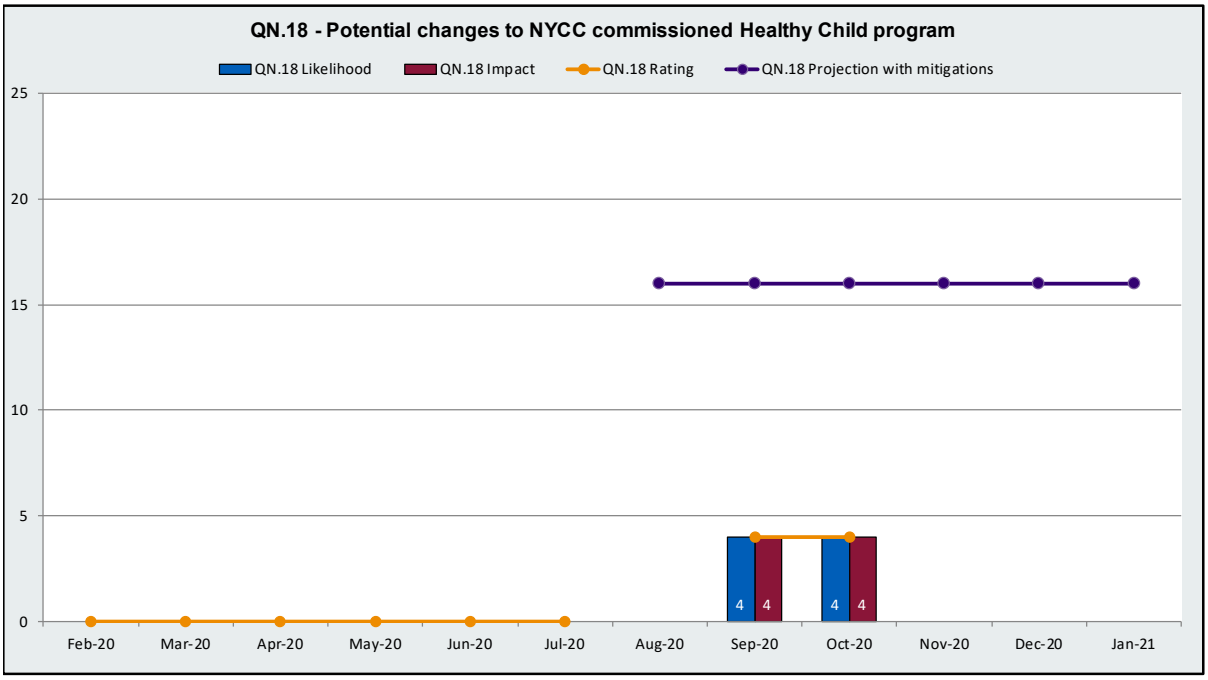
Lead Director	Michelle Carrington
Description and Impact on Care	The Healthy Child Programme (HCP) is a national public health programme. Commissioning responsibility for the programme sits with the Local Authority. It aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.



Mitigating Actions and Comments
06-Oct-20
In North Yorkshire, the HCP delivery is currently managed through a contractual relationship between North Yorkshire County Council (NYCC) and Harrogate and District Foundation Trust (HDFT). In order to achieve the NYCCC savings plan (necessary due to a reduction in Public Health Grant), changes and reduction in budget to the Health Child program are being proposed. These are currently being consulted with relevant stakeholders with changes expected to take place from April 2022 The new HCP model will create gaps in service delivery within the system, particularly for 5 – 19year olds which will impact upon health services. All impacted services are being consulted with to fully understand the resulting gaps in meeting children's needs and required mitigation. Latest proposals now received and being worked through. discussed at Governing Body with a request to formally write to NYCC outlining our concerns.

Item Number: 8

Name of Presenter: Steven Moss

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Counter Fraud Guidance for Primary Care

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

Reason for Report

It was previously discussed at the CCG's Audit Committee that the organisation's Counter Fraud Team would look at producing guidance for GP practices in the CCG area. The guidance was intended to assist GP practices in the prevention and detection of fraud by providing information on:

- The definition of fraud and how it occurs
- The types of fraud that are found in GP practices
- How fraud can be prevented
- How and where to report suspicions of fraud

The attached guidance is in draft form and feedback from members would be greatly appreciated.

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:

Recommendations

The Governing Body receive the paper.

Decision Requested (for Decision Log)

Counter Fraud Guidance for Primary Care received by the Governing Body.

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Steve Moss, Head of Anti-Crime Services, Audit Yorkshire

COUNTER FRAUD GUIDANCE FOR GP SURGERIES

Introduction

Understandably, fraud isn't the first thing you think about when you consider a career in the health service. Most people who join the NHS are surprised to learn that their organisation has a dedicated Local Counter Fraud Specialist.

Unfortunately, fraudsters do target the NHS. As a large, complex organisation opportunities may arise for unscrupulous people to try and divert money intended for patient care into their own pockets.

The NHS Counter Fraud Authority is tasked with overseeing the counter fraud approach taken by the NHS nationally. Their latest estimate puts the amount of money lost to fraud in the NHS in a single year at **£1.2 billion**. That's the equivalent of 40,000 staff nurses or 308,000 hospital beds.

This guidance document will take you through some of the unique risks faced by GP surgeries, as well as some of the most prevalent fraud trends which you should look out for.

At the end of this booklet, you'll find some handy checklists you can use to fraud proof your own practice.

If you have any questions on the contents of this guide, please don't hesitate to contact the Vale of York CCG Local Counter Fraud Specialists, Rosie Dickinson (rosie.dickinson1@nhs.net / 07825 228 175) or Steve Moss (steven.moss@nhs.net /07717 356707)

What is fraud?

Fraud is a criminal offence which is generally quite well understood but does often get confused with theft. In order for an offence of fraud to be proven, specific criteria need to be met.

Firstly, the person (or people) committing the offence need to have behaved in a **dishonest** manner with the deliberate **intention** of **misleading** someone else.

This needs to have been done with the aim of **making a gain** for themselves or another, or to cause the victim **to experience a loss or risk of a loss**.

There are three specific fraud offences that are frequently reported to the local counter fraud team:

Fraud by false representation - the offender commits this offence by making a false representation (lying). For example, if a contractor deliberately inflates the cost of building supplies on an invoice, this would be a false representation. Another example would be if a job applicant filled in an application form claiming that they held a particular qualification which they don't possess.

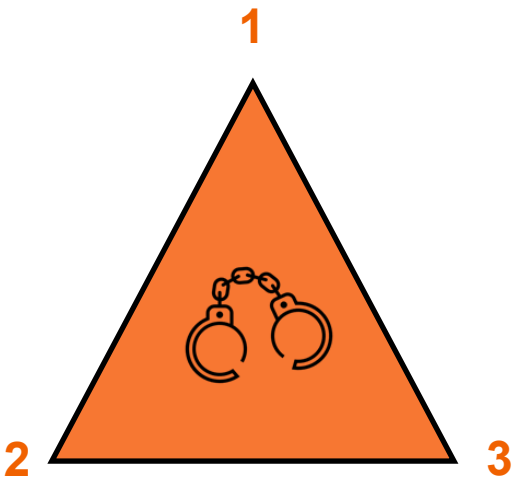
Fraud by failure to disclose - this offence applies where somebody fails to disclose information which they are legally expected to share. A good example of this is the section of a job application form where the applicant is asked to share any existing convictions or pending charges.

Fraud by abuse of position - this offence refers to occasions where a person is in a trusted job role which gives them access to something valuable. That could be access to a bank account, authority for making decisions about which contractors are awarded NHS contracts, or access to computer systems containing patient data. If a person abuses this access for their own personal gain they may be prosecuted for fraud by false representation.

Fraud offences carry a maximum sentence of **10 years in prison** and the potential to face an **unlimited fine.**

How does fraud occur?

In the 1950s a criminologist called Donald Cressey developed his own theory of how fraud takes place. He suggested that three factors needed to be present in order for fraud to take place.



The Fraud Triangle

1. **Opportunity** - there needs to be a window of
2. **Pressure -** the individual committing the offence needs to be under some form of pressure (e.g. in debt, struggling to make ends meet, dealing with stress or addiction)
3. **Rationalisation -** the individual needs to find a way of justifying their actions

You might be wondering what a 1950s criminology model has to do with your practice. It's useful to be aware of this theory as it provides the key to protecting your surgery.

Arguably, you have the most control over the **Opportunity** section of the fraud triangle. By reading through this guidance, you should be able to check your surgery for areas of opportunity which could be exploited. By following the **checklists** at the end of this document, you should be able to produce an action plan for reducing opportunities for fraud to impact your surgery.

It is also important to recognise the role of **Pressure** in the fraud triangle. For example, if a patient is repeatedly claiming to have lost their prescription, there may be a safeguarding issue which is underlying this. They may be struggling with an addiction or could be facing exploitation from a relative or criminal group.

Who commits NHS Fraud?

NHS Fraud comes in many different forms, and can be committed by several different groups.

Patients may adopt an alias in order to obtain additional medication, **contractors** may inflate costs or deliberately submit duplicate invoices, **organised criminals** may target NHS accounts teams, and unfortunately, a very small minority of **NHS staff** will attempt to defraud their employer.

How are GP surgeries affected?

Prescription Fraud

There are numerous ways in which you could be targeted by prescription fraud.

The simplest way for someone to commit this offence is to **steal** an unattended prescription pad.

Another area of risk comes from the ability of staff to **reprint prescriptions**. It is best practice to ensure that the ability to reprint prescriptions is only provided to appropriate staff.

You may come across patients who repeatedly claim that they have **lost their prescription**, or who use out-of-hours services to bypass safety measures at your practice.

Vulnerable patients can be **exploited** by family members, who could contact out-of-hours services to request a new prescription is issued on behalf of their relative.

Prescription Fraud Case Studies

Lisa Rowles

Junior receptionist who did not have the ability to reprint prescriptions

Waited until colleagues left the their work computers unattended

Issued 43 scripts for Zapain and Diazepam over 2 years

Found guilty of committing Fraud by Abuse of Position

Sentenced to 18 months in prison, 150 hours unpaid work and rehabilitation

Ashleen Murray

Stole a prescription pad during an appointment with her GP

Filled out and forged signatures on 22 prescriptions

Redeemed the prescriptions at pharmacies across a large area

Found guilty of 3 counts of Fraud by False Representation

Sentenced to 240 hours of unpaid work and 60 days of rehabilitation

Patient Identity Fraud

Patients may register at numerous medical practices using **false details** in order to access additional medication or services.

There have also been local cases in which patients who have been sent to prison have arranged for **associates** to attend their GP practices in order to secure prescriptions for controlled drugs.

Unfortunately, GP practices have little control over who registers as a patient. However, the simple act of **requesting proof of identity/address** can act as a deterrent as it shows your surgery is not an easy target.

Practice Funds

Practice funds are always going to be of interest for fraudsters.

Practice funds may be targeted by those outside of the organisation, such as unscrupulous contractors or organised criminals.

Unfortunately, practice funds can also be misappropriated by surgery staff. Although this is rare, whenever it does happen it is picked up by the press. A quick search on Google brings up numerous articles relating to high profile examples of where this has happened.

When practice funds are targeted, the impact can be devastating. At the end of this document you'll find a series of **checklists,** including one which will help you to consider whether you need to update or amend your current financial arrangements.

Practice Funds Case Study

Karen Evans

Karen was employed as a practice manager by a GP surgery in Manchester.

Within a month of starting her role, she had started to siphon off practice funds.

She falsified hundreds of patients records over a 15 month period. This even included marking several patient records as "End of Life Care", despite these patients not being on the End of Life pathway.

The fraud was first detected when the partners had to arrange a bank overdraft of £25,000 as they did not have enough money to pay their staff. This began an internal investigation which eventually discovered that Karen had moved £600,000 into her own bank accounts.

The money Karen had taken had been spent on gambling websites. At one point, she won £120,000 but lost all of it within days. It emerged that she had also defrauded a previous GP practice of £77,000 by claiming that the money had been used to pay for medical supplies.

As a result of Karen's actions, 4 of the 5 GPs at the practice had to step down or take early retirement. The patients whose files had been marked as End of Life had been badly affected too as they were caused significant distress by her actions.

Karen was sentenced to 3 years and 4 months in prison.

Current Fraud Trends Affecting the Whole NHS

Mandate Fraud

Mandate Fraud occurs when a fraudster **impersonates a genuine supplier** and requests that the bank details held on file are updated. This results in future invoices being paid into the **wrong bank account.**

Mandate Fraud is very appealing for fraudsters. It can be executed remotely and has a very real potential to result in **a massive pay day** for the criminals. Those committing this type of fraud are very determined and will go to significant lengths to fabricate the perfect disguise.

To do this, Mandate Fraudsters engage in **social engineering**. This is the process by which they research their target and ensure that their emails are cleverly designed to try and bypass even the most experienced NHS employees.

The scammer will **lift corporate branding** (including logos, fonts, signature structures etc.) from genuine emails and use this to make their own emails look correct. They may impersonate an **NHS employee**, making contact with the supplier to secure a list of invoices which are due for payment. They can then attach this list when they target NHS staff to lend their email a further appearance of authenticity. They may also try and **compromise an email account** in order to find out which names they need to drop into their communications with you, and can fabricate multiple fake email accounts from which they can pose as several genuine supplier employees.

During the Covid-19 pandemic, we have seen numerous attempts to target NHS organisations in the Yorkshire area. Some of these attempts have been extremely close to home, and very well constructed. We have had reports of these frauds being attempted against Trusts and CCGs in the local area. Unfortunately, **there is no reason** why a Mandate Fraudster would not target a GP surgery.

Please see the checklists at the end of the document to learn more about how to prevent Mandate Fraud from affecting your practice.

Mandate Fraud Case Study

Mersey Care NHS Foundation Trust

In 2018, Mersey Care NHS Foundation Trust were hit by a mandate fraud.

Criminals entered into communication with the Accounts Payable team, impersonating a genuine supplier who was used by the Trust.

The fraudster pretended to be a known contact within the supplier's organisation. They put in a request for their organisation's bank details to be updated shortly before submitting a single invoice which totalled over £900,000. Unfortunately, the invoice was paid, with the funds landing in a bank account controlled by the fraudsters.

Phishing

Mandate fraud is just one example of how phishing emails can target NHS organisations. There are many forms of phishing emails that you may encounter. The overall aim of a phishing email is to gain access to money, but they may take several different routes to do so. Phishing emails are designed to get you to do one of the following:

1. Send an **immediate payment** directly to a fraudster's bank account
2. To click on a link within the email which will take you to a **phishing website**, where your bank details, personal information, or log in credentials to genuine sites will be harvested
3. To **provide information** which will be used in another fraud later down the line (e.g. names of managers, people dealing with payments, suppliers which are being used etc.)
4. To download a **malicious attachment** which will infect your computer with malware

A key element of phishing is that it is designed to look like it has come from a genuine source. They may impersonate a legitimate company or even another member of NHS staff. There are several tactics that are used and that you should look out for. Please see the guide at the end of this document for advice on what to look out for and how to access specific training on this

Phishing Case Study

Intensive Care Nurse Loses £12k of Personal Savings

An intensive care nurse was contacted via phone call after a night shift.

The call appeared to be from her bank, Halifax. The number displayed on her phone screen matched the number which was printed on the back of her bank card.

The nurse was advised fraudulent activity had been detected on her bank account, with a payment of £7,000 due to leave her ISA imminently. She was persuaded to set up a new ISA and to transfer £12,000 into that account. The "new" account actually belonged to a fraudster.

This scam was actually several days in the making. The nurse had unfortunately fallen foul of a phishing email that had been sent to her, purporting to be from British Gas. It featured their official logo and claimed she had an overdue bill which was due to become very steep as late fees were going to be added.

The nurse was directed to click on a link which would allegedly take her to the British Gas website where she could prevent the late fees from being added and resolve the overdue bill. When she clicked on the link, she was taken to a phishing website where her personal and financial details were harvested.

This gave the fraudsters everything they needed to convincingly impersonate her bank on the phone. They had used a spoofing software to disguise their real number by making it look as though they were calling from Halifax customer services.

Fortunately, she has been refunded the money.

Pre Employment Checks

The pre-employment check process is absolutely vital to protecting the **security** of your practice and the **safety** of your patients. The process can sometimes seem like a paper exercise, and it may be tempting to push through and get the new starter on board. However, it is always worth reminding any staff who deal with recruitment the real reason why these checks are so important.

The checks are designed to verify the **identity** of the applicant, to ensure their **qualifications** are genuine and valid, and to establish whether the person has any **criminal convictions/pending charges** which would affect your decision to appoint them.

During the Covid-19 pandemic, the process of checking identity documents/qualifications and conducting interviews has been altered. In response, NHS Employers have released updated **guidance** which your staff should be aware of.

It may surprise you to learn that you can buy fake qualifications off eBay (where they are listed as a "novelty item"). There are also some hairraising stories out there about people who failed to disclose their criminal history when applying for NHS roles (for example, Craig Alexander, who was employed by NHS Brent after he failed to disclose that he had recently served a prison sentence for armed robbery).

Pre Employment Checks Case Study

Zholia Alemi

Zholia Alemi was employed in the NHS as a Consultant Psychiatrist for around 22 years. Originally from New Zealand, she had arrived in the UK in the mid 1990s as part of an international recruitment drive to fill NHS roles.

Zholia worked with vulnerable patients, and held roles at various NHS organisations all across the country.

Zholia first came to the attention of the police when she attempted to alter the will of one of her patients, an 87 year old lady who had dementia. Within 4 months of meeting the lady at a dementia clinic, Zholia had made an application for power of attorney and attempted to change her will so that the lady's £1.3 million estate would be left to her.

During the police investigation, they uncovered that Zholia had never passed her first year of medical training. When she arrived in the UK, Zholia had produced a fake certificate which she had presented in order to "prove" that she was properly qualified. Unfortunately, the legitimacy of this certificate was not checked and Zholia began her NHS career.

Zholia was sentenced to 5 years in prison for her attempt to alter the will of her patient. In addition, she has recently been charged with 13 offences against the NHS. This includes multiple counts of fraud by false representation, as well as a charge of making a false instrument which relates to the fabricated qualification certificate.

Zholia did not hold the right qualifications for the role she was carrying out for the NHS. There has already been one inquest into the death of a patient who had been in her care.

Prescription Fraud Checklist	
Are prescription pads securely stored and their whereabouts monitored?	
Are electronic prescriptions issued wherever appropriate?	
Are you happy with which members of staff are able to reprint prescriptions?	
Are all staff members advised to lock their computers when they leave their desks?	
Do you audit reprints of prescriptions to identify trends (e.g. the same patient is always reporting missing prescriptions, the same member of staff is always reprinting scripts for particular medications etc.)?	
Do you have a process in place to flag patients who repeatedly report lost or misplaced prescriptions?	
Are patients who repeatedly report lost prescriptions signposted for support or offered alternatives such as electronic prescriptions?	
Are you aware of how to flag a patient's record so that if they contact out of hours numbers call takers are aware of issues such as trying to gain access to particular drugs?	
Are all members of staff aware of the reporting routes for safeguarding concerns if family members are suspected of intercepting medication?	

Patient Identity Fraud Checklist	
Are patients asked to provide proof of identity and address on registering?	
Are patients who fail to supply proof of ID/address followed up when booking appoint-ments?	
Are surgery staff happy with which documents can be provided as proof of ID/address?	

Practice Funds Checklist	
Are financial responsibilities clearly defined and shared amongst appropriate staff?	
Are segregations of duties in place (e.g. different staff raise purchase orders and approve invoice payments)?	
If unable to use segregation of duties, are any transaction level limits in place?	
Are all payments to suppliers reconciled against invoices received before being made?	
Are documentation procedures in place? (e.g. remittance advice slips/deposit slips are used, filed and available for audit)	
Have you reviewed your bank mandate to ensure only current staff are named?	
Is there a reconciliation process in place to regularly compare bank statements to other internal records?	
Do partners review cheque payments?	
Are staff duties rotated, and all staff encouraged to take their annual leave?	
Are any spot checks conducted on practice accounts and financial records?	
Are comprehensive procedure notes available for relevant staff, outlining processes for dealing with income, expenditure, payroll etc?	
Do you review payroll records to ensure all salary payments are genuine? If possible, consider exception reporting which will alert you to payments that are over 10% higher than in the previous month.	
Have partners got access to the Payroll system in order to complete spot checks?	
Do you have an Anti-Fraud, Bribery and Corruption Policy, and do staff know how to report concerns?	

Mandate Fraud and Phishing Checklist	
Do staff members who make payments know about Mandate Fraud and how to spot Phishing emails? *(consider asking the LCFS for training on this if not)*	
Is there a set procedure in place to follow if a request is received for supplier's bank details to be updated?	
If a request for bank details to be updated is received, do staff make contact with the supplier by telephone to verify the request is genuine?	
Are emails requesting invoice payments of changes to bank details closely scrutinised?	
Do your staff know how to report concerns if they are worried about a request for changes to bank details or unusual requests for payments are received?	

A reminder - common tactics used in phishing emails to be aware of:

- Slightly amended email addresses - changes can be very minor
- Spelling and grammatical errors
- Use of pressure - by claiming your account will be shut down, late fees will be applied or you may not be paid this month if you don't comply
- Use of a bait - offers of refunds, "special offers", or information about pay rises etc.

Pre-Employment Checks Checklist	
Are recruiting staff aware of the updated guidance from NHS Employers?	
Are your new starters required to bring their original identity documents and qualification certificates on their first day?	
Has the practice considered what do if a new starter fails to bring their documents?	
Are qualification checks completed wherever proportionate to do so?	
Do you ensure that agency workers also provide proof of identification on arrival?	

Useful Resources

NHS Counter Fraud Authority

Information about fraud and the NHS, including a reference guide on the types of fraud most commonly encountered and an anonymous reporting option.

NHS Digital

Find NHS Digital advice on avoiding phishing emails by clicking on the link above. You can also find links to the NHS Digital campaigns on cyber security issues by clicking here.

NHS Employers

Click the link above to locate the latest guidance on pre-employment checks. You'll find detailed advice on various relevant topics such as how DBS checks are being carried out during the Covid-19 pandemic.

GOV.UK List of Proof of Identity Documents

The link above will take you to a list of proof of identity documents which are approved by the government. This list is useful to refer to when requesting new patients to provide proof of identity or address.

National Cyber Security Centre

Suspicious emails which are received at home can be reported to the National Cyber Security Centre. The website also provides lots of advice about staying safe online, with areas of the website dedicated to advice for keeping safe online at work and at home.

Action Fraud

A national organisation providing advice on all aspects of fraud. This is a useful resource for any patients, as there have been numerous scams throughout the pandemic in which NHS services (including GP surgeries) have been impersonated to defraud vulnerable people.

Further Advice and Guidance

If you have any questions about any of the contents within this guidance document, you are very welcome to contact the Vale of York CCG's Local Counter Fraud Specialists, Rosie Dickinson or Steve Moss. You can reach Rosie and Steve using the following details:

Rosie Dickinson, Local Counter Fraud Specialist rosie.dickinson1@nhs.net Tel: 07825 228 175

Steve Moss, Local Counter Fraud Specialist steven.moss@nhs.net Tel: 07717 356707

If you have a suspicion of fraud are unsure of where to report it please feel free to contact Rosie and Steve for advice.

Who Investigates Fraud at GP Practices?

It can be a little bit complicated establishing who will investigate an allegation of fraud where a GP surgery has been targeted. The interaction between GP Practices and a Local Counter Fraud Specialist usually arises when:

- A GP Practice contacts the CCG for general advice regarding a suspicion of fraud involving practice funds and the matter is passed to the LCFS to provide advice. In circumstances such as this, the advice is often to report the matter to the Police. However, with approval from the CCG the LCFS can provide fraud prevention guidance to the practice.

- The CCG has concerns about concerns the possible misuse or abuse of CCG funds by a practice and the matter is passed to the LCFS for investigation. Authority to investigate is dependent on who holds the contractual and financial liability.

- NHS England has concerns about the possibility of misuse or abuse of abuse of funds they have provided. NHS England have their own in-house team of LCFSs and their involvement in an investigation is again dependent on who holds the contractual and financial liability.

If you are ever in doubt about who to report a concern of fraud to, please do feel free to contact Rosie or Steve for advice and signposting. Please see the previous page for our contact details.

About Audit Yorkshire

The Vale of York CCG's counter fraud and internal audit service is provided by Audit Yorkshire.

Audit Yorkshire is an NHS internal audit, local counter fraud, local security management and advisory service provider which is hosted by York Teaching Hospital NHS Foundation Trust and supported by a consortium of NHS statutory bodies.

If you would like to read more about Audit Yorkshire please visit our website:

https://www.audityorkshire.nhs.uk/

If you would be interested in knowing more about the services that we could provide to your organisation please contact Audit Yorkshire using the following email address:

audityorkshire@york.nhs.uk

Item Number: 9

Name of Presenter: Michelle Carringtoon

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Covid-19 and staff risk assessment

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

Reason for Report

All NHS organisations have been asked to report on the measures in place to ensure that staff have been assessed against the risks presented by Covid-19, in light of data showing that a number of groups, including BAME staff, are at heightened risk. The attached report outines the current activities undertaken.

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

None identified.

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 report be noted.

Decision Requested (for Decision Log)

Report noted. (No decision required.)

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

Annexes (please list)

Appendix A – Letter from Chief People Officer, June 2020
Appendix B
Appendix C

Covid-19 and Equalities – the CCG response

Background

The Chief People Officer of NHS England, Prerana Issar, communicated with all NHS organisations in June 2020 to express concern over the disproportionate impact of the Covid-19 pandemic on ethnic minority staff, and asking that priority be given to carrying out risk assessments for all staff but in particular those known to be most at risk. The letter is attached as Appendix A to this report.

While the full picture of vulnerabilities is still developing, it has become apparent that people with a black or Asian background, people over 65, those with a BMI over 30, certain medical conditions including diabetes and COPD, and pregnant women particularly after 28 weeks, are at greater risk of adverse consequences. A number of NHS organisations have developed their own methodologies for assessing staff risk, and NHS Employers has shared examples of good practice for individual organisations to adapt.

The CCG response

The CCG has undertaken a programme of risk assessment for all staff, in addition to co-ordinating a response to NHS England for GP practice staff assessments.

The response within the CCG was managed by assistant director-level staff for their respective areas, and consisted of a questionnaire to staff with a follow-up discussion to cover issues raised by the questionnaire in addition to any other concerns. The questionnaire was based on material supplied by NHS Employers and was scored to give a risk rating for each member of staff. (See Appendix B, for the staff questionnaire.)

The majority of staff have scored a low risk rating, and this means that once it is considered safe to do so, the majority of staff will be able to return to the office/ normal duties. Where greater risk has been identified, work practices have been adapted accordingly.

In order to reduce risk, staff are working remotely wherever possible, and there are no immediate plans for a full return to office working. The CCG rents office space from City of York Council, who are not anticipating increasing the current building occupation levels until January, in order to maintain strict hygiene and social distancing. Where necessary, staff have been referred for occupational health assessments, for example for MSK-related issues, to ensure their wellbeing, and the CCG will support the purchase of additional equipment where necessary, eg for laptop stands, to reduce any physical risk associated with home-based working. Further support for staff wellbeing is available via the Employee Assistance Programme from the CCG's occupational health provider, and all staff have access to this, which includes counselling for mental health related issues.

GP Practice response

GP Practices have been asked to confirm via the weekly sitrep reporting system the percentage of at-risk staff (including BAME staff) that have been risk-assessed, and

the majority of practices can now confirm that all staff have been assessed. Guidance as to the type of duties that can be carried out has been provided via NHS Employers (see Appendix C, for types of duties at GP practices correlated to risk level).

Next steps

The CCG continues to monitor the latest advice from NHS England and NHS Employers regarding risks to staff, with mitigations in place to reduce risks for potentially vulnerable staff. Should further advice require additional monitoring or changes to the existing arrangements, this will be communicated to staff.

Publications approval reference: 001559

To:
Chairs and CEOs of NHS Trusts / Foundation Trusts
CCG Accountable Officers
GP Practices, General Dental Practices, Community Pharmacists, Primary Care Optometrists

cc:
Directors of Workforce
Primary Care Network Leads
ICS/STP Chairs
Regional Directors

24 June 2020

Dear colleague

Risk assessments for at-risk staff groups

As employers, we each have a legal duty to protect the health, safety and welfare of our own staff. Completing risk assessments for at-risk members of staff is a vital component of this. Thank you to the many of you who have completed risk assessments and continue to provide support for your at-risk staff during this challenging period.

Some staff, however, are reporting that they are yet to have their risk assessment completed.

All employers need to make significant progress in **deploying risk assessments within the next two weeks** and complete them – **at least for all staff in at-risk groups – within four weeks**.

We are asking organisations to **publish the following metrics from their staff reviews**, until fully compliant:

- Number of staff risk-assessed and percentage of whole workforce.
- Number of black, Asian and minority ethnic (BAME) staff risk assessments completed, and percentage of total risk assessments completed and of whole workforce.
- Percentage of staff risk-assessed by staff group.
- Additional mitigation over and above the individual risk assessments in settings where infection rates are highest.

This information should be made available to all staff either via the intranet, all-staff briefings, or similar. We also ask that these data become part of your Board Assurance Framework (or equivalent in a primary care context) and receive board-level scrutiny and ownership. For primary care providers, this would be a senior partner or the business owner as the employer with overall responsibility for their workforce.

Primary care

All primary care organisations remain legally responsible for securing appropriate occupational health (OH) assessments (including staff risk assessments) for their employees. Access to OH services based on the national occupational health specification published in 2016 has been commissioned by NHS England & NHS Improvement and may be via a local NHS trust OH department or an independent OH provider. We ask commissioners, primary care networks and practices to work together to:

- ensure local primary care staff know how to access support from their OH provider
- review OH service providers' current capacity and access to it
- share available OH capacity, or commission more to complement existing OH services via this Dynamic Purchasing Solution, if additional capacity or access outside normal working hours is needed

CCGs are asked to assure that this is happening comprehensively and speedily in their areas.

Support on risk assessments

After asking local NHS employers in April to begin risk assessing staff at potentially increased risk, the Faculty of Occupational Medicine published a risk reduction framework outlining risk factors in light of available scientific evidence. NHS Employers issued updated guidance in May, signposting useful materials. The NHS England/Improvement website contains practical tools and case studies on deploying risk assessments in primary and secondary care. Human Resource Directors (HRDs) have access to the HRD repository. Organisations may continue to use customised tools developed locally with their BAME networks.

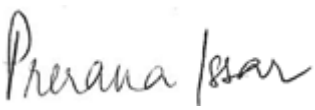
In addition, we have launched educational webinars for HRDs on risk assessments, and dedicated help: nhsi.ournhspeopleleaders@nhs.net

We recognise the sensitive nature of conversations around individual health and wellbeing. But these conversations must take account of the urgency with which we have to ensure our colleagues' safety. Risk assessments should not be viewed in

isolation – satisfactory deployment brings organisation-wide benefits including less absenteeism and sickness, fosters a safety-first culture, and helps ensure trust and engagement with staff. We know trusts and CCGs are working actively with Regional Directors and they will follow up with you including to share best practice.

Thank you again for your continued commitment to staff safety and wellbeing.

Best wishes



Prerana Issar
NHS Chief People Officer
NHS England and NHS Improvement

Dr Nikki Kanani MBE
Medical Director for Primary Care
NHS England and NHS Improvement

Amanda Pritchard
Chief Operating Officer
NHS England and NHS Improvement

Annex: Strategies for deploying individual risk assessments

Examples of good practice in individual risk assessment deployment include:

- Understanding the role of workplace assessment alongside individual risk assessments
- Creating a strategic risk stratification of the workforce – to target those at increased vulnerability first
- Working across the ICS/STP and with PCNs to manage any impact on staffing levels to meet anticipated demand and maintain services
- Clear direction that this is an organisational priority by the leadership team, including CEO ownership and making it a standing item at board meetings (or equivalent in other settings)
- Consistent messaging through all channels on the availability of risk assessments
- Co-production with local BAME networks
- All staff briefings, online training, and support sessions for line managers in deploying high quality risk assessments
- Creating a crib sheet for line managers on having conversations on risk assessments
- Ensuring OH services are adequately resourced to provide appropriate levels of support and that line managers know how to access this in all settings
- Using online and/or smartphone-enabled risk assessments to achieve better adoption
- Co-locating risk assessment meetings with staff facilities (eg staff rooms) or COVID-19 testing sites
- Setting dedicated days in the week for risk assessments
- Creating trained risk assessment helpers within organisations.

COVID-19 –Personal Circumstances Form (inc BAME Risk assessment) specifics)

Employee Name:		**Preferred contact number:**	
Job Title/Role:		**Preferred email address:**	
Payroll Number:		**Department / Team & Site:**	
Ethnicity	**What is your ethnic group?** Choose one option that best describes your ethnic group or background **White** 1. English/Welsh/Scottish/Northern Irish/British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe **Mixed/Multiple ethnic groups** 5. White and Black Caribbean 6. White and Black African 7. White and Asian 8. Any other Mixed/Multiple ethnic background, please describe		

	Asian/Asian British 9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese 13. Any other Asian background, please describe **Black/African/Caribbean/Black British** 14. African 15. Caribbean 16. Any other Black/African/Caribbean background, please describe **Other ethnic group** 17. Arab 18. Any other ethnic group, please describe		
Age:		**Gender:**	Male / Female / Non-binary
Pregnant:	Yes / No / n/a	**Underlying Health Condition/s:**	Yes / No
Pregnancy – Due Date:		**Lives with someone with underlying conditions / is shielding / is at risk for any other reason:**	Yes / No

Indicate current trimester:	1 / 2 / 3	**Does your role bring you into face to face contact with members of the public:**	Yes / No
Has dependents or living with extended family?		**Type of home[1] / housing and if this is classed as 'overcrowded'?[2]**	
Home address / location:		**Travel to work arrangements[3]:**	
Date of Discussion[4]:		**Line Manager Name and Job Title:**	

Review the options below, detailing staff comments and agreements, indicating where options are not applicable (n/a) and why.	
Is this role currently business critical?	Yes / No
Can this role be undertaken fully from home ?	Yes / No
If no, what steps would enable this individual to undertake the role fully?	
Are there reasons that would benefit the individual or the effective working of the individual to work from the office	Yes / No Are these health related Yes / No – please specify Other reasons / benefits
Does the employee or any of their household have any underlying health condition(s) that increase their risk	***(Detail response of employee and advise this can be revisited should the circumstances change).***

[1] Type of property needs manager to consider things such as shared areas in a block of flats (lift). Are people living in a bedsit where a kitchen or bathroom is shared?
[2] This is for the employee to determine and describe to the manager on the basis of their personal circumstances. Overcrowded in relation to their ability to work from that address
[3] Will they travel to work on public transport in which case the guidance should be advised to them about face coverings etc.
[4] Staff should be advised that if their circumstances change at any point following the discussion they should let their line manager know immediately so that further assessment can take place.

from COVID-19? What are the potential risks in relation to COVID within the working environment/service, e.g. direct contact with patients with the virus; occasional contact; potential social contact?	
Does the employee have any other general health and wellbeing issues or concerns?	
Does the employee have any concerns about their work place setting? (i.e. Office setting)	
Does the employee have any concerns about their work station whilst working from home place setting?	**Yes /No / N/A**
Does the employee have any other concerns (housing, financial, personal, caring responsibilities etc.) that may be affecting their well-being or their ability to undertake their current role?	
What adjustments / support could be provided to the employee to mitigate risks? Consider the list below: Signposting to support / information Equipment (e.g. PPE, work station assessment or equipment) Working flexibly or homeworking- we already have home working Change to working pattern Redeployment to another role	
Identify what adjustments have been agreed / are to be considered	**Details of adjustment and redeployment discussed, and outcome detailed below:**

Identify what changes to the employee's role / working location will take place. (Note, if homeworking, need to identify what equipment and IT access the employee will need. Manager to discuss with IT if required).	**Details of homeworking and agreement on how this will be managed, exchanged and approved:**

NB. Where personal circumstances change this form can be completed again and submitted as a central record.

Employee Signed:_____Manager Signed:_____Date:_____

Thank you for taking the time to complete the risk assessments that you have provided to your line managers. Since we asked you to do this we have received some additional guidance that may mean you need to add to your individual risk assessments and I would be grateful if you could do this by 4pm on 9 July 2020. If you do not contact your manager with any amendments by that date I will assume that you have not got any amendments or additions to make and your risk level will be assessed on the basis of the assessment we already have.

The clarity is around the conditions that are regarded as higher risk and how to calculate that on the basis of the severity of that condition and also the individuals BMI if over 40 requires a score. For ease of reference I have attached the link to the BMI calculator below:-

https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/

	Risk Categories by Condition		
Condition	**1 Low Risk**	**2 Moderate Risk**	**3 Significant Risk**
Pregnancy			Pregnant workers (at any stage) who have underlying health conditions
			Pregnant workers after 28 weeks gestation
Weakened Immune System (excluding cancers)		A weakened immune system as the result of conditions such as: ✦ HIV and AIDS ✦ SLE / Lupus ✦ Rheumatoid or medicines such as steroids ✦ Chemotherapy or immune modulators	Solid organ transplant recipients
			Bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
			People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell)
			People on immunosuppression therapies sufficient to significantly increase risk of infection

	Risk Categories by Condition		
Condition	**1 Low Risk**	**2 Moderate Risk**	**3 Significant Risk**
Cancers		Cancer – chemotherapy or XRT completed in the last 6 months	Cancer who are undergoing active chemotherapy or radiotherapy for lung cancer
			Cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
			People having immunotherapy or other continuing antibody treatments for cancer
			People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
			People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
Heart Conditions	Cardiac conditions such as previous heart attack with no	Heart valve disease that is severe and associated with symptoms (regularly feel breathless, or you have symptoms from your heart valve problem despite medication, or if you are waiting for valve surgery)	Chronic heart disease, such as heart failure
		You're recovering from recent open-heart surgery in the last three months (including heart bypass surgery)	

	ongoing problems, Controlled high BP etc.	Congenital heart disease (any type) if you also have any of the following: lung disease, pulmonary hypertension, heart failure, you're over 70, you are pregnant, or if you have complex congenital heart disease (such as Fontan, single ventricle or cyanosis)	
		Cardiomyopathy (any type) if you have symptoms such as breathlessness, or it limits your daily life, or you've been told you have problems with your heart function.	

	Risk Categories by Condition		
Condition	**1 Low Risk**	**2 Moderate Risk**	**3 Significant Risk**
Respiratory Conditions	Mild asthma- never hospitalised or needing oral steroids in last 2 years	Chronic (long-term) respiratory diseases, such as problematic asthma, COPD, emphysema or bronchitis that have required a hospital admission or a course of oral steroids within the last 2 years	People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD (including those who have required multiple hospital admissions or courses of oral steroids within the last 2 year), confirmed occupational lung disease and pulmonary hypertension
	Use of CPAP machine for Sleep Apnoea		
Neurological disorders	Mild multiple sclerosis only with sensory or visual changes	Chronic neurological conditions, such as Parkinson's disease, motor neurone disease, multiple sclerosis	

	Stable mild cerebral palsy (i.e. where they may walk a little awkwardly, but might not need any special help)	Learning disability or moderate cerebral palsy (.e. may need to use special equipment to be able to walk, or might not be able to walk at all or need lifelong care)	
	Well controlled epilepsy		
	Fibromyalgia / ME		
Renal Disorders	Kidney disease Stage 1 &2	Chronic kidney disease stage 3a	Chronic kidney disease stage 3b, 4 - 5

	Risk Categories by Condition		
Condition	**1 Low Risk**	**2 Moderate Risk**	**3 Significant Risk**
Liver Disorders	Minor derangement of liver function	Chronic liver disease, such as active hepatitis	
	Fatty liver disease		
	Haemochromatosis		
Other Conditions	Diabetes controlled by diet or tablets with no diabetic complications	Diabetes well controlled on insulin and without diabetic complications	Diabetes controlled on insulin or diabetes with diabetic complications or poor glucose control
	Coeliac disease	Problems with the spleen, such as sickle cell disease or spleen removed	Severe diseases of body systems

		Being seriously obese (a BMI of 40 or above)	

Safety Assessment And Decision (SAAD) Score (2)

SAAD Score (2) for BAME Community during a COVID-19 Pandemic Infection in General Practice

In the current climate with the COVID-19 pandemic there is significant concern amongst all clinicians around the potential consequences of being infected, this being exaggerated in the Black, Asian and Minority Ethnic (BAME) community due to the excess deaths faced by this cohort. In compiling this score card, the co-authors have approached the task with both a personal and professional responsibility. Some of the co-authors have suffered and recovered from a COVID-19 infection, some have buried a local colleague and friend who was a General Practitioner (GP) and some have expressed concern related to the disproportional deaths in the BAME community.

This scoring system has been constructed following a review of many research papers and guidance available. In some cases, there has been a lack of available data to make a clear recommendation and accordingly the group has reflected on the data available and used their clinical experience to propose a pragmatic approach**. The system has been developed for all staff within General Practice including both clinical and non-clinical staff. This is also applicable to all ethnicities within the practice.**

The recommendations and scoring below are guidance and where required the staff member and manager can with mutual agreement list alternative conditions that support the needs of the GP practice, whilst ensuring a safe work environment for the staff member.

In using this score card the practice manager or responsible clinician should adopt the following:

- Print the score card and pass to staff member
- Allow staff member to review the score card in advance of the meeting
- Arrange meeting to jointly go through the score card
- Record the findings by circling/ticking all relevant boxes
- Staff member having any one of the four risks in the 'high' risk category will automatically place themselves in the 'high' risk category irrespective of other variables
- Discuss mental health and well-being concerns with staff member (no score for this, tick the box once concerns discussed and any actions agreed)
- Complete each row and then add all rows to provide a total risk figure
- Based on the score, review the relevant roles for the staff member as highlighted below and according to their contractual duties
- Record any decisions made to mitigate/reduce risk
- Record a review date and store in staff file for future review (provide staff member a copy of the score card)
- **This score card is not for workers that fulfil the government criteria for 'Shielding' – these workers should follow national guidance and stay at home**

On the 5th May 2020, a number of the co-authors accompanied a well-loved, and highly respected local GP, Dr Saad Al-Dubbaisi to his final resting place. This scoring system is named after our friend and colleague SAAD

1 Dr Jiva, Dr Chauhan, Dr Choudry, Dr Butt, Dr Omofuma, Dr Atcha, Dr Mohammed, Dr Alam, Mr Butt

Safety Assessment And Decision (SAAD) Score (2)

SCORE CARD

Staff name: Manager name: Date:

	Points					
	1	2	3	4	High Risk	Row score
Age	40-49	50-59	60-69		70 and above	
Ethnicity	White Chinese Mixed origin	Indian	Bangladeshi Pakistani Middle East	Black		
	*__BAME Other__: Any staff that do not fall into one of the categories above, score according to other ethnicities above					
Gender	Female	Male				
Obesity (BMI) Appendix 1	Over 23 (exclude white/ Chinese/ mixed)		Over 30 (white/ Chinese/mixed)	Over 30 (exclude white/ Chinese/ mixed)	Over 40 (All groups)	
Pregnancy		Under 28 weeks			Over 28 weeks	
Medical Conditions- Appendix 2	One condition			Two conditions	Three or more conditions	
Vitamin D level Appendix 3	30-50	Under 30				

Total score:

Mental Health & Well-being Review: (Appendix 4) Done

Mild Risk Score: 1-8	Moderate Risk Score: 9-12	High Risk Score: 13 or above

Action taken:

Signed: Staff Manager

2 Dr Jiva, Dr Chauhan, Dr Choudry, Dr Butt, Dr Omofuma, Dr Atcha, Dr Mohammed, Dr Alam, Mr Butt

Roles and Responsibilities for Clinical and Non-Clinical Staff:

Risk Area	**Clinical Staff within General Practice**
Mild	Roles within General Practice: • F2F Hot sites • F2F Cold sites • Telephone Consultations • Video Consultations • 'Paper work' – hospital letters, blood results, medication reviews, prescriptions etc • Immunisations • Staff training (Video) • Coiling fitting • Cervical Screening • Home visits – COVID-19 • Home visits–non COVID-19 • Urgent phlebotomy • Death Certification Avoid: • Routine medicals eg HGV • Routine F2F medication/ Health reviews • Routine phlebotomy for annual reviews (unless related to specific drugs eg DMARDS) • Travel Vaccinations • Minor Surgery
Moderate	Roles within General Practice: • F2F Cold sites • Telephone Consultations • Video Consultations • 'Paper work' – hospital letters, blood results, medication reviews, prescriptions etc • Home visits -non COVID-19 • Staff training (Video) Avoid: • Routine medicals eg HGV • Routine F2F medication/ Health reviews • All phlebotomy • Travel Vaccinations • Cervical screening • Minor Surgery • Coil Fitting • Any Care Home Visits • All F2F COVID-19 engagement (Video permitted) • Death Certification

3 Dr Jiva, Dr Chauhan, Dr Choudry, Dr Butt, Dr Omofuma, Dr Atcha, Dr Mohammed, Dr Alam, Mr Butt

Safety Assessment And Decision (SAAD) Score (2)

High	Roles within General Practice: • Telephone Consultations • Video Consultations • 'Paper work' – hospital letters, blood results, medication reviews, prescriptions etc • Staff training (Video) • Work from home where possible Avoid: • Routine medicals eg HGV • Routine F2F medication/ Health reviews • All phlebotomy • Travel Vaccinations • Cervical screening • Minor Surgery • Coil Fitting • Any Care Home Visits • All F2F COVID-19 engagement (Video permitted) • Death Certification
	Non-Clinical Staff within General Practice
Mild	Continue working as normal but following infection control and safety precautions (ie masks when moving between rooms within the building, cleaning down work stations before and after use and ensure where possible social distancing both during work and during breaks)
Moderate	Follow infection control and safety precautions Adjust working hours where possible Face masks when working in shared rooms Working in a separate room where possible Minimal F2F patient contact (ie no front reception desk work)
High	Follow infection control and safety precautions No direct patient contacts Lone working or working in separate office with minimal movement within the building Working from home where possible

- Regularly review working environment with staff member
- Document actions agreed between staff and manager (Review 6 monthly or earlier if any conditions with staff change or during appraisals after first review)
- Raise any concerns about limitations in implementing safe environment for staff member with employer

Appendix 1: Obesity

Although many score cards available refer to obesity above a BMI of 30, data available is clear for the BAME community this risk increases with a BMI of 23, with further significant risk with a BMI of 27.5 and above.

Appendix 2: Medical Conditions

Each of the conditions below would be considered for the score card. Some of the conditions will be the same as the shielding category but will be 'severe' in the shielding category and 'mild' or 'moderate' for this score card. Medical conditions in each category should be assessed individually ie heart failure with a past history of heart attack would be considered as 2 points.

- Respiratory problems (Asthma (taking daily inhaled steroid)/COPD/Bronchiectasis)
- Heart Problems (Heart Failure, Angina, History of Heart Attack)
- Chronic Kidney Disease (stage 3 and above)
- Chronic Liver Disease including Hepatitis
- Chronic Neurological Conditions (Parkinson's, Motor Neurone Disease, History of Stroke (CVA), Multiple Sclerosis, Cerebral Palsy)
- Diabetes (Type 1 or 2)
- Reduced Immune Response - AIDS/HIV, regular oral steroids
- Hypertension (on one or more anti-hypertensive medication)
- Ongoing inflammatory bowel conditions (Crohn's, Ulcerative Colitis)

Appendix 3: Vitamin D

At present it would appear that the role played by Vitamin D is unclear in the management of Covid-19. It is uncertain as to whether it provides specific protection towards Covid-19 or whether it prevents respiratory complications. There does appear to be evolving evidence to suggest that in people who have Vitamin D levels of insufficiency or deficiency, the outcomes in patients who develop Covid-19 appear to adversely impact both mortality and morbidity. This appears to be level dependent and worse as levels of Vitamin D decline.

On balance the group are of the opinion that the benefits of taking Vitamin D replacement outweigh the risks associated with this.

Three of the GPs coincidentally from this group had their Vitamin D levels checked. All three are well with no known past medical history and take no medications. Their body mass indexes vary between 23-30. The Vitamin D blood levels returned with two GPs having a result around 24 and one having a blood Vitamin D level of 14.

Measurement of serum 25OHD, which is 25-hydroxy Vitamin D provides the best estimate of Vitamin D status.

We are of the opinion that members of staff working within general practice, from a BAME ethnicity should have the opportunity to have their Vitamin D levels checked. We suspect that BAME staff may be over represented in those with low levels of Vitamin D.

A subsequent blood test after three months of replacement therapy should be considered to check the response to Vitamin D replacement therapy.

Where results of Vitamin D levels are unavailable, BAME members of staff should be considered to have a minimum of Vitamin D insufficiency for the scoring system. Discretion can be applied as to whether to consider the level to be in the deficient range.

Local and national guidance should be followed relating to replacement therapy.

http://gmmmg.nhs.uk/docs/nts/NTS-Recommendation-on-Vitamin-D-deficiency-and-insufficiency-adults.pdf

Appendix 4 – Mental Health and Well-being

There could be significant mental trauma for the staff in light of the current situation. The manager should enquire about any support the staff may require with open ended questions such as 'What can I do to help?' or 'How can we help you?'. The meeting should take place in a quite private setting without interruptions to ensure the true feelings and concerns of the staff member can be captured. Any issues raised by staff need to be addressed with a bilateral discussion on what solutions are available to address the concerns raised with a documented plan with time line to implement any solutions.

Additional resources:

Coaching and support for primary care staff psychological well-being
https://people.nhs.uk/lookingafteryoutoo/

Well-being and resilience toolkit: https://beyond-coaching.co.uk/nhs-online-toolkit/

Well-being poster:
https://nshcs.hee.nhs.uk/wp-content/uploads/2020/04/A4-WELLBEING-POSTER.pdf

Health and well-being Response:
https://glosprimarycare.co.uk/wp-content/uploads/2020/04/Health-and-Wellbeing-package-Apr20.pdf

Communication Brief:
https://www.eastmidlandsdeanery.nhs.uk/sites/default/files/comms_brief_v2_07.04.20.pdf

Mental Health Helplines:
https://www.nhs.uk/conditions/stress-anxiety-depression/mental-health-helplines/

Support Now: https://people.nhs.uk/help/

COVID-19: Guidance on risk mitigation for BAME staff in mental healthcare settings (RCPsych):
https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/risk-mitigation-for-bame-staff

Appendix 5 – Work related precautions

Ensure staff are familiar with the following:

- Correct hand washing technique and duration
- Appropriate use of face masks around the building and access to appropriate PPE based on level of risk for clinical staff (both in clinic and for home visits)
- Social distancing in the building both during work and during breaks
- Review practice policy to ensure staff are responsible for reporting any illness to their line manager which could affect the safety of other staff or patients using the premises
- Staff familiar with symptoms of COVID-19 infection
- Staff familiar with how to arrange COVID-19 swab if required
- During the current pandemic staff kept up to date on changes in practice policies and adaptations to work environment

Appendix 6 – Examples of staff and scoring

Male – 2 points Indian – 2 points Age 56 – 2 points BMI 28 – 1 point No medical conditions – 0 point Vitamin D (38) – 1 point Score: 8 points Mild risk category
Female – 1 point Black – 4 points Age 42 – 1 point Diabetic (IDDM) – 1 point Vitamin D (14) – 2 points Score: 9 points Moderate risk category
Male – 2 points Egyptian – 3 points Age 64 – 3 points BMI 36 – 4 points Angina and Diabetic – 4 points No Vitamin D level – 1 points Score: 17 points High risk category

These examples are only for illustrative purpose. The scoring will depend on the individual staff member's views on their scoring within the table and a discussion with their manager on the required interventions to minimise or mitigate risk.

Co-authors:

Dr M Jiva MBE (Chair)	General Practitioner CEO, Rochdale & Bury Local Medical Committee Chair, Rochdale Health Alliance (GP Fed)
Dr Z Chauhan OBE	General Practitioner Chief Clinical & Governance Officer BARDOC
Dr B Choudry	General Practitioner GP Trainer
Dr F Butt	General Practitioner Chair, Rochdale & Bury Local Medical Committee Neighbourhood Chair, Bury East
Dr O J Omofuma	General Practitioner Board Member, Rochdale Health Alliance (GP Federation) Mental Health and Medical Student Education Lead
Dr Z Atcha	General Practitioner
Dr Z Mohammed	General Practitioner GP Trainer and appraiser Treasurer, Rochdale Health Alliance (GP Fed) Vice-Chair, Rochdale & Bury Local Medical Committee Clinical Director for Heywood
Dr B Alam	General Practitioner Governing Body Member, HMR CCG Chair, Rochdale Locality Engagement Group Prevention and Partnership Board Member Integrated Commissioning Board Member
Mr Asif Butt	Practice Manager Bury CCG Flu Group Practice Manager Lead Bury CCG IT Practice Manager Lead

Any feedback to be sent to:

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8 Dr Jiva, Dr Chauhan, Dr Choudry, Dr Butt, Dr Omofuma, Dr Atcha, Dr Mohammed, Dr Alam, Mr Butt

References

The references below where used to support constructive group discussion and assist in producing this document:

1. BAME COVID-19 Deaths – What do we know? Rapid evidence and data review 'Hidden in plain sight':file:///C:/Users/M%20Jiva/Downloads/BAME-COVID-Rapid-Data-Evidence-Review-Final-Hidden-in-Plain-Sight-compressed.pdf.pdf

2. Faculty of Medicine (2020) Risk Reduction Framework for NHS Staff at risk of COVID-19 infection (2020) https://www.fom.ac.uk/wp-content/uploads/Risk-Reduction-Framework-for-NHS-staff-at-risk-of-COVID-19-infection-12-05-20.pdf

3. Office of National Statistics (2020) Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

4. Risk stratification for Healthcare workers during CoViD1-19 Pandemic: using demographics, co-morbid disease and clinical domain in order to assign clinical duties. https://www.medrxiv.org/content/10.1101/2020.05.05.20091967v1.full.pdf+html

5. Risk reduction framework for NHS staff at risk of COVID-19 infection: https://www.fom.ac.uk/wp-content/uploads/Risk-Reduction-Framework-for-NHS-staff-at-risk-of-COVID-19-infection-12-05-20.pdf

6. NICE Public Health Draft Guidance – Assessing body mass index and waist circumference thresholds for intervening to prevent ill health and premature death among adults from black, Asian and other minority ethnic groups in the UK: https://www.nice.org.uk/guidance/ph46/documents/bmi-and-waist-circumference-black-and-minority-ethnic-groups-draft-guidance2

7. NICE Obesity - Identification, assessment and management: https://www.nice.org.uk/guidance/cg189/ifp/chapter/Obesity-and-being-overweight

8. GMMMG – Treatment of Vitamin D Deficiency and Insufficiency in Adults: http://gmmmg.nhs.uk/docs/nts/NTS-Recommendation-on-Vitamin-D-deficiency-and-insufficiency-adults.pdf

9. Evidence that Vitamin D supplementation could reduce risk of Influenza and COVID-19 infections and deaths: https://www.ncbi.nlm.nih.gov/pubmed/32252338

Item Number: 10

Name of Presenter: Denise Nightingale

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Update on work relating to physical health checks for people with severe mental illness (SMI)

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

Reason for Report
This paper provides an update on activity to deliver physical health checks for people with a severe mental illness in primary care and to renew the Local Enhanced Service in 2020/21 aimed at ensuring that 60% of 'active' patients on the mental health Quality Outcome Framework (QOF) receive a comprehensive physical health check at least annually.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

☒Financial
☐Legal
☒Primary Care
☒Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks

There may be disparity of service provision across some practices for patients with severe mental illness in accessing services.

This could further increase the differential between mortality and morbidity already recognised for those with a severe mental illness within the Vale of York.

Recommendations
Members of the Governing Body are asked to note and consider the contents of this paper.

Responsible Executive Director and Title	**Report Author and Title**
Denise Nightingale Executive Director	Sheila Fletcher. Commissioner, Adult Mental Health

Annex 1 Elements of the comprehensive assessment
Annex 2. Q2 data report

1. Background

Evidence shows that people with severe mental illness (SMI) die up to fifteen- twenty years younger than the average population; one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. This disparity in health outcomes is partly due to physical health needs being overlooked, both in terms of identification and treatment.

A target set by NHS England aims to increase the uptake of physical health checks for patients with SMI to 60% of 'active' patients on the mental health Quality Outcome Framework (QOF).

In March 2020, the VOY CCG Executive Committee approved funding to renew the Local Enhanced Service (LES) in primary care.

2. Evaluation of the 2019/20 LES

It is agreed that the physical health checks represent additional work over and above those included in the Quality Outcome Framework (QOF) but that the work is unlikely to result in an increase in the number of appointments as these patients are already invited for an annual health check.

In 2019/20, the LES was offered to all primary care practices as an interim position and implemented by 19 practices from October 2019.

The table below shows a steady upward trend in performance with achievement of the locally agreed 30% target.

Quarter	% of checks completed
Q4 (19/20)	17.6
Q1	25.8
Q2	26.1
Q3	27.3
Q4	30.0

Feedback from individual practice GPs and PCN clinical directors is they are supportive of the LES and recognise the importance of identifying and offering, where appropriate, early intervention and treatment for people with SMI. Other feedback included:

- Recommend consistent use of the Ardens template or re-designed QOF template as it systematically guides GPs to undertake the relevant checks
- Targeted campaigns to improve the uptake of the health checks were implemented, for example alerts added to all SMI patients as "pop ups" to remind clinicians to organise outstanding checks, also SMS campaigns to boost interest
- Named practitioners identified to lead on improving targets
- 36 staff attended training held in December 2019

- Although attendance rates when called for a health check are low, opportunistic contacts are key and need to be maximised
- Improved data sharing needed with TEWV - outcomes of physical health checks undertaken in secondary care not consistently forwarded to primary care
- Opportunities to link with QOF appointment but further time required for follow-up interventions
- Care navigators, voluntary sector organisations with links to social prescribing could play a crucial role in effective care planning and providing follow up support
- PCN clinical directors suggest that currently LES cannot be delivered on a PCN basis and in order to achieve improvements quickly it should be offered on an individual practice basis. This is related more to the maturity and workload for PCNs rather than the principle of it being led by them. GPs felt however that it is a long-term strategic objective for PCNs and a priority in terms of their work on reducing health inequalities.

3. 2020/21 LES

Taking into account the feedback from primary care, the CCG approved additional funding for the 2020/21 LES, representing an additional 30 minutes. This is to take account of the follow-up interventions and personalised care planning needed to ensure that people with SMI are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health.

Participating practices will receive an annual payment of £21.14 per patient on the Severe Mental Health Register for whom the first 6 elements of the physical health checks and relevant follow-up interventions, where indicated by the health checks, have been completed. The YOR LMC has indicated their support for the LES and it has been offered to all VOY CCG practices. All but three practices in Vale of York have agreed to implement. Two of these have declined and one has yet to confirm.

4. 2020/21 Activity

The table below shows quarterly performance so far in 2020/21.

Quarter	% of checks completed
Q1	24.7
Q1	22.6

4.1 Impact of COVID-19

SMI Health checks in Q1 this year was 24.7%, a reduction from the previous quarter of 30%.

This downward trend has continued in Q2 with performance at 22.6%. The overall CCG data return is available at Annex 2 below. The detailed data return is appended. In summary:

- Three practices failed to submit a return
- Overall, over 60% of patients received checks 1,2 and 6
- Less than 50% received checks 3, 4 and 5
- Only three practices achieved over 50% of patients receiving all six checks
- The lowest two performing practices achieved less than 10%.

At the start of the outbreak in March, necessary steps were taken to safeguard the health system from being overwhelmed and to free-up and protect staff. It is suggested that ongoing challenges to restore activity to usual levels, as part of the third phase NHS COVID response from 1st August 2020, had a significant impact on demonstrating improvements. Catch-up initiatives to reach out proactively to clinically vulnerable people coincided with planning for the biggest ever flu vaccination programme, on top of on-going workload and workforce pressures.

Social distancing measures also had an impact on individuals attending GP practices. In addition, blood testing has been hampered due to issues with the phlebotomy service at York hospital which has now been resolved.

Individual practices on signing up to the LES nevertheless have indicated their commitment to addressing this priority work.

Currently the expectation is that services under QOF continue and that patients are brought into COVID safe sites for face-face health checks. As we move into a second wave of the COVID-19 pandemic, discussions are ongoing with primary care to explore the potential for the checks to be done under Improving Access. Also, to explore the development of 'cold sites' and hub working to facilitate patient access and flow.

4.2 The CCG will provide additional support through:

- **Information sharing**

TEWV will enable appropriate sharing and exchanging of accurate and up-to-date information; for example shared test results.

The CCG is working with the Drug and Alcohol Service in York to identify patients under the care of this service who are also on practice SMI registers and who may reliably engage with the service in order to receive their health checks and follow-up interventions. This will include follow-up through primary care social prescribers to community based support and interventions. This could go some way to addressing unmet need in this cohort of patients, particularly around obesity and high-risk links to COVID.

- **A standardised template**

It is recommended, but not mandatory, that practices follow the guidance issued in relation to the Bradford Care Template which has been developed to support the implementation of this service specification. The template has been designed to be

completed within a half-hour nurse appointment. A user-friendly template is available within SystmOne and EMIS web platforms, it systematically guides healthcare professionals to identify patients with conditions including high blood pressure, diabetes and cardiovascular problems.

Similarly, The Ardens template is widely used by practices and also includes all the areas for monitoring within this service specification.

- **Free training and pathway guidance for practices**

The AHSN has funded an E-Learning Module in order for clinicians to access this training on line, which is also Continual Professional Development (CPD) recognised. There are 1000 free places.

Recommendations

The Governing Body is requested to note and comment on this report.

Annex 1

Physical Health Physical health Checks in Severe Mental Illness (PHSMI)

The comprehensive assessment should include:

1. A measurement of weight (BMI or BMI + Waist circumference)
2. A blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate)
3. A blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)
4. A blood glucose test (blood glucose or HbA1c measurement)
5. An assessment of alcohol consumption
6. An assessment of smoking status
7. An assessment of nutritional status, diet and level of physical activity
8. An assessment of use of illicit substance/non prescribed drugs
9. Medicines reconciliation and review
10. Indicated follow-up interventions
11. Access to relevant national screenings

12 General physical health enquiry into sexual health and oral health

CCGs are asked to report on the delivery of the relevant follow-up interventions where these are indicated by the health check. Data on interventions 7-12 is to be captured to support local understanding of service delivery and benchmarking in 2019/20 **and does not form part of the core standard measure.**

	2019/20 technical guidance ref.	Number of patients	Percentage of patients receiving check	Time period
The number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' (Denominator):	1.2.1	2,296		at period end
Of the above, patients who have had (Numerators):				
1. measurement of weight (BMI or BMI + Waist circumference)	1.4.1	1,494	**65.1%**	in 12 months to period end
2. blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate)	1.4.2	1,501	**65.4%**	
3. blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)	1.4.3	973	**42.4%**	
4. blood glucose test (blood glucose or HbA1c measurement)	1.4.4	1,057	**46.0%**	
5. assessment of alcohol consumption	1.4.5	1,041	**45.3%**	
6. assessment of smoking status	1.4.6	1,484	**64.6%**	
All six physical health checks - note this cannot be greater than the minimum figure reported in 1 to 6 above.	1.2.1	520	**22.6%**	

Note that an individual who has received all six physical health checks should **also** be reported against **each** physical health check, 1 to 6.

The number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' (Denominator):		**2,296**		at period end
Of the denominator above, patients who have had (Numerators):				
7. assessment of nutritional status/diet and level of physical activity	1.6.1	481	**20.9%**	in 12 months to period end
8. assessment of use of illicit substance/non-prescribed drugs	1.6.2	461	**20.1%**	
9. medicines reconciliation or review	1.6.3	1,438	**62.6%**	

SMI Register and physical Health Check performance - Q2 (30th September) 2020-21

PCN	GP System	Registered practice ID	Practice Name	2020-21 SMI Register Q1 2021	2020-21 SMI Register Q2 2021	Most Recent Qtr Difference	6 Core physical Health Checks Q1 2021: 1.Weight	2.BP Check	3.Blood Lipid	4.Blood Glucose	5.Alcohol Consumption	6.Smoking Status	7.Nutrition	8.Illicit Substances	9.Medicines Reconciliation	2021 Q1 Performance: All 6 physical Health Checks	Performance	2021 Q2 Performance: All 6 physical Health Checks	Performance	Change - Most Recent Qtr
York East	EMIS	B82080	MyHealth	81	83	2	60	59	17	29	31	56	5	1	9	13	16.0%	7	8.4%	-7.6%
York East	EMIS	B82081	Elvington	33	32	-1	20	23	12	14	11	20	0	0	29	7	21.2%	5	15.6%	-5.6%
York East	EMIS	B81036	Pocklington	92	0	-92	0	0	0	0	0	0	0	0	0	16	17.4%	0		-17.4%
York East total				**206**	**115**	**-91**	**80**	**82**	**29**	**43**	**42**	**76**	**5**	**1**	**38**	**36**	**17.5%**	**12**	**10.4%**	**-7.0%**
West, Outer and North East York	SystmOne	B82100	Front Street Surgery	47	46	-1	25	25	20	19	16	21	1	2	20	12	25.5%	8	17.4%	-8.1%
West, Outer and North East York	SystmOne	B82026	Haxby Group Practice	192	200	8	81	116	70	85	31	89	5	11	113	13	6.8%	14	7.0%	0.0%
West, Outer and North East York	SystmOne	B82071	Old School Medical Practice	24	21	-3	17	20	11	13	14	17	10	9	13	2	8.3%	9	42.9%	34.5%
WONE York Total				**263**	**267**	**4**	**123**	**161**	**101**	**117**	**61**	**127**	**16**	**22**	**146**	**27**	**10.3%**	**31**	**11.6%**	**1.3%**
Priory Medical Group		**B82005**	**Priory Medical Group**	**450**	**461**	**11**	**368**	**308**	**191**	**211**	**311**	**366**	**198**	**199**	**329**	**127**	**28.2%**	**122**	**26.5%**	**-1.8%**
Selby Town	SystmOne	B82074	Posterngate Surgery	99	99	0	62	60	42	45	54	68	10	7	71	28	28.3%	28	28.3%	0.0%
Selby Town	SystmOne	B82097	Scott Road Medical Centre	81	85	4	57	62	47	47	42	52	29	29	49	38	46.9%	28	32.9%	-14.0%
Selby Town	SystmOne	B82018	The Escrick Surgery	14	13	-1	10	7	7	7	8	8	6	7	10	4	28.6%	3	23.1%	-5.5%
Selby Town	EMIS	B82041	Beech Tree	90	88	-2	71	61	43	48	35	60	0	2	35	21	23.3%	23	26.1%	2.8%
Selby Town Total				**284**	**285**	**1**	**200**	**190**	**139**	**147**	**139**	**188**	**45**	**45**	**165**	**91**	**32.0%**	**82**	**28.8%**	**-3.3%**
South Hambleton And Ryedale	SystmOne	B82068	Helmsley Medical Centre	29	29	0	25	28	19	20	17	22	16	14	24	17	58.6%	14	48.3%	-10.3%
South Hambleton And Ryedale	SystmOne	B82077	Kirkbymoorside Surgery	41	41	0	24	32	33	30	31	31	27	26	34	20	48.8%	22	53.7%	4.9%
South Hambleton And Ryedale	SystmOne	B82619	Terrington Surgery	8	8	0	8	7	6	6	5	7	2	2	7	3	37.5%	4	50.0%	12.5%
South Hambleton And Ryedale	EMIS	B82002	Millfield Surgery	41	0	-41	0	0	0	0	0	0	0	0	0	14	34.1%	0		-34.1%
South Hambleton And Ryedale	EMIS	B82033	Pickering Medical Practice	68	65	-3	43	47	47	46	43	48	15	21	59	33	48.5%	28	43.1%	-5.5%
South Hambleton And Ryedale	EMIS	B82064	Tollerton	17	17	0	15	15	13	10	12	14	8	5	14	7	41.2%	9	52.9%	11.8%
South Hambleton And Ryedale	EMIS	B82079	Stillington	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0.0%
South Hambleton And Ryedale total				**204**	**160**	**-44**	**115**	**129**	**118**	**112**	**108**	**122**	**68**	**68**	**138**	**94**	**46.1%**	**77**	**48.1%**	**2.0%**
Tadcaster & Selby	SystmOne	B82073	South Milford Surgery	47	45	-2	19	25	22	24	15	23	2	2	30	18	38.3%	10	22.2%	-16.1%
Tadcaster & Selby	SystmOne	B82105	Tadcaster Medical Centre	37	37	0	26	25	19	23	21	32	10	8	22	9	24.3%	14	37.8%	13.5%
Tadcaster & Selby	EMIS	B82031	Sherburn	41	40	-1	32	32	23	25	18	26	4	6	33	10	24.4%	8	20.0%	-4.4%
Tadcaster & Selby Total				**125**	**122**	**-3**	**77**	**82**	**64**	**72**	**54**	**81**	**16**	**16**	**85**	**37**	**29.6%**	**32**	**26.2%**	**-3.4%**
York City Centre	EMIS	B82098	Jorvik Gillygate Practice	218	243	25	152	148	74	74	98	142	14	17	188	39	17.9%	43	17.7%	-0.2%
York City Centre	EMIS	B82101	East Parade (Merged with Jorvik)	26		-26										6	23.1%		#DIV/0!	#DIV/0!
York City Centre	EMIS	B82021	Dalton Terrace	105	105	0	71	76	45	47	31	64	1	1	78	13	12.4%	12	11.4%	-1.0%
York City Centre	EMIS	B82047	Unity	0	81	81	49	44	32	33	31	42	2	3	60	0		15	18.5%	18.5%
York City Centre Total				**349**	**429**	**80**	**272**	**268**	**151**	**154**	**160**	**248**	**17**	**21**	**326**	**58**	**16.6%**	**70**	**16.3%**	**-0.3%**
York Medical Group	**SystmOne**	**B82083**	**York Medical Group**	**457**	**457**	**0**	**259**	**281**	**180**	**201**	**166**	**276**	**116**	**89**	**211**	**107**	23.4%	**94**	20.6%	**-2.8%**
CCG Total				**2338**	**2296**	**-42**	**1494**	**1501**	**973**	**1057**	**1041**	**1484**	**481**	**461**	**1438**	**577**	**24.7%**	**520**	**22.6%**	**-2.0%**

Heat Map

PCN	GP System	Registered practice ID	Practice Name	2020-21 SMI Register Q1 2021	2020-21 SMI Register Q2 2021	1.Weight	2.BP Check	3.Blood Lipid	4.Blood Glucose	5.Alcohol Consumption	6.Smoking Status	7.Nutrition	8.Illicit Substances	9.Medicines Reconciliation	2021 All 6 physical Health Checks Q1	2021 All 6 physical Health Checks Q2	
York East	EMIS	B82080	MyHealth	81	83	72.3%	71.1%	20.5%	34.9%	37.3%	67.5%	6.0%	1.2%	10.8%	16.0%	8.4%	
York East	EMIS	B82081	Elvington	33	32	62.5%	71.9%	37.5%	43.8%	34.4%	62.5%	0.0%	0.0%	90.6%	21.2%	15.6%	
York East	EMIS	B81036	Pocklington	92	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.4%	0.0%	
West, Outer and North East York	SystmOne	B82100	Front Street Surgery	47	46	54.3%	54.3%	43.5%	41.3%	34.8%	45.7%	2.2%	4.3%	43.5%	25.5%	17.4%	
West, Outer and North East York	SystmOne	B82026	Haxby Group Practice	192	200	40.5%	58.0%	35.0%	42.5%	15.5%	44.5%	2.5%	5.5%	56.5%	6.8%	7.0%	
West, Outer and North East York	SystmOne	B82071	Old School Medical Practice - Copmanthorpe	24	21	81.0%	95.2%	52.4%	61.9%	66.7%	81.0%	47.6%	42.9%	61.9%	8.3%	42.9%	
Priory Medical Group	SystmOne	B82005	Priory Medical Group	450	461	79.8%	66.8%	41.4%	45.8%	67.5%	79.4%	43.0%	43.2%	71.4%	28.2%	26.5%	Old School Medi
Selby Town	SystmOne	B82074	Posterngate Surgery	99	99	62.6%	60.6%	42.4%	45.5%	54.5%	68.7%	10.1%	7.1%	71.7%	28.3%	28.3%	
Selby Town	SystmOne	B82097	Scott Road Medical Centre	81	85	67.1%	72.9%	55.3%	55.3%	49.4%	61.2%	34.1%	34.1%	57.6%	46.9%	32.9%	
Selby Town	SystmOne	B82018	The Escrick Surgery	14	13	76.9%	53.8%	53.8%	53.8%	61.5%	61.5%	46.2%	53.8%	76.9%	28.6%	23.1%	
Selby Town	EMIS	B82041	Beech Tree	90	88	80.7%	69.3%	48.9%	54.5%	39.8%	68.2%	0.0%	2.3%	39.8%	23.3%	26.1%	
South Hambleton And Ryedale	SystmOne	B82068	Helmsley Medical Centre	29	29	86.2%	96.6%	65.5%	69.0%	58.6%	75.9%	55.2%	48.3%	82.8%	58.6%	48.3%	
South Hambleton And Ryedale	SystmOne	B82077	Kirkbymoorside Surgery	41	41	58.5%	78.0%	80.5%	73.2%	75.6%	75.6%	65.9%	63.4%	82.9%	48.8%	53.7%	
South Hambleton And Ryedale	SystmOne	B82619	Terrington Surgery	8	8	100.0%	87.5%	75.0%	75.0%	62.5%	87.5%	25.0%	25.0%	87.5%	37.5%	50.0%	
South Hambleton And Ryedale	EMIS	B82002	Millfield Surgery	41	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	34.1%	0.0%	
South Hambleton And Ryedale	EMIS	B82033	Pickering Medical Practice	68	65	66.2%	72.3%	72.3%	70.8%	66.2%	73.8%	23.1%	32.3%	90.8%	48.5%	43.1%	
South Hambleton And Ryedale	EMIS	B82064	Tollerton	17	17	88.2%	88.2%	76.5%	58.8%	70.6%	82.4%	47.1%	29.4%	82.4%	41.2%	52.9%	
South Hambleton And Ryedale	EMIS	B82079	Stillington	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Tadcaster & Selby	SystmOne	B82073	South Milford Surgery	47	45	42.2%	55.6%	48.9%	53.3%	33.3%	51.1%	4.4%	4.4%	66.7%	38.3%	22.2%	
Tadcaster & Selby	SystmOne	B82105	Tadcaster Medical Centre	37	37	70.3%	67.6%	51.4%	62.2%	56.8%	86.5%	27.0%	21.6%	59.5%	24.3%	37.8%	
Tadcaster & Selby	EMIS	B82031	Sherburn	41	40	80.0%	80.0%	57.5%	62.5%	45.0%	65.0%	10.0%	15.0%	82.5%	24.4%	20.0%	
York City Centre	EMIS	B82098	Jorvik Gillygate Practice	218	243	62.6%	60.9%	30.5%	30.5%	40.3%	58.4%	5.8%	7.0%	77.4%	17.9%	17.7%	
York City Centre	EMIS	B82101	East Parade (Merged with Jorvik)	26	0										23.1%		
York City Centre	EMIS	B82021	Dalton Terrace	105	105	67.6%	72.4%	42.9%	44.8%	29.5%	61.0%	1.0%	1.0%	74.3%	12.4%	11.4%	East
York City Centre	EMIS	B82047	Unity	0	81	60.5%	54.3%	39.5%	40.7%	38.3%	51.9%	2.5%	3.7%	74.1%	0.0%	18.5%	
York Medical Group	SystmOne	B82083	York Medical Group	457	457	56.7%	61.5%	39.4%	44.0%	36.3%	60.4%	25.4%	19.5%	46.2%	23.4%	20.6%	
VoY CCG				**2338**	**2296**	**65.1%**	**65.4%**	**42.4%**	**46.0%**	**45.3%**	**64.6%**	**20.9%**	**20.1%**	**62.6%**	**24.7%**	**22.6%**	

Item Number: 10

Name of Presenter: Denise Nightingale

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Update on work relating to physical health checks for people with Learning Disabilities (LD)

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

Reason for Report
This paper provides an update on activity to deliver annual health checks for people age 14 years and over with a learning disability in primary care.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks

- ☒Financial
- ☐Legal
- ☒Primary Care
- ☒Equalities

Covalent Risk Reference and Covalent Description

Emerging Risks

There may be disparity of service provision across some practices for patients with learning disabilities in accessing services. This could further increase the differential between mortality and morbidity already recognised for those with a learning disability within the Vale of York.

Recommendations
Members of the Governing Body are asked to note and consider the contents of this paper.

Responsible Executive Director and Title	**Report Author and Title**
Denise Nightingale Executive Director of Transformation, Complex Care and Mental Health	Carl Donbavand Programme Lead (Complex Care and Mental Health)

1. Background and national drivers

- The Long Term Plan sets out as a priority that at least 75% of people with a learning disability age 14 and over have a health check each year
- Compared to the general population, the median age of death is 23 years younger for men with a learning disability and 27 years younger for women with a learning disability (DH&SC, 2020)
- Nationally between 10 April and 15 May there have been 386 deaths of people with a learning disability/Autism (a 134% increase)

The national quality improvement actions for care of people with learning disabilities is focused upon the restoration of proactive annual health checks in primary care and ensuring that seasonal flu vaccination is maximised in this group of people in order to optimise their health and to reduce preventable morbidity and mortality.

2. 2020/21 Phase 3 plan and performance

As part of the CCG phase 3 recovery planning a trajectory, as shown in table 1 below, has been set to increase the uptake of LD annual health checks to 579 by the 31st March 2021.

Table.1 shows the quarterly planned recovery targets for 2021/21.

Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Total	Total Register size
0	181	171	227	579	1012

The table below shows the actual quarterly activity so far in 2020/21.

Quarter	Number completed	Percentage completed (quarterly figure)
Q1 2020/21	48	4.8%
Q2 2020/21	Pending	Pending

Impact of COVID-19

At the start of the outbreak in March, necessary steps were taken to safeguard the health system from being overwhelmed and to free-up and protect staff. LD Health checks in Q1 20-21 was 4.8%, a reduction from the previous quarter of 27.3%, which potentially reflects these measures. Similarly, evidence indicates that social distancing has had an impact on individuals attending GP practices.

Currently the expectation is that proactive annual health checks for people with learning disabilities continue.

Actions completed:

- Meetings with PCN and practices to raise awareness of health inequalities and funding opportunities.
- Development of a Quality Improvement (QI) support and facilitation offer.
- A CCG LD health check Programme Assurance Group across primary care and mental health commissioning teams has been established, working to a single programme plan.
- BI colleagues are working develop more timely and robust monthly monitoring data to support practices with QI activity (e.g. flu registers vs LD registers).
- Planning is underway for a CCG wide LD health check training event to take place on 6th November 2020, which will be delivered by local clinical champions.
- A personalised care transformation funding bid was successful. The additional resource will be targeted at addressing health inequalities and using approaches in line with the personalised care compressive model (e.g. personalised care and support planning, care co-ordination roles).

Actions Planned

- A CCG wide LD health check training event is planned for primary care staff on 6th November 2020.
- Two practices are in receipt of the CCGs QI support and facilitation offer, which will be rolled out to other practices in a targeted manner.
- Communications and engagement plans to raise awareness of health checks with support from LA partners.
- Health promotion, sharing best practice guides and accessible resources with practices (e.g. easy read guides/leaflet)
- A PTL LD health check event for January 2021 to share local QI and innovative models of delivery to support GP resilience
- Collaboration with NYCCGs and LA to explore opportunities and avoid any duplication.

Recommendations

The Governing Body is requested to note and comment on this report.

Item Number: 11

Name of Presenter: Caroline Alexander

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS Vale of York Clinical Commissioning Group

Report Title – Winter Resilience Planning 2020/21

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

Reason for Report

In preparing for the delivery of health services over the winter period organisations and systems have been asked to develop their resilience plans based on three integral areas:

- winter and seasonal pressures,
- a second wave of Covid-19, restoration, and
- recovery of elective work as described in phase 3 recovery plans.

NHS Vale of York CCG supports the York/Scarborough Health and Care Resilience Board, working alongside health and social care system partners in this geographical area.

The CCG has worked with system partners to collectively develop the system seasonal resilience plans for 2020/21 using intelligence gained from review of winter 2019/20 and scenario planning work involving all partners and supported by the Humber Coast and Vale (HCV) ICS Urgent and Emergency Care Network.

There are robust system arrangements in place for monitoring the delivery of the system resilience plan which includes daily monitoring and effective responses and management of system escalation (aligned to Emergency Preparedness Resilience and Response and Operational Pressures Escalation Level reporting).

The local system will commence national winter reporting to NHSE/I on November 2nd 2020, when twice weekly regional feedback calls will be instigated along with a 7 day reporting requirement.

The system resilience plans have been signed off by all system partners and are due to be submitted to NHSE/I and HCV ICS for assurances by the first week in November 2020.

Oversight and monitoring of the System Resilience Plans will be undertaken by the York & Scarborough Health & Care Resilience Board.

The escalation plans to support a second wave of COVID and peak escalation actions are being developed by all system partners and a local system surge plan will be proposed to North Yorkshire and York Gold Command in early November. This will inform a refresh of the local to Emergency Preparedness Resilience and Response and associated business continuity plans for organisations.

Strategic Priority Links

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

Local Authority Area

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

Impacts/ Key Risks	**Risk Rating**
☐Financial ☐Legal ☒Primary Care ☒Equalities	The system winter resilience plans support the delivery of urgent and emergency care and are linked to the risk UPC.10 in respect of delivery of the A&E 4 hour access target.

Emerging Risks

The impact of the second wave of COVID-19 and mitigations to be captured in the system surge plans will sit alongside the winter escalation and resilience plans.

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

Governing Body is asked to accept and note this paper further to approvals by the CCG Finance and Performance Committee on the 22nd October 2020.

Decision Requested (for Decision Log)

Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam Accountable Officer NHS Vale of York CCG	Caroline Alexander m NHS Vale of York CCG

Item Number: 12

Name of Presenter: Caroline Alexander

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Surge Escalation Planning

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

Executive Summary

- Health and care system partners have been working together to respond to the demands which have been placed on organisations during the COVID-19pandemic.
- Services are now being restored across health (acute care, primary care, community care, mental health care, complex care and care for people with learning disabilities).
- In September North Yorkshire and York system partners submitted detailed plans to NHSE/I to show how capacity in acute settings (including mental health) could be safely restored back to 'pre-COVID' levels – the phase 3 recovery plans.
- The phase 3 recovery plan for North Yorkshire and York shows that NHSE/I recovery trajectory targets can be achieved subject to enactment of surge plans.
- Subsequent to submission of the phase 3 recovery plans NHSE/I have asked systems to consider different scenarios of demand for acute beds during a second wave of COVID.
- Partners are finalising their surge plans including the escalation and de-escalation actions that might be required to manage a peak in the second wave.
- Workforce is a consistent underpinning risk across second surge plans and mitigating actions to manage this risk must be prioritised across the system.

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	**Risk Rating**
☐Financial ☐Legal ☒Primary Care ☒Equalities	The system surge escalation plans support the resilient delivery of non-COVID and COVID care and protection of patients and staff. There is a risk that not having a system surge plan which can support escalations and de-escalations during the peak(s) of a second wave of COVID will impact on the delivery of these services.

Emerging Risks

The impact of the second wave of COVID-19 and mitigations to be captured in the system surge plans will sit alongside the system winter resilience plans and Phase 3 recovery plans of non-COVID care. The single greatest common risk across all these plans for resilient delivery of care throughout the winter period is the workforce capacity available.

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: N/A

Recommendations

Governing Body is asked to note this update and the work of local system partners to develop surge plans through the Silver Command COVID structure and System Delivery Executive. These plans will be reviewed by the CCG Executive Committee and Finance & Performance Committee during November and approval would be through the North Yorkshire & York Gold Command.

Decision Requested (for Decision Log)

Responsible Executive Director and Title	Report Author and Title
Phil Mettam, Accountable Officer NHS Vale of York CCG	Caroline Alexander Assistant Director of Performance and Delivery NHS Vale of York CCG

Surge and Escalation Planning

1.0 Background

Health and care system partners have been working together to respond to the demands which have been placed on organisations during the Covid pandemic. Over the summer health care providers began restoring the provision of all services across health (acute care, primary care, community care, mental health care, complex care and care for people with learning disabilities).

The process of restoring services has been made in line with national infection prevention and control (IPC) guidelines, and with the support of available local independent sector and voluntary sector capacity in order to be able to safely deliver non-Covid care pathways while existing with Covid.

This restoration work, co-ordinated through the North Yorkshire and York System Leadership Executive (NYSLE), now encompasses:

- Delivering plans to recover pre-Covid levels of activity in the system
- Managing typical winter demand and system pressures
- Responding to a potential second wave (or surge) of Covid cases.

2.0 Recovery Planning

In September North Yorkshire and York (NY&Y) system partners submitted detailed plans and a comprehensive narrative to NHSE to show how capacity in acute settings (including mental health) could be safely returned back to 'pre-Covid' levels whilst also maintaining the safe, infection controlled environments which have been established. The period covered in the plans is from September 2020 through to March 2021 and is referred to as the 'phase 3 recovery plan', phase 1 being the initial emergency response and phase 2 being the switching back on of urgent clinical services during the summer.

The phase 3 plan lays out the monthly activity trajectories through to March 2021 across the main hospitals to meet the monthly targets set by Simon Stevens in July 2020. These are summarised below:

	Monthly Activity Recovery Trajectory Targets (as a percentage of corresponding activity in 2019/20)						
	Sept 20	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
Electives	80%	90%	90%	90%	90%	90%	90%
Day cases	80%	90%	90%	90%	90%	90%	90%
First Attendances	100%	100%	100%	100%	100%	100%	100%
Follow-ups	100%	100%	100%	100%	100%	100%	100%

The phase 3 plan for North Yorkshire and York shows that these trajectories can be achieved with some support from the independent sector subject to significant surge activity. The plans anticipate typical additional winter pressures and ongoing demand from Covid patients.

Initial planning has been predicated on prioritising cancer and urgent/emergency care pathways and maintaining safe, segregated capacity. Phase 3 recovery plans for cancer will continue to be developed over winter during a possible second surge of Covid cases.

The plan also articulates the importance of strong out of hospital care (primary care, community care, social care) in keeping patients safe and well at home to avoid unnecessary referrals. Good out of hospital care also enables patients to be safely and quickly discharged from hospital to free up capacity. Our shared commitment will continue to be 'home first' by default, using discharge to assess as the framework for streaming people into the right location to meet their needs.

Key out of hospital elements in the recovery plan include:

- Hot pathways implemented across primary care
- Increased virtual wards in the community including rehabilitation to support new discharge process
- Thirty additional beds, nursing and residential, commissioned to support effective discharge across North Yorkshire.
- Out of hours strengthened in Scarborough
- Development of primary care Opel escalation system underway
- On-going work to develop additional phlebotomy clinics to support urgent diagnostics, routine care and health checks
- Wave 1 Covid laptops still in place to support remote working, video consultations and online consultations for General Practice
- Joint system coordinators in place to ensure discharge command centres functioning 7 days a week

3.0 Planning for a second surge in Covid-19 cases

Subsequent to submission of the phase 3 recovery plan NHSE/I have asked systems to consider different scenarios of demand for acute beds during a second wave of Covid and the possible consequential impact on hospital activity. It must be emphasised the scenarios provided were not forecasts but different situations ranging from minimal demand less than what has already been built into the recovery plan through to higher levels and peaks.

An initial modelling exercise was carried out by hospitals using the scenarios and now all partner organisations are finalising their surge plans. To complete these plans clinicians will also consider the escalation and de-escalation actions that might be required to manage a peak in the second wave of Covid during the winter period,

while ensuring as much of the planned non-Covid care restored to date continues to be delivered alongside emergency, urgent and cancer care.

The North Yorkshire and York Silver Command Group will collectively review these plans in late October so that there is a clear understanding of how surge plans will be enacted across the system. This will minimise unexpected impacts and maximise opportunities for mutual aid.

In addition presentations have been made by all Integrated Care Systems (ICSs) to the NHSE/I North East and Yorkshire regional team to consider risks related to managing a second wave in a number of key areas as follows:

- Patient care - safety, governance, social care and infection prevention and control measures
- Workforce capacity
- Demand – winter pressures and urgent & emergency care
- Demand – critical care and capacity planning
- Primary Care – links to vaccination plans influenza and COVID-19
- Testing – links to acute flow, discharge flow and workforce
- Pharmacy – links to dual running and EU Exit
- Procurement, PPE and logistics
- Recovery – links to restoration, maintaining services and independent sectors
- Cyber preparedness and digital resilience – links to business continuity

Workforce is a consistent underpinning risk across these 10 areas including the uncertain impact of self-isolation (directly and indirectly including childcare) and the risk of staff fatigue/burn out. Mitigating actions to manage these risks will continue to be prioritised across the system.

4.0 Recommendations

Governing Body is asked to note:

- the progress being made by the CCG and other partners to implement recovery planning, preparing for winter and minimising the risk of a second wave of Covid, through a coordinated planning process.

Item Number: 13

Name of Presenter: Simon Bell

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Financial Performance Report Month 6

Purpose of Report
For Information

Reason for Report

To brief members on the interim financial management arrangements for the April to September period, and to update on the planning process for October to March.

To update members on the financial performance of the CCG, achievement of key financial duties, and forecast outturn position for 2020/21 as at the end of September 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
☐ Equality Impact Assessment
☐ Data Protection 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)

Governing Body noted the report.

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

Finance and Contracting Performance Report – Executive Summary

April 2020 to September 2020

Month 6 2020/21

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. Allocation adjustments – The CCG incurred £919k of COVID-19 related expenditure in August, and a backdated allocation adjustment has been received in September for this, bringing the total COVID-19 related allocation to £4.29m. The CCG has received a 'true-up' allocation adjustment of -£130k for April to August, bringing the overall April to August financial position to break-even.

At the end of September, the CCG is reporting a £3.58m overspend which is made up as follows -

- £1.18m COVID-19 related spend in September. Total COVID-19 related spend for April to September is £5.47m, of which £4.29m is offset by the allocation adjustment already received to cover April to August.
- A £2.40m overspend expected to be offset by a 'true-up' allocation adjustment for September. This marks a changed position from the April to August financial position, which saw an allocation reduction of £130k to offset non-COVID related underspends. This movement is partly due to changes in national and regional guidance on expenditure that should be recognised in M1-6, and partly due to a review undertaken in month 6 to ensure that all reasonable costs are taken into account for the final 'true-up' adjustment process.

2. Financial Management for October onwards – A North Yorkshire and York plan submission for the October to March period was approved by an Extraordinary Governing Body on 15th October in advance of a system submission deadline of the 20th October and an organisational deadline of the 22nd October. This was based on the CCG's draft financial plan for 2020/21 with adjustments made for the on-going COVID-19 financial arrangements and to take account of the latest national guidance.

NHS Vale of York CCG was able to deliver an overall surplus of £1.50m within the organisational share of the system financial envelope, but has agreed a system breakeven adjustment to ensure each organisation can plan to deliver breakeven excluding any issues recognised nationally as outside local determination. For CCGs these nationally recognised issues currently relate to the additional roles reimbursement central top-up, £1.02m and Primary Care Medical funding, £318k allocations that have been confirmed, but not yet included within allocations and for Trusts it relates to the reduction in non-clinical income.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				Forecast Outturn (Full Year)			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation (see note)	3.1	3.1	(0.0)	G	6.4	6.3	0.1	G
In-year total expenditure does not exceed total allocation (Programme and Running costs - see note)	263.7	267.2	(3.6)	R	528.5	528.5	0.0	G
Better Payment Practice Code (Value)	95.00%	99.47%	4.47%	G	95.00%	>95%		G
Better Payment Practice Code (Number)	95.00%	97.13%	2.13%	G	95.00%	>95%		G
CCG cash drawdown does not exceed maximum cash drawdown					516.4	516.4	0.0	G

- In-year total expenditure is currently showing as exceeding allocation, as the CCG's allocation is expected to be adjusted retrospectively through the Month 1 to 6 break even arrangements.

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn Apr-Sep			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	3.4	3.1	0.3	G	6.6	6.3	0.3	G
Programme spend within plan	260.3	264.1	(3.9)	R	521.9	522.2	(0.3)	R
Cash balance at month end is within 1.25% of drawdown	511	226	285	G				

- 'Programme spend within plan' – Actual expenditure is higher than plan within the Year to Date and forecast position, which will be amended through allocation adjustments in order to deliver an overall break even position for April to September. After allocation adjustments, there will be a small overspend of £0.3m on programme budgets which is offset by an equivalent underspend on running costs.

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Detailed Narrative

Report produced: October 2020

Financial Period: April 2020 to September 2020 (Month 6)

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1. Update to financial planning and reporting arrangements

September marks the last month under the current financial arrangements under which a 'true-up' process is in place. For the April to September period, retrospective allocation adjustments are made as follows –

- To fund all COVID-19 related expenditure
- Further 'true-up' allocations will be made where expenditure variances are deemed to be reasonable – this will return CCGs to a break even position for the period.

The CCG incurred £919k of COVID-19 related expenditure in August, and a backdated allocation adjustment has been received in September for this, bringing the total COVID-19 related allocation to £4.29m. The CCG has received a 'true-up' allocation reduction of £130k for April to August, bringing the overall April to August financial position to break-even.

At the end of September, the CCG is reporting a £3.58m overspend which is made up as follows -

- £1.18m COVID-19 related spend in September. Total COVID-19 related spend for April to September is £5.47m, of which £4.29m is offset by the allocation adjustment already received to cover April to August.
- A £2.40m overspend expected to be offset by a 'true-up' allocation adjustment for September. This marks a changed position from the April to August financial position, which saw an allocation reduction of £130k to offset non-COVID related underspends. This movement is partly due to changes in national and regional guidance on expenditure that should be recognised in M1-6, and partly due to a review undertaken in month 6 to ensure that all reasonable costs are taken into account for the final 'true-up' adjustment process.

A North Yorkshire and York plan submission for the October to March period was approved by an Extraordinary Governing Body on 15th October in advance of a system submission deadline of the 20th October and an organisational deadline of the 22nd October. This was based on the CCG's draft financial plan for 2020/21 with adjustments made for the on-going COVID-19 financial arrangements and to take account of the latest national guidance.

The Vale of York CCG was able to deliver an overall surplus of £1.50m within the organisational share of the system financial envelope, but has agreed a system breakeven adjustment to ensure each organisation can plan to deliver breakeven excluding any issues recognised nationally as outside local determination.

For CCGs these nationally recognised issues currently relate to the additional roles reimbursement central top-up and Primary Care Medical funding allocations that have been

confirmed, but not yet included within allocations and for Trusts it relates to the reduction in non-clinical income.

2. Year to Date position

The year to date position in the table below covers April to September. The budget for these months is based on the CCG's draft financial plan, with a £2.48m adjustment to reduce the overall plan to meet the current allocation as advised by NHSE.

The year to date position includes £5.47m of COVID-19 related spend, against which a £4.29m allocation adjustment had been received. The COVID-19 related variance is therefore £1.18m, relating to September expenditure. The table below adjusts for this in order to show variances against plan excluding COVID-19 related spend.

	YTD Position (£000)					
	Budget	**Actual**	**Variance**	**COVID related variance**	**Variance excl COVID spend**	**Comments**
Acute Services	133,315	133,596	(281)	(10)	(271)	£369k overspend on YAS due to amendment to M1-6 block. £61k underspend on RSS due to reduced referral volumes
Mental Health Services	29,580	28,613	967	(29)	996	£1.00m underspend on non-recurrent payment to TEWV (£2m full year value) - addressed through provider true up process for M1-6. £225k underspend on MHIS investments in plan over and above TEWV block payment, £233k reduced activity MH Out of Contract & SRBI
Community Services	16,078	16,031	47	(0)	48	
Continuing Healthcare	18,507	19,274	(767)	(977)	210	In year underspends across Continuing Healthcare and FNC, partly offset by FNC prior year pressure of £336k
Other Services	8,832	8,946	(114)	(0)	(113)	NHS Property Services higher than plan value £180k. This is to bring the position in line with the latest annual charging schedules and to provide for two mental health properties previously assumed to be dealt with via Property Vacation Notices.
Prescribing	26,834	28,058	(1,223)	(0)	(1,223)	£566k prior year pressure due to March prescribing figures, £657k in year overspend against plan
Primary Care	4,844	6,129	(1,284)	(147)	(1,138)	£1.01m Improving Access - not in financial plan as usually funded through non-recurrent allocation, dealt with through the 'true-up' for Apr to Sep, £156k YTD PMS premium (funding on delegated line)
Primary Care Delegated Commissioning	24,190	23,501	689	(8)	697	£361k slippage on investment reserve provided in plan (difference between Primary Care allocation and detailed expenditure plan), £156k PMS premium (spend is shown under Primary Care line above), £67k underspend on Dispensing Doctors
Running Costs	3,397	3,077	319	(2)	322	Various underspends across pay (vacancies) and non pay
Reserves	554	0	554	0	554	Funding provided in reserves for potential YAS contract adjustment and VoY share of system recovery project costs
Position against CCG financial plan	**266,132**	**267,225**	**(1,093)**	**(1,175)**	**82**	
NHSE Allocation adjustment	(2,478)	0	(2,478)	0	(2,478)	Adjustment in reserves - difference between CCG financial plan and base allocation. Apr to Aug following true-up allocation adjustment -£2.18m (offset by M1-5 underspends). M6 difference between CCG plan and allocation -£299k
Reported YTD position	**263,654**	**267,225**	**(3,571)**	**(1,175)**	**(2,396)**	

3. Forecast

The forecast position covers two distinct phases of the financial year, as follows –

- For April to September, the plan is based on the CCG's draft financial plan, with a £2.48m adjustment to reduce the overall plan to meet the current allocation as advised by NHSE. Expenditure shown is the year to date position. This section of the table identifies an expected £3.57m allocation adjustment to cover September COVID spend, and to adjust the CCG financial position for this period to break even.
- For October to March, the plan figures are based on the updated organisational plan for submission on 22nd October. Within this plan, the CCG remains within its financial envelope and is able to under commit on its share of the North Yorkshire and York (NY&Y) system growth and COVID funding. The NY&Y system plan overall is for a breakeven position, after adjusting for known national issues, however within this individual organisations have surplus and deficit positions. Partner organisations within the system have agreed to a breakeven adjustment so that all organisations reach a breakeven position.

The forecast table on the following page shows April to September plan and outturn, as well as October to March plan.

Forecast Outturn 2020/21

	Forecast Position (£000)										
	April to September			October to March			Financial Year				
	Plan	Forecast	Variance	Plan	Forecast	Variance	Plan	Forecast	Variance	Comments Apr-Sep	Comments Oct-Mar
Acute Services	133,315	133,596	(281)	132,513	132,513	0	265,827	266,108	(281)	£369k overspend on YAS due to amendment to M1-6 block. £61k underspend on RSS due to reduced referral volumes	Based on block contract arrangements for remainder of financial year, no NHS charges for non contracted activity, and IS activity above M1-4 baseline being funded nationally
Mental Health Services	29,580	28,613	967	29,491	29,491	0	59,072	58,105	967	£1.00m underspend on non-recurrent payment to TEWV	
Community Services	16,078	16,031	47	16,036	16,036	0	32,114	32,067	47		
Continuing Healthcare	18,507	19,274	(767)	14,983	14,983	0	33,490	34,257	(767)	£977k COVID spend in Sep to be reimbursed. In year underspends across Continuing Healthcare and FNC, partly offset by FNC prior year pressure of £336k	QIPP and high costs risk reserve removed from October to March plan. Reduction in spend is due to Apr-Sep including £4.01m COVID related spend, which is to be funded from central Hospital Discharge Programme for Oct-Mar
Other Services	8,832	8,946	(114)	8,541	8,541	0	17,374	17,487	(114)		
Prescribing	26,834	28,058	(1,223)	26,834	26,834	0	53,669	54,892	(1,223)	£566k prior year pressure due to March prescribing figures, £657k in year overspend against plan	Anticipated continued pressure on prescribing budgets has been included in planning returns as a risk to delivery, and mitigations identified
Primary Care	4,844	6,129	(1,284)	4,935	4,935	0	9,779	11,063	(1,284)	£1.01m Improving Access - not in financial plan as usually funded through non-recurrent allocation, dealt with through the 'true-up' for Apr to Sep, £156k YTD PMS premium (funding on delegated line). £147k COVID spend in Sep to be reimbursed	£1.01m added into plan for Improving Access. Reduction in spend is due to Apr-Sep including £1.02m COVID related spend
Primary Care Delegated Commissioning	24,190	23,501	689	24,033	24,033	0	48,223	47,534	689	£361k slippage on investment reserve provided in plan (difference between Primary Care allocation and detailed expenditure plan), £156k PMS premium (spend is shown under Primary Care line above), £67k underspend on Dispensing Doctors	Investment reserve removed from plan for Oct-Mar
Running Costs	3,397	3,077	319	3,219	3,219	0	6,616	6,296	319	Underspends across pay and non pay	
COVID related spend	0	0	0	409	409	0	409	409	0		Identified costs to be funded by CCG from system COVID allocation
Reserves & Contingency	554	0	554	262	262	0	816	262	554	Slippage on investments and cost pressures provided for in plan	
Position against CCG financial plan	**266,132**	**267,225**	**(1,093)**	**261,257**	**261,257**	**0**	**527,389**	**528,482**	**(1,093)**	Net position against CCG plan is £82k underspend for Apr-Sep, offset by £1.18m of COVID spend in September	
COVID-19 Retrospective Allocation adjustments	(2,478)	0	(2,478)	0	0	0	(2,478)	0	(2,478)	Shortfall in notified Apr-Sep allocation compared to CCG financial plan, partly offset by M1-5 'true-up' allocation	No retrospective allocation adjustments for Oct-Mar
COVID-19 Retrospective Allocation adjustments anticipated	0	(3,571)	3,571	0	0	0	0	(3,571)	3,571	Anticipated increase to allocation for Sep COVID spend £1.18m, and Sep 'true-up' £2.40m	No retrospective allocation adjustments for Oct-Mar
Reported forecast position	**263,654**	**263,654**	**0**	**261,257**	**261,257**	**0**	**524,911**	**524,911**	**0**		
Notified Allocation	263,654			262,754			526,408				Allocation includes £260.85m CCG allocation, £1.10m NY&Y system growth funding and £0.81m NY&Y COVID allocation
System breakeven adjustment	0			(1,497)			(1,497)				Adjustment across NY&Y system partners to deliver breakeven position across all organisations
Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		

4. Allocation

The allocation as at Month 6 is as follows:

Description	Value
Allocation at Month 5	£263.09m
COVID-19 costs Aug	£0.92m
True-up allocation Aug	(£0.36m)
Total allocation at Month 6	**£263.65m**

5. Underlying position

There has been no change to the assessment of the CCG's underlying position of a £26.7m deficit since the previous Financial Performance report.

6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 30 September 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.

The CCG achieved its month end cash holding target.

Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Executive Committee

Date of Meeting	7 and 14 October 2020
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee maintained an overview of the financial position and also discussed wider system imperatives, including:

- Urgent Care
- Hepatitis B vaccinations

The Committee received positive updates on joint working the City of York Council and NHS North Yorkshire CCG.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 16

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	8 October 2020
Chair	Julie Hastings

Areas of note from the Committee Discussion

Through discussion of seeking assurance in primary care the need for an overall review of the CCG's approach to quality assurance had been identified.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Item Number: 17
Name of Presenter: Stephanie Porter

Meeting of the Governing Body

Date of meeting: 5 November 2020

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Commissioning Committee Recommendations

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

Reason for Report

These are the latest recommendations from the Medicines Commissioning Committee – June, July and September 2020.

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:

Recommendations

For information only

CCG Executive Committee have approved these recommendations

Decision Requested (for Decision Log)

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

Responsible Executive Director and Title	**Report Author and Title**
Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse	Jamal Hussain – Senior Pharmacist Callie Turner – Pharmacy Technician

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee June 2020

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	Nil				
NHSE commissioned Technology Appraisals – for noting					
2.	**TA628: Lorlatinib for previously treated ALK-positive advanced non-small-cell lung cancer**		Lorlatinib is recommended, within its marketing authorisation, as an option for treating anaplastic lymphoma kinase (ALK)-positive advanced non-small-cell lung cancer (NSCLC) in adults whose disease has progressed after alectinib or ceritinib as the first ALK tyrosine kinase inhibitor or crizotinib and at least 1 other ALK tyrosine kinase inhibitor. It is recommended only if the company provides lorlatinib according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
3.	**TA629: Obinutuzumab with bendamustine for treating follicular lymphoma after rituximab**		Obinutuzumab with bendamustine followed by obinutuzumab maintenance is recommended, within its marketing authorisation, as an option for treating follicular lymphoma that did not respond or progressed up to 6 months after treatment with rituximab or a rituximab-containing regimen. It is recommended only if the company provides it according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
4.	**TA630: Larotrectinib for treating NTRK fusion-positive solid tumours**		Larotrectinib is recommended for use within the Cancer Drugs Fund as an option for treating neurotrophic tyrosine receptor kinase (NTRK) fusion-positive solid tumours in adults and children if: • the disease is locally advanced or metastatic or surgery could cause severe health problems and • they have no satisfactory treatment options. It is recommended only if the conditions in the managed access agreement for larotrectinib are followed.	RED	No cost impact to CCGs as NHS England commissioned.

Formulary applications or amendments/pathways/guidelines				
4.	Remdesivir injection in the Treatment of COVID-19	Approved as per the NHSE guidance and MHRA Early Access to Medicines Scheme	RED	No cost impact to CCGs as NHS England commissioned and currently provided free of charge as part of EAMS.
5.	H2 Antagonist Supply Issues – update to formulary	The formulary had not been updated to reflect the current supply problems with ranitidine and possibly other H2 antagonists. The MCC retrospectively approved the update to the formulary.	n/a	No cost to CCGs expected as alternative is to use PPIs which are cheaper or similar in price to H2 Antagonists.
6.	Ketorolac Eye Drops	Request to change RAG status for ketorolac eye drops used post eye surgery from RED to AMBER SI not approved. Agreed that as a short-term, time limited course current RED status appropriate, and also need to prevent any safety issues from it potentially being added to repeat prescriptions long term.	RED	No cost to CCGs expected as reflects current prescribing practice.
7.	NHSE Supply of Additional DOACs During COVID-19	MCC agreed to share/cascade the NHSE/I guidance with relevant stakeholders to refer to if they were considering switching from warfarin to a DOAC. MCC agreed that all 4 DOACs will remain on formulary and advise that clinicians should select, in conjunction with shared decision making with the patient, the most clinically appropriate DOAC for the individual patient. Please note the NHSE guidance is not advocating switches from DOAC to DOAC.	n/a	No cost to CCGs expected as decision reflects current prescribing practice.

NHS
Vale of York
Clinical Commissioning Group

Recommendations from York and Scarborough Medicines Commissioning Committee July 2020

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA633: Ustekinumab for treating moderately to severely active ulcerative colitis**		Ustekinumab is recommended as an option for treating moderately to severely active ulcerative colitis in adults when conventional therapy or a biological agent cannot be tolerated, or the disease has responded inadequately or lost response to treatment, only if: • a tumour necrosis factor‑alpha inhibitor has failed (that is the disease has responded inadequately or has lost response to treatment) or • a tumour necrosis factor‑alpha inhibitor cannot be tolerated or is not suitable, and • the company provides ustekinumab at the same price or lower than that agreed with the Commercials Medicines Unit.	RED	No significant resource impact is anticipated NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option and the overall cost of treatment will be comparable to the current treatment options available. This treatment option is only available to patients when other treatment has failed (that is the disease has responded inadequately or has lost response to treatment), or they have not been able to tolerate or are otherwise inappropriate for a TNF-alpha inhibitor.
2.	**TA626: Avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure**		Avatrombopag is recommended, within its marketing authorisation, as an option for treating severe thrombocytopenia (that is, a platelet count of below 50,000 platelets per microlitre of blood) in adults with chronic liver disease having a planned invasive procedure. The scope for this multiple technology appraisal included both avatrombopag and lusutrombopag. However, because of a delay in getting an agreed list price for avatrombopag, this topic was split into 2 separate appraisals. Please see NICE technology appraisal guidance 617 for recommendations on lusutrombopag.	RED	No significant resource impact is anticipated NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations will be less than £5 million per year in England (or £9,000 per 100,000 population). The technology is a further treatment option and due to this the overall incremental cost of treatment is not deemed to be significant. Lustrombopag was approved as a RED drug at Feb 2020 MCC meeting The addition of avatrombopag in the treatment pathway may help reduce the need for platelet transfusions. It may also help increase the time in which procedures can be scheduled and reduce hospital stays. Note though that this will be additional cost to CCG drug budget as funding arrangements for platelet transfusions do not come from drugs budget.

<table>
<tr><td colspan="5">NHSE commissioned Technology Appraisals – for noting</td></tr>
<tr><td>3.</td><td><u>TA632: Trastuzumab emtansine for adjuvant treatment of HER2-positive early breast cancer</u></td><td>Trastuzumab emtansine is recommended, within its marketing authorisation, as an option for the adjuvant treatment of human epidermal growth factor receptor 2 (HER2)‑positive early breast cancer in adults who have residual invasive disease in the breast or lymph nodes after neoadjuvant taxane-based and HER2‑targeted therapy. It is recommended only if the company provides trastuzumab emtansine according to the commercial arrangement.</td><td>RED</td><td>No cost impact to CCGs as NHS England commissioned.</td></tr>
<tr><td colspan="5">Formulary applications or amendments/pathways/guidelines</td></tr>
<tr><td>4.</td><td>Nebulised Hypertonic Saline (Sodium chloride 7%, Respi-Clear®)</td><td>Approved change in RAG status from AMBER SC to AMBER SI as no monitoring requirements for GPs.
Agreed that Respi-Clear® to be brand of choice as the cheapest.
Approved formulary indications agreed as:
In patients aged six years and over and with the following conditions:
•Cystic Fibrosis (CF)
•Non CF bronchiectasis
•Chronic Obstructive Pulmonary Disease
•Patients with reduced ability to expectorate bronchopulmonary secretions e.g. patients with a tracheostomy, patients with neurological impairment leading to weak cough and patients with an active chest infection limiting their ability to clear secretions
And, where usual treatment isn't sufficiently effective. (eg physiotherapy airway clearance, adequate systemic hydration, dornase alpha for those with CF, carbocisteine where indicated)</td><td>AMBER Specialist Initiation</td><td>No cost to CCGs expected as reflects current prescribing practice.
<table><tr><th>Product</th><th>Monthly primary care cost</th></tr><tr><td>Nebusal 7%
PulmoClear 7%
Respi-Clear 7%
Resp-Ease 7%
Salineb 7%</td><td>60 x 4ml £27.00
60 x 4ml £18.94
60 x 4ml £16.97
60 x 4ml £21.60
60 x 4ml £20.60</td></tr><tr><td>0.9% nebuliser solution
0.9% injection 10ml</td><td>x 20 = £9.85 (x60 = £29.55)
x10 = £3.24 (x60 = £19.44)</td></tr></table></td></tr>
<tr><td>5.</td><td>Modafinil for excessive daytime sleepiness in Parkinson's disease

(unlicensed indication)</td><td>Approved request to add to formulary and share care for an additional indication as per NICE NG71 for excessive daytime sleepiness in Parkinson's disease.
Note Leeds and Hull already include on their formularies for this indication.</td><td>AMBER Shared Care</td><td>Up to 5 patients per year
£204.60 -£772.80 for 5 patients per year.</td></tr>
<tr><td>6.</td><td>Dornase alfa and inhaled antibiotics in CF</td><td>Approved change in RAG status from AMBER SC for existing patients to AMBER SI as no monitoring requirements for GPs.</td><td>AMBER Specialist Initiation (for</td><td>No cost to CCGs expected.</td></tr>
</table>

		To remain RED for new patients as now NHSE commissioned tariff excluded drug. Note Leeds and Hull already have as AMBER Specialist Initiation.	existing patients.	
7.	Antihistamines medal ranking	Updated version approved. Updates to prices, some items removed due to no longer being available, reference made to CCG self-care guide.	n/a	No cost to CCGs expected as reflects current prescribing practice.
8.	Hydroxycarbamide in Psoriasis SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
9.	Dronedarone SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
10.	Riluzole for ALS SCG	Reviewed and updated shared care guideline approved. Addition of Riluzole oral suspension 25mg/5ml to shared care guideline and formulary also approved as an alternative to crushing tablets, as crushing tablets may block feeding tubes in some patients.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice. Cost per patient per month: Riluzole 50mg tablets £44.96/56 Riluzole oral suspension 25mg/5ml £200/600ml
11.	Sulfasalazine SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
12.	Leflunomide SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
13.	Methotrexate SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
14.	Mycophenolate (non-transplant) SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
15.	Modafinil SCG	Reviewed and updated shared care guideline approved with addition of excessive daytime sleepiness in Parkinson's disease as an additional indication.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
16.	Long acting somatostatin analogues SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.

17.	Somatotrophin SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
18.	Cinacalcet Primary Hyperparathyroidism SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
19.	Ciclosporin SCG	Reviewed and updated shared care guideline approved with addition of uveitis and nephrotic syndrome as additional indications.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.
20.	Mercaptopurine SCG	Reviewed and updated shared care guideline approved.	AMBER Shared Care	No cost to CCGs expected as reflects current prescribing/drug monitoring practice.

Recommendations from York and Scarborough Medicines Commissioning Committee September 2020

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA631: Fremanezumab for preventing migraine**		Fremanezumab is recommended as an option for preventing migraine in adults, only if: • the migraine is chronic, that is, 15 or more headache days a month for more than 3 months with at least 8 of those having features of migraine • at least 3 preventive drug treatments have failed and • the company provides it according to the commercial arrangement. Stop fremanezumab if the migraine frequency does not reduce by at least 30% after 12 weeks of treatment. Locally agreed that ideally after 3 oral preventative drug treatments botulinum toxin should be tried before Fremanezumab – seeking legal advice if this is in keeping with NICE TA.	RED	In England NICE expect: 58,900 people with chronic migraine are eligible for treatment with fremanezumab each year. This is from prevalent cases. By the end of year 2024/25, 20% of people eligible will have commenced treatment with fremanezumab. 45% of people's chronic migraine responds to treatment at 12 weeks – based on trial data for migraine frequency reduction of 30%. 55% of people stop treatment after 12 weeks of treatment. 5,300 people will have fremanezumab from year 2024/25 onwards once market share has reached 20% Cost impact from NICE costing template: o VoY = £138,745 net impact by year 5 o Scarborough & Ryedale = £43,251 net impact by year 5 NICE estimate that: o VoY = 16 new patients per year, of this 7 respond to treatment o Scarborough & Ryedale = 5 new patients per year, of this 2 respond to treatment. In reality within YFT there are currently 50 patients that have not responded to botulinum toxin therapy. The costings are based on the fact that these patients will start fremanezumab in year one. From the trial data on average 45% of patients get a 30% or greater reduction in migraine free days after 12 weeks. The costings assume only 45% of patients will continue treatment after 12 weeks. Have built in a 10% increase in patients that receive fremanezumab on a year by year basis. The 22 patients currently on Aimovig will transition to fremanezumab in year 3 if it does not get approved by NICE. Year one costs = £111,000 Year two costs £94,380 Year three costs = £156,300

NHSE commissioned Technology Appraisals – for noting				
2.	TA638: Atezolizumab with carboplatin and etoposide for untreated extensive-stage small-cell lung cancer	Atezolizumab with carboplatin and etoposide is recommended as an option for untreated extensive-stage small-cell lung cancer in adults, only if they have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1, and the company provides atezolizumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
3.	TA639: Atezolizumab with nab-paclitaxel for untreated PD-L1-positive, locally advanced or metastatic, triple-negative breast cancer	Atezolizumab with nab‑paclitaxel is recommended, within its marketing authorisation, for treating triple-negative, unresectable, locally advanced or metastatic breast cancer in adults whose tumours express PD‑L1 at a level of 1% or more and who have not had previous chemotherapy for metastatic disease. It is recommended only if the company provides atezolizumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
4.	TA640: Treosulfan with fludarabine for malignant disease before allogeneic stem cell transplant	Treosulfan with fludarabine is recommended as an option for conditioning treatment before allogeneic haematopoietic stem cell transplant (allo-HSCT) for people with malignant diseases for whom a reduced intensity regimen, such as low-dose busulfan with fludarabine, would be suitable.	RED	No cost impact to CCGs as NHS England commissioned.
5.	TA641: Brentuximab vedotin in combination for untreated systemic anaplastic large cell lymphoma	Brentuximab vedotin with cyclophosphamide, doxorubicin and prednisone (CHP) is recommended, within its marketing authorisation, as an option for untreated systemic anaplastic large cell lymphoma in adults. It is only recommended if the company provides brentuximab vedotin according to the commercial arrangement.	RED	No cost impact to CCGs as NHS England commissioned.
6.	TA642: Gilteritinib for treating relapsed or refractory acute myeloid leukaemia	Gilteritinib monotherapy is recommended as an option for treating relapsed or refractory FLT3‑mutation-positive acute myeloid leukaemia (AML) in adults only if the company provides gilteritinib according to the commercial arrangement. Gilteritinib should not be given as maintenance therapy after a haematopoietic stem cell transplant	RED	No cost impact to CCGs as NHS England commissioned.
7.	TA643: Entrectinib for treating ROS1-positive advanced non-small-cell lung cancer	Entrectinib is recommended, within its marketing authorisation, as an option for treating ROS1-positive advanced non-small-cell lung cancer (NSCLC) in adults who have not had ROS1 inhibitors. It is recommended only if the company provides entrectinib according to the	RED	No cost impact to CCGs as NHS England commissioned.

		commercial arrangement.		
8.	**TA644: Entrectinib for treating NTRK fusion-positive solid tumours**	Entrectinib is recommended for use within the Cancer Drugs Fund as an option for treating neurotrophic tyrosine receptor kinase (NTRK) fusion-positive solid tumours in adults and children 12 years and older if: • the disease is locally advanced or metastatic or surgery could cause severe health problems and • they have not had an NTRK inhibitor before and • they have no satisfactory treatment options. It is recommended only if the conditions in the managed access agreement for entrectinib are followed.	RED	No cost impact to CCGs as NHS England commissioned.
Formulary applications or amendments/pathways/guidelines				
9.	Clonidine:for the treatment of dystonia in children	Y&S Formulary to mirror Leeds APC decision from June 2020 as tertiary centre treatment	AMBER SI	No cost impact to CCGs as position reflects current prescribing practice for this indication.
10.	Co-enzyme Q10 (Ubidecarenone/Ubiquinone) capsules and liquid (unlicensed) for treatment of Inborn errors of CoQ10 synthesis & mitochondrial disorders/cytopathies	Y&S Formulary to mirror Leeds APC decision from June 2020 as tertiary centre treatment	AMBER SI	No cost impact to CCGs as position reflects current prescribing practice for this indication.
11.	Diazoxide - 50mg/mL (30mL) Proglycem brand (unlicensed) and 50mg tablets for treatment of Hyperinsulinism Hyperammoniaemia Syndrome (HIHA)	Y&S Formulary to mirror Leeds APC decision from June 2020 as tertiary centre treatment	AMBER SI	No cost impact to CCGs as position reflects current prescribing practice for this indication.
12.	Oestrogel : for the treatment of Gender Dysphoria in Adults	Y&S Formulary to mirror Leeds APC decision from June 2020 as tertiary centre treatment	AMBER SI	No significant cost impact to CCGs expected as one of several similarly priced treatment options.
13.	ACARIZAX® sublingual tablets 12 SQ-HDM for house dust mite allergy	Y&S Formulary to mirror Leeds APC decision from June 2020 as tertiary centre treatment	RED	No cost impact to CCGs as RED drug.

<table>
<tr><td>14.</td><td>Enalapril</td><td>Request for addition of enalapril onto formulary as 1st line for any new patients diagnosed with HF as a long-term treatment until able / suitable for switch to sacubitril/valsartan (Entresto) was not approved.

Currently ramipril is used. National/NICE guidance does not specify which ace inhibitor should be used.

No justification for change as no clear evidence of benefit of enalapril over Ramipril.</td><td>NOT APPROVED</td><td>No cost impact to CCGs as formulary application not approved.
<table>
<tr><th>Product</th><th>Monthly secondary care cost (£)</th><th>Monthly primary care cost (£)</th></tr>
<tr><td>Ramipril (max 10mg daily; capsules)</td><td>0.36</td><td>1.20</td></tr>
<tr><td>Lisinopril (max 35mg daily)</td><td>0.36 (20mg) + 0.24 (20mg) + 0.18 (5mg)

= 0.78</td><td>1.06 (20mg) + 1.01 (10mg) + 0.87 (5mg)

= 2.94</td></tr>
<tr><td>Enalapril (max 20mg twice daily)</td><td>2.28</td><td>4.24</td></tr>
</table></td></tr>
<tr><td>15.</td><td>Dailiport®</td><td>Dailiport® is a once a day tacrolimus prolonged release branded generic, which has demonstrated bioequivalence to Advagraf® (tacrolimus prolonged release). It has been approved by Leeds to be added to formulary
The only people they will be starting this in for now are new patients that we are considering for a once a day preparation due to:
• Neurological side-effects e.g. difficulties sleeping at night
• Very small total dose
• Concerns about compliance e.g. Younger or transition patients, variable trough
levels
• Patient choice’</td><td>AMBER Shared care</td><td>No cost impact to CCGs as NHS England commissioned.
Nil expected as cheaper than equivalent dose of Advagraf®</td></tr>
<tr><td>16.</td><td>Melatonin (Slenyto®) 1mg and 5mg modified release tablets for treatment of insomnia in children and adolescents aged 2-18 with Autism Spectrum Disorder (ASD) and / or Smith-Magenis syndrome, where sleep hygiene measures have been insufficient.</td><td>Approved Slenyto® melatonin 1mg and 5mg modified release tablets in line with licensed indications only once guidance from TEWV in place and supported by Acute Trust Paediatricians.
• 1st line remains: melatonin 2mg modified release tablets (Circadin®), crushing if needed
• Rosemont melatonin 5mg/5ml oral solution (alcohol-free and propylene glycol free) - for patients only unable to use crushed tablets.
• May reduce prescribing of the more costly unlicensed Melatonin liquid preparations in this patient population.
• TEWV to produce guideline on use of Slenyto® highlightling cost differential and emphasing to use Circardin where possible and only use oral solution if absolutely necessary. This guidance will also be</td><td>AMBER Shared care</td><td>ASD = 1.5% of the population. 80% have sleep difficulties = 1.25% of the population. . However most will manage with immediate release tablets, liquids or circadin. Smith magenis syndrome has a melatonin night time deficit with melatonin produced in the day as part of the genetic condition. It affects 1 in 15000 to 25000 so very rare.

Slenyto 2 mg daily x 30 days = £41.20
Circadin 2 mg daily x 30 days = £15.39
Slenyto 5 mg daily x 30 days = £103.00
Circadin 4 – 6 mg daily x 30 days = £30.78 - £46.17

Risk of creep in use if used outsider limited licensed indication. This creep in use could have significant</td></tr>
</table>

		shared with paediatric teams in Acute Trusts for them to follow. • Existing patients with ASD and and / or Smith-Magenis requiring melatonin should not be switched to Slenyto®. This approval is for new patients only with Autism Spectrum Disorder (ASD) and / or Smith-Magenis syndrome.		cost impact of approx. £200,000 per CCG (£100,000 for Vale of York) if even just 50% of patients on Circadin switch to Slenyto.
17.	Methotrexate Shared Care Guideline – addition of Sarcoidosis	Approved addition of Sarcoidosis as an indication.		None as no change in practice.
18.	Modafinil for excessive daytime sleepiness in Parkinson's disease Shared Care Guideline	Approved addition of excessive daytime sleepiness in Parkinson's disease as an indication following recent formulary approval. Recommended treatment option in NICE guidance.	AMBER Shared Care	Up to 5 patients per year £204.60 -£772.80 for 5 patients per year.
19.	Guidance on the Self-Monitoring of Blood Glucose for Adults with Diabetes for Primary Care in North Yorkshire and York	Approved	n/a	Nil expected
20.	Asthma & COPD Pathways - updated	Approved.	n/a	No significant cost impact expected.