Vale of York
Clinical Commissioning Group

GOVERNING BODY MEETING

1 July 2021 9.30am to 11.30am

'Virtual' Meeting

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

The agenda and associated papers will be available at:
www.valeofyorkccg.nhs.uk

AGENDA

STANDING ITEMS – 9.50am				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members' Interests in the Business of the Meeting	To Note	All
3.	Pages 4 to 14	Minutes of the meeting held on 6 May 2021	To Approve	All
4.	Pages 15	Matters arising from the minutes		All
5.	Pages 16 to 20	Accountable Officer's Report	To Receive	Phil Mettam Accountable Officer
6.	Pages 21 to 49	Quality and Patient Experience Report	For Decision	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
7.	Verbal	Coronavirus COVID-19 Update	To Note	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse Stephanie Porter Interim Executive Director of Primary Care and Population Health

8.	Pages 50 to 60	Board Assurance Framework	To Receive	Abigail Combes Head of Legal and Governance
ASSURANCE – 11.05am				
9.	Pages 61 to 62	2020/21 Annual Report and Accounts (Full Report and Annual Audit Letter circulated separately)	To Ratify	Simon Bell Chief Finance Officer
FINANCE – 11.10am				
10.	Pages 63 to 72	Financial Performance Report 2021/22 Month 2	To Receive	Simon Bell Chief Finance Officer
RECEIVED ITEMS – 11.25am **Committee minutes are published as separate documents**				
11.	Pages 73 to 76	Chair's Report Audit Committee: 22 April and 28 May 2021		
12.	Page 77	Chair's Report Executive Committee: 28 April, 5, 12, 19, 26 May, and 2, 9 and 16 June 2021		
13.	Page 78	Chair's Report Finance and Performance Committee: 22 April and 27 May 2021		
14.	Pages 79 to 80	Chair's Report Primary Care Commissioning Committee: 27 May 2021		
15.	Pages 81 to 82	Chair's Report Quality and Patient Experience Committee: 13 May 2021		
16.	Pages 83 to 101	Medicines Commissioning Committee Recommendations: March, April and May 2021		
NEXT MEETING				
17.	Verbal	Date to be confirmed	To Note	All
CLOSE – 11.30am				

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 'Virtual' Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 6 May 2021

Present

Dr Nigel Wells (NW) (Chair)	Clinical Chair
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
Phil Goatley (PG)	Lay Member, Chair of Audit Committee and Remuneration Committee
Julie Hastings (JH)	Lay Member, Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Stephanie Porter (SP)	Interim Executive Director of Primary Care and Population Health
Dr Chris Stanley (CS)	Central Locality GP Representative
Dr Ruth Walker (RW)	South Locality GP Representative

In Attendance (Non Voting)

Abigail Combes (AC) – part	Head of Legal and Governance
Chris Davis (CD) – item 3	Head of Mental Health Partnerships, Tees, Esk and Wear Valleys NHS Foundation Trust and NHS Vale of York CCG
Emma McKenzie (EM) – item 3	Converge / Discovery Hub Team Lead, York St John University
Dr Andrew Moriarty (AM)	YOR Local Medical Committee Locality Officer for Vale of York
Michèle Saidman (MS)	Executive Assistant
Sharon Stoltz (SS)	Director of Public Health, City of York Council

Eight members of the public watched the "live stream" prior to the presentation to MC for which when many friends and colleagues also joined.

The agenda was discussed in the following order.

STANDING ITEMS

1. Apologies

There were no apologies.

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.

The following declarations were made in respect of members' additional roles:

- MC as Interim Director of Quality and Nursing for Humber, Coast and Vale Health and Care Partnership two days per week
- CS as a member of the Humber, Coast and Vale Strategic Digital Board
- RW as GP Clinical Lead for Humber, Coast and Vale Mental Health Collaborative half a day per week
- NW as Clinical Lead for Humber, Coast and Vale Health and Care Partnership

No pre-emptive action was required by the Chair as a result of those conflicts declared and the nature of the business planned in the meeting. If a conflict of interest arose during the meeting mitigation would be agreed with the Chair on a case by case basis.

3. Mental Health Service User Story

In introducing this item DN commended CD's support for the work on integration of mental health services, noting he had played a key role in facilitating the recent City of York Mental Health Summit and community mental health services developments in Selby.

CD referred to the presentation 'Northern Quarter Community Mental Health Project and Community Mental Health Transformation' update which included information relating to: York Mental Health Partnership 'Connecting our City'; its vision/design principles; key messages of the Northern Quarter Project - A community approach to mental health and wellbeing; community mental health transformation funding; and illustration of the coproduction of 24/7 support person centred hubs.

EM, who had been instrumental in setting up the approach of peer support and access workers within the Discovery Hub, presented the following experience of a colleague.

16 months ago, I started a new job employed by the NHS. I work in a small team whose aim is to enrich people's life through education. My role in the team is to offer support for the students accessing any of the courses we provide.

On the surface someone starting a new job may seem like an ordinary everyday event, however for me it was the culmination of over two years hard work of not only me but also the team I now work for.

On my own I would not have managed to achieve this goal as I had been suffering from anxiety and depression for many years, I think it is very hard for people to understand just how much this illness robs you of your sense of self identity and worth, as if this isn't bad enough the longer you are ill the longer lasting the effects are.

I am pretty sure that most people will have heard of a few descriptives of depression "lack of motivation, low self-worth, no longer enjoying things that once brought happiness and joy". While these are all true it could be simply put as losing hope. When I was younger I used to teach Tae Kwon Do and one of the five tenets was indomitable spirit the courage and confidence to try again and not be subdued or overcome in the face of fear or failure. However, after many years battling my own inner demons I thought my hope and spirit had been lost and held out very little hope of help from the team that now was offering help.

It would take far too long to document the full journey I undertook, but the team who helped me affectively held on to hope for me when I couldn't and constantly reminded me that my hope and spirit would return to me one day even if I didn't believe, it was almost like they were looking after it for me while I couldn't.

I try to remember now that depression is not a permanent state of mind but more of a visitor, who still visits but also leaves.

Members expressed appreciation for the powerful, personal story commending the individual's insight.

Detailed discussion ensued including: sharing lessons learnt and successes across the system; emphasis on the need for a holistic, person centred approach on the 'journey' to restoring mental health wellbeing; maintaining and increasing digital opportunities emanating from response to COVID-19 in addition to face to face and postal access to courses; and evaluation of the impact of the services.

In response to RW enquiring about similar opportunities in Selby to those described for York EM explained that, although the Converge team was small, one of its members ran Brighter Futures in Selby, a collaborative building on networking opportunities with developing connections. She also explained the ease of the referral and application process to both Converge and, for individual support, to the Discovery Hub and detailed the various opportunities which now included weekend and evening courses at The Haven where external tutors participated in addition to Converge tutors. Converge was also launching pilot Open University style courses in June/July which would be evaluated with a view to expansion.

DN emphasised the perspective of community mental health transformation highlighting the need for culture change to provide 'wrap around' care to meet needs without thresholds and with a partnership approach of providing support. She also noted the context of 'place' rather than organisation.

CD highlighted RW's leadership in Selby with regard to primary mental health workers and associated networks. He also advised that evaluation of outcomes was a key part of the community mental health transformation and referred to the action plan from the City of York Mental Health Summit noting that the issue of thresholds was one of the considerations. In respect of the latter RW referred to the challenges in primary care where demand was currently greater than capacity as a result of the pandemic and expressed concern that removal of thresholds may have similar impact for mental health services.

The Governing Body:

Expressed appreciation for the in-depth service user story.

CD and EM left the meeting

4. Minutes of the Meeting held on 4 March 2021

The minutes of the 4 March meeting were agreed.

The Governing Body:

Approved the minutes of the meeting held on 4 March 2021.

5. Matters Arising from the Minutes

NW noted the matters arising were ongoing or may be covered in later agenda items.

6. Accountable Officer Update

PM referred to the report which provided updates on the local and system financial position; system restoration and recovery in the era of COVID; City of York Mental Health Summit; primary care protected learning time; and potential for local COVID-19 testing.

In addition to noting that 2021/22 was expected to be a challenging but comparatively low risk year from the financial perspective, PM expressed appreciation both to SB and the Finance Team for their work in achieving a break-even position for 2020/21 and also to PG and the Audit Committee. PM additionally advised that the draft accounts had been completed with the same high level of competency as in previous years.

With regard to system restoration PM referred to the focus on acute care waiting lists and backlog noting discussions both locally and regionally about potential establishment of community diagnostic hubs. There was also the potential for targeted lung health checks, currently provided in Hull, to be expanded to York which would support addressing health inequalities. PM emphasised that the personalised care offer would require innovative approaches, particularly in view of financial constraints.

PM reported on progress with development of 'place':

- For Selby an event was planned for June to create momentum around a ten year plan to transform health and care in the town and related districts using the Selby Matters brand.
- The first meeting of the York Health and Care Alliance Board had taken place and the Interim Chief Executive of the Humber, Coast and Vale Integrated Care System had expressed support for continuation of this work.
- Further discussions were planned for proportionate arrangements in Ryedale.

PM noted that the local Population Health Hub was being established on a virtual basis and highlighted the City of York Mental Health Summit, referred to earlier in the meeting by CD; work was taking place across partners in respect of an action plan for the next six months, the next 15 months and the next three years.

In conclusion PM explained that the CCG had been invited by NHS England and NHS Improvement, in its regulator capacity, to complete a self-assessment for 2020/21 by the end of the following week. He requested that, if asked, Governing Body members contribute noting that this would be part of the CCG's legacy.

With regard to the recent protected learning time event NW noted that, in addition to staff wellbeing and resilience of Practice staff, there had also been focus on localities, 'place' and Primary Care Networks and their emerging plans. He also highlighted the context of pressures being experience by primary care as referred to earlier.

The Governing Body:

Received the Accountable Officer report.

7. Quality and Patient Experience Report

In introducing this item MC highlighted that, alongside the serious concerns about waiting lists, there were areas of positive progress that should be recognised, including in mental health and work with children, which the CCG was striving to future proof. She also noted the context of learning from response to COVID-19, such as providing online services where appropriate.

MC explained that the Quality and Patient Experience Committee would usually have met prior to Governing Body to discuss and scrutinise this report and highlight issues for Governing Body. However, unusually the Committee had not met due to an unavoidable issue with quorum therefore the report, supported by JH as Chair of the Quality and Patient Experience Committee, provided a summary of key issues, developments and risks. MC also noted that work was taking place in respect of quality assurance and safety in primary care and also medicines management; these areas would be included in the next report.

MC highlighted the Care Quality Commission's outcome report following an unannounced inspection of a number of Tees, Esk and Wear Valleys NHS

Foundation Trust's in-patient wards in January 2021. Concerns about risk assessment and risk management processes had resulted in the Care Quality Commission's 'Inadequate' rating of the acute wards for adults of working age and psychiatric intensive care units for both safe and well-led.

MC reported that Tees, Esk and Wear Valleys NHS Trust had immediately commenced improvement work. She explained that, due to the level of concern, Tees, Esk and Wear Valleys NHS Foundation Trust were at Risk Summit Level in terms of escalation to NHS England and NHS Improvement. The Regional Chief Nurse had established a Quality Board which had met for the third time the previous day. MC reported on discussions at the meeting to provide assurance to members:

- All 56,000 patients were being reviewed from a risk management perspective. The focus was on areas identified by the Care Quality Commission but the change of approach would be implemented across the organisation.
- A rapid improvement event had taken place which had identified further areas that were also being addressed.
- Safety plans had been revised to a simplified, streamlined format providing assurance that people were protected from harm as much as possible. This included community patients.

MC additionally explained that a reframed holistic, harm minimisation approach to risk management was being adopted. The key issue of whether there was a need to increase staffing levels, which would have a significant cost impact, was being considered at system level. In this regard MC emphasised that if the CCG diverted planned commitments the Mental Health Investment Standard to support increased staffing there would be impact on services that had been prioritised, for example waiting lists for children with eating disorders and Child and Adolescent Mental Health Services.

Whilst welcoming the work on risk management and harm minimisation, DN reiterated the impact of reducing investment in other key areas noting that the Mental Health Investment Standard priorities, recently submitted to Humber Coast, and Vale Integrated Care System, had been jointly agreed with Tees, Esk and Wear Valleys NHS Foundation Trust. DN also noted that funding for staffing was recurrent and neither NHS Vale of York CCG nor NHS North Yorkshire CCG was in a position to make this commitment. Additionally, an impact assessment on services affected would be required. DN also highlighted the plans had been agreed in the context of the CCG's historic under investment in mental health services and, if funding was diverted, there would be impact both on the CCG's performance trajectory and for individuals.

MC therefore sought and received Governing Body support for a risk to be added to the risk register.

Chief Nursing Officer Award

Ruth May (RM), Chief Nursing Officer for England, joined the meeting. While paying tribute to the contribution of nurses and midwives for their support through the pandemic - locally, nationally and globally - RM advised that she had joined

specifically to express personal thanks to MC for her leadership of nurses over a number of years. RM referred to MC's pivotal role in the pandemic and support to the system and, more widely, commended MC's improvement work, contribution to diversity and commitment to the Vale of York population.

RM presented MC with the Chief Nursing Officer Gold Award in recognition of her outstanding contribution to and leadership of the nursing profession across the Vale of York.

Sarah Fiori (SF), Head of Quality Improvement and Research, added a tribute on behalf of the CCG.

SF and RM left the meeting

8. Coronavirus COVID-19 Update

SP reported that the vaccination programme continued to progress well. She advised that, in the context of vaccination not being mandatory, the CCG was working with City of York Council Public Health Contact Tracers and GP Practices to understand reasons for vaccination offer not being taken up and for appropriate assurance to be provided.

SP noted that one case of COVID-19 had been reported the previous day.

SP advised that supply was expected to be variable for May but noted that, as the Moderna vaccine was now available at Askham Bar Vaccination Centre, there were three types being delivered, although the focus was currently predominantly on second doses. SP confirmed the expectation that the target of all eligible groups having been offered vaccination by mid July would be met subject to centres having received sufficient supply and noted additional opportunities such as 'pop up' clinics, work with traveller communities and also support during Ramadan.

Additionally, in York a collaborative approach had been adopted in recognition of the capacity challenge and the need to have at scale efficiencies. In this regard workforce at Askham Bar Vaccination Centre included a staffing bank; a number of Practices and Primary Care Networks were sub-contracting into this service. SP noted that work was taking place to ensure access to vaccine facilities across rural communities, including the potential for a 'vaccine bus', and advised that at the CCG's May meeting with Practice Managers she would, in addition to discussion of vaccine delivery, raise the concerns described by HE.

SS commended the joint working in response to the pandemic highlighting support provided to enable people to make informed decisions about vaccination. She emphasised the aspect of continuing this approach post pandemic.

HE referred to the fact that the offer of vaccination was progressing in the 40s age group. She detailed concerns about hostility and verbal abuse being experienced by teams who were undertaking follow up with people who had not taken up offer of vaccine in this group. In addition to this being a wholly inappropriate response, HE emphasised the perspective of the overall need for the population to be protected.

Detailed discussion ensued in the context of primary care capacity and resilience, both clinical and non clinical, and the return to business as usual with additional activity including the potential for a COVID-19 booster vaccination.

In response to PM referring to support for General Practice in terms of delivery of core services, AM advised that discussions were taking place in various forums, including the Local Medical Committee, in the context of both capacity and resilience but also in the context of waiting lists and the waiting well. He highlighted the need for a single forum and offered to participate in this.

JH reiterated the perspective of as many people as possible being vaccinated for the protection of all and the need for a single message across the system in support of staff wellbeing and resilience. SP advised that ongoing work would include engagement with regional communication teams in this regard. She noted that engagement was required with the population as well as the system in relation to prioritisation and management of primary care workload. Potential flexibility to enable focus on patient need required consideration locally and regionally.

NW assured members that this work would be progressed outside the meeting. He noted that concerns about primary care capacity and resilience had also been raised with the Humber, Coast and Vale Integrated Care System and NHS England and NHS Improvement.

The Governing Body:

Noted the update

7. Quality and Patient Experience Report Continued

In continuing her report MC commended the partnership working in response to COVID-19. She referred to the significant impact on the mental health of staff in care homes earlier in the pandemic and noted that at the present time only one member of staff had tested positive through routine testing in York care homes. However, an outbreak in a Selby factory highlighted the need for continued vigilance and maintaining 'hands, face, space'. MC also referred to the situation in India advising that this had had impact on recruitment of nurses in the UK.

In terms of risks managed by the Governing Body MC advised in respect of QN 13 *Hepatitis B vaccine in renal patients* that details were being finalised pending this service being taken over by York Teaching Hospital NHS Foundation Trust and with regard to QN *18 Potential changes to the North Yorkshire County Council commissioned Healthy Child programme* final post consultation plans had been delayed in the context of due diligence, feedback and lessons learnt through the COVID-19 pandemic.

In response to DB referring to risk QN08 *Risks associated with growing waiting lists* and enquiring whether these patients were aware that they were being clinically reviewed, MC acknowledged that, although based on clinical need, there was potential for improved communication.

The Governing Body:

Received the Quality and Patient Experience Report confirming assurance of the work being undertaken to understand and support the quality and safety of commissioned services.

In relation to the risk register:

- Confirmed assurance that risks to quality and safety for the CCG were identified with appropriate mitigations in place.
- Approved the risk *QN 16 Initial Health Assessments for Looked After Children – reduced capacity to meet demand* be archived as this had been incorporated within *QN 07 Referral for initial health checks – timeliness of City of York Council referrals.*
- Agreed that the risks relating to Tees, Esk and Wear Valleys NHS Foundation Trust following the Care Quality Commission inspection be added to the Governing Body risk register.

9. Board Assurance Framework

AC presented the Board Assurance Framework which included strategic objectives, progress against priorities and a summary of all risks noted by the organisation. She noted that the risk register was shorter than historically due to committees acceptance of risk or events, recognition that the CCG was unable to address a risk or the fact that a risk had been resolved. AC additionally highlighted inclusion of the strategic objective relating to population health. She also noted that a risk not accepted at the recent Finance and Performance Committee had, as requested, been incorporated in the Board Assurance Framework particularly in respect of the population health objective but also relating to staff through the current transition.

PG additionally commended both the CCG and the Governing Body on progress in risk management.

The Governing Body:

Received the Board Assurance Framework.

ASSURANCE

10. Risk Management Policy and Strategy

AC referred to the Risk Management Policy and Strategy that, following Governing Body's review of the risk appetite statement on 1 April 2021,had been approved by an Extraordinary Audit Committee meeting on 8 April 2021.

SB noted the need for an amendment at 12.8 *Finance Risk* as the CCG was no longer in Legal Directions. He would discuss appropriate wording with AC outside the meeting.

The Governing Body:

Ratified the Risk Management Policy and Strategy subject to amendment as above.

AC left the meeting

11. Workforce Race Equality Standard 2020 / NHS People Plan

This item had been deferred.

FINANCE

12. Financial Performance Report 2020/21 Month 12

SB confirmed that the CCG's financial outturn for 2020/21 was break-even, in line with plan, with a small technical surplus of c£3k and, subject to External Audit, the CCG would have the draft audit findings later in the month.

SB explained that the CCG had submitted a break-even plan for the first half of 2021/22 for which the majority of parameters were nationally set. As in 2020/21 contract values for the main NHS providers and the majority of uplifts required, including contracts with primary care and the Mental Health Investment Standard, were also nationally set. SB advised that the first half of the current year was expected to be more challenging than the second half of 2020/21 noting that, in line with negotiations with HM Treasury, efficiency requirements were being reintroduced; for the CCG this would likely impact prescribing, complex care and continuing healthcare budgets. There was also c£0.5m unidentified savings in the plan but this was not currently considered to be a significant risk. SB added that, subject to negotiation with HM Treasury, the second half of 2021/22 was expected to be more challenging than the first half.

In response to NW enquiring about the national perspective, SB explained that a return to pre COVID-19 levels of funding was not anticipated but noted that areas where there had been historic financial deficits were being asked, albeit on a reduced scale, to achieve more efficiency than areas where this had not been the position.

The Governing Body:

Noted the update.

RECEIVED ITEMS

The Governing Body noted the following items as received:

13. Audit Committee chair's report and minutes of 25 February and 8 April 2021.

14. Executive Committee chair’s report and minutes of 10, 17 and 24 February, 3, 10, 24 and 31 March, 7, 14 and 21 April 2021.

15. Finance and Performance Committee chair's report and minutes of 25 February and 25 March 2021.

16. Primary Care Commissioning Committee chair's report and minutes of 25 March 2021.

17. Quality and Patient Experience Committee chair's report and minutes of 11 February and 11 March 2021.

18. Medicines Commissioning Committee Recommendations of December 2020 and February 2021.

19. Next Meeting

The Governing Body:

Noted that the date of the next meeting would be confirmed following review of frequency.

In closing the meeting NW emphasised the need to remain vigilant particularly in light of the easing of the pandemic restrictions. He also expressed appreciation to CCG colleagues for their continued work in the face of uncertainty.

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

ACTION FROM THE GOVERNING BODY MEETING ON 6 MAY 2021 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 April 2020	COVID-19 update	• Review learning on the part of both teams and organisations	All	Ongoing
7 January 2021	Quality and Patient Experience Report	• Feedback session to be arranged for clinical leads for care homes	MC	

Item Number: 5

Name of Presenter: Phil Mettam

Meeting of the Governing Body

Date of meeting: 1 July 2021

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 To receive 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: 1 JULY 2021

Accountable Officer's Report

1. Local and system financial position

1.1 At the end of May the CCG has continued its strong financial management performance and is reporting a small overspend but forecasting a breakeven position for the first half of the year (H1), in line with plan. There are increasing financial challenges to our own position when compared to H2 from 2020-21 and we are beginning to see an emerging pressure on our Continuing Healthcare budget, which is no doubt linked to the Hospital Discharge Programme in terms of both demand and complexity of care coming through.

1.2 It is also important to be aware that there are two key components outside of our core funding in the first half of the year. Firstly, the Hospital Discharge Programme, for which the CCG now has a fixed budget and is actively working with system partners to ensure we manage within. Secondly, the Elective Recovery Fund (ERF) where ICS' organisations are reimbursed for elective activity over and above 2019-20 levels. At this stage financial reporting is based on an expectation that additional costs will be reimbursed in full but as this is based on system performance there is some risk that individual organisations may not be.

1.3 I am pleased to be able to report that the overall North Yorkshire and York sub-system financial position is positive within the provider sector where York and Scarborough Teaching Hospitals NHS Foundation Trust having started the year off well and making strong progress with their part of the ERF.

2. Recovery and transformation

2.1 After the shock to the system of COVID-19, 'normal' activity within primary care is now growing in parallel to the continuing vaccination / COVID-19 workload. Referrals into secondary care, and activity, are growing too. The impact of the long hours and intense pressures on colleagues and partners across the system during the pandemic is that many staff are exhausted. This is the case in primary care, community care and in secondary care. This limits the health system's ability to increase capacity by asking staff to work extra hours. In turn, this severely reduces the number of additional consultations, outpatient, diagnostic and theatre sessions that can be brought online to address pent up demand in primary care and backlogs in secondary care.

2.2 Health inequalities, exacerbated by COVID-19, continue to be assessed and the output of the assessment will drive and focus work to reduce inequalities.

2.3 The direct impact of COVID-19 on our local population health continues to be addressed. There remains a dedicated COVID-19 ward at York Hospital and some eight COVID-19-positive inpatients were reported in the report of 13 June

2021. Long covid is being addressed, in accordance with national guidelines, by means of a multi-disciplinary assessment service, in place since March 2021. The service runs out of York Hospital and the assessment identifies requirements for ongoing support services for patients, who are subsequently contacted with details of these services. The multi-disciplinary team consists of input from a consultant respiratory physician, a respiratory specialist nurse, a physiotherapist, a psychologist, and an occupational therapist. Cardiology and neurology expertise is called on when appropriate. It is noteworthy that this is a new, additional demand on our stretched services.

2.4 The CCG and partners have completed plans for the first half of the financial year 2021-22. Splitting plans and the planning process into H1 (April to September) and H2 (October to March 2023) is a requirement of NHS England. The H1 plans have been submitted to NHSE, aggregated at Humber Coast and Vale Integrated Care System level. Guidance for H2, containing mandated planning assumptions, etc, is expected in July 2021, at which point planning for the second half of the year can begin in earnest.

2.5 Support using capacity from independent sector partners continues into 2021-22. The capacity addresses outpatient activity, both first and follow up, and surgical activity, both day case and normal inpatient. The contribution from the independent sector is especially significant while throughput in NHS buildings is constrained due to modifications to pathways necessitated by COVID-19.

2.6 Work on increasing diagnostic capacity has included continuing to explore the implementation of nationally funded Community Diagnostic Hubs. These will provide quick and easy access to a range of elective diagnostic tests on the same day, supporting earlier diagnosis, greater convenience to patients and the drive to reduce health inequalities. Two models have been considered for our population, both led by GP federations. This is an exciting time, and the CCG is working with colleagues at Humber Coast and Vale Integrated Care System to ensure our local population benefits from the availability of additional, national funding to develop Community Diagnostic Hubs.

2.7 Key recovery / transformation programmes continue. These includes the 'Waiting Well' Programme which will develop a communication approach to address the concerns of long waiting patients, particularly those waiting for surgery, and a risk stratification approach to ensure patient safety. This programme grows in importance as waiting lists grow. GP workloads are intensified by more and more calls to GP surgeries enquiring about delays. This adds to the workload of already hard-pressed GPs and the Waiting Well Programme will help alleviate patient concerns and reduce call numbers. Other programmes include an improved musculoskeletal service. These provide specialist clinical review of patients with musculoskeletal conditions by a 'first contact practitioner', a qualified autonomous clinical practitioner who is able to assess, diagnose, treat and discharge a person in a community setting. A further workstream, the ophthalmology programme, aims to integrate the eye

care pathway from community optometrists and GPs to secondary care thus improving eye care, increasing patient convenience, and reducing pressures on secondary care.

2.8 Cutting across all this work is the need to continue to develop and embed a personalised care framework in care delivery by all individuals and teams, and empowering local people to better engage in self-care and care planning with their clinicians and support services. The first contact practitioner developed in the musculoskeletal service, discussed above, is an excellent example of this. Much of the work of the first contact practitioner is to help patients develop their self-management knowledge and skills, reducing the impact and limitations of, sometimes chronic, and difficult conditions.

2.9 These are uniquely challenging, exciting and difficult times for the CCG, our partners and our patients. The value and importance of working collaboratively with our partners locally, and across Humber Coast and Vale Integrated Care System, is being demonstrated once more as we move into the final year of the CCG's existence. The Department of Health and Social Care's White Paper, Integration, and innovation: working together to improve health and social care for all, sets out legislative proposals for a health and care bill expected later this year which will draw the existence of the CCG to a close. Responsibilities, and staff, will transfer to Humber Coast and Vale Integrated Care System by the end of March 2022 and it is within this organisational context that the interests of patients in the Vale of York footprint will be protected and assured into the future.

3. Primary Care Protected Learning Time

3.1 The next Protected Learning Time session will take place on as another virtual session on the afternoon of the 6 July 2021. WE are looking forward to another useful, positive event where Vocare will be covering primary care urgent appointments to allow general practice the time to share and learn.

4. Emergency Preparedness, Resilience and Response

4.1 The CCG is working with its partners to plan for the Winter 2021-22 period. Plans include preparedness for winter flu and what may happen if there is a COVID-19 surge. We are also focusing on plans with the acute sector to address children and respiratory illness as there is likely to be an earlier presentation of this as restrictions ease.

4.2 In the CCG's transition to move to the local Integrated Care System (ICS), we have begun work to map local committees and how their important work links into the ICS.

5. Recommendation

5.1 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: 1 July 2021

NHS
Vale of York
Clinical Commissioning Group

Report Title: Quality and Patient Experience Report

Purpose of Report
For Decision

Reason for Report

The June Quality and Patient Experience Committee was a focused meeting on quality in primary care. The presentations relating to the Medicines Management Team workstream, primary care engagement and feedback, and the Primary Care Networks end of year review are attached; the full report of the latter is published with the May Primary Care Commissioning Committee papers. The Committee also received an update on development of the Primary Care Dashboard which will be presented to Governing Body at a future meeting.

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. Not applicable

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

Risks/Issues identified from impact assessments: Not applicable

Recommendations

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

Decision Requested (for Decision Log)

Governing Body is requested to determine whether members are assured of the work being undertaken to understand and support the quality and safety of commissioned services.

In relation to the risk register Governing Body is requested:

- To be assured that risks to quality and safety for the CCG are identified with appropriate mitigations in place

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

Appendices

Presentations:

- Primary Care Engagement and Feedback
- Primary Care Networks End of Year Report
- Medicines Management Team Workstreams

1. INTRODUCTION

Quality and Patient Experience Committee held a focused meeting on Quality and Safety in Primary Care as the sole topic of its meeting on the 10th June. The aim being to ensure that in addition to intelligence shared at Primary Care Commissioning Committee, there is oversight and assurance of the quality of services at QPEC.

2. PRIMARY CARE ENGAGEMENT AND FEEDBACK

The committee heard about work undertaken to understand the experience of patients currently accessing primary care. Both positive and negative patient stories were shared which equally demonstrated examples such as the quick response and onward referral for someone with a suspected cancer and frustrations experienced by people upon gaining initial access. A range of common positive and common negative patient feedback is shared.

Experience from front line staff, particular reception staff was also shared and the challenges faced when demand is exceeding capacity within the practice.

Examples of work undertaken to engage with patients to inform service development were shared and noting the importance of co-production with patients and members of the local population to help shape local services.

Please see Appendix 1 for full presentation

3. Primary Care Network End of Year Review

Presentation and discussion was held regarding each PCN end of year review. This encompassed the following aspects

- How the PCN has responded and continues to respond to the impacts of the pandemic and keep patients safe
- How despite the pandemic significant progress has been made i.e. with proactive approaches to physical health checks for people with a learning disability or severe mental health illness
- How the PCN is engaging with their local communities to help shape and transform services
- The vision that the PCN has to transform services to focus upon population health needs (and not 'wants') and progress made against this journey
- Progress in developing the workforce (PCN People) to offer greater resilience, range of ways of meeting health needs and the additional challenges that these bring i.e. the need for additional space, change in ways of working, mentoring and supervision.

The remaining and ongoing challenge for primary care is the ability to meet the increasing needs for each population, upon a background of more capacity and appointments currently being delivered now than pre-pandemic, yet this is not meeting the level of patient demand and need. This in turn translates and contributes to wider system pressures.

Please see Appendix 2 for full presentation

In order to gain clear oversight and assurance regarding the quality and safety within primary care, a dashboard is currently in advanced stages of development and will be shared with Governing Body once validated.

4. MEDICINES MANAGEMENT

The CCG Medicines Management Team (MMT) works across and between providers to ensure quality and safety approaches to prescribing.
An overview of the workstreams currently underway can be seen in Appendix 3

Please see Appendix 3 for full presentation

5. RISKS TO QUALITY AND SAFETY

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

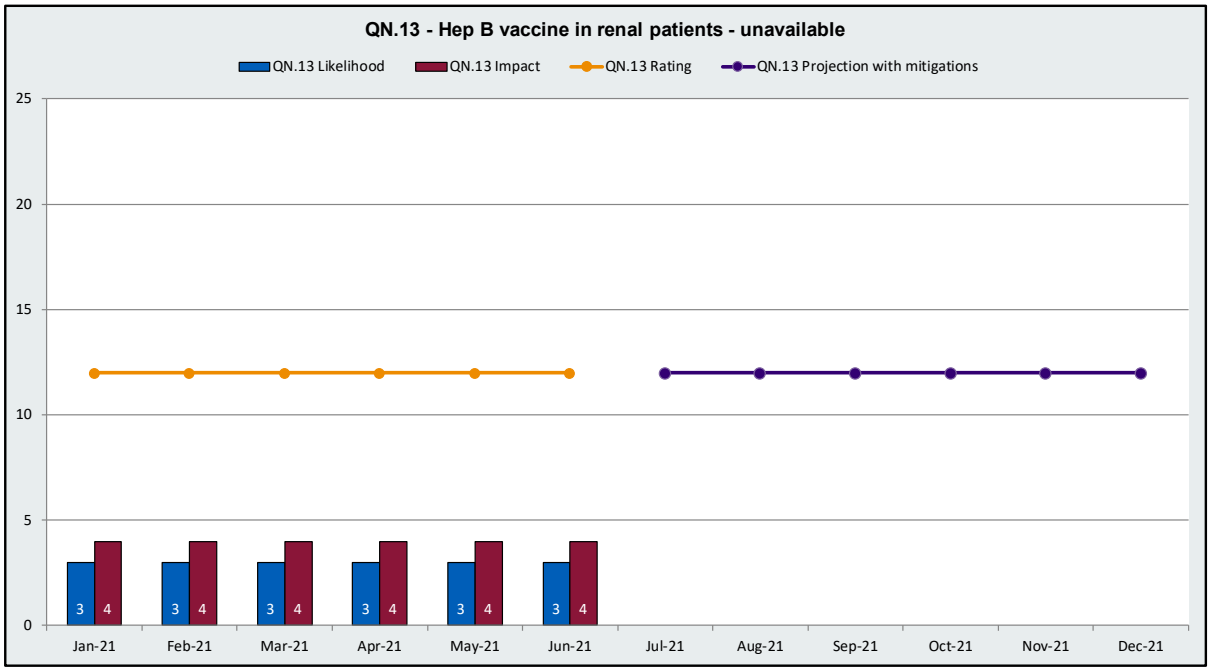
Risks being managed by QPEC will be updated at the next committee on the 8th July 2021. These are:

Risk No	Risk Description
QN03	Quality of commissioned specialist nursing services (children)
QN07	Referral for initial health checks – timeliness of CYC referrals
QN08	Risks associated with Growing waiting lists
QN09	SEND Inspection and failure to comply with National Regulations
QN 12	Missed pertussis jab for expectant mothers posing a risk to unborn babies
QN 19	Risk to quality and safety to residents in care homes due to normal oversight and assurance frameworks not in place
QN 20	Risk to patient safety due to increased rates of nosocomial infections
QN 21	Children and Young people's therapy waiting times at York and Scarborough Teaching Hospitals NHS FT
QN 22	Quality and safety of acute hospital discharges following the introduction of new discharge standards during the pandemic.

Updates on the risks managed by Governing Body

QN 13 Hep B vaccine in renal patients:

Risk RefB3:N17B3:N19B3:N21B3:N23B3:N30E	**QN.13**
Title	**Hep B vaccine in renal patients - unavailable**
Operational Lead	Paula Middlebrook
Lead Director	Michelle Carrington
Description and Impact on Care	There is not an adequately commissioned Hepatitis B vaccination service for renal patients leading to a risk that patienst may not receive it.



Mitigating Actions and Comments

Date: 24th June 2021

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.

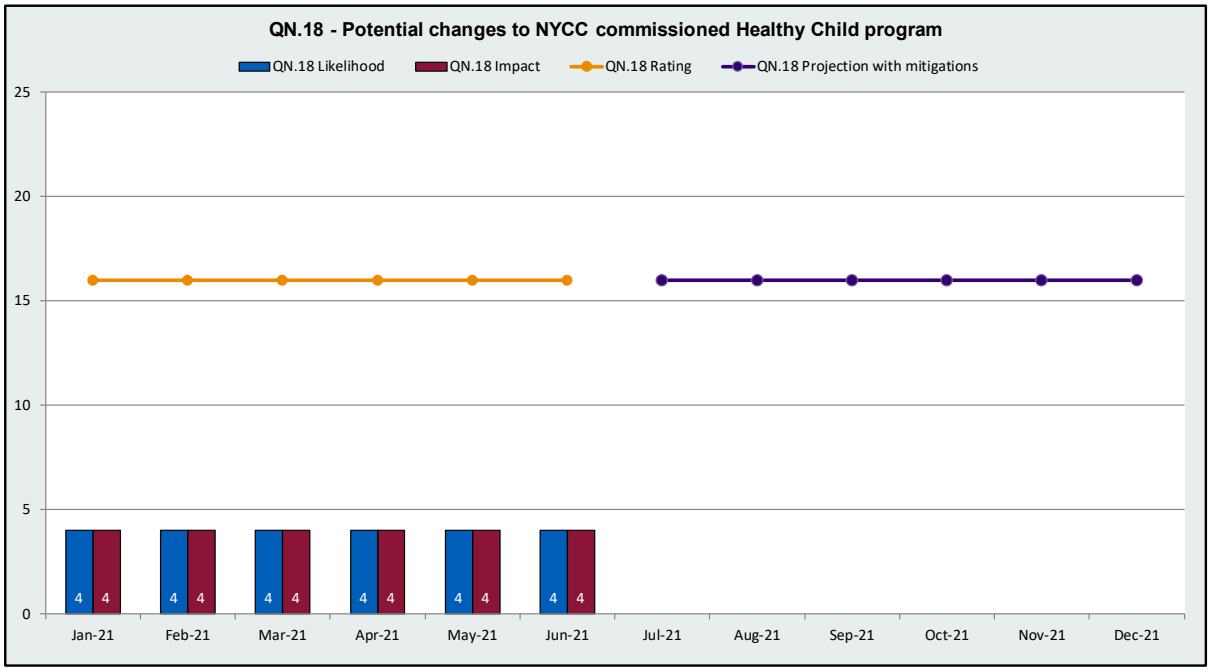
Due to lack of advance notice, YTHFT informed the CCG that they are unable to meet this need due to the additional resource that is required in clinic capacity and personnel to deliver the service.

Local GPs have continued to provide vaccination at the request of YTHFT with a formal agreement in place until the end of March 21. The Trust has delayed progress to develop and agree long term model due to the impact of covid on internal services, however following a meeting with the Trust and renal services on the 19th March, the Trust is committed to develop a sustainable model. VoY CCG has confirmed with the Trust that funding to support a sustained model will be supported by the CCG.

The Trust is further delayed in determining a model that meets both the needs of North Yorkshire and Vale of York commissioned services and avoiding risks of 'missing' indvidual patients. Further clarity being sought regarding North Yorskire commissioning intention. The increase of primary care demand generally is noted and may increase the risk as primary care is unable to meet the gap in provision.

QN 18 Potential Changes to NYCC commissioned Healthy Child Program

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 new HCP model will create gaps in service delivery within the system, particularly for 5 – 19year olds which will impact upon health services.



Mitigating Actions and Comments

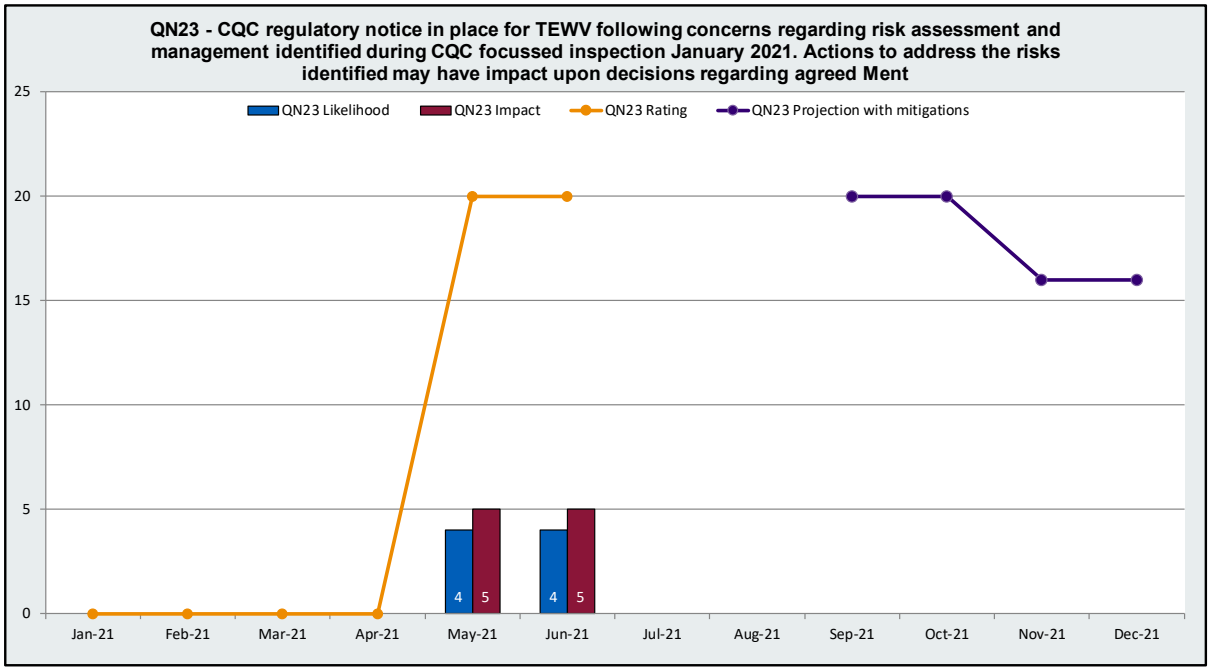
Date: 24th June 2021

Mitigation to maange the emerged risk with regards to lack of health attendance at Initial Child Protection Conferences (ICPC) when 5-19 practitioner is not in attendance as is not involved in the care of the child / Young person has been developed. (GP's do not attend all ICPC's due to clinical commitments and short time frames involved)

The Designated Professionals have submitted a business case to NY and Y CCG's which has been agreed . This proposal describes a model by which the CCG employ a band 7 Specialist practitioner within the Primary Care safeguarding team to represent the 'health' contribution at ICPC's This model ensures that the health contribution to risk assessment and decision making is fully compliant with the safeguarding process . The appointment of this post is now being managed through the external recruitment process.

QN23 CQC Regulatory Notice in place for TEWV

Risk Ref	QN23
Title	CQC regulatory notice in place for TEWV following concerns regarding risk assessment and management identified during CQC focussed inspection January 2021. Actions to address the risks identified may have impact upon decisions regarding agreed Mental Health Investment priorities which have been agreed due to population need and attainment of MH Long Term Plan requirements and therefore the quality, safety and performance impact of that investment on services.
Operational Lead	Paula Middlebrook
Lead Director	Denise Nightingale
Description and Impact on Care	In January 2021 the CQC undertook an unannounced focussed inspection to Adults of Working Age in patient areas and PICU within TEWV. Concerns were idenitfied regarding identification of individual patient risk and underpinning systems to ensure risks are effectively managed alongside trustide learning from incidents and serious incidents. This has led to a regulatory notice. Whilst immediate actions have been put into place to change risk processes, further investment has been identfied as a need for in patient areas which may compromise the ability to invest in previously identfied and agreed priorities associated with population health need and attainment of the MHIS associated with the Long Term Plan.



Mitigating Actions and Comments
24th June 2021
NHSE/I led Quality Board established which is meeting monthly. NYCCG Chief Nurse representing both NYCCG and VoY CCG. Trust Action plan regarding the section 29a improvement notice returned to CQC on 21st May. Progress and assuranec of delivery is being monitored by the Quality Board. The immediate actions from the section 29A warning notice have now been completed Desk top review underway by NHSE/I EQIA in progress for the proposed in patient workforce investment, with further work required to understand full mitigations and QIA assessment upon any risks to agreed MHIS priorities. CCG participated in local Peer REview site visits in May Combined NY CCG & VoY CCG Quality & Performance Group fully established to ensure focus upon local quality and safety with separate VoY CCG Contract Management Board to ensure oversight and deciison making regarding the VoY contract.

6. RECOMMENDATIONS

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

Appendix 1

Primary care

Engagement and feedback

QPEC – 10 June 2021

Positive patient stories

Access for care relating to cancer screening

During Lockdown One I found a lump in my left breast. I checked constantly for 24 hours and, when it didn't disappear I phoned my GP. It was 8.30am and I was asked if I could be at the surgery by 9am, which I could. After a full inspection, the GP referred me to the hospital. She did this whilst I was in the consulting room and said the hospital would be in touch within 48 hours. As I walked back to my car in the surgery car park my phone rang. It was the hospital asking me to come to an appointment 5 days later. I attended that appointment and it was found, luckily, not to be cancer. The relief I felt was huge (single parent, 3 kids) and I was so grateful to our wonderful NHS.

I know how difficult and how much pressure the NHS has been under during the pandemic but when it mattered they were still there for me.

Online/Telephone:

Having repeat prescriptions online or via phone. Within 2 hours of ordering my repeat the pharmacy were contacting me to inform me my prescription was ready.

I haven’t been at the surgery for long so don't have a lot of experience but had my prescription processed quickly which was good – I also found the call back on the telephone system useful. To minimise contact it was good that swabs could be done at home but they didn’t come with any instructions.

I did manage to speak to Dr *****today and just to say a huge thank you for making such a quick appointment for me and also for taking the time to email me. It is really appreciated.

I had a requirement to seek an appointment – given the fact there was a queue you knew where you were and once I got through, I was dealt with efficiently and my experience was perfectly ok given the circumstances. I got a call back and was referred to another clinician and dealt with quickly I was quite impressed.

Negative stories

Building access to appointments (Selby) – Healthwatch focus group with a disability group in March 2021

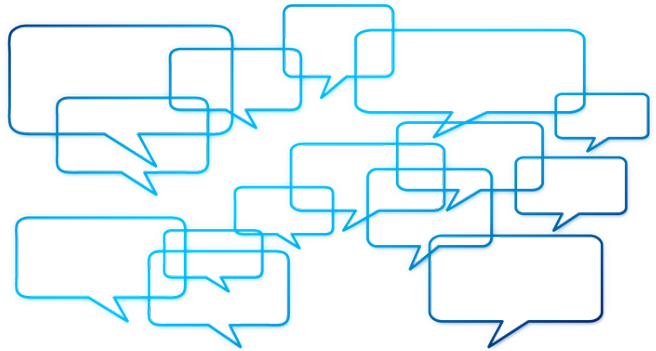
I'm with a GP practice and you just cannot get into the building, the lights are off, the blinds are down and even if you do get in the reception has its shutter down and they only open it slightly to speak to you. I'm going to move practice when covid is over. I suffer chronic pain and it's really bad recently but I don't ring as I would get no further than a phone call. There is no point. It has got worse since lockdown, and I know someone else who is thinking about leaving. If you ring to speak to a GP, then a nurse rings you and you wonder why people are frustrated.

Phone access and booking appointments:

York practice: For the past three weeks I have been phoning the surgery, every other day to get a non-urgent appointment. Today I have sat on hold for a nurse appointment for 1 hour, as number 1 in the queue. Last week i was on hold for 40 minutes and once the phone was hung up on me. The week before I was on hold for 40 minutes again and when I got through I was told there were no doctors' appointments for that day. I realise that non-urgent case are not a priority in this pandemic however my non-urgent case is in relation to long covid symptoms. I have been suffering with anxiety and depression alongside this and not been able to get an appointment is really not helping.

Healthwatch York feedback from a patient with anxiety: “From my own experience, I have found it very difficult to access an appointment. I have had numerous health issues over the last year and simply getting an appointment has been a huge headache. I now have anxiety just trying to ring the GPs. I was contacted a couple of days ago regarding a blood result which means I need to speak to the GP. Receptionist couldn’t make an appointment and suggested I ring on Monday in an attempt to get an appointment on the Friday. Monday mornings are dreadful trying to get through, so I am already anxious about making the call. Even if you do get a telephone consult, it is usually within a 4 hour slot…and in my working role I can’t be available for that length of time.”

Patient feedback



How we receive feedback:

- Compliments and complaints
- Surveys
- Healthwatch
- Focus groups – urgent care, wheelchair forum, carers forum
- National patient survey
- Project work
- Primary care sharing data

Staff Feedback – one receptionist feedback

Negatives

1. Patients ignoring the posters on the door and walk in for queries, even though our information at the entrance asks them only to come in if asked to do so. We get a lot of patients not happy at this, accuse of us of scaremongering, being rude and say that it's ridiculous, call us Rude when asked to leave and phone the surgery.
2. complaints at the telephone message which we have taken lead from the NHS guidance and then tailored to our practice.
3. complaints due to the length of the telephone queue (pre covid - patients could get through to the surgery without much of a wait).
4. some pts can't understand why they can't book straight in for a F2F appt and are not happy with a telephone appt initially. Generally these patients are not accepting of change and just want to come in to see their GP as they used to. On the other hand younger patients tend to prefer the telephone consult.
5. more than ever, we cannot currently meet the demand for appointments and patients are often asked to call back another day to try then for an appointment, which is causing frustration. We have been told py several that we are using covid as an excuse for the lack of availability.
6. One patient remarked Covid is a conspiracy theory, you're using it as an excuse, I've been working all the way through covid without excuses unlike the GPs.
7. Pre - covid we were booking GP appts up to 4 weeks ahead. At the height of the pandemic we changed to on the day appts only. Now we are trying to navigate our way back to our pre covid system, patients can't understand whey they can't have an on the day appt for a routine call. Their expectations seem to have changed somewhat.
8. We are often told well If I die, it will be your fault, or I could be dead before that appt. Of course it was an urgent appt we would have put them in for an emergency appointment, but these remarks are for routine follow ups/reviews.

- The reception team have been hit really hard since this last lock down , taking the brunt of our patients frustrations. There are so many calls, it can take up to an hour to clear the queue of calls first thing in a morning or after lunch time. Having patients swear, and shout down the phone used to be a rare occurance but is very frequent at present.

- **Positives for the reception team**, increased IT systems, so pts can sent in photos, requests using AccuRx or similar. More telephone appts as these were few in the past. Many patients thanking us for our assistance throughout the pandemic, Lovely gifts and cards at Christmas, more patients signing up for online services and electronic prescriptions. Patients have been more eager to update their contact details so they don't miss their link for their vaccination.

Common themes - issues

- Getting through on the telephone
- Not enough appointments
- Flexibility – eg people work and cannot wait for a 4 hour window for a call back, or phone in at 8am when they are travelling/taking the children to school
- Risk of people not being seen because they couldn’t get through
- Those who do not have digital access
- Vulnerable/at risk patients

Common themes - positive

- Care of staff – lots of praise
- Online
  - NHS app for booking appointments/prescriptions
  - Email advice
  - Video consultations/telephone – much better for people who work/care/cannot get out the house or don’t have transport
- Specialist care – eg Parkinson's nurses and care coordinators
- Health checks
- Coaching/intervention
- Quick referrals

Comms and raising awareness to support general practice

How?

- Social media and website
- Press – printed and online
- Radio and TV
- Voluntary sector and networks
- Healthwatch
- Working across NY&Y and with the local authority
- Spokes people and community leaders
- Forums
- Newsletters and leaflets

Examples

- Your GP practice is open
- NHS app and online service
- New roles in primary care – you don't always need to see a GP
- Help us to help you/Choose well
- Specialist roles – care coordinators, PNS
- Awareness weeks – MH, Dementia, Carers

Focused pieces of engagement

- Population Health Management – Selby
- Parkinson's Nurse Specialist
- Carers Champions
- Easingwold community services
- Urgent care – Selby
- Diabetes care York
- ADHD and Autism
- Covid survey

Where next?

Based on the deep dive today – where do we want to do some more focused work?

Appendix 2

Primary Care

PCN End of Year Review

Transformation

- By working more closely together, 4 of the 5 York Central PCNs are now using Klinik (for treatment and urgent care workflow) and are moving towards a single patient record system.
- We are shaping community Diagnostic Hub conversation through their GP federation (Nimbus) with a view to maintaining the Askham Bar Vaccination Centre as a primary/community care hub for York residents.

In the Spotlight

- Exceeding pre-pandemic rate of primary care appointments.
- All 5 PCNs are working together in a single provider organisation (Nimbus).
- Nimbus has become the voice of York Central GPs at York 'place'.
- Involved in Urgent Care transformation to inform 'place' redesign.

On Track

- Delivered IA and Opel 4 cover in 2020-21 and shaped the collaborative future of PCNs in central York.
- Achieved the NHS England model for primary care in York at multiple levels.
- Expanded capacity by employing locum nurses and GPs with more sessions to cover annual leave.
- Released partner sessions and increased practice management to ensure efficient practice functioning and setting up of the vaccination programme.
- ·Supported the established of COVID oximetry@home.

York Central in Numbers

There are 11 practices and 5 PCNs which make up York Central. This are is coterminous with City of York Council.

Across the Vale of York CCG, there was over 167,000 appointments in March 2021 and York Central PCNs have 10% more appointments available now than pre-pandemic.

Face to face appointments in York Central PCNs are currently at 90% capacity.

York Central PCNs

End of year review

Engaging with our Communities

- Built on relationships already established with other central York stakeholders through York Health and Care Collaborative to locally define delivery of Ageing Well, Frailty, and population health/inequalities agendas for York 'place'.
- We have provided increased support for vulnerable and housebound patients, engaged additional GPs and Mental Health Practitioners (not funded via ARRS), and created an access team to review and improve access for patients.
- Improved system networking by linking with wide range of stakeholders including community pharmacy as part of the vaccination campaign.

Our workforce

PCNs across Central York utilised an average of 73% of available ARRS funding with £1,077,000 invested in additional roles.

New posts include: Pharmacists, Practitioners, Primary Care Mental Health Workers, Physician Associates, Social Prescribing Link Workers, Health and Wellbeing Coach, and Care Co-ordinators.

Priory Medical Group recruited primary care mental health workers to support patients in advance of the Additional Roles funding expected in 2021/22 and, in doing so, have established a model now being replicated by other York Central PCNs.

4 out of 5 PCNs are

Exceeding LD checks target

Our Covid-19 response

- Established Covid SPA to support patients at high risk of rapid decline and supported asylum seekers and Peppermill Court services.
- Mass flu and covid vaccination (local and national) delivered through Nimbus at the Askham Bar Vaccination Centre.
- Over 200,000 vaccines delivered across the 5 PCNs, of which over 173,000 were delivered to CYC residents.

Transformation

- Worked with partners to establish earlier diagnosis and earlier support for patients with dementia.
- Development of new same day urgent care pathways.
- Improved pathways of care for people with mental illness.
- Partnership working with community services to provide better joined up care.
- Increased the number of people who are seen in 2 hours in a crisis.
- 40% increase in health checks for people with serious mental illness.
- New posts to support people with cancer and those at end of life.
- Development of new heart failure pathway.
- Implemented a new first contact physiotherapy service.
- 50% increase in recording patients with a recognised learning. disability - facilitating improved support.
- Introduced a new holistic nurse-led review for all cancer patients.
- 29% increase in severe mental illness checks.

Our patients

We are a rural Primary Care Network made up of 7 practices covering approximately 600 square miles across the Vale of York and North Yorkshire.

Throughout the COVID-19 pandemic we offered alternative ways of accessing primary care, including e-consultations and telephone triage.

We also maintained face-to-face appointments for those who have needed them and improved access to MSK services.

Engaging with our communities

- Building partnerships and networks across health, care, local authorities, district councils and the voluntary sector
- Designing urgent care for a rural community
- Involving people who have Parkinson's in shaping joined up personalised care
- Delivered an extensive neighbourhood-based flu campaign that led to exceptional uptake.
- Improved how we contact patients who find it hard to access our services.
- Easingwold community services review
- Focus on dementia.

82.1% LD checks complete

EXCEEDING TARGET

South Hambleton & Ryedale PCN

End of year review

94% COVID-19 vaccination rate

In the spotlight

- Vaccination roll out, volunteer network, new surgery openings, General Practice 2020 award wins and PCN of the Year all featured in the local and regional media.
- Social media development with practices and patients to ensure clear messaging on COVID-19 vaccines, NHS App downloads and health awareness.
- Campaigns to support additional roles: 'What is a PCN?'
- Our work with care coordination has a national profile.

Our workforce

Additional workforce to enhance the primary care team includes recruitment **10 new posts** - the highest uptake of additional roles in the Vale of York.

These roles include: Clinical Pharmacists, Social Prescribing Link Workers, Care Co-ordinators, First Contact Practitioner Physiotherapists and Pharmacy Technicians.

The team will increase to include an Occupation Therapist, Nursing Associates and Assistant Mental Health Practitioners over the next few months.

Our COVID-19 response

- Set up two vaccination sites in Easingwold and Pickering.
- Achieved 94% in cohorts 1 to 9.
- Fantastic partnership working with a huge network of volunteers, and partners in the district councils and county council.
- Vaccinations delivered at home for our most vulnerable residents.

Tadcaster and Rural Selby PCN

End of year review 20-21

Transformation

- Established a **frailty clinic** at Selby War Memorial Community Hospital in partnership with colleagues from the Trust, and community therapy teams – one stop clinic to provide a comprehensive assessment for those needing support.
- Enhanced **services for home visiting** through the addition of paramedic roles across the PCN.
- Worked with partners to enhance primary care based **mental health services** through the appointment of new mental health practitioner roles.
- Supported patients through the social prescribing link worker service, **supporting and signposting** patients to services across the Selby District.
- Delivered **12 week programmes of support** through health and well being coaches.
- Worked with our patients to develop **improved services** around blood pressure monitoring and hypertension.

Who Are We?

Tadcaster and Rural Selby Primary Care Network
3 practices: South Milford, Sherburn in Elmet, and Tadcaster.

A rural primary care network that is ~34 square miles with a patient population of over 28,000 people.

Our workforce

Additional workforce to enhance the primary care team with additional roles including:

Care Coordinators, Social Prescribing Link Worker, Health and Wellbeing Coaches, and Paramedics

Currently recruiting: Mental Health Practitioner, Primary Care Network Manager, and Pharmacists.

On Track

- Focus on structured medicines review for patients on more than 10 medications.
- Over 80% of women attending for cervical smear tests with extra clinics established.
- Focus on cancer pathways.
- Health and Wellbeing Coaches - 112 referrals and over 450 consultations in 4 months.
- Social Prescribing Link Worker - 115 home visits and 397 calls in 6 months.

Our Priorities

- Supporting patients with hypertension
- Obesity
- Cardiovascular disease
- Urgent same day primary care response

Engaging with our communities

- Campaigns to raise awareness of additional roles.
- Vaccination roll out and volunteer network both featured n the local and regional media.
- Social media development with practices and patients to ensure clear messaging on COVID vaccines, NHS App downloads and health awareness.
- Communications around 'what is a PCN?'

Examples of Support

Signposting and connecting people to:

- Welfare and benefits advice
- Debt management support
- Volunteering opportunities
- Mental Health and wellbeing advice
- Access to aids and community equipment
- Assistance with applications – attendance allowance, disability home improvements and housing applications.
- Information and support to attend local groups

Our Covid-19 response

- Set up of clinics to deliver the vaccination. Working with partners to set up the vaccinations at the airfield.
- Over 30,000 vaccines delivered.
- Partnership working with a huge network of volunteers, and partners in the district councils and county council.
- Vaccines delivered at home for our most vulnerable residents

Our priorities

- **Primary and community care** redesign
- **Community engagement**
- **Strategic partnership** and Assets
- **Population health management** – focusing on the needs of our communities to deliver the ambition for a healthier and more equal Selby.
- Specific **focus on dementia, mental health , obesity, frailty and cardiovascular disease**. Future focus on vulnerable children.

Who Are We?

Selby Town Primary Care Network
4 practices: Beech Tree Surgery, Escrick Surgery, Posterngate Surgery, and Scott Road Medical Centre.

We are an urban Primary Care Network with a patient population of over 50,000.

Our workforce

We have appointed additional workforce to enhance the primary care team for our patients. Including an additional 11 new posts.

Roles include: Clinical Pharmacists, Social Prescribing Link Workers, Care Co-ordinators, First Contact Practitioner Physiotherapists and Pharmacy Technicians.

Recruiting to: Health Care Assistant focussing on LD and SMI, Primary Mental health Workers and Advanced Nurse Practitioner.

Our COVID-19 response

- Set up of the Summit joint vaccination programme and site.
- Over 41,000 vaccine doses delivered.
- 100% of our populating with learning difficulties have received the COVID-19 vaccine.
- Achieved 94% in cohorts 1 to 9
- Partnership working with a huge network of volunteers, and partners in the district councils and county council.
- Vaccinations delivered at home for our most vulnerable residents

Selby Town PCN

End of year review 20-21

Working towards a healthier, more equal and more resilient Selby.

Transformation

- Provided additional support for our patients with learning disabilities to support annual health checks and care planning - 82% of LD patients have had health checks.
- Invested in new primary care posts to support patients with dementia and their families, significant increase in the number of people receiving a diagnosis and earlier support.
- Participated in a Yorkshire and Humber programme to improve the health of our community (population health management approach with a focus on frailty and hypertension.
- Co-created a frailty clinic at Selby War Memorial Community Hospital to provide a comprehensive assessment for those needing support.
- Established a new mental health partnership group to improve links between services, and to develop shared priorities for improving the mental health of our communities.
- Worked with partners to redesign urgent care services across the Selby District: developing an urgent treatment centre model and improving same day access for urgent primary care.

Engaging with our communities

- Vaccination roll out, volunteer network and new surgery openings all featured in the local and regional media.
- Working with voluntary and community sector colleagues on mental health.
- Social media development with practices and patients to ensure clear messaging on COVID-19 vaccines, NHS App downloads and health awareness.

Our ambition

We will keep working to improve:

- Patient experience.
- Quality of care.
- Population health.
- The experience of primary care, community health and care staff.

Appendix 3

MMT Workstreams

QPEC

Current Projects

- **CPCS**
- Community Pharmacy consultation service was launched by the NHS in 2019 and recently began taking referrals directly from GP practices, previously they were commissioned to take referrals from NHS 111.
- The service aims to alleviate pressures on GPs by upskilling care navigators and reception staff to refer patients to community pharmacies for the treatment of minor ailments.
- Current uptake is quite low but we are working with the regional NHSE lead to further raise awareness of the service and promote its use.
- **ONS**
- Work with NY CCG to update current Oral Nutritional Supplements formulary.
- Requires input from all the trusts in the footprint as well as the community dietetics team to ensure product choice approval
- Part of the work involves the role of how to promote food first before putting patients on to ONS products

Current Projects

- **OptimiseRX Alignment with NYCCG**

- Reviewing messages to ensure they remain appropriate and are in line with the joint medicine formulary
- Ensure the messages continue to promote safe and cost-effective prescribing
- Align messages with North Yorkshire to ensure the messages are consistent across the board
- Develop new messages in response to recommendations made by the medicine commissioning committee to ensure they mirror the formulary

- **Medicines Safety**

- Attend the joint medicine safety group with North Yorkshire CCG
- Attend the York and Scarborough Trust medicine safety group meeting
- Attend the regional medicine safety officer meeting
- Safety topics discussed and agreed to disseminate to practices asking for assurance where appropriate and following up through agreed channels
- Recent monthly safety topics include:
  - Adrenaline Auto-Injectors
  - Emergency Steroid Alert Card
  - Sodium Valproate
  - Methotrexate
- Ad-hoc safety topics, alerts and information sent to practices as and when appropriate

Current Projects

- **RSS guidance review**

- Currently reviewing all RSS guidance on a regular basis in preparation for REI
- Ongoing project with over 200 documents to review over the next 6 months
- Guidance documents are written and reviewed by the hospital specialist teams, a GP with interests and CCG pharmacist.
- Assess the guidance to support up to date evidence-based practice and prescribing in line with the local formulary
- Guidance documents are approved by the CEAG committee
- No identified issues, although very time consuming with the current resources.

- **Proxy ordering**

- Proxy ordering project currently being rolled out in GP practices and care homes across the Vale of York and on a much wider scale across the HCV
- Proxy ordering is the facility for members of care home staff to be able to order residents repeat medications via an online platform, after resident consent.
- Joint guidance developed with North Yorkshire CCG for GP practices (both EMIS and SystmOne) and for care homes
- Guidance took to pilot in care home and GP practice who expressed an interest in implementing proxy ordering
- Further roll out pending. HCV communications are being developed for practice and care home engagement

Current Projects

- **Electronic Repeat Dispensing**
- Electronic Repeat Dispensing (eRD) was introduced in July 2009 as a non-compulsory method of dispensing repeat prescriptions electronically
- From April 2019, as stated in the GP contract, eRD became a contractual obligation for all patients where it is clinically appropriate and the patient consents.
- eRD allows the prescriber to authorise and issue a batch of prescriptions for up to 12 months with just one digital signature
- Reduction in admin time for GP practices
- Collated resources for GP practices
- Support practices in identifying suitable patients
- Answer technical queries via the NHSE team
- Currently 6 practices unwilling to proceed with the roll-out of eRD

Other projects

Melatonin Audit

- Audit currently being undertaken to identify patients prescribed Melatonin and if the prescribing is in line with the shared care guidance

Zolendronic Acid Pilot

- Zoledronic audit completed to assess current service and if it meets requirements of pilot

Shared Care Guidance/ Amber LES

- Update as required

Selfcare promotion in collaboration with NYCCG MMT

RxLine

- General clinical and commissioning queries

Medicines Commissioning Committee

APC Alignment

Item Number: 8

Name of Presenter: Abigail Combes

Meeting of the Governing Body

Date of meeting: 1 July 2021

NHS
Vale of York
Clinical Commissioning Group

Report Title – Board Assurance Framework

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

Reason for Report
The Governing Body should receive the Board Assurance Framework for review and comment. The updates are provided in red and the risk summary is on the final slide.

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

N/a

Emerging Risks

N/A

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

The Governing Body is asked to review and receive the Board Assurance Framework

Decision Requested (for Decision Log)

The Governing Body is asked to review and receive the Board Assurance Framework

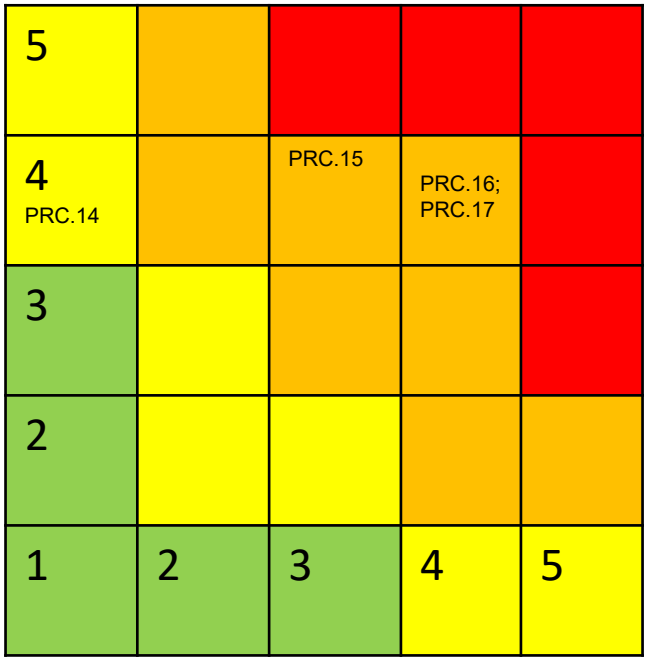
Responsible Executive Director and Title	**Report Author and Title**
Phil Mettam – Accountable Officer	Abigail Combes – Head of Legal and Governance

Annexes (please list)
Board Assurance Framework

NHS Vale of York CCG
Strategic Objectives

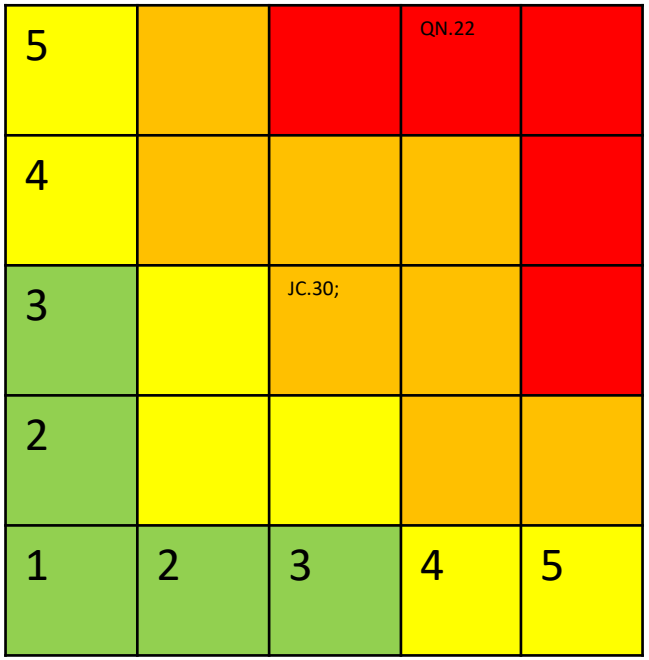
Support General Practice and wider primary care system to maintain a level of resilience to deliver safe and sustainable services.
Support innovation and transformation in the development of sustainable mental health and complex care services
Working with partners to deliver the recovery of acute care across elective, diagnostic, cancer and emergency care
Achieving and supporting system financial sustainability
Work with system partners to ensure provision of high quality, safe services. Work as partners to safeguard the vulnerable in our communities to prevent harm
Support the wellbeing of our staff and manage and develop the talent of those staff
Work with partners to tackle health inequalities and improve population health in the Vale of York

Support primary care to deliver services in a sustainable way whilst developing strong system partnership



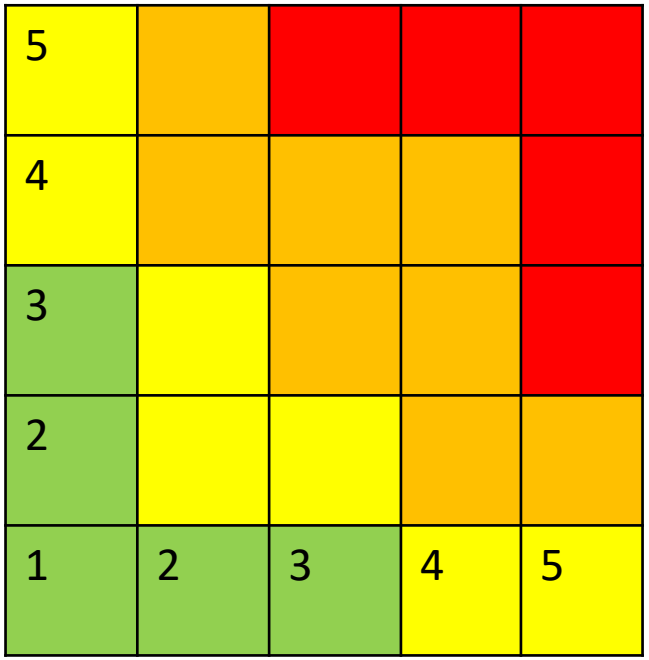
Current Priority	Exec Lead	Actions	Direction of risk travel
Continued support to practices to work in a Covid Safe way whilst responding to restoration of services	Steph Porter	Remote working for Practices - Maintain and embed all the total triage models in primary care - IT developing a 'use your own device' solution which will enable Practice staff to work flexibly from home, and securely access Practice systems/resources using their own PC's or laptops. - Supporting additional IT models to support practice resilience such as Klinik/Push Dr - Continued flexibility around the use of extended access/hours appointments to support Practice resilience to deal with any key issues such as access to hospital phlebotomy services (they can use their evening/weekend appointments to offer phlebotomy themselves, during core hours for example). - Discussions with NECS and NHSEI re. potential funding to support 2 x Selby Practices to move to SystmOne – at which point all South locality Practices across the 2 PCN's would be using the same clinical system with an ability to share records to support business continuity.	Stable but risk remains. Current incident levels reducing
OPEL escalation reporting framework	Steph Porter	- System recognition of capacity restraints in primary care on a daily basis - Engagement with DoS to limit 111 access to support response to short term capacity issues - Consistency of understanding of mutual aid at different levels of OPEL practice and PCN level has improved considerably and practices are reporting appropriately	Stable and agreement reached for escalation response
'SUPPORTING GENERAL PRACTICE: ADDITIONAL £120m FUNDING FOR APRIL-SEPTEMBER 2021'	Steph Porter	1. Increasing GP numbers and capacity 2. Supporting the establishment of the simple COVID oximetry@home model 3. First steps in identifying and supporting patients with Long COVID 4. Continuing to support clinically extremely vulnerable patients and maintain the shielding list 5. Continuing to make inroads into the backlog of appointments including for chronic disease management and routine vaccinations and immunisations 6. On inequalities, making significant progress on learning disability health checks, with an expectation that all CCGs will without exception reach the target of 67% by end September 2021 (ICS proposed revised date) 7. Potentially offering backfill for staff absences where this is agreed by the CCG, required to meet demand	Plans in place

Support innovation and transformation in the development of sustainable mental health and complex care services



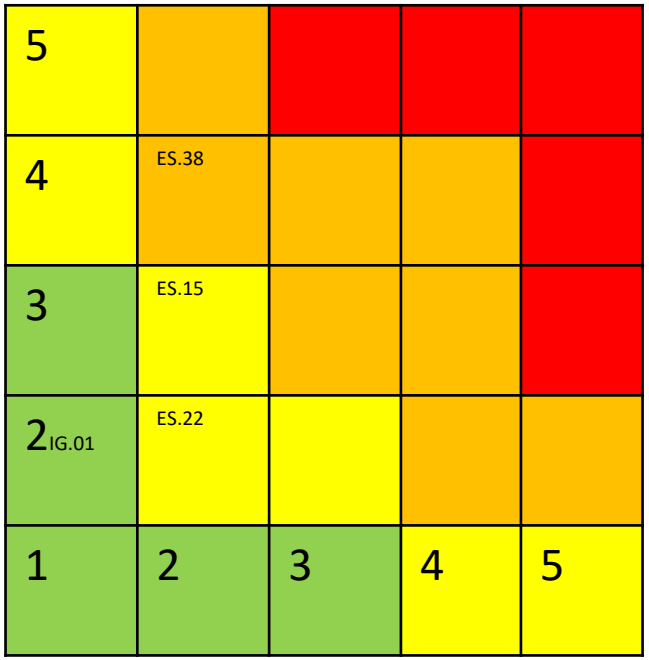
Current Priority	Exec Lead	Actions	Direction of risk travel
Mental Health Recovery	Denise Nightingale	• Accelerating preventative programmes to address inequalities such as health checks for people with Learning Disabilities (LD) or Serious Mental Illness (SMI) • Focus on recovery due to the expected surge in demand in mental health and crisis services which includes acute liaison and the resilience hubs and a review of the all age crisis line. • Continue to support integration between community and primary care under the 'Right Care Right Place' programme and key link workers reaching into primary care. • Co-development of a dementia strategy in York and continue to establish and deliver an improvement programme to address dementia diagnosis and dementia care • Re-procurement of adult ADHD and Autism diagnostic and treatment services • CQC regulatory notice in place for TEWV following concerns regarding risk assessment and management identified during CQC focussed inspection January 2021. Actions to address the risks identified may have impact upon decisions regarding agreed Mental Health Investment priorities which have been agreed due to population need and attainment of MH Long Term Plan requirements and therefore the quality, safety and performance impact of that investment on services.	Increasing due to potential surge in demand
Hospital discharge requirements	Denise Nightingale	• Continue to facilitate hospital discharge policies through extended discharge to assess models in collaboration with system partners and care providers • Continue to provide CHC support to multidisciplinary discharge hub teams. • Nationally revised discharge to assess policy and funding arrangements are expected (scheme 4) which are intended to support people through a period of rehabilitation or recovery before CHC eligibility assessments take place. Continue to revise processes and operational requirements with system partners in line with revised funding policy and funding. • Re-imaging the use of CCG CHC fast track funding to provide improved end of life care services. In the second phase up to the end of 2021/22 the CCG will work with partners to develop a more integrated end of life care coordination offer with oversight from a lead provider model.	Stable
Keeping people safe with complex care needs and CHC assessments	Denise Nightingale	• The service has fully completed the backlog of deferred CHC assessments as a result of the first covid-19 wave, and continues to resume CHC assessments in line with nationally prescribed operational and performance standards (e.g. CHC assessments to be completed within 28 days). • Continue to provide proportionate virtual reviews of people with fully funded CHC packages of care which require case management and support to providers of care with clients that have new or existing equipment needs. • Lead on development of closer alignment and integration of	Stable

Working with partners to deliver the recovery of acute care across elective, diagnostic, cancer and emergency care



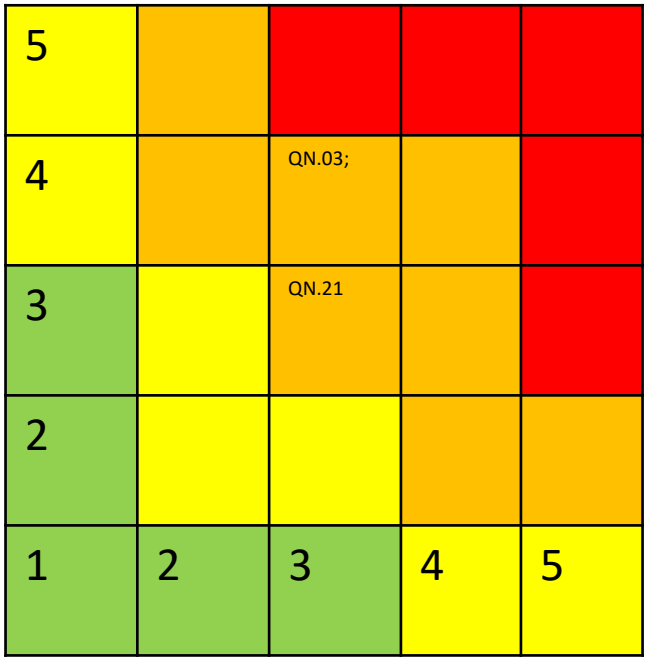
Current Priority	Exec Lead	Actions	Direction of risk travel
To optimise all elective capacity available to reduce long waits and minimise risk to patients	Phil Mettam	▪ Single oversight of all acute providers' waiting lists (PTLs) across the HCV by the Collaborative of Acute Providers (CAP), including high priority urgent 'P2' cancer and non-cancer patients ▪ Provision of **mutual aid** between providers to target highest risk/ longest waits where possible supported by Clinical Prioritisation Panel ▪ **Optimising all available capacity** across NHS and IS providers by: - Delivering on plans to undertake day case activity in IS at a level some 33% higher in the period April – Sept 2021 compared to the same period in 2019, and at a level of 95% higher for elective inpatients comparing the same periods – VoY CCG patients - Acute providers to move to top quartile productivity & performance in key specialties (Cardiology, Orthopaedics, ophthalmology) - Acute providers working together with four key specialties to explore how to optimise all available capacity and develop elective hubs which can manage low risk, high volume surgery more efficiently ▪ Provide support and care for patients who may wait for long periods on waiting lists informed by risk stratification based on health inequalities **[Waiting Well]** ▪ Manage pressure on waiting lists by optimising referrals with earlier expert input and increasing virtual consultations **[Outpatient Transformation]**	Static as refreshed recovery and transformation plans are mobilised
To optimise all diagnostic capacity available to reduce long waits, address backlogs and support clinicians in remote monitoring of patients and cancer diagnosis	Phil Mettam	▪ HCV Diagnostics Board refreshing all recovery priorities for endoscopy, CT, MRI and other imaging. Includes focus on optimising referrals to diagnostics, developing a resilient workforce and targets investment in networked reporting and mobile capacity to support shared access across HCV as collaborative acute providers ▪ Options for locating Community Diagnostics Hubs/ capacity across the HCV linked to recovery plans (including the most affected cancer pathways) and where possible to help address the highest health inequalities ▪ Scoping of Local Diagnostics to support local clinicians in accessing more capacity and help remote monitoring of patients (includes ECG, BP monitoring, Echo, Doppler, FeNO and spirometry) will be refreshed in the development of a wider NY&Y Diagnostics strategy ▪ Mobilisation of targeted lung health checks across the HCV ▪ All cancer screening programmes have now been restored with an impact on some diagnostic pathways as a result of screening	Improving as refreshed recovery and transformation plans are mobilised
To support partners in achieving the shift in urgent care capacity out of hospital to reduce pressure on ED and help system flow	Phil Mettam	▪ Work to transform urgent care delivery by out of hospital providers through more integrated models of delivery co-designed to optimise capacity and resilience will be led by providers working as integrated collaboratives at place ▪ Urgent & Emergency Care Network (UECN) priorities for further building capacity and resilience in all out of hospital urgent care delivery will support diversion away from ED and getting patients safely to the right place at the right time for their care ▪ SDEC pathways continue to demonstrate impact on numbers of avoidable admissions ▪ Improved local model of discharge planning aligned to national discharge to assess best practice has developed during the COVID response. The future operational delivery model for discharge for the North Yorkshire & York Geographical Partnership will be developed in 21/22.	Improving as refreshed recovery and transformation plans are mobilised through the UECN with local place partners

Achieving and supporting system financial sustainability



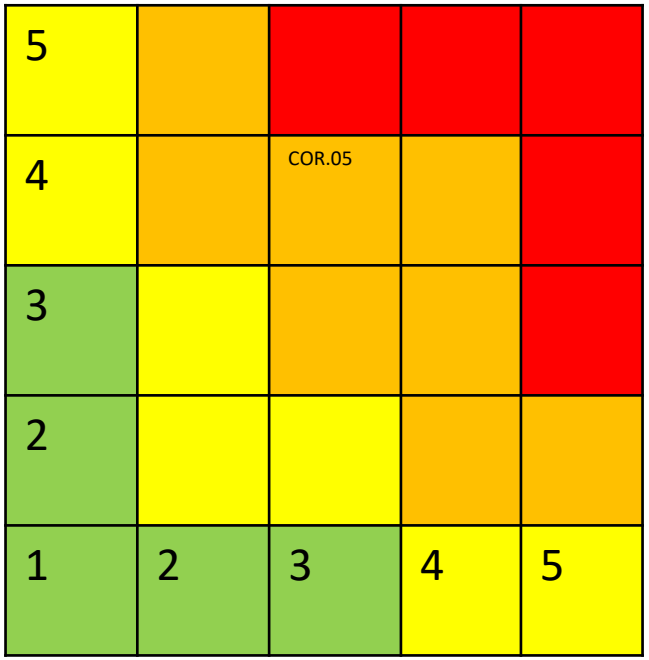
Current Priority	Exec Lead	Actions	Direction of risk travel
Maintaining financial planning, management and reporting approach	Simon Bell	- Completion and submission of organisational and system financial planning returns in line with ICS and national guidance and timetable. - Triangulate planning requirements across the ICS, North Yorkshire and York sub-system and with the relevant providers - Ensure appropriate financial governance arrangements are in place and complied with.	Stable
Optimising financial flows and access to funds across the sub-system and ICS	Simon Bell	- Establish and manage funding tracker to ensure there is a clear understanding of funding streams and ownership of them across the CCG - Triangulate funding requirements and transactions across the ICS, particularly host commissioning organisations, North Yorkshire and York sub-system and onto the relevant provider. - Establish and maintain clear processes around Hospital Discharge Programme costs with City of York Council - Build funding details into financial plans and monthly reporting and monitoring processes. - Ensure IS national funding is maximised in support of managing elective waiting list reduction while mitigating any risk of local arrangements being non-compliant with emergent guidance on reimbursement by collective, regular review and risk sharing arrangements.	Stable
Contribute effective support to place, integration, and public health management development programme	Simon Bell	- Contribute to the development financial framework for place, CYC integration, and PHM programme of work - Ensure the balancing of risk and progressive development of place.	Stable

Work with system partners to ensure provision of high quality, safe services.
Work as partners to safeguard the vulnerable in our communities to prevent harm



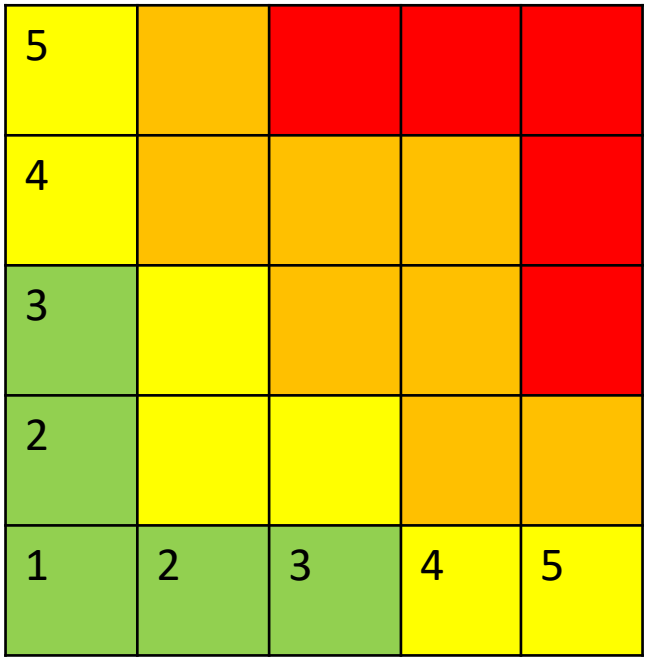
Current Priority	Exec Lead	Actions	Direction of risk travel
Supporting providers to ensure provision of high quality, safe services	Michelle Carrington	• To establish proportionate approaches to seeking assurance regarding quality and safety, and supporting providers in quality improvement. • Work with TEWV and with the NHSE Led Quality Board to ensure CQC compliant actions are undertaken to ensure safe care. • Work with TEWV to improve patient safety systems and processes, • Transition to new NHSE/I governance arrangements and review of QSGs • Continue to work with YSFT to improve patient safety systems and processes, building upon collaborative approach established between CCG and Trust Patient safety / Governance Team. • Build connections with CCG Primary Care Team to strengthen approaches to quality & safety particularly around Enhanced offer to Care Homes and review of Local Enhanced Services • Working collaboratively with LA and health partners to improve and sustain services for children and young people with Special Educational Needs / Disabilities. (SEND) and ensure we meet our statutory responsibilities.	Increased
Supporting Independent providers /Care Homes through covid to prevent suffering and deaths	Michelle Carrington	• Working alongside Local Authorities provide direct support to care homes, independent providers and supported living to ensure homes are up to date with current IPC / covid procedures to maintain safety of residents and staff. • Twice weekly calls with LA, Public Health as part of the Care Home Resilience Gold Call for strategic overview and decision making to ascertain any care homes requiring testing and any priority areas for delivery of training, support and assurance visits. • Facilitate root cause analysis of any Covid outbreaks/ cases to understand weak areas or lessons learned to inform changes to practice and future prevention. • Work with system partners to build upon the enhanced offer to care homes including from primary care and community services • Support primary care to deliver the covid vaccination booster program and seasonal flu vaccination program to care home residents and social care staff.	Stable
To protect vulnerable people and health and care services from the impacts of flu and covid.	Michelle Carrington	• Coordinate and ensure delivery of the anticipated extended flu vaccination program – due to commence Sept 2021. Second Flu letter awaited to confirm program • Continue to work with Public Health and local system partners to progress covid vaccination programme to cohorts in line with JCVI guidance and ensure any disadvantaged / highly vulnerable groups are enabled to be vaccinated	Stable

Support the wellbeing of our staff and manage and develop the talent of those staff



Current Priority	Exec Lead	Actions	Direction of risk travel
NHS People Plan actions	Michelle Carrington	NHS People Plan has been released and the CCG has identified actions that it needs to take which have been approved by the Remuneration Committee and the Governing Body.	Stable
Staff welfare conversations and new approach to talent management appraisals	Michelle Carrington	Well-being conversations have been undertaken and progression underway for Talent Management Appraisals. **Roll out of REACT MH conversation training commenced in line with the new Organisational Development Offer**	Stable
Ensure staff are supported through transition to new ICS arrangements	Michelle Carrington	Very regular dialogue with staff at Time to Talk sessions Actively connect with Staff Engagement Group to ensure the voice of staff is heard and acted on Ensure staff have regular 1:1s which are documented and focussed on providing support and enabling confidence during the transition Ensure staff have annual appraisals in the next 6 months to determine support and development during transition and beyond into the new arrangements Ensure any opportunities for functions and roles in place, geographical partnership and ICS are transparent and open to our existing people in line with the people principles **VoY CCG & NY CCG 'Our People Plan 2021-2022' – Organisational Development , Learning and Development Plan launched via Time to Talk June 21.**	**increased**

Work with partners to tackle health inequalities and improve population health in the Vale of York



Current Priority	Exec Lead	Actions	Direction of risk travel
Support the embedding of a prevention agenda across all areas of the CCG's work	Steph Porter (Peter Roderick leading)	Key areas of work include: - BP@Home programme to tackle unmanaged hypertension - Pulse oximeters for COVID +ve patients - Contribution to work on respiratory health and diabetes at HCV level - Supporting work of YHCC including prevention workstream focussing on alcohol, smoking and obesity - Working through the Inclusion health tool with PCNs - Selby Health Equity Audit	Stable
Implement the Wave 3 planning focussing on 8 high impact Health Inequalities areas	Steph Porter (Peter Roderick leading)	Actions currently being progressed across NY+Y through SLE are: - Protect the most vulnerable from COVID-19 - Restore NHS services inclusively - Develop digitally enabled care pathways in ways which increase inclusion - Accelerate preventative programmes - Particularly support those who suffer mental ill health - named executive board member responsible for tackling inequalities - Ensure datasets are complete and timely - Collaborate locally in planning and delivering action to address health inequalities	Stable
Develop a population health management approach across the CCG area	Steph Porter (Peter Roderick leading)	- Optum programmes in Selby Place and York City currently running - Enhanced Finance and Contracting programme in York 'place' currently running - **Through the York Health and Care Alliance, develop a Population Health Hub, focussing population health management tools on priorities for the York system including Diabetes/Obesity, Learning disabilities and autism, and complex packages of care** - **Develop with HCV partners a 'Waiting well programme' including the prioritisation of P4 patients waiting for procedure and the provision of a care and support offer while waiting for surgery**	Stable

Risks referred to in BAF

Red risks (score of 25 – 20)	Improving or worsening	Amber risks (score of 20-10)	Improving or worsening	Green risks (Score 10 and below)	Improving or worsening
PRC.16 – Primary care reputation following long waits	★			PRC.14 – LD health checks	↓
PRC.16 – GP wellbeing concerns and burnout	★			IG.01 - data may be compromised in the NECS transition	↓
QN.22 – TEWV CQC compliance and quality and safety concerns	★			QN.21 - Therapies	–
QN.03 – Specialist nursing service quality	–			ES.22 – cash balance availability	–
COR.05 Risk of vacancy freeze and staff exit due to uncertainty over NHS change	–			ES.38 - Failure to deliver a sustainable financial plan	↑
PRC.15 – Serious Mental Illness health checks not being done in a timely manner	–			ES.15 – Create sustainable financial plans	↑
				JC.30 – Dementia targets not being met	↑

Item Number: 9

Name of Presenter: Simon Bell

Meeting of the Governing Body

Date of meeting: 1 July 2021

NHS
Vale of York
Clinical Commissioning Group

Report Title: Annual Report and Accounts 2020-21

Purpose of Report
To Ratify

Reason for Report

The Annual Report and Accounts (circulated separately) have been approved by the Audit Committee on 28 May 2021.

The CCG's external auditors' Annual Audit Letter is also circulated separately.

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

Not Applicable

Emerging Risks

Not Applicable

Impact Assessments

Please confirm below that the impact assessments have been approved and outline any risks/issues identified. Not applicable

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

Risks/Issues identified from impact assessments: Not applicable

Recommendations

Not applicable.

Decision Requested (for Decision Log)

The Governing Body is asked to ratify the Annual Report and Accounts 2020/21.

Responsible Executive Director and Title	**Report Author and Title**
Simon Bell, Chief Finance Officer	Natalie Fletcher, Head of Finance Chris Park, Financial Accountant Helena Nowell, Planning and Assurance Manager

Item Number: 10

Name of Presenter: Simon Bell

Meeting of the Governing Body

Date of meeting: 1 July 2021

NHS
Vale of York
Clinical Commissioning Group

Report Title – Financial Performance Report Month 2

Purpose of Report
For Information

Reason for Report

To update members on the financial performance of the CCG, achievement of key financial duties, and forecast outturn position for H1 2021/22 as at the end of May 2021.

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

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 2021 to May 2021

Month 12 2021/22

NHS
Vale of York
Clinical Commissioning Group

Financial Performance Headlines

ISSUES FOR DISCUSSION AND EMERGING ISSUES

1. **Reported position against plan** – At the end of May 2021 the CCG is reporting small Year to Date (YTD) overspend, and a breakeven forecast position, in line with plan, when adjusted for anticipated allocations.

2. **Elective Recovery Fund** – Integrated Care Systems are to be reimbursed for elective activity over and above 2019-20 levels. For CCGs this will relate to additional independent sector activity. At this stage financial reporting is based on an expectation that additional costs will be reimbursed in full. However, because this funding is based on system performance there is some risk that individual organisations will not be reimbursed in full – for example, if activity in some organisations is below their 2019-20 baseline it will affect the amount of system funding available to be allocated. Due to the early stage in the financial year, actual activity information and baseline adjustments have not yet been reported. As the methodology for reimbursement is clarified the CCG will be able to firm up its understanding of the financial risk linked to ERF.

2. **Continuing Healthcare forecast outturn** – The CHC forecast based on current information from QA is an overspend of £2.2m which relates to increased patient numbers on fully funded and fast track packages, and an increased average cost of fast track packages. Due to the magnitude of this overspend further 'deep dive' analysis is required to understand the levels of certainty around the forecast, and identify mitigations to manage this within the CCGs financial plan and allocation.

Financial Performance Summary

Summary of Key Finance Statutory Duties

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation (see note)	1.1	1.0	0.1	G	3.3	3.2	0.2	G
In-year total expenditure does not exceed total allocation	90.7	92.8	(2.1)	R	271.1	276.6	(5.5)	R
Better Payment Practice Code (Value)	95.00%	99.66%	4.66%	G	95.00%	>95%		G
Better Payment Practice Code (Number)	95.00%	97.27%	2.27%	G	95.00%	>95%		G
CCG cash drawdown does not exceed maximum cash drawdown					271.0	271.0	0.0	G

- In-year total expenditure is currently showing as exceeding allocation because Outside of Envelope expenditure is included as follows:
  - Hospital Discharge Programme £0.96m YTD and £2.62m forecast
  - Elective Recovery Fund £1.01m YTD and £2.84m forecast

Financial Performance Summary

Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	1.1	1.0	0.1	G	3.3	3.2	0.2	G
Programme spend within plan	89.6	91.7	(2.1)	R	267.8	273.5	(5.6)	R
Cash balance at month end is within 1.25% of drawdown	513	231	282	G				

- In-year programme expenditure is currently showing as exceeding plan because Outside of Envelope expenditure is included as follows:
  - Hospital Discharge Programme £0.96m YTD and £2.62m forecast
  - Elective Recovery Fund £1.01m YTD and £2.84m forecast

NHS Vale of York Clinical Commissioning Group Financial Performance Report

Detailed Narrative

Report produced: June 2021

Financial Period: April 2021 to May 2021 (Month 2)

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1. Summary of reported financial position

At the end of May 2021 the CCG is reporting a small Year to Date (YTD) overspend, and a breakeven forecast position, in line with plan, when adjusted for anticipated allocations.

Current reporting covers the first half of the financial year only (H1) from April to September. The financial framework, allocations and financial plan have all been produced on this basis with H2 guidance and planning process expected to take place later in the summer.

The CCG's financial plan submission for H1 was a break-even position against allocation. Outside of allocation there are two key areas of funding as follows.

- The Hospital Discharge Programme (HDP) continues for H1 of 2021-22, with revisions to the funding arrangements. Patients discharged from hospital from 1 April 2021 will have their Continuing Healthcare needs funded from HDP for 6 weeks and from 1 July 2021 this reduces to 4 weeks, after which funding reverts to the CCG and local authority. For H1 an Integrated Care System (ICS) total for HDP funding has been provided and this has been split indicatively across CCGs with each having to absorb a share of the potential overcommitment of plans against the nationally fixed envelope. The CCGs forecast HDP spend is within expected funding but this remains tight and will need to be carefully monitored with jointly agreed plans to mitigate spend, where appropriate, in place.
- Elective Recovery Fund – Integrated Care Systems are to be reimbursed for elective activity over and above 2019-20 levels. For CCGs this will relate to additional independent sector activity. At this stage financial reporting is based on an expectation that additional costs will be reimbursed in full. However, because this funding is based on system performance there is some risk that individual organisations will not be reimbursed in full – for example, if activity in some organisations is below their 2019-20 baseline it will affect the amount of system funding available to be allocated. Due to the early stage in the financial year, actual activity information and baseline adjustments have not yet been reported. As the methodology for reimbursement is clarified the CCG will be able to firm up its understanding of the financial risk linked to ERF.

Expenditure in the financial position relating to HDP and ERF are shown in an 'Outside of Envelope' column in the YTD and forecast tables that follow, to allow a comparison of CCG financial performance against plan excluding these items.

2. Year to Date position

The year-to-date position in the table below covers April to May. The first three columns show the position as per the CCG's financial ledger. Individual lines have been adjusted for outside of envelope spend. The total amount of £1.97m in the 'Outside envelope' column is made up of £1.01 ERF and £0.96m HDP.

	YTD Position (£000)					
	Ledger Position					
	Budget	**Actual**	**Variance**	**'Outside envelope'**	**Adjusted variance**	**Comments**
Acute Services	46,522	47,507	(985)	1,036	51	£1.0m ERF related expenditure expected to be funded through reimbursement arrangements. Small underspends on non-contracted activity and RSS team
Mental Health Services	9,960	9,899	60	0	60	Small underspend on S117 placements (£65k)
Community Services	5,464	5,418	46	(37)	9	
Continuing Healthcare	5,440	6,690	(1,251)	971	(280)	£971k HDP spend, reimbursement to follow. YTD overspend on CHC packages of £579k due to increases in fast track and fully funded cases, partly offset by £251k underspend on FNC.
Other Services	2,958	2,957	2	0	2	
Prescribing	9,004	9,218	(214)	0	(214)	£168k overspend due to impact of prior year prescribing figures (i.e. February and March actuals higher than 2020/21 year end accruals)
Primary Care	1,687	1,713	(26)	1	(25)	£56k overspend on PMS premium payments, £23k underspend on Local Enhanced Services
Primary Care Delegated Commissioning	8,578	8,374	205	0	205	£67k income relating to GP returners in 2020/21. £56k underspend on PMS premium payments, offset on Primary Care line above. Underspend on small reserve in delegated budgets.
Running Costs	1,109	1,034	76	0	76	Underspend on various vacancies across CCG
Unidentified QIPP	0	0	0	0	0	
Reserves	(15)	0	(15)	0	(15)	
YTD Financial Position	**90,708**	**92,810**	**(2,102)**	**1,971**	**(131)**	

3. Forecast

The forecast outturn position in the table below covers H1 (April to September). The first three columns show the position as per the CCG's financial ledger. Individual lines have been adjusted for outside of envelope spend. The total amount of £5.47m in the 'Outside envelope' column is made up of £2.84m ERF and £2.62m HDP.

	Forecast Position (£000)					
	Ledger Position					
	Plan	Forecast	Variance	'Outside envelope'	Adjusted variance	Comments
Acute Services	138,719	141,513	(2,794)	2,863	68	£2.8m ERF related expenditure expected to be funded through reimbursement arrangements. Small underspends on non-contracted activity and RSS team
Mental Health Services	30,203	30,089	114	0	114	Small underspend on S117 placements (£92k)
Community Services	16,192	16,314	(122)	133	11	
Continuing Healthcare	16,319	18,965	(2,646)	2,461	(185)	£2.5m HDP spend, reimbursement to follow. The CHC forecast based on current information from QA is an overspend of £2.2m which relates to increased patient numbers on fully funded and fast track packages, and an increased average cost of fast track packages. Due to the magnitude of this overspend further 'deep dive' analysis is required to understand the levels of certainty around the forecast, and identify mitigations to manage this within the CCGs financial plan and allocation. Therefore month 2 reporting assumes that this overspend will be partly mitigated and a net overspend of £1.0m remains within the M1-6 forecast. This is partly offset by an underspend of £739k on Funded Nursing Care and £118k on vacancies in the CHC Clinical Team.
Other Services	8,875	8,872	3	0	3	
Prescribing	27,013	27,227	(214)	0	(214)	£168k overspend due to impact of prior year prescribing figures (i.e. February and March actuals higher than 2020/21 year end accruals)
Primary Care	5,060	5,202	(142)	12	(130)	£169k overspend on PMS premium payments
Primary Care Delegated Commissioning	25,735	25,571	164	0	164	£169k underspend on PMS premium payments, offset on Primary Care line above
Running Costs	3,328	3,161	167	0	167	Underspend on various vacancies across CCG
Unidentified QIPP	(501)	(501)	0	0	0	Assumes full delivery of the £501k unidentified QIPP in H1
Reserves & Contingency	205	204	1	0	1	
H1 Forecast Financial Position	**271,147**	**276,616**	**(5,469)**	**5,469**	**0**	

4. Allocation

The allocation as at Month 2 is as follows:

Description	Value
Baseline allocation as per financial plan	**£268.97m**
Service Development Funding (SDF) and Spending Review (SR) allocation	£2.18m
Total in-year allocation at Month 2	£271.15m

5. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31st May 2021.

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 11

Chair's Report: Audit Committee

Date of Meeting	22 April and 28 May 2021
Chair	Phil Goatley

Areas of note from the Committee Discussion

22 April

- The main purpose of this Committee was to approve the draft Annual Report and Accounts for 2020/21. Committee Members were very pleased to be able to compliment the Finance Team on another excellent set of draft statutory documents produced in challenging circumstances and to a tight timescale.

- Audit Committee provided feedback to the CCG's external auditors as part of the annual review of their effectiveness. Members felt that the CCG had a broadly positive relationship with Mazars and the external audit team but commented that the relationship could be even more positive if our external auditors brought more intelligence and commentary to their work in the CCG from auditing other NHS bodies and the wider public sector.

- The results of the annual review of Audit Committee effectiveness were reported and were positive across the board.

- Our internal auditors reported on their progress in delivering programmed audit work and this was up to date. Audit Committee Members were pleased to see that the improvement in response to agreed audit recommendations both in terms of the timelines of delivery of agreed actions and having meaningful responses from managers had been maintained despite the challenging context for this.

- Audit Committee members were pleased to hear that there were no reported conflicts of interest in the last quarter.

28 May

- The main purpose of this Committee was to approve the Annual Report and Accounts for 2020/21. Audit Committee members complimented the Finance Team again on another excellent set of statutory documents. Our external auditors were also very complimentary about the standards to which the Annual Report and Accounts had been completed and the professionalism and flexibility shown by the Finance Team in helping them complete their work.

- Audit Committee received the Annual Counter Fraud Report for 2020/21 which was positive. This included a self-assessment against the NHS Counter Fraud Authority's Standards for Commissioners. Where compliance with these standards was wholly within the control of the CCG full compliance has been achieved. In the areas where this was not the case this was due to delayed actions or inactions by other key NHS players, affected many more bodies than the VoYCCG and did not therefore raise any reason for concern locally.

- Our internal auditors reported on their progress in delivering programmed audit work and this was up to date. Audit Committee Members were particularly pleased to see that the recent audit of risk management and governance in the CCG had achieved the highest level of assurance awarded by our auditors. There has been no area which our internal auditors have scrutinised in 2020/21 that has achieved less than one of the two highest levels of assurance which is an excellent result.

- Our internal auditors also delivered their Annual Report for 2020/21 which includes the Head of Internal Audit Opinion that is a key underpinning of the CCG's governance arrangements. The opinion was that "Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently." Again this is a very positive independent commentary on the CCG's key management arrangements.

Such was the positive picture received across the board by Audit Committee Members that a letter has been sent to all CCG staff thanking and congratulating them for their excellent work on behalf of patients and the pubic throughout 2020/21. This is appended to these messages for Governing Body Members' information.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

NHS
Vale of York
Clinical Commissioning Group

PG/ms

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1 June 2021

Dear All

We wanted to write to you following our last Audit Committee which was held on 28 May.

We concede that we may not deal with all of the most exciting issues across the CCG here. However we are one of many public organisations that is funded by compulsory levy (since none of us can legally avoid paying our taxes or national insurance). Audit Committee covers things that, taken together, are the essential foundations on which high quality and cost effective services to the public and our patients are sustainably built.

Last Friday we witnessed some remarkable outcomes which we wanted to share with you. Our auditors who are independent commentators and arbiters on what we all do were full of praise across the board. In every area that our internal auditors have looked at this year the CCG has achieved one of the two highest levels of assurance that can be awarded and there have been only minor recommendations for improvements. Our external auditors, who's work centres on validating the statutory accounts of the CCG and ensuring that what we do delivers value for money, were equally positive about what they had found across the CCG. They also made a point of saying that this is not the picture they find in all the organisations they look at.

Both sets of auditors were not only positive about the standards of work and service that they found but also the attitude of CCG staff in being very dedicated and flexible. This professional commitment is for us all the more praiseworthy given the challenging context in which it has been delivered. For some of us the COVID-19 pandemic will have had personal impacts and/or impact on family and friends. For all of us there has been the challenge of significantly increased workloads as the CCG has been in the forefront of the fight against COVID-19, not least through the organisation of a highly successful mass vaccination programme. We have also had to confront the difficulties presented by enforced remote working over the last year and the uncertainties posed by our migration towards the new Humber, Coast and Vale Integrated Care System (HCVICS).

We wanted to take this opportunity to thank and congratulate you personally for all that you have done to be part of such a consistently positive picture. We also want to mark what a pleasure and privilege it is for the three of us to serve alongside you as Lay Members.

What the auditors have told us speaks volumes about the high levels of personal and professional integrity in CCG staff which will no doubt continue to be clearly demonstrated over the next year and beyond in the strong and positive legacy which the CCG will have and transfer into the HCVICS.

With Very Best Wishes

David Booker
Chair of Finance and Performance Committee

Phil Goatley
Chair of Audit and Remuneration Committees

Julie Hastings
Chair of Primary Care Commissioning and Quality and Patient Experience Committees

Vale of York
Clinical Commissioning Group

Item 12

Chair's Report: Executive Committee

Date of Meeting	28 April, 5, 12,19, 26 May and 2, 9 and 16 June 2021
Chair	Phil Mettam

Areas of note from the Committee Discussion

The Committee continues to balance a focus on the delivery of CCG statutory duties and the shaping of the transition to the NHS structures implied by the proposed legislation. This has included preparing issues for discussion at CCG statutory committees, and also developing thinking on how to align CCG functions with the developing role of the Integrated Care System, the geographic partnerships across North Yorkshire and York, and at 'place'.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 13

Chair's Report: Finance and Performance Committee

Date of Meeting	22 April and 27 May 2021
Chair	David Booker

Areas of note from the Committee Discussion

22 April

The Committee agreed new objectives and will now meet formally bimonthly, following the May meeting. Additionally, an informal briefing meeting will be held every other month and planned dates will remain scheduled, to accommodate any urgent business.

The Committee agreed to accept and approve the Procurement and Engagement Strategy for the Community Eye Care Service.

27 May

The Committee discussed and approved two contract procurement matters, one of which required Governing Body ratification.

Areas of escalation

As described above.

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 14

Chair's Report: Primary Care Commissioning Committee

Date of Meeting	27 May 2021
Chair	Julie Hastings

Areas of note from the Committee Discussion

- Medicines Management activity is being aligned with North Yorkshire via the joint Medicines Commissioning Committee.

- The Committee was updated from a finance perspective. Last year Vale of York CCG was brought to break even. Accounts were being concluded on this basis and were currently in the last stage of being audited. For this year we noted risks emerging regarding national determined pots of money: Hospital Discharge Programme, Elective Recovery Fund, with primary care it will be the Additional Roles money. However, we still anticipate reaching break even in line with plan.

- The Committee received a report - written by Shaun Macey, Fiona Bell-Morritt, Gary Young and Project Support Officers Louise Cordon and Heather Wilson - delivered by Fiona and Gary who wished to express their thanks to primary care colleagues around the richness of the detail and timeliness of their involvement in the end of year report in this truly exceptional year.

- The eight Primary Care Networks have performed extraordinarily well. Their achievements, resilience and their needs led approach, especially for our vulnerable, their partnership approach integrating across the system including our voluntary sector colleagues. They have also moved forward in their management and governance whilst integrating the new roles and helping deliver the vaccination programme.

- The COVID Infection rates are mercifully low. Out of the 303 thousand residents in Vale of York we have a headline 69% of the population who have already received first vaccination, almost the same number have received their second dose. These statistics primarily reflect the predominance of our older adult population within the Vale. York Central has a higher population of working age and younger people including students. We are currently delivering vaccine to residents over 30 years of age. Working closely with local authority colleagues on breaking down barriers, finding easier access for this cohort, offering late night, evening, and weekend sessions, and working on a governance structure for workplace vaccination programmes. Working with additional pharmacists to deliver a dispersed model, the next one due to come on stream is in Acomb. The contact tracers have been

invaluable, especially their work with those who have not yet taken up the vaccine offer. Contacting people to understand why, sharing valuable advice/information, they are able to have a longer, fuller conversion and offer the opportunity to access their right to a COVID vaccination should they then choose to do so.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Vale of York
Clinical Commissioning Group

Item 15

Chair's Report: Quality and Patient Experience Committee

Date of Meeting	13 May 2021
Chair	Julie Hastings

Areas of note from the Committee Discussion

The Committee welcomed Ashley Green, Chair of Healthwatch North Yorkshire, who shared the findings of their recent report which described the recent audit around the accessibility to primary care, via their web pages, across North Yorkshire. The rationale being the increased reliance on technology during the pandemic, access to online services being of paramount importance to patients, with a particular focus on COVID-19 information and shared the outcomes. It was felt that this could be progressed to the Primary Care Commissioning Committee with responses/actions from primary care, which could be managed through the CCG Primary Care Team and the Engagement Team.

The Committee expressed their appreciation for the continued progress in respect of the vaccination delivery programme. Despite a brief interruption due to the decline in availability of vaccine, we are assured that we will be back on track by the end of the month. There have been no outbreaks in our care homes; local figures indicate a significant reduction in statistics despite an isolated outbreak at a Selby factory. The newly formed Health Inequalities Group are working within the community and voluntary sector to ensure we offer our Eastern European, homeless, gypsy and traveller populations access to vaccination and accessible information.

The Committee invited Caroline Alexander, Peter Roderick, and Nigel Wells to share their vision for the Waiting Well Project. There were currently 5.9 million patients on our waiting lists and more joining at a rate of 50% higher than last year. Waiting Well is part of the Humber, Coast and Vale Integrated Care System elective recovery programme, using a predictive modelling risk stratification methodology to identify patients on waiting lists, primarily those classified as low risk P4. Work has already identified that some people's risk has increased and this is a step to enable people not only to feel valued, but also supported with additional health enabling tools.

Areas of escalation

N/A

Urgent Decisions Required/ Changes to the Forward Plan

N/A

Item Number: 16

Name of Presenter: Stephanie Porter

Meeting of the Governing Body

Date of meeting: 1 July 2021

NHS
Vale of York
Clinical Commissioning Group

Report Title – Medicines Commissioning Committee Recommendations March, April and May 2021

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

Reason for Report

These are the latest recommendations from the Medicines Commissioning Committee – March, April and May 2021.

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)

Recommendations noted.

Responsible Executive Director and Title	**Report Author and Title**
Stephanie Porter Interim Executive Director of Primary Care and Population Health	Jamal Hussain – Senior Pharmacist Faisal Majothi – Senior Pharmacist Callie Turner – Pharmacy Technician

Recommendations from York and Scarborough Medicines Commissioning Committee March 2021

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA672: Brolucizumab for treating wet age-related macular degeneration** **Commissioning: CCG, tariff excluded**		Brolucizumab is recommended as an option for treating wet age-related macular degeneration in adults, only if, in the eye to be treated: • the best-corrected visual acuity is between 6/12 and 6/96 • there is no permanent structural damage to the central fovea • the lesion size is less than or equal to 12 disc areas in greatest linear dimension and • there is recent presumed disease progression (for example, blood vessel growth, as shown by fluorescein angiography, or recent visual acuity changes). It is recommended only if the company provides brolucizumab according to the commercial arrangement. If patients and their clinicians consider brolucizumab to be one of a range of suitable treatments, including aflibercept and ranibizumab, choose the least expensive (taking into account administration costs and commercial arrangements). Only continue brolucizumab in people who maintain an adequate response to therapy. Criteria for stopping should include persistent deterioration in visual acuity and identification of anatomical changes in the retina that indicate inadequate response to therapy.	Listed as RED drug	Discussed and approved at Feb 2021 MCC meeting.
2.	**TA675: Vernakalant for the rapid conversion of recent onset atrial fibrillation to sinus rhythm (terminated appraisal)** **Commissioning: CCG**		NICE is unable to make a recommendation about the use in the NHS of vernakalant for the rapid conversion of recent onset atrial fibrillation (7 days or less) to sinus rhythm in adults who have not had surgery. This is because Correvio Ltd did not provide an evidence submission for the appraisal. The company has confirmed that it does not intend to make a submission because it considers there is insufficient evidence.	Not listed	No cost impact to CCGs as appraisal terminated by NICE and insufficient evidence to approve use.

3.	**TA676: Filgotinib for treating moderate to severe rheumatoid arthritis** **Commissioning: CCG**	Filgotinib, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to intensive therapy with 2 or more conventional disease-modifying antirheumatic drugs (DMARDs), only if: • disease is moderate or severe (a disease activity score [DAS28] of 3.2 or more) and • the company provides filgotinib according to the commercial arrangement. Filgotinib, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to or who cannot have other DMARDs, including at least 1 biological DMARD, only if: • disease is severe (a DAS28 of more than 5.1) and • they cannot have rituximab and • the company provides filgotinib according to the commercial arrangement. Filgotinib, with methotrexate, is recommended as an option for treating active rheumatoid arthritis in adults whose disease has responded inadequately to rituximab and at least 1 biological DMARD, only if: • disease is severe (a DAS28 of more than 5.1) and • the company provides filgotinib according to the commercial arrangement. Filgotinib can be used as monotherapy when methotrexate is contraindicated or if people cannot tolerate it, when the criteria in sections 1.1, 1.2 or 1.3 are met. Choose the most appropriate treatment after discussing the advantages and disadvantages of the treatments available with the person having treatment. If more than 1 treatment is suitable, start treatment with the least expensive drug (taking into account administration costs, dose needed and product price per dose). This may vary from person to person because of differences in how the drugs are taken and treatment schedules. Continue treatment only if there is a moderate response measured using European League Against Rheumatism (EULAR) criteria at 6 months after starting therapy. If this initial response is not maintained at 6 months, stop treatment. When using the DAS28, healthcare professionals should take into account any physical, psychological, sensory or learning	RED	Note difference in DAS score compared to other JAK inhibitors used for moderate treatment. NICE estimate uptake of 15% of eligible patients by 2024/25. Filgotinib is the first advanced treatment (e.g. first JAK inhibitor or biologic) recommended for people who have moderate RA. Existing treatments for people who have moderate RA are generic. For people who have severe RA, a number of advanced treatment options are already recommended and used. Expect 20 patients from YFT per year. Will be more costly if used in moderate group over existing DMARDs, but more cost effective than other JAK inhibitors or biologics in the severe group. YFT will audit use in moderate group to provide some reassurance around use A confidential commercial arrangement is in place.

		disabilities, or communication difficulties that could affect the responses to the DAS28 and make any adjustments they consider appropriate.		
4.	**TA678: Omalizumab for treating chronic rhinosinusitis with nasal polyps (terminated appraisal)** **Commissioning: CCG**	NICE is unable to make a recommendation about the use in the NHS of omalizumab for treating chronic rhinosinusitis with nasal polyps because Novartis Pharmaceuticals did not provide an evidence submission. The company has confirmed that it does not intend to make a submission for the appraisal because the technology will not be launched in the UK for treating this indication.	Listed as RED drug in 3.4.2 (asthma) and 13.5.3 (chronic urticarial)	No cost impact to CCGs as appraisal terminated by NICE and insufficient evidence to approve use.
5.	**TA679: Dapagliflozin for treating chronic heart failure with reduced ejection fraction** **Commissioning: CCG**	Dapagliflozin is recommended as an option for treating symptomatic chronic heart failure with reduced ejection fraction in adults, only if it is used as an add-on to optimised standard care with: • angiotensin-converting enzyme (ACE) inhibitors or angiotensin-2 receptor blockers (ARBs), with beta blockers, and, if tolerated, mineralocorticoid receptor antagonists (MRAs), or • sacubitril valsartan, with beta blockers, and, if tolerated, MRAs. Start treatment of symptomatic heart failure with reduced ejection fraction with dapagliflozin on the advice of a heart failure specialist. Monitoring should be done by the most appropriate healthcare professional. People whose symptoms continue or worsen on optimised doses of standard care based on ACE inhibitors or ARBs can only start sacubitril valsartan under the supervision of a specialist with access to a multidisciplinary team. So dapagliflozin should only be started on advice from a heart failure specialist in primary, secondary or community care.	Decision deferred to April 2021 MCC meeting to allow for guideline to support use locally to be produced.	The list price of dapagliflozin is £36.59 per 28-tablet pack (excluding VAT; BNF online, accessed November 2020). The annual treatment cost is £476.98. In the absence of dapagliflozin, the uptake of sacubitril valsartan is expected to increase to 50% by year 5. In the future it is expected that 25% of the eligible population will receive dapagliflozin as an add-on to optimised standard care with sacubitril valsartan, with beta blockers, and, if tolerated, MRAs by year 5 and 50% people to receive dapagliflozin as an add-in to optimised standard care based on ACE inhibitors or ARBs, with beta blockers, and, if tolerated, MRAs. Based on the assumptions used for England, this is equivalent to a cost of around £10,000 per 100,000 population. NICE estimate that: NY CCG = 28 patients on dapagliflozin by Year 5, total cost impact £43,271 by Year 5. VoY CCG = 24 patients on dapagliflozin by Year 5, total cost impact £37,309 by Year 5.

NHSE commissioned Technology Appraisals – for noting				
6.	**TA671: Mepolizumab for treating severe eosinophilic asthma** **Commissioning: NHSE**	Mepolizumab, as an add-on therapy, is recommended as an option for treating severe refractory eosinophilic asthma, only if: it is used for adults who have agreed to and followed the optimised standard treatment plan and • the blood eosinophil count has been recorded as 300 cells per microlitre or more and the person has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, or has had continuous oral corticosteroids of at least the equivalent of prednisolone 5 mg per day over the previous 6 months or • the blood eosinophil count has been recorded as 400 cells per microlitre or more and the person has had at least 3 exacerbations needing systemic corticosteroids in the previous 12 months (so they are also eligible for either benralizumab or reslizumab). Mepolizumab is recommended only if the company provides it according to the commercial arrangement. If mepolizumab, benralizumab or reslizumab are equally suitable, start treatment with the least expensive option (taking into account drug and administration costs). At 12 months: • stop mepolizumab if the asthma has not responded adequately or • continue mepolizumab if the asthma has responded adequately and assess response each year.	RED as per NICE TA431: for treating severe refractory eosinophilic asthma.	No cost impact to CCGs as NHS England commissioned. Commissioned by NHS England - treatment may only be prescribed at Sheffield Teaching, Leeds Teaching and Hull and East Yorkshire Hospitals (but this is under review May 2017) TA671 replaces TA431.
7.	**TA673: Niraparib for maintenance treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy** **Commissioning: NHSE**	Niraparib is recommended for use within the Cancer Drugs Fund as an option for maintenance treatment for advanced (FIGO stages 3 and 4) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer after response to first-line platinum-based chemotherapy in adults. It is recommended only if the conditions in the managed access agreement for niraparib are followed.	Listed as RED drug in 8.1.5	No cost impact to CCGs as NHS England commissioned.

8.	**TA674: Pembrolizumab for untreated PD-L1-positive, locally advanced or metastatic urothelial cancer when cisplatin is unsuitable (terminated appraisal)** **Commissioning: NHSE**	NICE is unable to make a recommendation about the use in the NHS of pembrolizumab for untreated PD-L1-positive, locally advanced or metastatic urothelial cancer when cisplatin is unsuitable. Merck Sharp & Dohme has confirmed that it does not intend to make a complete evidence submission for the appraisal. This is because it does not consider that the new evidence collected when pembrolizumab was in the Cancer Drugs Fund (NICE's technology appraisal guidance 522) shows that it works well enough in this patient population to be cost effective.	Listed as RED drug in 8.1.5	No cost impact to CCGs as NHSE commissioned and appraisal terminated by NICE.
9.	**TA677: Autologous anti-CD19-transduced CD3+ cells for treating relapsed or refractory mantle cell lymphoma** **Commissioning: NHSE**	Treatment with autologous anti-CD19-transduced CD3+ cells is recommended for use within the Cancer Drugs Fund as an option for relapsed or refractory mantle cell lymphoma in adults who have previously had a Bruton's tyrosine kinase (BTK) inhibitor. It is only recommended if the conditions in the managed access agreement for autologous anti-CD19-transduced CD3+ cells treatment are followed	Not listed as not a drug	No cost impact to CCGs as NHS England commissioned.
10.	**HST14: Metreleptin for treating lipodystrophy** **Commissioning: NHSE**	Metreleptin is recommended, within its marketing authorisation, as an option for treating the complications of leptin deficiency in lipodystrophy for people who are 2 years and over and have generalised lipodystrophy. Metreleptin is recommended as an option for treating the complications of leptin deficiency in lipodystrophy for people who are 12 years and over, have partial lipodystrophy, and do not have adequate metabolic control despite having standard treatments. It is only recommended if they have an HbA1c level above 7.5%, or fasting triglycerides above 5.0 mmol/litre, or both.	For information only.	No cost impact to CCGs as NHS England commissioned. A single National Specialist Service for people with lipodystrophy was established in 2011 at Addenbrooke's Hospital in Cambridge. Treatment with metreleptin is currently provided there as part of an early access programme, under the National Severe Insulin Resistance Service at the hospital.

Formulary applications or amendments/pathways/guidelines				
11.	Prucalopride for constipation in men	Review of Prucalopride on the York formulary as the product license changed to include men as well as women in May 2015. Approved for use in men as well as women following 6 months treatment of at least 2 classes of laxative at maximum tolerated doses, review after 4 week	AMBER SI	No cost impact to CCGs expected as reflects current prescribing practice.

Recommendations from York and Scarborough Medicines Commissioning Committee April 2021

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA681: Baricitinib for treating moderate to severe atopic dermatitis** **Commissioning: CCG, tariff excluded**		Baricitinib is recommended as an option for treating moderate to severe atopic dermatitis in adults, only if the disease has not responded to at least 1 systemic immunosuppressant, such as ciclosporin, methotrexate, azathioprine and mycophenolate mofetil, or these are not suitable, and the company provides it according to the commercial arrangement. Assess response from 8 weeks and stop baricitinib if there has not been an adequate response at 16 weeks, defined as a reduction of at least 50% in the Eczema Area and Severity Index score (EASI 50) from when treatment started and 4 points in the Dermatology Life Quality Index (DLQI) from when treatment started. When using the EASI, take into account skin colour and how this could affect the EASI score, and make appropriate clinical adjustments. When using the DLQI, take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI, and make any appropriate adjustments.	Listed as RED drug in 10.1.3	Add to formulary as RED drug in chapter 13 with link to NICE TA. No significant cost impact to CCGs expected. Baricitinib is an oral treatment therefore easily administered compared to other treatments that may need subcutaneous injection. Duplimab is the current alternative. Baricitinib costs £10,500/year (list price) and dupilumab ~£17,000/year (list price, not PAS). If used in 30% of patients instead of dupilumab, baricitinib could save £26,000 per 100,000/year. A confidential commercial arrangement is in place.
2.	**TA682: Erenumab for preventing migraine** **Commissioning: CCG, tariff excluded**		Erenumab is recommended as an option for preventing migraine in adults, only if they have 4 or more migraine days a month, at least 3 preventive drug treatments have failed, the 140 mg dose of erenumab is used and the company provides it according to the commercial arrangement. Stop erenumab after 12 weeks of treatment if in episodic migraine (less than 15 headache days a month) the frequency does not reduce by at least 50% OR in chronic migraine (15 headache days a month or more with at least 8 of those having features of migraine) the frequency does not reduce by at least 30%.	Listed as RED drug in 4.7.4.2 as per FoC scheme.	Add to formulary as RED drug with link to NICE TA. NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year (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 similar. Erenumab also has a discount that is commercial in confidence. 20 patients been receiving via FoC scheme which will now transfer to CCG funding. Erenumab costs £4,638/year (list price).

NHSE commissioned Technology Appraisals – for noting				
3.	**TA680: Lenalidomide maintenance treatment after an autologous stem cell transplant for newly diagnosed multiple myeloma** **Commissioning: NHSE**	Lenalidomide is recommended as maintenance treatment after an autologous stem cell transplant for newly diagnosed multiple myeloma in adults, only if the dosage schedule is 10 mg per day on days 1 to 21 of a 28-day cycle and the company provides lenalidomide according to the commercial arrangement.	Listed as RED drug in 8.2.4	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
4.	**TA683: Pembrolizumab with pemetrexed and platinum chemotherapy for untreated, metastatic, non-squamous non-small-cell lung cancer** **Commissioning: NHSE**	Pembrolizumab with pemetrexed and platinum chemotherapy is recommended as an option for untreated, metastatic, non-squamous non-small-cell lung cancer (NSCLC) in adults whose tumours have no epidermal growth factor receptor (EGFR)-positive or anaplastic lymphoma kinase (ALK)-positive mutations. This is only if it is stopped at 2 years of uninterrupted treatment, or earlier if the disease progresses and the company provides pembrolizumab according to the commercial arrangement.	Listed as RED drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
5.	**TA684: Nivolumab for adjuvant treatment of completely resected melanoma with lymph node involvement or metastatic disease** **Commissioning: NHSE**	Nivolumab is recommended, within its marketing authorisation, as an option for the adjuvant treatment of completely resected melanoma in adults with lymph node involvement or metastatic disease. It is recommended only if the company provides nivolumab according to the commercial arrangement.	Listed as RED drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
6.	**TA685: Anakinra for treating Still's disease** **Commissioning: NHSE**	Anakinra is recommended as an option for treating Still's disease with moderate to high disease activity, or continued disease activity after non-steroidal anti-inflammatory drugs (NSAIDs) or glucocorticoids. It is only recommended for • adult-onset Still's disease that has responded inadequately to 2 or more conventional disease-modifying antirheumatic drugs (DMARDs) and systemic juvenile idiopathic arthritis in people 8 months and older with a body weight of 10 kg or more that has not responded to at least 1 conventional DMARD.	Not listed	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned. The resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population).

7.	**TA686: Blinatumomab for previously treated Philadelphia-chromosome-positive acute lymphoblastic leukaemia (terminated appraisal)** **Commissioning: NHSE**	NICE is unable to make a recommendation about the use in the NHS of blinatumomab for treating Philadelphia-chromosome-positive relapsed or refractory acute lymphoblastic leukaemia. This is because Amgen UK has confirmed that it does not intend to make an evidence submission for the appraisal. Amgen UK considers that there is unlikely to be enough evidence that the technology is a cost-effective use of NHS resources for this population.	Listed as Red drug in 8.1.5	Add link to NICE TA and that not approved for this indication. No cost impact to CCGs as NHSE commissioned and NICE unable to issue a recommendation.
8.	**TA687: Ribociclib with fulvestrant for treating hormone receptor-positive, HER2-negative advanced breast cancer after endocrine therapy** **Commissioning: NHSE**	Ribociclib plus fulvestrant is recommended as an option for treating hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer in adults who have had previous endocrine therapy only if exemestane plus everolimus is the most appropriate alternative to a cyclin-dependent kinase 4 and 6 (CDK 4/6) inhibitor, and the company provides ribociclib according to the commercial arrangement.	Listed as Red drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned. The resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population).
9.	**TA688: Selective internal radiation therapies for treating hepatocellular carcinoma** **Commissioning: NHSE**	The selective internal radiation therapy (SIRT) SIR-Spheres is recommended as an option for treating unresectable advanced hepatocellular carcinoma (HCC) in adults, only if used for people with Child–Pugh grade A liver impairment when conventional transarterial therapies are inappropriate, and the company provides SIR-Spheres according to the commercial arrangement. The SIRT TheraSphere is recommended as an option for treating unresectable advanced HCC in adults, only if used for people with Child–Pugh grade A liver impairment when conventional transarterial therapies are inappropriate, and the company provides TheraSphere according to the commercial arrangement. The SIRT QuiremSpheres is not recommended for treating unresectable advanced HCC in adults.	Non-applicable – is a medical device not a drug	None as these types of products are not normally listed on the formulary. No cost impact to CCGs as NHSE commissioned.
Formulary applications or amendments/pathways/guidelines				
10.	**NG144: Cannabis-based medicinal products**	March 2021: NICE has issued a clarification on recommendations for the use of unlicensed cannabis-based medicinal products for severe treatment-resistant epilepsy. This clarification has the same status as the guideline and should be read alongside it.	Only cannabidiol (Epidyolex) listed on the formulary as per the NICE TAs in chapter 4.8.1	No further action. Unlicensed cannabis-based medicinal products for severe treatment-resistant epilepsy are non-formulary and therefore available where that is clinically appropriate in an individual case. They are not listed as NOT APPROVED.

		This clarification relates to the interpretation of the aspect of the guideline concerned with the use of cannabis-based medicinal products to treat severe treatment-resistant epilepsy in children. (NICE has published separate technology appraisal guidance on cannabidiol with clobazam for treating seizures associated with Lennox-Gastaut syndrome and Dravet syndrome). The guideline made research recommendations for the use of unlicensed cannabis-based medicinal products for severe treatment-resistant epilepsy. The committee took the view, based on the evidence available at the time, that there was insufficient evidence of safety and effectiveness to support a population-wide practice recommendation (that is, a recommendation relating to the whole population of people with severe treatment-resistant epilepsy). The fact that NICE made no such population-wide recommendation should not however be interpreted by healthcare professionals as meaning that they are prevented from considering the use of unlicensed cannabis-based medicinal products where that is clinically appropriate in an individual case. Patients in this population can be prescribed cannabis-based medicinal products if the healthcare professional considers that that would be appropriate on a balance of benefit and risk, and in consultation with the patient, and their families and carers or guardian. There is no recommendation against the use of cannabis-based medicinal products. For more information about why the committee decided not to recommend against use of these products, see the rationale section of the guideline.		
11.	Atorvastatin 30mg + 60mg tablets	Agreed to add atorvastatin 30mg +60mg film coated tablets to the formulary as NOT APPROVED on the grounds of cost. They cost significantly more than the other strengths of Atorvastatin.	BLACK	Atorvastatin 10mg x28 = £1.00 Atorvastatin 20mg x28 = £1.40 Atorvastatin 40mg x28 = £1.42 Atorvastatin 80mg x28 = £2.03 Atorvastatin 30mg x28 = £24.51 Atorvastatin 60mg x28 = £28.01

				In last 12 months VoY CCG £3,246 items = 116 NY CCG £3,822 items = 124
12.	MST Sachets – discontinued	Agreed to remove from formulary as discontinued by manufacturer	n/a	No cost impact expected as alternatives are cheaper than MST sachets.
13.	Adalimumab for refractory chronic non-bacterial osteomyelitis / osteitis (CNO) (all ages)	Agreed to add to the formulary as as NOT APPROVED for this indication as per the NHSE policy.	BLACK	No cost impact to CCGs as NHSE commissioned and not commissioned by NHSE.
14.	Acetylcysteine 600mg effervescent tablets (NACSYS) – mucolytic for COPD	Key benefit of NACSYS is lower tablet burden (once daily preparation, compared to carbocisteine which is 8 capsules daily) No plan to switch patients to NACSYS but would be a suitable alternative to those who would prefer a once daily option or who have a history of poor compliance- note NACSYS is effervescent to may also be suited to those with swallowing difficulties as oppose to the more costly carbocisteine liquid. Note the COPD guideline approved in November 2020 has the mucolytic listed as an alternative to carbocisteine. Approved for use in North Yorkshire CCG / Already on the formulary as AMBER SC for use in pulmonary fibrosis.	GREEN	No significant cost impact to CCGs expected as similar in price to carbocisteine capsules and cheaper than using carbocisteine liquid. Carbocisteine- £5.11 for 120 capsules (up to 8 capsules OD) or £7.28 for 300ml 250mg/5ml solution NACSYS- £5.50 for 30 tablets (1 OD preparation) Small increase in price- 0.39p for 28 day supply when compared to Carbocisteine capsules (based on carbocisteine daily dose of four capsules daily. (based on March 2021 Drug Tariff Price)
15.	Metyrapone for hypercortisolism (Cushing's syndrome)	It was approved by Harrogate APC in Nov 2020 as Amber Shared Care. Nothing currently on formulary for this group of patients. Endocrine Society guidance recommends Metyrapone as the first line treatment option for the medical management of Cushing's Syndrome and usual practice is to stabilize patients on this steroidogenesis inhibitor pre-operatively. It is recommended also as second-line treatment after Trans-Sphenoidal Surgery in patients with CD, either with or without Radiotherapy/radiosurgery; as primary treatment of Ectopic ACTH Secretion (EAS) in patients with occult or metastatic EAS; and as adjunctive treatment to reduce cortisol levels in adrenocortical carcinoma (ACC).	AMBER SC	Metyrapone 250mg capsules x 100 at £363.66 available from AAH Dose is 250mg to 6g daily Cost per month per patient = £102 to £2446 Approx 4 patients on treatment currently (York)

<table>
<tr><td></td><td></td><td>It is also recommended as the de facto glucocorticoid antagonist of choice in patients who are not surgical candidates (eg TSS or Bilateral Adrenalectomy) or who have persistent disease after surgery.</td><td></td><td></td></tr>
<tr><td>16.</td><td>Tamoxifen for hereditary haemorrhagic telangiectasia</td><td>Request for review of RAG status from RED to Amber specialist initiation.
Change approved on basis that whilst unlicensed indication GPs are familiar with the drug itself.</td><td>Changed from RED to AMBER SI.</td><td>Tamoxifen 20mg daily - 30 tabs =- £12.48 Annual cost = Approx £149

Treatment for approx. 10 patients is £1,490 per annum</td></tr>
<tr><td>17.</td><td>Migraine Pathway to Include Erenumab</td><td>Approved and mirrors relevant NICE TAs to use the most cost-effective agent.</td><td>n/a</td><td>n/a</td></tr>
<tr><td>18.</td><td>Advanced therapy for atopic dermatitis flowchart</td><td>Approved</td><td>n/a</td><td>n/a</td></tr>
<tr><td>19.</td><td>Darbepoetin guideline UPDATE</td><td>Only change is
CCG logo
contact details
the monitoring box for the specialist team – add reticulocyte haemoglobin content
<table><tr><td>U&E’s ,FBC and reticulocyte haemoglobin content (RetHE)*, Ferritin and Bone Profile
*RetHe is included on ‘reticulocyte count’</td><td>Monthly during the correction phase then Every 2 to 3 months once the maintenance treatment dose has been established.</td></tr><tr><td>Vitamin B12 and folate</td><td>Every 12 months</td></tr></table></td><td>n/a</td><td>n/a</td></tr>
<tr><td>19.</td><td>Sativex for Spasticity in MS Shared Care</td><td>Approved as per NICE NG144 which allows use for Spasticity in MS, and suggests prescribing should be on a shared care basis due to practicalities around prescribing/patient collecting a supply. Noted that not specific drug monitoring required by GP.</td><td>Change from RED to AMBER SC for this indication only.</td><td>No significant cost impact to CCGs

YEAR 1: Assuming 10 new patients in year one of whom 7 continue beyond the 4 week trial period (FOC) = £14,700 to £31,500 in primary care across both VoY and NY CCG.

YEAR 2: Assuming 10 new patients in year 2 of whom 7 continue beyond the 4 week trial period plus 7 patients</td></tr>
</table>

				from year 1 = £31,500 to £65,100 in primary care across both VoY and NY CCG. NICE estimate cost impact of £52,000 per year for VoY CCG and £61,000 per year for NY CCG once steady state reached from year 4.
20.	TEWV Citalopram & Escitalopram - maximum dose reductions & ECG algorithm - updated	Approved. The previous version of this guidance recommended a baseline ECG in any new patient being considered for treatment with citalopram or escitalopram. It has come to our attention that this is not required in all patients, only in those with pre-existing cardia disease. The algorithm has been amended accordingly.	n/a	n/a

Recommendations from York and Scarborough Medicines Commissioning Committee May 2021

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
CCG commissioned Technology Appraisals					
1.	**TA679: Dapagliflozin for treating chronic heart failure with reduced ejection fraction** **Commissioning: CCG, tariff included**		Dapagliflozin is recommended by NICE as an option for treating symptomatic chronic heart failure with reduced ejection fraction in adults, only if it is used as an add-on to optimised standard care with: • angiotensin-converting enzyme (ACE) inhibitors or angiotensin-2 receptor blockers (ARBs), with beta blockers, and, if tolerated, mineralocorticoid receptor antagonists (MRAs), or • sacubitril valsartan, with beta blockers, and, if tolerated, MRAs. Start treatment of symptomatic heart failure with reduced ejection fraction with dapagliflozin on the advice of a heart failure specialist. Monitoring should be done by the most appropriate healthcare professional. People whose symptoms continue or worsen on optimised doses of standard care based on ACE inhibitors or ARBs can only start sacubitril valsartan under the supervision of a specialist with access to a multidisciplinary team. So dapagliflozin should only be started on advice from a heart failure specialist in primary, secondary or community care. MCC agreed to ensure compliance with impending deadline to implement NICE TA to add to formulary to as an AMBER Specialist Recommendation drug as per the criteria specified by NICE in the TA subject to: • Monitoring being done by heart failure nurses • Heart failure nurses to discuss risks of DKA with a patient and give PIL to patient – and communicate to GP that this has been done MCC also agreed that a local supporting guidance on the use of Dapagliflozin in HF is needed asap.	AMBER SR	The list price of dapagliflozin is £36.59 per 28-tablet pack (excluding VAT; BNF online, accessed November 2020). The annual treatment cost is £476.98. In the absence of dapagliflozin, the uptake of sacubitril valsartan is expected to increase to 50% by year 5. In the future it is expected that 25% of the eligible population will receive dapagliflozin as an add-on to optimised standard care with sacubitril valsartan, with beta blockers, and, if tolerated, MRAs by year 5 and 50% people to receive dapagliflozin as an add-in to optimised standard care based on ACE inhibitors or ARBs, with beta blockers, and, if tolerated, MRAs. Based on the assumptions used for England, this is equivalent to a cost of around £10,000 per 100,000 population. NICE estimate that: NY CCG = total cost impact £43,271 by Year 5. (+£93,000 on drug costs, -£49,000 on hospitalisations) VoY CCG = total cost impact £37,309 by Year 5. (+£80,000 on drug costs, -£47,000 on hospitalisations)
2.	**TA694: Bempedoic acid with ezetimibe for treating primary**		Bempedoic acid with ezetimibe is recommended as an option for treating primary hypercholesterolaemia (heterozygous	Decision deferred to confirm place in	NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing this TA in England will be less than £5 million per year (or £9,000 per 100,000

	hypercholesterolaemia or mixed dyslipidaemia **Commissioning: CCG, tariff included.**	familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if: • statins are contraindicated or not tolerated, • ezetimibe alone does not control low-density lipoprotein cholesterol well enough, and • the company provides bempedoic acid and bempedoic acid with ezetimibe according to the commercial arrangement. Bempedoic acid with ezetimibe can be used as separate tablets or a fixed-dose combination**.**	therapy in those whose dose of statin cannot be increased to usually max recommended dose.	population). This is because the technology is a further treatment option and the overall cost of treatment will be similar. Bempedoic acid and 2 of the other treatment options have discounts that are commercial in confidence. Bempedoic acid and bempedoic acid–ezetimibe costs £55.44 per 28 day pack, excluding VAT (NHS List Price) Based on NHS List price per patient: • Bempedoic acid and bempedoic acid–ezetimibe = £721 pa • Evolocumab or Alirocumab = £4368 - £4432 pa • Statins = £16 - £33 pa depending on dose on statin used • Ezetimibe = £33 pa
NHSE commissioned Technology Appraisals – for noting				
3.	**TA689: Acalabrutinib for treating chronic lymphocytic leukaemia** **Commissioning: NHSE**	Acalabrutinib as monotherapy is recommended as an option for untreated chronic lymphocytic leukaemia (CLL) in adults, only if: • there is a 17p deletion or TP53 mutation, or • there is no 17p deletion or TP53 mutation, and fludarabine plus cyclophosphamide and rituximab (FCR), or bendamustine plus rituximab (BR) is unsuitable, and • the company provides the drug according to the commercial arrangement. Acalabrutinib as monotherapy is recommended, within its marketing authorisation, as an option for previously treated CLL in adults. It is recommended only if the company provides the drug according to the commercial arrangement.	Listed as RED drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
4.	**TA690: Teduglutide for treating short bowel syndrome (terminated appraisal)** **Commissioning: NHSE**	NICE is unable to make a recommendation about the use in the NHS of teduglutide for treating short bowel syndrome because Takeda withdrew its evidence submission. Another company has taken over the rights to teduglutide and has confirmed that it wishes to make a new submission for the appraisal. This will be scheduled into NICE's work programme.	Not listed	No action for MCC. For information only.
5.	**TA691: Avelumab for untreated metastatic Merkel cell carcinoma** **Commissioning: NHSE**	Avelumab is recommended as an option for treating metastatic Merkel cell carcinoma in adults who have not had chemotherapy for metastatic disease. It is recommended only if the company provides avelumab according to the commercial arrangement.	Listed as RED drug in 8.1.5	Patients are referred to a tertiary centre for treatment - Hull or Leeds

6.	**TA517 Avelumab for treating metastatic Merkel cell carcinoma** **Commissioning: NHSE**	In April 2021, recommendation 1.2 was updated and replaced by NICE's technology appraisal guidance on avelumab for untreated metastatic Merkel cell carcinoma. This recommendation has been updated and replaced by avelumab for untreated metastatic Merkel cell carcinoma (NICE technology appraisal 691).	Listed as RED drug in 8.1.5	No action for MCC. For information only.
7.	**TA692: Pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy** **Commissioning: NHSE**	Pembrolizumab is not recommended, within its marketing authorisation, for treating locally advanced or metastatic urothelial carcinoma in adults who have had platinum-containing chemotherapy. This recommendation is not intended to affect treatment with pembrolizumab that was started in the Cancer Drugs Fund before this guidance was published. For those people, pembrolizumab will be funded by the company until they and their NHS clinician consider it appropriate to stop**.**	Listed as RED drug in 8.1.5	Add link to NICE TA and that not approved for this indication. No cost impact to CCGs as NHSE commissioned.
8.	**TA693: Olaparib plus bevacizumab for maintenance treatment of advanced ovarian, fallopian tube or primary peritoneal cancer** **Commissioning: NHSE**	Olaparib plus bevacizumab is recommended for use within the Cancer Drugs Fund as an option for maintenance treatment of advanced (International Federation of Gynecology and Obstetrics [FIGO] stages 3 and 4) high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer in adults when there has been a complete or partial response after first-line platinum-based chemotherapy plus bevacizumab, and the cancer is associated with homologous recombination deficiency (HRD). It is recommended only if the conditions in the managed access agreement for olaparib are followed.	Listed as RED drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
9.	**TA695: Carfilzomib with dexamethasone and lenalidomide for previously treated multiple myeloma** **Commissioning: NHSE**	Carfilzomib plus lenalidomide and dexamethasone is recommended as an option for treating multiple myeloma in adults, only if they have had only 1 previous therapy, which included bortezomib, and the company provides carfilzomib according to the commercial arrangement.	Listed as RED drug in 8.1.5	Add link to NICE TA. No cost impact to CCGs as NHSE commissioned.
Formulary applications or amendments/pathways/guidelines				
10.	Aerochamber Plus Flow-Vu anti-static VHC	Approved as a replacement for to existing Aerochamber spacer in new patients requiring a spacer as easier to use. To be considered for existing patients at time of their next regular COPD or asthma review.	GREEN	No significant cost impact expected. Drug Tariff May 2021 Aerochamber Plus with adult, child or infant face mask = £8.44 AeroChamber Plus Flow-Vu Anti-Static with mask = £8.72 AeroChamber Plus Flow-Vu Anti-Static + Youth version = £5.22 Aerochamber Plus = £5.06

11.	Sodium Zirconium SCG	Approved in anticipation of primary care rebate scheme being approved to support change in RAG status from RED to AMBER SC	AMBER SC.	No significant cost impact expected.
12.	Sativex SCG	Approved to support change in RAG status from RED to AMBER SC in management of spasticity in MS.	AMBER SC	Change in RAG status approved in April 2021 MCC recommendations.
13.	Acetylcysteine (oral) for Pulmonary Fibrosis	Approved change in RAG status from AMBER SC to AMBER SR for use pulmonary fibrosis. This gives it the same RAG status as its use in COPD as there so difference in monitoring between the two conditions.	AMBER SR	No significant cost impact expected. No used locally by YFT but may be recommended by tertiary centres in Leeds and Newcastle.