ANNEX D

Improving Care for All

Vale of York Clinical Commissioning Group

Integrated Plan 2012/13-2015/16

A patient centred approach

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Section 1: Foreword

Welcome to the Vale of York Clinical Commissioning Group's strategy document.

This document contains our plans for the coming three years and sets out the evidence on which they are based.

The Health and Social Care Act that created Clinical Commissioning Groups has at its heart a desire to increase the involvement of both clinicians and the public in the design of the healthcare system. The Vale of York Clinical Commissioning Group has been keen, from the outset, to engage in a meaningful way with the public and patients. We are already seeing the fruits of these efforts in the form of our Patient Forum and in the way that patients were involved in the restructuring of the Urgent Care services in York Hospital.

The public were also involved in the development of our "Vision, mission and values", something of which we are very proud. This "Vision" will serve us well as a guiding star, something to refer to when we are facing very difficult dilemmas on the provision of services. Our predecessor organisation, the North Yorkshire and York PCT, has struggled to balance the books for years. In the last four years the PCT received over £100 million in "exceptional" payments to allow them to declare financial balance. As a Clinical Commissioning Group in the new NHS these payments will not be available to the Vale of York and so we must take other steps to achieve financial balance each and every year. This places a huge responsibility on the CCG team who must square the circle of increasing demand for services against a flat budget allocation.

The strategy laid out in this document explains how we intend to achieve this goal.

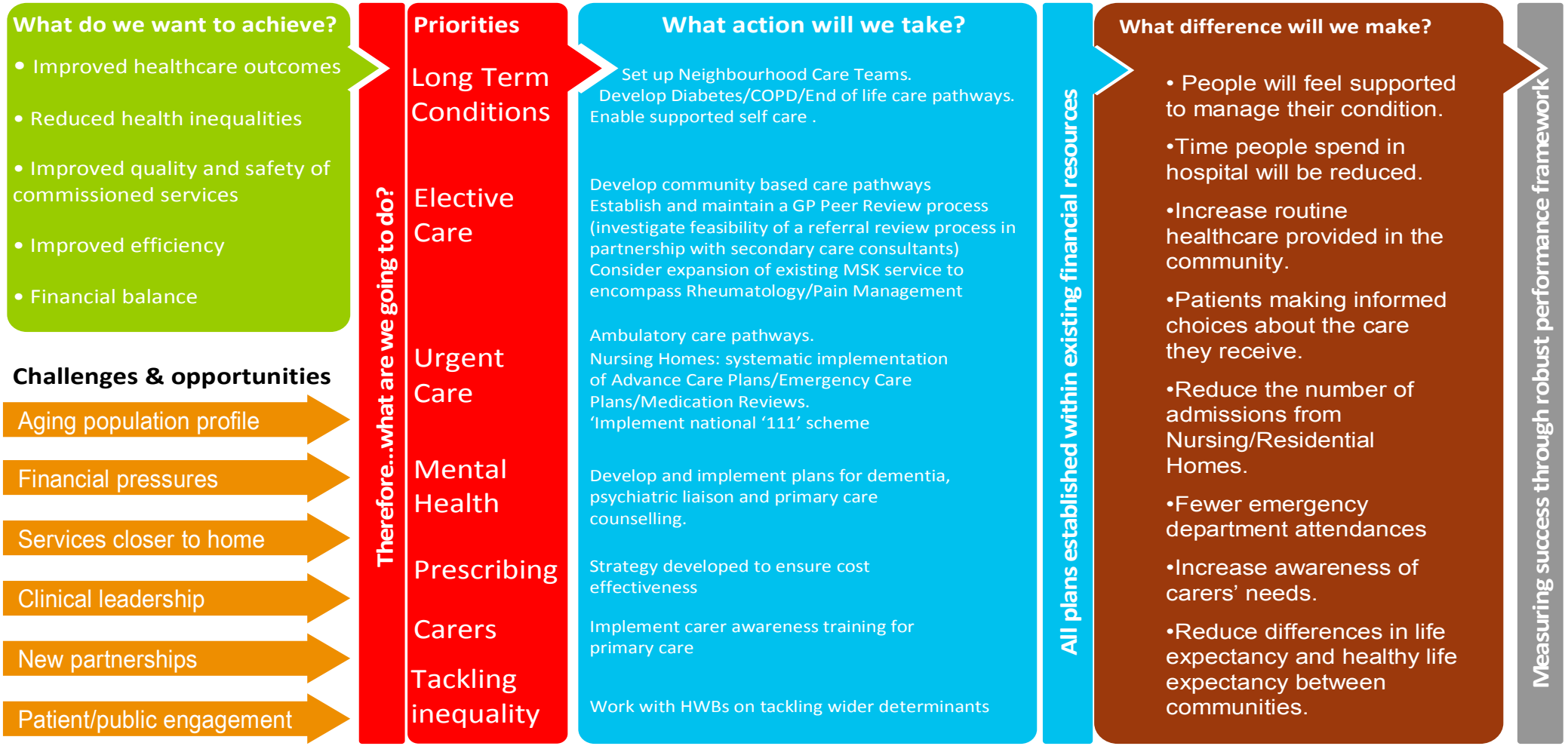
Whilst this strategy is as accurate as we can make it today, these plans may develop in the near future as the results of the "North Yorkshire Review Part 2" become available. We may also have to integrate changes in response to requests from the NHS Commissioning Board as we expect that we will be subject to a high level of oversight until we are in recurrent balance.

Dr Mark Hayes
Chief Clinical Officer
Vale of York Clinical Commissioning Group

Vale of York Clinical Commissioning Group: Strategic Plan 2012/13 – 2015/16

Vale of York CCG Vision: To achieve the best health & wellbeing for everyone in our community

Quality | Innovation | Equality | Courage | Empathy | Integrity | Communication | Respect



What will enable us to do this?

Working together with partners for an integrated approach | Engaging with patients, communities, voluntary sector and clinicians | Informed decision making | Maximising use of technology | Establishing the CCG, developing its leaders and staff

Where we are now

Section 3: Context

3.1 Why do we need a strategy?

We need a strategy as a means of identifying, and then addressing, the requirements and needs of the residents within our locality.

On a practical level this strategy will assist in:

- Providing a framework against which to make sensible decisions.
- Focussing the limited clinical time that is available to us into the right areas.
- Establishing objectives and a clear sense of purpose for the member practices of our Clinical Commissioning Group (CCG), the Governing Body leads and employees.
- Enabling us to demonstrate success i.e. we said and then we did.
- Providing focus on key outcome areas, e.g. addressing longer term resource issues.
- Providing the platform that will enable us to address our statutory requirement, for example, the Quality, Innovation, Prevention and Productivity (QIPP) challenge.
- Meeting the requirements of the North Yorkshire Review (it must noted that changes may be required as a result of the North Yorkshire Review Part 2 being undertaken by KPMG).

In developing this strategy we have also had to consider the statutory functions we will need to deliver as we move through the transition from a shadow organisation, through the required authorisation process to finally becoming a statutory organisation.

The functions (see below) required for us to become a statutory organisation have been considered and can broadly be split into five broad categories. The work programme that supports this strategy will identify how we will deliver its key priorities and in so doing build our capacity and capability in each of the categories. The workforce requirements have been addressed via a separate organisational development strategy.

Health Needs Assessment	Support for redesign	Public & Patient Engagement / Communications	Commissioning
Developing Joint Strategic Needs Assessments, building on collected data to forecast local health needs and identify gaps in service provision.	Developing clinical specifications and pathway redesign, service evaluations, and performance management.	Engaging with the public, patients and key stakeholders. Media/press handling and social marketing.	Responding to service needs through identification of best value providers. Formal contract management and negotiation.
Back office – Maintaining core functions that underpin the successful running of an organisation, such as finance, business intelligence, IT systems and support, human resources and legal services. To be sustained through a mixture of in-house provision and outsourcing working closely with our partners in the Yorkshire and Humber Cluster Commissioning Support Unit			

3.2 General Overview

Vale of York Clinical Commissioning Group Health Profile

The Vale of York Clinical Commissioning Group (VoYCCG) covers an area including York, Selby, Easingwold, Pocklington and parts of Ryedale. The area comprises 36 GP practices, and a registered population of 332,665. For a detailed breakdown of the health profile, including our provider landscape, please go to Appendix 2. However a summary of activity levels with our main provider, York Hospital Foundation Trust, can be found overleaf.

Predicted Hospital Activity levels at the Vale of York Main Acute Provider York Hospital Foundation Trust (NYY)

Activity Assumptions Based on Current Levels as at Quarter 1 April to June 2012

	12/13 Activity	13/14 Activity	14/15 Activity	15/16 Activity	13/14 %	14/15 %	15/16 %
Planned	38,860	39,171	39,562	39,958	0.8%	1.0%	1.0%
Unplanned	32,679	32,940	33,270	33,603	0.8%	1.0%	1.0%
All Outpatients	333,468	336,136	339,497	342,892	0.8%	1.0%	1.0%
Accident & Emergency	77,619	78,240	79,022	79,812	0.8%	1.0%	1.0%

Demographic Growth	**2.8%**	**3.0%**	**3.0%**
Planned	1,088	1,175	1,187
Unplanned	915	988	998
All Outpatients	9,337	10,084	10,185
Accident & Emergency	2,173	2,347	2,371

QIPP	**-2.0%**	**-2.0%**	**-2.0%**
Planned	-777	-783	-791
Unplanned	-654	-659	-665
All Outpatients	-6,669	-6,723	-6,790
Accident & Emergency	-1,552	-1,565	-1,580

note 1 - 12/13 activity assumptions taken from total NYY actvity @ 95%
note 2 - 12/13 FOT activity based on Quarter 1 actual
note 3 - does not include Pocklington GP Practice

Activity Assumptions Based on Agreed Contract Levels for 12/13

	12/13 Activity	13/14 Activity	14/15 Activity	15/16 Activity	13/14 %	14/15 %	15/16 %
Planned	37,385	37,684	38,061	38,442	0.8%	1.0%	1.0%
Unplanned	31,428	31,679	31,996	32,316	0.8%	1.0%	1.0%
All Outpatients	328,967	331,599	334,915	338,264	0.8%	1.0%	1.0%
Accident & Emergency	77,750	78,372	79,156	79,947	0.8%	1.0%	1.0%

Demographic Growth	**2.8%**	**3.0%**	**3.0%**
Planned	1,047	1,131	1,142
Unplanned	880	950	960
All Outpatients	9,211	9,948	10,047
Accident & Emergency	2,177	2,351	2,375

QIPP	**-2.0%**	**-2.0%**	**-2.0%**
Planned	-748	-754	-761
Unplanned	-629	-634	-640
All Outpatients	-6,579	-6,632	-6,698
Accident & Emergency	-1,555	-1,567	-1,583

note 1 - Activity assumptions taken from total NYY contract @ 95%
note 2 - 12/13 is based on agreed contract with YFT
note 3 - does not include Pocklington GP Practice.

WHERE WE WANT TO BE

Our residents request...

"I need support to manage my condition…"

"If I go to hospital I want to get home as soon as possible…"

"I want to be supported by people who know me…"

Section 4: Vision, Mission, Values

The development of this strategy will be in line with the vision, mission and values that we have agreed with our membership and our residents, that being:

Our Vision

- To achieve the best health and wellbeing for everyone in our community.

Our Mission

- To commission excellent healthcare on behalf of and in partnership with everyone in our community.
- To involve the wider Clinical Community in the development and implementation of services.
- To enable individuals to make the best decisions concerning their own health and wellbeing.
- To build and maintain excellent partnerships between all agencies in Health and Social Care.
- To lead the local Health and Social Care system in adopting best practice from around the world.
- To ensure that all this is achieved within the available resources.

Our Values

- **Communication** – Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.
- **Courage** – We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.
- **Empathy** – We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.
- **Equality** – We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.
- **Innovation** – We believe in continuous improvement and we will use the creativity of our stakeholders and staff.
- **Integrity** – We will be truthful, open and honest; we will maintain consistency in our actions, values and principles.
- **Measurement** - Successful measurement is a cornerstone of successful improvement.

- **Prioritisation** – We will use an open and transparent process to arrive at value driven choices.
- **Quality** - We strive to be the best that we can be and to deliver excellence in everything we do.
- **Respect** – We have respect for individuals, whether they are patients or staff colleagues; we respect the culture and customs of our partner organisations.

Section 5: Developing our priorities over the 3 years

5.1 What we see Vale of York Clinical Commissioning Group becoming

Our transition through the new clinical commissioning system has been based on being proactively informed by our clinicians about service changes that need to happen in order to improve quality, access, efficiency and outcomes. This will continue to be the case throughout our ongoing development. We will utilise the opportunities that face to face contact with patients and their carers provides us with. We will therefore be in a position to apply the important insights gained at GP practice level into where we can direct our efforts to improve what health care services will be, and how they should be, provided in the future.

Added to the clinical viewpoint will be the evidence of need and views gained from our public engagement processes (for an example of this see Appendix 3).

We will also utilise the abundance of health intelligence available to us via the Joint Strategic Needs Assessment (JSNA) documents, which we have developed with our local authority partners. All our priority areas identified in Section 7 have been highlighted in the JSNAs associated with our locality.

Taking into account this rich vein of information and evidence will allow us to be confident that any changes we implement will bring about real improvements in the health outcomes and experiences of our resident population. However, we will further ensure this through the use of strategic criteria for projects within annual work programmes, those being:

- Do specific projects:
    - Improve healthcare outcomes?
    - Reduce inequalities in health outcomes?
    - Improve the quality and safety of commissioned services?
    - Improve efficiency?
    - Have the support of clinicians, partners, patients?
    - Support the delivery of other strategies and plans e.g. VoYCCG Financial Strategy?

An example of how strategic criteria were used to prioritise the 2012/13 work programme can be found in Appendix 4.

HOW WE ARE GOING TO GET THERE

Our residents request...

"I want to be supported by people who know me…"

"If I get ill I want to be treated at home…"

"I need support to manage my condition…"

"I don't want to end Up in a home…"

Section 6: Implementing our strategy

6.1 Delivery

As a new organisation within the equally new NHS architecture we are aware that we will be unable to achieve the implementation of this strategy in isolation. We need to ensure that we have the knowledge and skills to understand, nurture and maintain the relationships needed to be good commissioners and good corporate citizens, and as a consequence provide positive benefits for our residents.

We understand the importance of good collaborative working with other commissioners, particularly City of York Council, North Yorkshire County Council and East Riding County Council and also with the emerging NHS Commissioning Board. In addition VoYCCG along with the four other local Clinical Commissioning Groups in North Yorkshire have established a collaborative commissioning forum that has developed risk sharing arrangements and established CCG lead commissioning arrangements for specific areas service provision requiring economies of scale.

We will use what we know about our communities to engage with different people and groups in ways that best meet their needs, and to communicate messages which aim to improve health.

We will utilise the intelligence gained through our engagement activities to ensure patients', carers' and the public's experiences, views and opinions are integral to our planning and commissioning of services.

We will also develop our relationships with our providers to ensure that we better record the information we receive so to ensure increased impact on shaping local health services and health outcomes.

We will also work in partnership with our public health colleagues to actively contribute to the health prevention agenda, expanding our residents' knowledge and expertise about self-care and exploring use of initiatives such as collaborative social marketing approaches.

We will ensure that decisions made about the commissioning, delivery and development of services are based on the bedrock successful engagement processes, in line with our Public and Patient Engagement Strategy (see Appendix 5) thus being in line with local needs, reflecting the wishes of local people. Therefore our engagement processes will be embedded within the following key levels:

- Integrity – shaping overall relationships with patients, the public and other key stakeholders.

- Strategic engagement – involvement with local engagement and scrutiny structures in relation to our vision and plans e.g. Health &

Wellbeing Boards, Overview & Scrutiny Committees, and LINks/HealthWatch.

- Patient experience – supporting delivery of service developments and changes.

This strategy provides an opportunity to bring together the priorities we have initially identified with the delivery and engagement processes described above. What follows, therefore, are our proposed detailed delivery plans 2012/13 which will support the initiation of this five year strategy. Our intention will be to review and update these plans on an annual basis.

6.2 Quality

We are committed to effectively implementing all quality-related duties, powers and functions which will transfer to (VoYCCG) and ensuring that our population continues to receive health and care services that are of high quality across the three quality domains:-

- patient safety
- clinical effectiveness
- patient experience

The Operating Framework for the NHS in England 2012/13 sets out the priorities for the year and the core purpose of the NHS remains the delivery of quality services for our patients. We strive to be the best that we can be and to deliver excellence for patients in everything we do.

VoYCCG GPs and managers meet with their acute providers on a monthly basis at Contract Management Boards and Sub Contract Management Boards for Quality and Performance meetings to receive assurance on the quality of care commissioned by VoYCCG and to discuss the challenge any performance issues with the provider.

We aim to deliver this through:

Improving Patient Safety

- Work with the acute trusts to reduce their hospital mortality rates
- Actively performance manage and disseminate learning from Serious Incidents and Complaints, including promotion of the Duty of Candour
- Use National Reporting & Learning System data to monitor trends in reported incidents and ensure that lessons learnt are implemented.
- Reduce Hospital Acquired Infections in line with agreed trajectories
- Improve collection of data in relation to pressure ulcers, falls, urinary tract infections and Venous Thrombembolism (VTE).
- Ensure robust arrangements are in place for safeguarding adults and children

Commissioning Clinically Effective Care

- ❖ Commission services based on National Institute for Clinical Excellence (NICE) quality standards and ensure all providers are compliant with the relevant standards.
- ❖ Appointed a GP Clinical Lead to oversee the VoYCCG quality agenda
- ❖ Targeting areas of concern raised by external or local intelligence, including proactive assurance of performance against national standards, and ensuring that action from lessons learnt is taken effectively.
- ❖ Implementing the rollout of Neighbourhood Care Teams to improve care for patients with long-term conditions and ensure that learning from Plan, Do, Study, Act cycles is shared across VoYCCG.

Improving Patient Experience

- ❖ Increase the use of patient stories methodology.
- ❖ Introduction of the Friends & Family Test and real time data capture of patient/carer experience
- ❖ Eliminate mixed-sex accommodation to maintain patient dignity
- ❖ Monitor the results of NHS patient and staff surveys and ensure that action is taken to resolve any significant concerns.
- ❖ Work with providers to ensure they publish quality accounts/key agreed NHS datasets
- ❖ Review findings from Care Quality Commission (CQC) inspections and ensure providers are fully compliant with CQC standards.

There are a range of areas where VoYCCG will be actively monitor our contracts and work with providers to rectify any concerns identified including:-

- ✓ Clearing the backlog of patients waiting over 52 weeks for general surgery at York Hospital
- ✓ Cancer targets – improvement in the 62 day waits following screening
- ✓ Improvement in ambulance turnaround times at acute trusts
- ✓ Rollout of Psychiatric Liaison Service at acute trusts
- ✓ Increased use of Choose & Book for hospital referrals

In 2012 VoYCCG agreed a Commissioning for Quality and Innovation (CQUIN) scheme with our acute providers which incorporates the four national indicators:-

- ✓ VTE risk assessment
- ✓ Patient Experience based on the results of the NHS Inpatient Survey
- ✓ Safety Thermometer
- ✓ Dementia

In addition, we agreed local quality indicators for:-

- ✓ Improvement programme for Neighbourhood Care Teams
- ✓ 60% of acute admissions to be seen by a decision making clinician within 4 hours of admission

- ✓ Reduction in the length of stay in the elderly bed base in acute hospitals
- ✓ Improvement in the occupancy rate in the elderly medicine bed base at community hospitals
- ✓ Improve continuity of care between secondary and primary care when patients are discharged from hospital.
- ✓ End of Life Care – Death in the place of choice

VoYCCG and our acute providers will agree baseline positions in the second quarter of 2012/13 and improvement trajectories to be achieved by the fourth quarter. The Quality Team will reconcile the data on a quarterly basis to determine whether or not the acute trusts qualify for the CQUIN payments.

Section 7: Specific Delivery Plans: 2012/13

7.1 Our priorities

Based on the use of the strategic criteria described previously our areas of priority for 2012/13 are as follows:

Long Term Conditions

- ✓ We will be recognised for delivering proactive healthcare services rather than a reactive one. We will put the patient at the centre of everything we do and will develop joint care plans with them to help manage their long term conditions. This is a relevant approach as the VoYCCG locality will face an increasing elderly population in future years that are likely to be living longer with potentially multiple long term conditions.

- ✓ Along with our commissioning and provider partners we will develop a more stream-lined and co-ordinated approach to long term conditions care planning. Integral to all this will be the development of care pathways that support our patients through their condition.

- ✓ We will take the lead on the development of more localised services for patients with long term conditions and will address any gaps in local clinical knowledge and that addresses the cost pressures associated with secondary care admissions.

- ✓ We will work towards ensuring delivery of an inclusive and multi-disciplinary approach to patient needs assessment and health care delivery by involving all professionals working in general practice, community services, social care and voluntary sector.

- ✓ We will put in place an evidence based process to risk profiling of our patients, identifying those at highest risk of going into crisis and proactively putting in place care plans (see above) to avoid this.

Elective (Planned) Care

- ✓ The Vale of York locality, in general, has a high dependency on secondary care services. We want to ensure our patients are seen in the most appropriate care setting for their condition.

- ✓ We will support the care closer to home agenda and continue to investigate how we can develop specialist health support in the community where it is deemed that secondary care level input is not required.

Urgent Care

- ✓ We will work with our member practices and Nursing and Residential Home providers to ensure that processes are put in place to ensure

care is provided in the Homes and that admission into hospital is avoided wherever this is practicable.

- ✓ We will work with our secondary care partners to ensure that care pathways associated with ambulatory care conditions are robust and provide avoidance to hospital admission wherever possible.

Mental Health

- ✓ We will ensure our patients have sustained access to appropriate mental health services.
- ✓ We will focus on areas where current services do not fully support patients or areas we feel that an improvement in service can be made.

Prescribing

- ✓ Our prescribing processes will be as effective as possible to maximise patient safety and best utilise our prescribing budget.

Tackling Inequality

- ✓ We will work with our Health and Well Being Board partners to reduce the gap in healthy life expectancy between the most and least deprived members of our population.

Children

- ✓ We will ensure that the children are able to reach their full physical and mental potential, whatever that level of potential may be.

All the above will be done within our financial allocation to ensure delivery of value for money in all our commissioned services and in accordance with our Financial Strategy (see Appendix 6). Supporting the delivery of this strategy is our Quality, Improvement, Productivity, Prevention (QIPP) programme which has been developed to allow us to make real sustainable changes through transformation delivering quality improvements for our residents as well as supporting the drive for value for money. Details of the QIPP programme for 2012/13 can be found in Appendix 7, this being further developed for the years 2013/14 and 2014/15.

7.2 Our Delivery Plans

Long Term Conditions
What do we aim to deliver?
We plan to support the increasing numbers of individuals living with long term conditions by: ❖ Ensuring patients are at the right level of care all of the time. ❖ Ensuring we have productive community teams incorporating cross-professional and cross-provider working. ❖ Seamless service provision between health and social care providing benefits for users including: ○ An improved, less confusing experience for all those concerned – patients, carers, families. ○ Optimum care provision and improved communication. ○ Timely and accurate liaison with all relevant providers. ❖ Maximising independence and enabling service users to resume living at home safely in a time efficient manner, which includes: ○ Supporting care at home. ○ health promotion/self management education
How will we deliver this?
We will deliver this by: ❖ Designing and implementing a new integrated care model (known as Neighbourhood Care Teams) to support individuals with long term conditions. ❖ Proactively identify people at risk of crisis through a GP practice based 'risk stratification' model ❖ Regular Multi-Disciplinary Team (MDT) meetings supported by above risk stratification model ❖ Promote self care via Personalised Care Plans, initiated via above MDT meetings. ❖ Evaluate existing care pathways for COPD and diabetes and implement change where appropriate and clinically expedient.
How will we know we have delivered?
✓ 17 Neighbourhood Care Teams will have been established covering every GP practice within our locality. ✓ Every Neighbourhood Care Team will be undertaking regular MDT meetings proactively identifying patients at potential risk of hospital admission and providing them with Personalised Care Plans to provide care for them in the community. ✓ Care pathways for COPD & diabetes will have been evaluated and necessary amendments made to make them as cost effective as possible whilst maintaining a high level of care for our residents.
How will delivery benefit our community?
✓ A service that truly has the patient at the centre of everything we do. ✓ An increase in the level of care provided in the community with more of our residents being treated in their own homes. ✓ A strengthening of partnership working with our partners from the local authorities, secondary and community care and the voluntary sector. ✓ A service based on a continual process of improvement. ✓ A reduction in the number of our residents being admitted to hospital as emergencies by x.
When will we deliver?
✓ All NCTs will be in place by April 2013. ✓ Changes to the COPD care pathway will be completed by March 2013 ✓ Changes to Diabetes care pathway will be completed by March 2013.

Elective (Planned) Care

What do we aim to deliver?

We plan to evaluate a number of elective (planned) care pathways to enable a number of procedures that are currently provided in a hospital setting to be transferred to the community and making them more accessible to our residents.

How will we deliver this?

- ❖ Our GPs will work with their hospital clinical colleagues to develop a partnership approach towards developing plans across the following specialties:
  - Dermatology;
  - Gynaecology
  - Cardiology
  - Ophthalmology

How will we know we have delivered?

- ✓ We will have services previously provided in a hospital setting based in the community.
- ✓ We will have improved access to advice and information for the above specialties.
- ✓ We will have increased the knowledge and awareness of the management for specialties identified
- ✓ The level of patient satisfaction for the specialties identified will have increased.
- ✓ Reduction in the number of GP initiated hospital referrals by *x*

How will delivery benefit our community?

- ✓ The services associated with the above specialties will be more accessible to our residents.
- ✓ The care pathways for the specialties identified will be more streamlined whilst maintaining their cost effectiveness.
- ✓ Improved support and education to GP practices in the management of routine conditions within the specialty areas identified.
- ✓ Our residents placed at the centre of care provision.

When will we deliver?

- ✓ Changes to the Dermatology care pathway will be completed by March 2013.
- ✓ Changes to the Gynaecology care pathway will be completed by October 2012.
- ✓ Changes to Cardiology care pathway will be completed by December 2012.
- ✓ Changes to Ophthalmology care pathway will be completed by April 2013

Urgent Care

What do we aim to deliver?

We will be looking to review and modify a number of elements within the urgent care pathway. The work is as a direct consequence of that carried out during 2011/12 by Vale of York CCG clinicians. The focus will be to look at urgent care pathways associated with ambulatory care (medical care not needing admission), falls and catheterisation. We will also be looking at how can reduce admissions from Care Homes (Nursing and Residential)

We will also be working further on initiative begun in 2011 around developing an integrated unscheduled care service.

How will we deliver this?

- ❖ We will look to develop a partnership approach between our GPs and their hospital clinical colleagues to develop the care pathways associated with this programme.
- ❖ Improve the competencies between GP care and hospital care practitioners, and create a more integrated approach to delivering urgent care.
- ❖ We will be developing a partnership approach with the Nursing Homes in our locality, working together to see if we can prevent some emergency admissions to hospital.
- ❖ We look to integrate the Out-of-Hours service within our plans

How will we know we have delivered?

- ✓ We will have reduced the number of emergency/urgent admissions into the hospital.
- ✓ We will have reduced the inappropriate use of emergency services through patients being signposted to the appropriate service.
- ✓ Care Homes will have agreed to take into account their residents Advance Care Plans, Emergency Care Plans and End of Life Plans.
- ✓ Care Homes, in associated GP practices, will have in place plans to undertake regular medication reviews for their residents
- ✓ We will have an integrated workforce, between GPs, hospital care and out of hours care, in place.
- ✓ We will have fewer emergency/urgent admissions originating from Nursing Care Homes

How will delivery benefit our community?

- ✓ All our residents who access emergency services will receive a clinical response and outcome that is appropriate to their clinical needs.
- ✓ Fewer inappropriate ED attendances
- ✓ Our residents attending the emergency department will be signposted to the appropriate service for their health need.
- ✓ Patient experience and satisfaction improved.
- ✓ Care Home residents will be treated in accordance with their wishes and will have plans in place to avoid unnecessary hospital admission.

When will we deliver?

- ✓ Changes to the care pathways associated with Nursing and Residential Homes will be completed by December 2012.
- ✓ Changes to the ambulatory care pathways will be completed by February 2013

Mental Health
What do we aim to deliver?
Improved care for people with mental health problems in the acute trust.
How will we deliver this?
❖ By developing a psychiatric liaison service
How will we know we have delivered?
✓ Clear system in place to support patients with mental health problems in acute trust ✓ Positive patient and carer feedback ✓ Positive staff feedback ✓ Monitoring agreed outcomes via Quality reports.
How will delivery benefit our community?
✓ Reduction in length of stay ✓ Reduction in discharge to nursing homes ✓ Improved patient and carer satisfaction
When will we deliver?
✓ Stage one, psychiatric liaison in elderly has started aim to build to cover all wards by end of 2013 ✓ Psychiatric liaison in the Emergency Department – 2013-14 depending on financial situation ✓ Wider liaison service will depend on finances
What do we aim to deliver?
❖ Improved care for people with dementia
How will we deliver this?
✓ By education across acute trust, GPs and their staff, in nursing homes and in the wider community ✓ By commissioning dementia care navigators
How will we know we have delivered?
✓ Records of education provided ✓ Positive patient and carer feedback ✓ Positive staff feedback ✓ Dementia awareness monitoring of community services and businesses ✓ Monitoring agreed outcomes via Quality reports.
How will delivery benefit our community?
✓ Improved quality of life for patients and carers ✓ Reduced crisis admissions ✓ Reduced stress for staff
When will we deliver?
✓ Guidelines to GP – 2012 ✓ Dementia training at acute trust ongoing 2012-13 ✓ Community awareness joint funded post starts October 2012 ✓ Ongoing awareness and training for nursing homes via dementia forum
What do we aim to deliver?
Improved access to talking therapies
How will we deliver this?
❖ By completing the review of counselling services and IAPT, and thinking imaginatively with provider and voluntary sector partners to

deliver services within a severely restricted budget
How will we know we have delivered?
✓ Improved equitable access to services ✓ Positive patient feedback
How will delivery benefit our community?
✓ Early access to intervention to manage mental distress ✓ Improved patient satisfaction
When will we deliver?
✓ Completion of review April 2013. ✓ Innovative solutions discussions 2013. ✓ Commission new services 2013-14.

Prescribing
What do we aim to deliver?
Prescribing is an every day intervention in the NHS. We aim to ensure that prescribing in VoY is optimal in terms of patient safety and clinical and cost effectiveness. We aim to ensure that prescribing interventions in primary care: • are safe • are appropriate for the individual • are necessary • are offered with any necessary support to ensure that the prescribing intervention is optimal • are reviewed at appropriate intervals • stay within the dedicated budget • comply with local and national guidance • comply with any relevant legislation • take place within agreed frameworks and according to local policy and procedure where appropriate
How will we deliver this?
To deliver this it is vital that prescribers are well informed of clinical and cost effectiveness issues and make unbiased prescribing decisions. VoY therefore needs to: • provide timely, high quality, robust prescribing information • appraise local and national data and use this to inform policy on use of drugs – new and existing • have a robust approach to managing the introduction of new drugs • ensure prescribers are aware of their responsibilities around prescribing have an effective performance monitoring and management function in able to support prescribers and improve standards where necessary.
How will we know we have delivered?
We will know if we have delivered if we stay within the prescribing budget - or if not that we are able to account for why not (noting that there may be other influences on the prescribing budget that may not be within our control). We will know by scrutiny of prescribing data and through governance processes whether prescribing safety is being maintained.
How will delivery benefit our community?
Appropriate, optimal use of medicines will ensure that adverse effects of medicines are minimised and that patients get the best possible health gain from the use of their medicines. Staying within budget will minimise pressure from prescribing interventions on other healthcare budgets.

Tackling Inequality

What do we aim to deliver?

Improve health outcomes for people living in the most deprived areas within the VoYCCG locality. In addition improve the health outcomes for groups of people most likely to experience poor health and/or struggle to access/health services.

The Joint Strategic Needs Assessments covering our locality identify that health inequalities are prevalent. The work of the Fairness Commission highlights the links between low income and poorer health outcomes.

People living in some areas within the VoYCCG locality can expect to live on average 10 years less than other residents if they are male or 3.5 years less if they are female. We believe this is deeply unfair, and jars against our vision to achieve the best health and wellbeing for everyone in our community.

There are clear links between other types of deprivation and poor health outcomes, so it is the same areas and communities where there are more people experiencing a range of issues, from substance misuse and unemployment to mental health problems and long-term health conditions.

To reduce health inequality therefore requires us to address both the causes and effects of these complex issues around deprivation in particular communities and areas of VoYCCG.

How will we deliver this?

With our Health and Well Being Board partners use the Marmot framework and its 6 domains as a holistic approach to reducing health inequalities in VoYCCG.

- ✓ Consider the impact on health inequalities in every decision we make and every policy we develop.
- ✓ Allocate our resources to where they are needed most, particularly those areas or groups of people who suffer poorer health outcomes.
- ✓ As organisations, work in an integrated way with individuals and communities who suffer poorer health outcomes, understanding the complex and cross-cutting nature of issues relating to health inequality, many of which are rooted in wider social factors. We will endeavour to understand and address the key issue or issues which can act as a catalyst to improving broader outcomes, rather than trying to solve individual problems as separate organisations.
- ✓ Co-design approaches to improving health and wellbeing of communities in York who experience the poorest outcomes. We will work with individuals and communities to develop community based solutions which will make the biggest difference to their health and wellbeing.
- ✓ We will commit to investing in a range of community approaches, including more outreach work, working closely with both communities of interest and geographic communities, who experience lower health outcomes. We acknowledge that these approaches take time to yield results, so where there is evidence of impact, we will commit to funding these in the long term where possible.
- ✓ Take a smarter approach around communicating health and wellbeing messages with our residents. We will:
  - undertake joint campaigns across all partners
  - use our understanding of communities and individuals to target communication

- adopt innovative marketing approaches which actively engage people
- utilise health champions to go to places where older people are rather than expecting people always to come to us.

✓ We will work with and acknowledge the positive impact that existing partnerships and task groups are making in their work to address health inequalities.

How will we know we have delivered?

✓ Reduce the rate of premature death from chronic conditions
✓ Improve mental health and well being

Children

What do we aim to deliver?

The children of VoYCCG are our future. We have a duty to ensure that the children are able to reach their full physical and mental potential, whatever that level of potential may be. Children also have a right to be children and to enjoy their childhood years free from avoidable morbidity and mortality. We aim to support out resident children to be healthy, happy children, young people and adults where positive lifestyle choices are instinctive thereby taking the first steps towards improving the number of healthy years experienced as they grow older. In partnership with our Health & Well Being Boards we concentrate on the following priorities:

- Helping all York children enjoy a wonderful family life
- Supporting those who need extra help
- Promoting good mental health

In promoting this concept we take seriously our duty to safeguard our local children and young people. We intend to ensure that the safeguarding of children and young people is a primary consideration in all our commissioning endeavours.

How will we deliver this?

- ❖ Health lifestyle programmes to stop the growth in levels of obesity in our children and start to reduce levels.
- ❖ Developing age appropriate schemes to promote healthy choices and lifestyle.
- ❖ Ensure support is available to families to deliver our commissioning aims.

How will we know we have delivered?

- ✓ Stop the growth in the percentage of children recorded as obese at ages 5 and 11
- ✓ A range of age appropriate schemes and literature is available to promote healthy choices and lifestyles

How will delivery benefit our community?

- ✓ Children will live longer, healthier lives – will also have an impact upon the wider family from the changes in lifestyle.
- ✓ Easier access to relevant schemes and literature.

When will we deliver?

- ✓ Schemes will be put in place during 2012/13 in accordance with our plans developed with our Health & Well Being Board partners.

Appendices

Appendix 1: Glossary of terms

Ambulatory Care
Health services provided on an outpatient basis. Specifically relating to those who visit and depart a health care facility on the same day following treatment.

Authorisation
A process whereby a Clinical Commissioning Group has satisfied the NHS Commissioning Board of the matters set out in the Health and Social Care Act 2012.

Care Pathways
Patient focused care programmes, representing a sequence of care events, and how they should link to one another.

Clinical Commissioning Group
A group led by GPs that will, from April 2013, be responsible for how NHS funding in their community will be spent.

Commissioning
A means of getting best value for the local population through translating aspirations and need, by documenting service requirements and then buying those services.

Development GP
Need a definition

Deprivation
The state of having little or no money and few or no material possessions.

Financial Allocation
The budget provided to statutory health organisation to meet the health needs of its population.

Governing Body
Responsible for arranging for the provision of specified health services within a Clinical Commissioning Group locality as per the Health and Social Act 2012.

Health and Well Being Board
Health and Well Being Boards bring together the key commissioners in an area. To including representatives of Clinical Commissioning Groups, Directors of Public Health, children's services, and adult social services, with at least one democratically elected councillor and a representative of HealthWatch. They will assess local needs and develop a shared strategy to address them, providing a strategic framework for individual commissioner's plans.

Health Needs Assessment
A process that identifies current and future health needs, which informs service planning.

Joint Strategic Needs Assessment
A process that identifies current and future health and well being needs, which informs service planning.

Management GP
Need a definition

NHS Commissioning Board
The NHS Commissioning Board created under the Health & Social Care Act 2012 to be responsible for arranging for the provision of health services in England.

Nursing Home
A residential institution equipped to care for those unable to look after themselves.

Outcomes
A change in status resulting from a specific action or a series of actions.

Primary Care
The term for the health services from providers who act as the principal point of consultation for patients e.g. GPs.

QIPP (Quality, Innovation, Prevention & Productivity)
Over 2011/12 - 2014/15 the NHS will face significant additional demand for services arising from the age and lifestyle of the population as well as the need to fund new technologies and drugs. To meet this challenge, the NHS needs to deliver recurrent efficiency savings of up to £20 billion by 2014/15. Quality, Innovation, Productivity and Prevention (QIPP) is the response to the challenge of improving the quality of care the NHS delivers whilst at the same time making these savings.

Residential Home
A home where residents receive personal care.

Residents of Vale of York Clinical Commissioning Group
Those people who are registered with a member GP practice of VoYCCG.

Secondary Care
A service provided by medical specialists who generally do not have first contact with patients e.g. hospital consultants.

Shadow Organisation
An established Clinical Commissioning Group that is not authorised statutory body (see above). During this period the CCG's commissioning performance

will be overseen by an established statutory body e.g. NHS North Yorkshire & York.

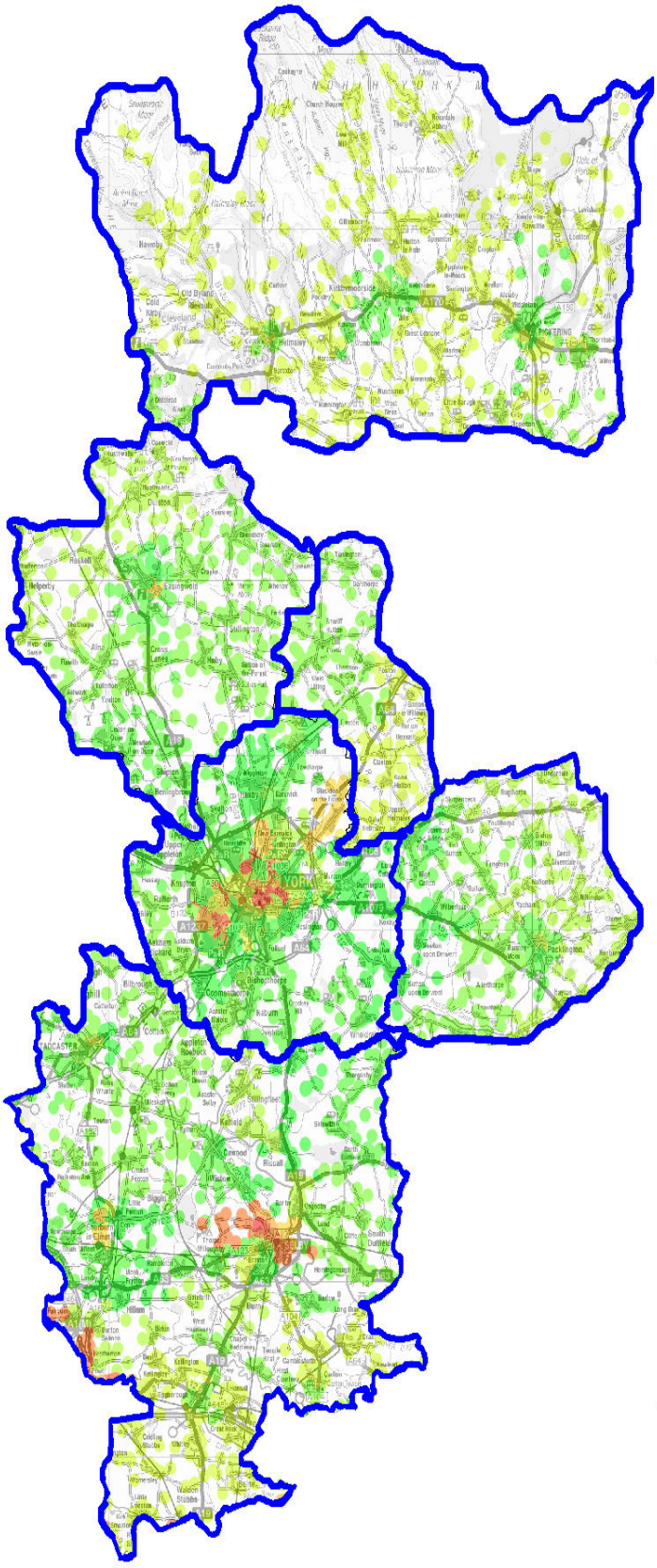
Social Marketing
The application of commercial marketing strategies to promote public health.

Specification
A document describing the requirements of a particular service.

Stakeholders
Those that can influence or be affected by an organisation's actions

Strategy
A method or plan chosen to bring about a desired future.

Appendix 2: Vale of York Clinical Commissioning Group Health Profile



Vale of York Clinical Commissioning Group Area

Map of Deprivation

IMD 2010 Ranking
relative to England

- 0.9 to 1 Least deprived
- 0.8 to 0.9
- 0.7 to 0.8
- 0.6 to 0.7
- 0.5 to 0.6
- 0.4 to 0.5
- 0.3 to 0.4
- 0.2 to 0.3
- 0.1 to 0.2
- 0 to 0.1 Most Deprived

Postcode centroids coloured by IMD 2010.

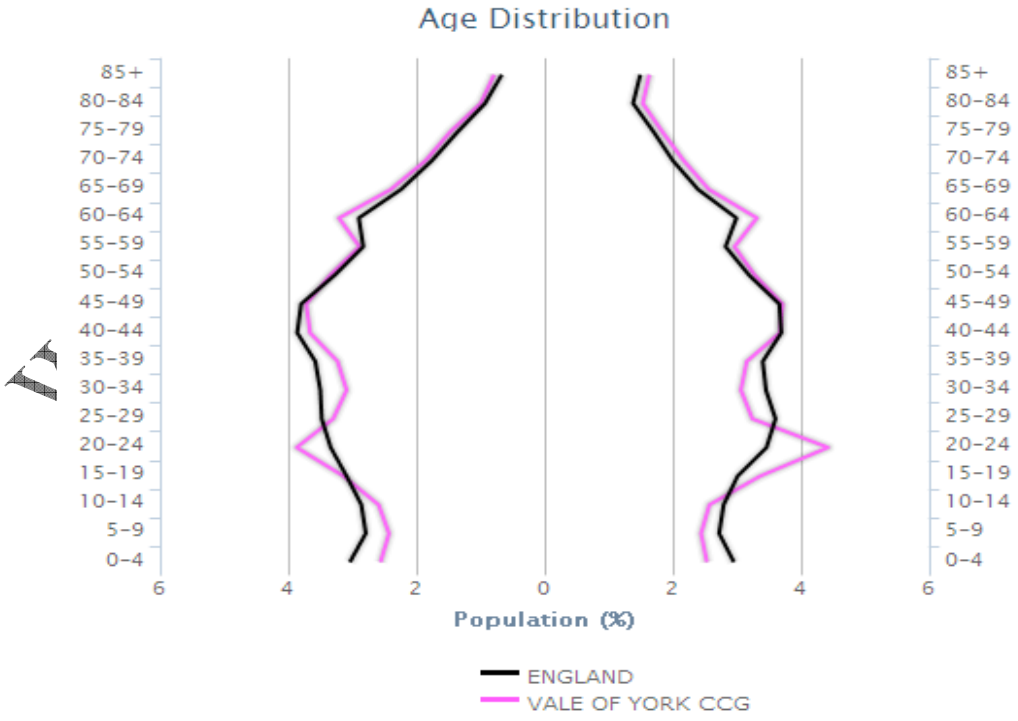
The VoYCCG locality is a mixture of urban and rural, with the majority of the population living in York, which has approximately 200,000 people living within the local authority area outlined above. VoYCCG also includes parts of North Yorkshire County Council and East Riding Local Authority areas which cover a much larger proportion of the geographical area. As a result, there are particular issues relating to the rurality of the area, especially in relation to access to services. Only 2% of the North Yorkshire County Council area (which includes Selby and the areas above York on the map) has a population density of more than 4 people per hectare and over four fifths of North Yorkshire is defined as 'super sparse' (with fewer than 0.5 people per hectare).[1]

Deprivation

Whilst the locality may be generally perceived as affluent, there are areas of specific deprivation within York and Selby as indicated on the map. There are also households with significant deprivation in the more affluent areas which the statistics can obscure. There are around 14,500 people who live in areas classified as being the 20% most deprived areas in the country[2]. The most deprived areas within the VoYCCG locality are the Westfield, Guildhall, Clifton, Heworth, Hull Road wards in York, and Selby (town).

Population profile

The age profile for VoYCCG is similar to the profile for England as a whole. However, there is a significant exception within the 20-24 age range due to the two universities in the locality (see diagram below).



[1] North Yorkshire JSNA 2008-11
[2] Index of Multiple Deprivation and ONS Population Estimates

Aging Population

For City of York Council residents, 2010 data shows that since 2001 there has been a rise of 24% in the number of people aged 80 or more years and this trend is set to continue with an additional anticipated increase of 62% by 2021. For North Yorkshire County Council residents it is estimated that there will be a 48% increase in the number of 65-84 year olds and a 65% increase in people aged over 85 for the period between 2001 and 2021.

These potential increases have significant implications for the provision of services in a society where people are living longer and may have increasingly complex needs.

Black and Minority Ethnic

There is a growing black and minority ethnic (BME) population in York, due in part to the continuing expansion of university and higher education facilities within the city. The 2001 census put York's BME population[3] at 4.9 per cent. The more recent Joseph Rowntree Foundation study in 2010 suggested this had now grown to 11 per cent of York's total population by 2009[4]. The study identified 92 different ethnic and national origins in the city and 78 different first languages[5]. For North Yorkshire, the 2001 put its BME population at 1.1%, which is also growing, only more slowly, in line with the national trend.

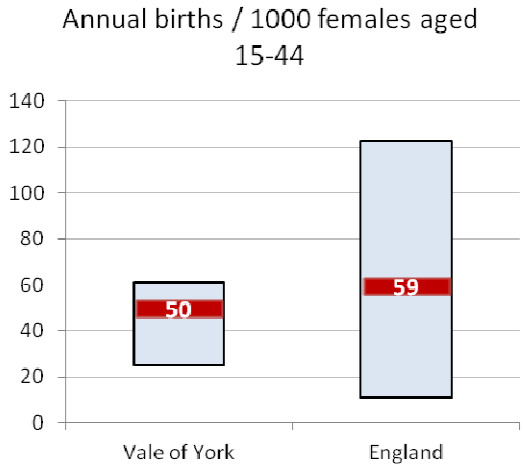
Lesbian, Gay, Bisexual or Trans Living

There is a lack of data with regards to lesbian, gay, bisexual or trans living in the VoYCCG locality (and nationally), however various government surveys suggest the percentage of the national population who are lesbian, gay, bisexual or trans is somewhere between 2% and 7% of the population.

Births and migration

VoYCCG has a birth rate which is lower than the national average, reflected in lower than average fertility rates among females aged 15-44.

Despite this, the population in the VoYCCG locality is increasing, and it is estimated[6] to have higher net migration than both the region and the UK. VoYCCG's birth rate is lower than the death rate, therefore the increase in population of can be assumed to be largely due to migration.



[3] All groups other than White British
[4] JRF – Mapping rapidly changing population growth. A case study in York 2010
[5] JRF – Mapping rapidly changing population growth. A case study in York 2010
[6] ONS Mid Year 2010 estimates

3.3 Provider landscape

Secondary care providers

In 2010/11 VoYCCG had 101,404 inpatient admissions. The table below shows the main providers that were used and the number of admissions at each provider, the number of admissions that were elective (planned).

Provider	Number of admissions (%)	*Of which elective*	% of Provider total
York Teaching Hospital	84,945 (84%)	*35,167*	87.8%
Leeds Teaching Hospital	4,264 (4%)	*2,692*	1.7%
Scarborough Hospital	2,095 (2%)	*930*	4.3%
Ramsey Healthcare	2,049 (2%)	*2,049*	2.3%
Other	8,051 (8%)	*3,236*	n/a
Total	101,404 (100%)	*44,734*	n/a

As can be seen from the above figures the vast majority of patients requiring a secondary care episode utilise services at York Teaching Hospital NHS Foundation Trust (YHFT) (88%).

The current contract value for YHFT with the VoYCCG is £151 million. This includes adjustments made for a number of key areas within the 2012/13 QIPP programme. If these areas are not realised the contract will over perform and will reflect a considerable cost pressure. For a full cost breakdown of our current contracts please go to the Financial Strategy in Appendix 6

VoYCCG has assigned clinical leads in key roles to work closely with lead clinicians from YHFT. This partnership approach is expected to result in the development of innovative approaches to the delivery of existing secondary care services, maximising cost effectiveness and clinical efficiency to improve patient experience and outcomes, whilst maintaining the highest quality standards.

Community providers

Current mainstream community nursing provision is available seven days a week between the hours of 8.30am and 6pm. It provides care for housebound patients unable to leave their home without substantial support. Community services also provide: intermediate care service provision through Community Matrons, Case Managers, physiotherapy and occupational therapy. Further services include:

- Health Visitors
- Physiotherapy
- Falls Prevention
- Fast Response
- Occupational Therapy
- Continence Services
- Tissue Viability
- Heart Failure Nurses
- Respiratory Nurses
- Specialist Palliative Care
- Nutrition and Dietetics Advice
- Diabetes Specialist Nursing

Community services have recently been transferred to YHFT thus providing an excellent opportunity to both integrate pathways of care and review current service provision. VoYCCG has identified this as a priority and have assigned a clinical lead to work with YHFT colleagues to achieve the aim of establishing a more integrated way of working between community, GP practice and social care teams.

Community hospitals and walk-in centre

There are three community hospitals and one walk-in centre within the VoYCCG locality. Patients are supported by a team of specialists including nursing staff, physiotherapists and occupational therapists, dieticians, speech and language therapists, social care providers, consultants and GPs.

Selby War Memorial Community Hospital *(check title is correct)*: 24 beds and outpatient services that include:

- Audiology;
- Children's and Adolescent Services
- Dermatology
- ENT
- Endocrinology
- Gastroenterology
- Geriatric Medicine
- General Surgery
- Gynaecology
- Orthopaedics
- Ophthalmology
- Podiatry
- Rheumatology
- Urology
- Vascular Surgery

In addition the Community Hospital provides a nurse staffed Minor Injuries Unit, diagnostic facilities (e.g. X-ray and ultrasound) and rehabilitation facilities (e.g. physiotherapy and occupational therapy)

St Monica's Hospital, Easingwold: 12 beds. In addition it also provides respite care, convalescent care, physiotherapy (including outpatient clinics), occupational therapy, musculoskeletal services and also a Haemodialysis satellite unit.

In addition to the above practices to the north of the CCG locality also access **Malton Community Hospital** (30 beds). These beds are covered overnight and at weekends by an Out of Hours service. The Community Hospital also provides outpatient services covering:

- Children's and Adolescent Services
- Cardiology
- Diabetic Medicine
- Dermatology
- ENT
- Endocrinology
- Gastroenterology
- General Surgery
- Gynaecology
- Obstetrics
- Orthopaedics
- Ophthalmology
- Respiratory Medicine
- Rheumatology
- Urology
- Vascular Surgery

In addition the Community Hospital provides a Minor Injuries Unit, which is a nurse practitioner service, overseen by GPs during weekends and evenings.

York walk-in centre: is currently a nurse-based facility fro the treatment of minor injuries and illnesses. Following a recent review of urgent care services the walk-in centre has transferred to a location adjacent to the emergency department at York Hospital as part of ongoing work around the development of an Urgent Care Centre.

Rehabilitation Units are designed to prevent unnecessary admission to or facilitate earlier discharge hospital. The units providing this in the Vale of York Clinical Commissioning Group locality are:

- White Cross Court Rehabilitation Unit (23 beds with 12 single rooms)
- St Helens Rehabilitation Unit (20 beds with 8 single rooms)
- Archways Rehabilitation Unit (22 bedded community unit) – provides both 'step up' care from home and 'step down' care from hospital. It is within the community services contract unlike White Cross Court and St Helens which are within the acute care contract.

Other Providers

A range of further contracts exist that directly support patient pathways.

- **Yorkshire Ambulance Service (YAS) –**We have identified pathway redesign and service developments which will enhance the value of this contract particularly with regard to patient outcomes and experience.

- **Voluntary Sector Contracts and Grants –** the CCG has a number of contracts covering a range of third sector providers. In the future the CCG will seek to maximise the benefits of these contracts and identify further opportunities for collaborative working.

Any Qualified Provider

Any Qualified Provider (AQP) is a way of commissioning NHS services where patients can choose who provides their care from a list of providers that meet the necessary quality standards and are willing to deliver the service for a locally set tariff. Providers can be from the NHS, private or voluntary sectors.

Providers do not receive any guarantees of volume of work as it will be up to patients to decide which provider they choose. Providers will therefore not know the number of patients they are likely to treat from month to month.

Three services covering the VoYCCG locality have been identified as being commissioned via AQP in 2012, those being:

- Non-obstetric Utlrasound – expectation that contracts will be awarded by the end of September 2012.
- Podiatry – expectation that contracts will be awarded by April 2013.
- Wheelchair service – expectation that the advertisement of this service will be published during the autumn of 2012.

3.4 Engagement/Involvement

Primary Care Involvement

Harnessing the added value of clinical input from primary care is key to delivering this strategy in terms of stimulating innovation, improving quality and ensuring value for money. Consequently the CCG will encourage awareness, engagements and ultimately ownership of commissioning decisions and in the delivery of its objectives and work programme associated with this strategy.

To enhance communication between the VoYCCG Governing Body and constituent practices, four development groups have been established, each with a Development GP Governing Body member assigned to it. A structured approach to engagement has been agreed via a monthly GP Forum, for which

each constituent practice has agreed to send a clinical representative. In addition a monthly newsletter, 'Update', highlighting current issues and news is sent to each practice.

Working with partners and stakeholders

We are proactively engaging with a wide range of local partners including local authorities, acute/community care providers, voluntary/independent sector providers, clinicians and patients/carers to ensure our plans reflect local need and that partners play a key role in any change in health service provision that may take place.

We recognise that there are many stakeholders and partners with whom we need to engage over time and in a variety of ways. We developed Public and Patient Engagement Strategy in February 2012 (see public and patient section below). To compliment this we are also in the process of developing a Communication Strategy which will enable an effective communication programme be utilised to support the effective engagements of this strategy with partners and stakeholders.

Health and Well Being Boards

VoYCCG will be represented on three Health and Well Being Boards covering City of York Council, North Yorkshire County Council and East Yorkshire County Council.

As part of the work programme associated with each Health and Well Being Board, we are anticipating that we will participate and update on a number of developments including:

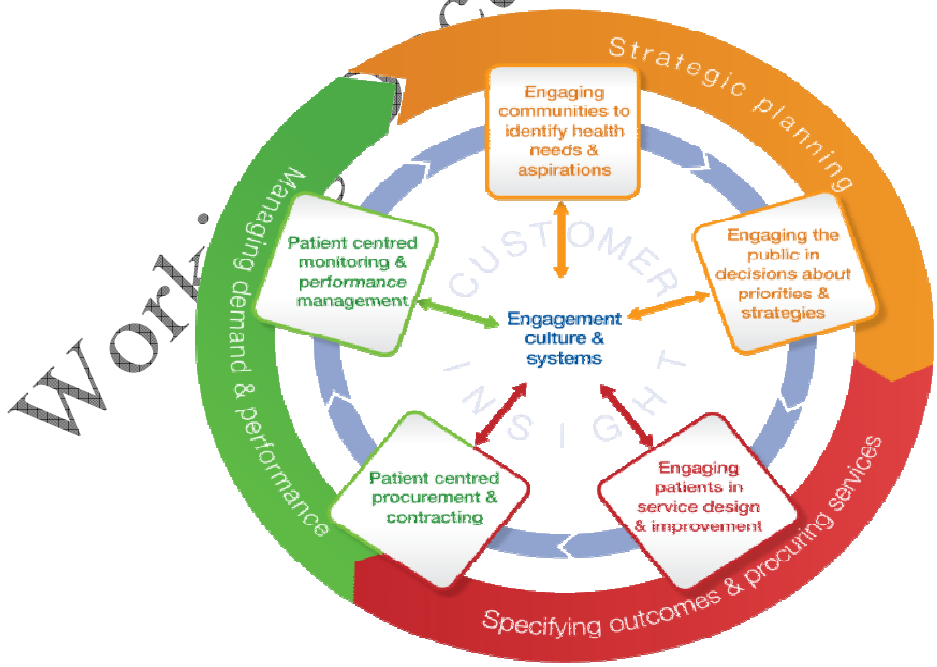
- Delivery of a Joint Strategic Needs Assessment identifying a broad range of health determinants and subsequently engaging with local practices regarding the emerging implications.
- Development of a Health and Wellbeing Strategy.
- Regular updates in relation to the development of the VoYCCG, including the development of this strategy and the VoYCCG authorisation process.
- Review of all joint commissioning arrangements between health and social care.

We acknowledge the importance of joint working with the Health and Well Being Boards and recognise the benefits gained through both the alignment and integration of commissioning strategies/plans.

Public and patients

We are committed to excellent patient care and it is essential that strong relationships and engagement processes are developed with our resident population. In so doing local people will be able to be meaningfully involved in the development and implementation of this strategy. It is vital that our residents are actively engaged in shaping the planning and delivery of local services in order to ensure that their needs and wants are met, and that healthcare is accessible and responsive to their view and experiences. We have a unique position in that we are able to communicate with patients on a daily basis via interaction with our member practices and welcome the opportunity to harness this experience in order to develop strong and effective ties with our community.

The following diagram illustrates how effective community engagement will inform all aspects of our commissioning, from detailed planning to commissioning services through to managing performance. It is these fundamental principles that formed our Public and Patient Engagement Strategy (see Appendix 4). As part of our engagement strategy we intend to have regular public events to discuss planning and delivery of local services, feedback from the event that took place in July 2012 can be found in Appendix 3.



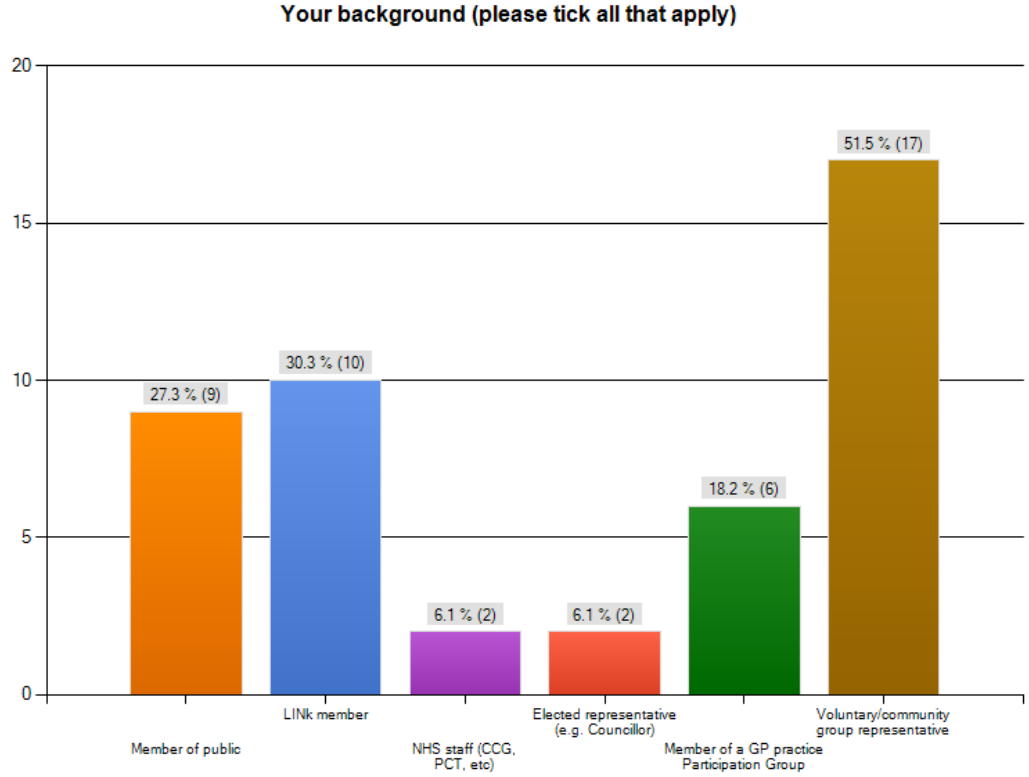
To drive this agenda forward we have appointed two Governing Body leads (the Chair and a Management Governing Body member) who will actively develop a range of public and patient engagement processes, working closely with a Steering Group, which includes four lay public members, and a dedicated public engagement officer with experience in developing effective communication methods.

Appendix 3: Vale of York CCG Public and Patient Congress
28 June 2012

Evaluation Results

1. Please tell us your background (please tick all that apply)

The majority of people attending the Congress were from local voluntary or community groups, 10 people were LINk members and 9 described themselves as a member of the public. 6 people were from GP practice Patient Participation Groups.



2. How useful overall did you find the information presented?

How useful overall did you find the information presented?		
Answer Options	**Response Percent**	**Response Count**
Unsatisfactory	2.6%	1
Satisfactory	10.5%	4
Good	50.0%	19
Excellent	36.8%	14
	answered question	**38**
	skipped question	**0**

3. How satisfied were you with the presentations?

How satisfied were you with the presentations?		
Answer Options	**Response Percent**	**Response Count**
Unsatisfactory	2.6%	1
Satisfactory	7.9%	3
Good	52.6%	20
Excellent	36.8%	14
answered question		**38**
skipped question		**0**

4. **Did you feel you were given enough opportunity to have your say and get your views across?**

Did you feel you were given enough opportunity to have your say and get your views across? (0 being not at all, to 3 being very well)		
Answer Options	**Response Percent**	**Response Count**
0 Not at all	2.6%	1
1	15.8%	6
2	36.8%	14
3 Very well	44.7%	17
answered question		**38**
skipped question		**0**

5. **How confident are you that the opinions given will be considered and used to influence future decision making?**

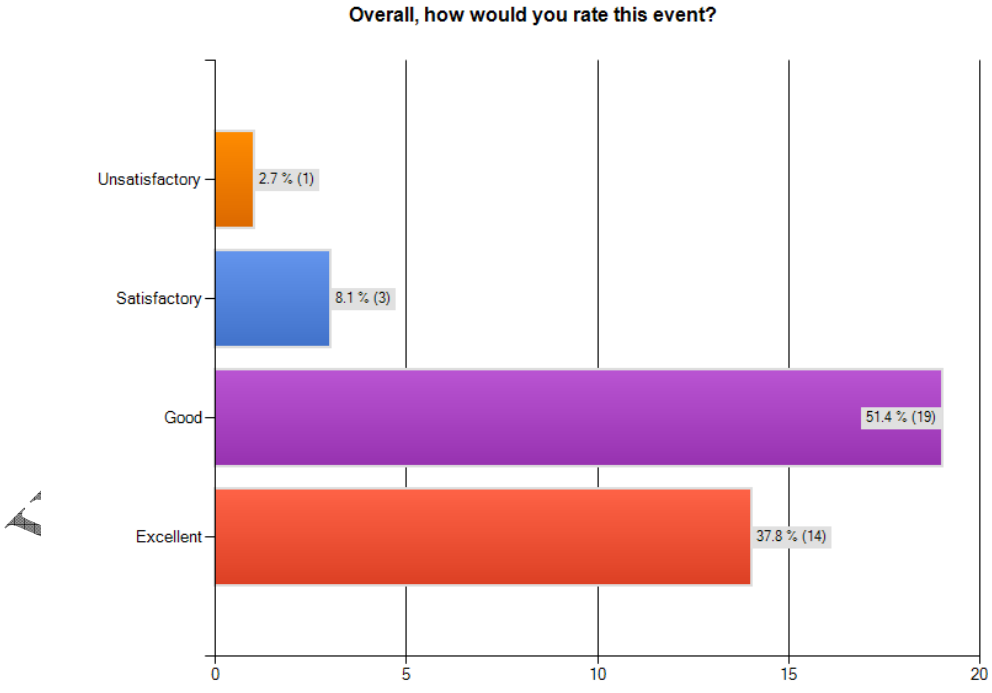
How confident are you that the opinions given will be considered and used to influence future decision making? (0 being not at all, to 3 being very well)		
Answer Options	**Response Percent**	**Response Count**
0 Not at all	2.7%	1
1	24.3%	9
2	48.6%	18
3 Very well	24.3%	9
answered question		**37**
skipped question		**1**

6. How would you rate the environment of the event?

Event environment (location, venue, catering, time, etc.)		
Answer Options	**Response Percent**	**Response Count**
Unsatisfactory	8.1%	3
Satisfactory	13.5%	5
Good	45.9%	17
Excellent	32.4%	12
Any comments?		7
	answered question	**37**
	skipped question	**1**

7. Overall – how satisfied were you with the event?

The vast majority of those who answered this question (37 people), felt that the event was either good (19) or excellent (14). One person ticked unsatisfactory. This respondent was a member of the public and was unsatisfied with all aspects of the event – however, they have said they would like to be invited to future events and wants to get involved in discussion groups.



7. What topics would you like to see being covered at future Public and Patient Congress events?

A cloud analysis of the most frequent words used shows the following:

- Real "consultation" about real issues Items that Vale of York CCG WILL be going to make decisions about. An item to cover health and social care "integration".
- Dementia and mental health – using facilities to support both
- Cooperation between health and social services at local levels
- Cooperation between hospitals, ambulance service, and social services
- Personal responsibility to be more involved in health care. Inviting all voluntary groups and represent – informed choice passed down to individuals.
- Progress reports on today's issues
- Patient Participation Groups in local areas – e.g. how they are run.
- Patient reps on the Steering Group – How will they be representative of patients? These reps should not be appointed by health professionals
- Progress on alternative support
- People to have an opportunity to express views on where wastage could be prevented and quick and easy savings to be made
- The challenge to the existing NHS and it's institutions (Hospitals, clinics, health centres) of greater private [involvement]
- Medical datums for intervention, e.g. at what value is one decided to be, say, diabetic
- Public involvement avenues
- Holistic Planning! Geographic and democratic nature of such a large rural county
- Progress in relation to the joint working between health and social care.
- 2. Partnership working with voluntary sector providers
- Not sure it's for the Public and Patient Congress – but some form of direct engagement with Voluntary Sector re: what services they feel they can deliver and how this might happen
- More specific topics
- Complaints, public supervisions, accountability, suggestions, monitoring
- Shared budgets with Local Authorities
- How you are monitoring and evaluating patient outcomes (Qualitative) as well as financial results and 'numbers treated'

- Working with the voluntary sector. Valuing existing voluntary services and good practice.
- Voluntary sector and patient participation. Carers, mental health
- How the voluntary sector can be more involved in developing plans.
- Carers
- Mental Health
- Addressing social issues. Deprivation/ Inequality alongside healthcare/ promotion / Integrated work between voluntary, third sector. What can third sector bring? Third sector presentation.
- Link between social services and GP practices - i.e. neighbourhood teams?
- Top 10 cost factors involved in £19m deficit instead of reading the "Worst nightmare" says North Yorkshire & York PCT Chief" in local media.
- 3. Presentation by Public Health doctor on new responsibilities in the area.

9. Would you like to be invited to future events?

36 out of 37 people who answered this question said Yes – 97%

10. Would you like to get involved in future discussion groups?

30 people said they would. One person answered No.

11. Interest in which discussion groups/ future work?

The table below shows the level of interest expressed by those who answered. The highest level of interest was in relation to carers, then long-term conditions, end of life care and dementia.

I am particularly interested in (please tick all that apply)		
Answer Options	**Response Percent**	**Response Count**
All long term conditions	57.1%	20
Diabetes	28.6%	10
Heart disease	25.7%	9
Stroke	40.0%	14
Chest conditions	17.1%	6
Psychiatric Liaison	40.0%	14
End of life care	54.3%	19
Urgent Care	42.9%	15
Ophthalmology	17.1%	6
Gynaecology	25.7%	9
Dermatology	22.9%	8

Rheumatology & Pain Management	40.0%	14
Dementia	48.6%	17
Carers	57.1%	20
Anything else?		6
	answered question	**35**
	skipped question	**3**

Anything else?

3 respondents stated Mental Health
1 person mentioned Orthopaedics
1 person specified Disabilities
2 people stated that they were interested in all of the above issues.
1 commented that All other health AND social care issues were of interest

12. Contact details

35 people have given their contact details

13. Name of the Congress

Our Steering Group feels that the name 'Congress' is a bit too business-like. People attending the event were asked to put forward any alternatives that may help encourage more patients and the public to attend.

The most important words or phrases were:

- 5 people suggested the term Forum in one way or another
- 3 people are ok with the name Congress

All responses are listed below

- In Kent we called our group the 'Health Matters Reference Group'
- Forum
- I Like 'Congress'
- Happy with Congress
- Public and patient participation event
- The name is not important. What is important is that patients have confidence in CCGs, in that they are open and honest
- Agree – Consultation to replace Congress
- Liaison meetings
- Forum
- Public Involvement Forum
- Discussion or simply Meeting!
- Conference
- Your Health – For All Events VoYCCG
- Forum
- Congress is OK

- Community Conversation
- VoY CCG Participate
- Forum
- Steering? Way Forward? Discussion? Input? Ideas?
- Empowering Engagement in Health and Social Care
- "Consultation" Event

14. General Comments

The vast majority of the comments made were very positive. There were a few suggestions – mainly around choosing more accessible venues for future events, and more publicity.

All comments are listed below:

- Where are the under 30's? The average age of the public must have been 50+... I'm a bit dubious about the Question Time's relevance Everyone should have a name badge - with at least their first name
- Very informative evening. The public need to be aware of this type of event
- Need more focus on agenda
- Interesting
- Stop hiding information to the public - cluster group minutes, reducing spending on “local clinical value treatments”
- Many thanks for the opportunity to get involved and I hope that any of my comments are treated as positive
- Very out of the way – no public transport, only car users could attend
- It was well worth the long (because of rush hour) and steamy journey
- Quite encouraging, much better than I expected (This is a compliment!)
- Feel more medically friendly with a bit more understanding of your problems and commitment
- Can you give reassurance that if citizens wish to be cared for by NHS service and not private companies (even if the latter are competitive) that they will be unless no alternative is available?
- These events are a really good source of information but need to be more localised
- A useful discussion
- Very positive event
- Excellent
- Looking forward to the next one. I don’t feel that all participants understood the financial implications of what they ‘preferred’ in session 1
- Excellent event
- Excellent approach. Need more clinicians (pharmacists etc) here too
- Extremely interesting and enjoyable. Longer time for meeting people/networking would have been nice
- Would like some attention given to the professional services the voluntary sector offers. The materials / information / publicity for the event could have been greater. The vol sector appears as an ‘also ran’. We are essential!

- Can you please make the next event more accessible
- Thanks!
- Well worth attending to share ideas
- Event could be held with environmental/ green considerations – e.g. public transport accessible. Good fruit though, and well done on organisation/ planning.
- More publicity around events please.
- Myself and our X Practice Manager only discovered the existence of this Public, Patient Event last week! Great idea. Hopefully say on website return comments/ feedback so I can add to my PPG Noticeboard?

Appendix 4: Details of priority setting process

VALE OF YORK CLINICAL COMMISSIONING GROUP

Board Meeting

2 February 2012

Report From: **Rachel Johns**
Associate DPH and Locality Director

Report Subject: **Prioritisation Update**

Report Status: **Open**

1. Introduction

At the board session on 5 January 2012, VOYCC continued to develop the approach to prioritisation. Once again Sue Baughan from the Public Health Observatory assisted which was very useful. The session covered:

- Agreeing the strategic objectives
- Agreeing the associated prioritisation criteria
- Weighting the criteria
- Testing this with existing or potential areas of work
- Rapid filtering of the strategic plan long list.

2. Corporate objectives

Work on the Vision and Values is well developed and will shortly be finalised. These set out how VOYCC will work and have a direct relationship to the strategic objectives which set out what VOYCC has to do. After debate and discussion it was agreed that the strategic objectives for Vale of York CCG are to:

- Improve healthcare outcomes
- Reduce health inequalities
- Improve the quality and safety of commissioned services
- Improve efficiency
- Achieve financial balance

3. Prioritisation Criteria

The board agreed that these corporate objectives mean that future decisions and activity should be prioritised and considered against the following critiera:

- Does it improve healthcare outcomes?
- Does it reduce inequalities in health outcomes?

- Does it improve the quality and safety of commissioned services?
- Does it improve efficiency?
- Is it feasible and strategic? (supported by clinicians, partners, patients)

It was recognised that any action would need to be considered within the financial constraints of the CCG but it was agreed that this consideration would be applied separately from the initial prioritisation process as resource implications may have an absolute impact and should not be hidden.

4. Weighting the Criteria

Although the board found it relatively straightforward to agree the prioritisation criteria, it was recognised that they may not carry equal weight and an exercise was undertaken to consider the relative importance given by attending board members.

The board discussed variations in their individual weightings which was useful for both prioritisation and organisational development. It was recognised that partners and public stakeholders might apply different weightings and this will be pursued in the next steps.

The average weightings given by the 11 board members present were:

Does it improve healthcare outcomes?	11.5
Does it reduce inequalities in health outcomes?	11.27
Does it improve the quality and safety of commissioned services?	9.68
Does it improve efficiency?	8.55
Is it feasible and strategic? (supported by clinicians, partners, patients)	9

5. Testing Against Areas of Work

The board used the criteria to test the relative prioritisation of three areas within the draft strategic plan. This was a useful process which gave results which were broadly in line with expectations:

Criteria	Weight	Levels of Care		111		Smoking in Long term Conditions	
		Score	Weighted Score	Score	Weighted Score	Score	Weighted score
Does it improve healthcare outcomes?	11.5	3	34.5	1	11.5	5	57.5
Does it reduce inequalities in health outcomes?	11.3	3	33.8	2	22.5	5	56.4
Dose it improve the safety and/or quality of commissioned services?	9.7	5	48.4	3	29.0	1	9.7
Does it improve efficiency?	8.5	5	42.7	3	25.6	5	42.7
Is it feasible and strategic?	9	5	45.0	5	45.0	3	27.0
		Total	204.5	Total	133.7	Total	193.3

It should be noted that as the average weights were not dramatically different they would not have changed the order of prioritisation but did influence the relative difference.

6. Rapid Filtering of Long List

Due to time constraints and a lack of worked up detail it was not possible to apply these criteria to every topic included in the long list of priorities within the draft strategic plan. However it was possible to consider each of them against a spectrum of Impact (summary of first four criteria) and Feasibility. This allowed further work to focus on those which are likely to have the greatest impact and chance of success within 2012/13.

The following is a simplified representation of the discussion.

High Impact / Low Feasibility	High Impact / High Feasibility
Dermatology Urgent assessment Cardiology Psychiatric Liaison	Long Term Conditions (including smoking) Nursing Home care Dementia Ophthalmology End of Life
Low Impact / Low Feasibility	**Low Impact / High Feasibility**
	Gynaecology Neurology MSK extension

7. Next Steps

This process agreed strategic objectives, piloted prioritisation for VOYCC and allowed rapid filtering of strategic plan work areas. It was generally recognised that this was a very useful process which required further refinement and consideration of the views of partners and the public. The strategic plan will be updated to reflect the work to date and further sessions will refine this process to allow for longer term planning. This will include a session with Patients Congress, likely to be in the early summer.

Appendix 5:

Communication and stakeholder engagement strategy 2012/13

Version 0.6, August 2012

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Appendices

Appendix 1: Structure to delivering public and patient engagement

Appendix 2: Patient Engagement Continuum

Appendix 3: Patient Experience and Engagement Commissioning Cycle

1.0 Introduction

This strategy outlines the engagement and communications approach, processes and activities that we, NHS Vale of York Clinical Commissioning Group (CCG), will employ during 2012/13 and beyond.

It has been written in accordance with our vision, mission and values and seeks to support their delivery.

Our vision is:
"To achieve the best health and wellbeing for everyone in our community."

Our mission is to:

- commission excellent healthcare on behalf of, and in partnership with, everyone in our community;
- involve the wider clinical community in the development and implementation of services;
- enable individuals to make the best decisions concerning their own health and wellbeing;
- build and maintain excellent partnerships between all agencies in health and social care;
- lead the local health and social care system in adopting best practice from around the world;
- ensure that all this is achieved within the available resources.

Our values are:

- Communication **– Open and clear communication at all times, inside and outside the organisation, is essential for us to succeed. We recognise that the messages we send out need to be clear to everyone who receives them.**
- Courage **– We have the courage to believe that our community has the capacity to understand complex health issues and that it can be trusted to participate in making decisions on the allocation of health resources.**
- Empathy **– We understand that not all ills can be cured. We understand the suffering this causes and we work to reduce it.**

- Equality **– We believe that health outcomes should be the same for everyone. We will reduce unnecessary inequality.**
- Innovation **– We believe in continuous improvement and we will use the creativity of our stakeholders and staff.**
- Integrity **– We will be truthful, open and honest and will maintain consistency in our actions, values and principles.**
- Measurement **– We recognise that successful measurement is a cornerstone of successful improvement.**
- Prioritisation **– We will use an open and transparent process to arrive at value driven choices.**
- Quality **- We strive to be the best that we can be and to deliver excellence in everything we do.**
- Respect **– We have respect for individuals, whether they are patients or staff colleagues. We respect the culture and customs of our partner organisations.**

2.0 Overarching objectives of this strategy

The objectives of this strategy are to:

- **provide a robust communication and engagement framework for us to follow, in line with the requirements for authorisation and wider policy;**
- **empower our members and staff to appreciate the need for communications and engagement as part of their role within the CCG;**
- **ensure a clear and consistent voice between our CCG and its various stakeholders;**
- **facilitate dialogue between our CCG and its stakeholders to ensure they are part of the decision making process and uphold the our commitment to 'no decision about me, without me';**
- **develop and maintain mutual goodwill and understanding between our CCG and its stakeholders, resulting in the formation of a positive reputation amongst stakeholders;**
- **ensure that information about our CCG and its business is readily available and accessible to those who need it;**
- **ensure that we are able to fulfil our statutory duties;**
- **position our CCG as the leader of the local NHS.**

3.0 Communication and engagement governance

The patient and public engagement element of this strategy has been developed by the NHS Vale of York CCG Public and Patient Engagement Steering Group which comprises the following members:

Prof Alan Maynard (Chair)	Vale of York CCG
Sian Balsom	York CVS/ & nominated rep for North Yorkshire and York Forum
Chris Edmondson	Lay Member
Sarah Harrison	North Yorkshire LINk
Helen Mackman	Lay Member
Carol Pack	York LINk
Juliana Sharp	Lay Member
Pat Sloss	Yorkshire and Humber CSS
Dr Cath Snape	Vale of York CCG
Graham Tissiman	Lay Member

Communications Steering Group

A Communications Steering Group has also been established which is responsible for delivering the communication elements of this strategy. The members of this group are:

Dr Shaun O'Connell	**(Vale of York CCG)**
Dr Cath Snape	**(Vale of York CCG)**
Dr David Hayward	**(Vale of York CCG)**
Rachel Potts	**(Vale of York CCG)**
Alex Trewhitt	**(North Yorkshire and Humber CSU)**

4.0 Policy context for this strategy

The context in which we operate will significantly influence the delivery of communications and engagement in the future. National and local policy acknowledges and promotes the need to improve involvement in and communicating core values, actions and strategies to local communities.

4.1 The Health and Social Care Act 2012

CCGs are required by law to:

- involve the public in the planning and development of services;
- involve the public on *any* changes that affect patient services, not just those with a "significant" impact;
- set out in their commissioning plans on how they intend to involve patients and the public in their commissioning decisions;
- consult on their annual commissioning plans to ensure proper opportunities for public input;
- report on involvement in their Annual Report;
- have lay members on their governing body;
- have due regard to the findings from the local HealthWatch;
- consult Local Authorities about substantial service change;
- have regard to the NHS Constitution in carrying out their functions;

- act with a view to securing the involvement of patients in decisions about their care; and
- promote choice.

4.2 Developing Clinical Commissioning Groups – Towards Authorisation

This guidance advises that the proposed content of the authorisation process is built around six domains, one of which is 'meaningful engagement with patients, carers and their communities'. As part of being granted authorisation, we are required to demonstrate capability across each of the domains.

4.3 NHS Operating Framework 2012/2013

The Operating Framework for 2012/2013 outlines that the need for good systematic engagement with staff, patients and the public is essential so that service delivery and change is taken forward with the active involvement of local people.

4.4 The Equality Act 2010

The Equality Act 2010 promotes that patients should have equal access to care when they need it. To support development of commissioning plans and decision making, it is essential that particular attention is paid to effective engagement and communication methods for disadvantaged, vulnerable groups and for people who currently struggle to access services. Communication needs of staff, patients and members of the public should be carefully considered and engagement is important to ensure we understand the impact of its decisions on different people.

4.5 The NHS Constitution

The NHS Constitution came into force in January 2010. It places a statutory duty on NHS bodies and explains a number of rights which are a legal entitlement. One of these is the right to be involved directly or indirectly through representatives:

- **in the planning of healthcare services;**

- **the development and consideration of proposals for changes in the way those services are provided; and**
- **in the decisions to be made affecting the operation of those services.**

4.6 The York and North Yorkshire Compacts

A national Compact has been in place since 1998 involving national and local government and the voluntary/community sector. It outlines a way of working that improves their relationship for mutual advantage. The Coalition Government renewed the Compact agreement with the civil society organisations in England in December 2010. Both York and North Yorkshire have a Compact agreement supported by the unitary Local Authorities and the voluntary and community sector. Within both Compact agreements there is an overarching statement which set out the principles, undertakings and commitments to work together for mutual advantage. This is underpinned by specific codes of practice on key areas of collaboration. We will explore the potential for becoming a signatory of both Compact agreements.

5.0 Priority areas for patient and public engagement

We want to involve people at every stage of the commissioning cycle, using their knowledge and experiences of local health services. This will cover:

- **assessing the needs** of our population to help us determine what and where services need to be provided;
- **reviewing existing service provision** to identify gaps in provision and potential for improvements;
- **deciding priorities**, identifying which areas of work will be done;
- **Designing services** and ensuring our community is engaged at the beginning of any service development;
- **producing an annual plan** to provide details of spending, future plans and how the public have been engaged;
- **managing performance** and monitoring performance against plans;
- **seeking public and patient views** on their experience of local health services.

5.1 How we will get there

Assessing needs - the Joint Strategic Needs Assessment (JSNA) will be the main method for assessing current and future needs at a population level and will be the responsibility of the Health and Well Being Boards that cover our CCG locality. Working with these Boards, we will develop robust processes to ensure public and patient engagement is integral in the development of the JSNA.

Reviewing existing service provision

a. Complaints, concerns and experiences will be used to identify areas of development.

b. Patient surveys of current services ensuring all specifications/contracts for new services include patient feedback as part of an evaluation process.

c. Develop a system for accepting ideas (see appendix 1 for proposed PPE structure)

d. Discussions with relevant 'joint working groups' e.g. mental health, older people, children and young people, carers.
e. Public and Patient Forum, open to everyone, will be held twice a year.

Deciding priorities

Deciding priorities will be the role of the CCG Governing Body (which includes lay representation) and needs to be transparent to the public. This should include:

a. An explicit review of alternatives.
b. Discussions with relevant 'joint working groups'.
c. Involvement of the CCG Public and Patient Forum (see appendix 1).

Designing services

a. Every service design process includes patient and public engagement (PPE), taking into account patients, public, interest groups and geography.
b. PPE is identified in initial project plans within business cases.
c. Discussions with relevant 'joint working groups' e.g. for mental health, older people, children and young people and carers.

Managing performance of services

a. Ensure all new services include patient feedback as part of the evaluation process.
b. Robust links with Health and Wellbeing Boards.
c. Discussions with relevant 'joint working groups'.

Annual Plan

a. Plan to be written in plain English
b. Widely circulated using joint distribution where possible.
c. Available online and in different formats.
d. Discussed at Patient/Public Forum.

'No decision about me without me'

All services will ensure genuine patient centred care with patient participation, e.g. implementation of informed decision making and encouraging use of decision making tools where appropriate.

Future developments

Progress on delivering this strategy will be reviewed and reported on annually. This will provide an opportunity to take into account relevant local and national issues that may be arising, e.g. personalisation.

6.0 Structure to delivering public and patient engagement (see appendix 1)

We have established two key mechanisms for facilitating engagement with patients and the public:

- **Patient and Public Engagement (PPE) Steering Group**
  The remit of the group is to oversee and monitor engagement, develop, implement and review progress on the PPE strategy. The group also provides guidance to CCG commissioners, thus ensuring PPE is embedded in all commissioning activities.
  The specific activities used to engage will vary depending on the different topics for review.
- **Public and Patient Forum**
  The Public and Patient Forum will be held twice a year. The Forum is open to the public, all stakeholder and patient reference groups. It will receive reports from the PPE Steering Group on work being undertaken by the CCG as well as being encouraged to contribute to discussions on CCG activities.

We will use the 'Patient Engagement Continuum' as a way of identifying a number of ways of engaging with the public (see appendix 2) and the Patient

Experience and Engagement Commissioning Cycle (appendix 3) will be used to identify at what points we work with patients and stakeholders in the commissioning process

7.0 Our approach to clinical engagement

Clinical engagement is critical to ensure we gain support from our clinical colleagues for the decisions we make as an organisation.

Our engagement with clinicians will be ongoing and the way in which we facilitate engagement will vary depending on the nature of the issue.

However, we have already established two key mechanisms to ensure the opinions of local clinicians are heard and considered as part of our commissioning cycle, both of which are detailed below.

GP forum

The GP Forum is held once a month and is open to all GP Practice staff across the Vale of York.

Each Forum focuses on a particular theme which gives attendees the opportunity to discuss the issue in detail and feed back their ideas to the group. Themes discussed at GP Forums held so far have included:

- Reducing non-elective admissions and managing patient flow
- Telehealth
- NHS Constitution
- Prescribing

Occasionally, the GP Forum will be held in the format of a 'consultation café' whereby secondary care consultants are available to discuss specialist areas with attendees. Our first consultation café proved very successful and gave attendees the opportunity to discuss specialist areas such as:

- Gynaecology

- ENT
- Urology
- Cardiology

The outcomes of the Forum are fed into the commissioning cycle and reported via the monthly GP Practice Update.

Project specific steering groups

There is a need for us to facilitate engagement with organisations that have a role to play in the successful delivery of specific CCG-led projects.

This will involve the creation of specific steering groups comprising representatives from partner organisations to ensure they are integral to the development of the project.


Vale of York CCG
• Patients at the centre – Kenneth
• Partnership working
• Clinical engagement

8.0 Communicating with our stakeholders

We have a wide range of stakeholders with whom we need to communicate with. Wherever possible, we will establish mechanisms to facilitate dialogue with them to ensure we can respond appropriately to their needs.

The following table highlights the priority **stakeholders along with recommendations for when they should be communicated with (note that the method of communication is covered in section 11).**

Stakeholder	When to communicate with them
GP practices within the CCG	**Staff working within GP Practices are considered to be primary internal stakeholders. They must therefore be kept informed of issues and developments in a timely manner and be made aware of issues before they become public knowledge.** **As GP Practice staff have direct contact with patients, they should be seen and treated as CCG ambassadors who have a high level of influence over shaping public perceptions toward the CCG.**
Political stakeholders (including Overview and Scrutiny Committees)	**Political stakeholders have a significant level of influence over the success of CCG projects and can also play an important role in terms of reputational management amongst members of the public.** **Political stakeholders should be communicated with at a personal level, which will largely be achieved through members of the CCG building trusting relationships with them.** **The level of communication required with political stakeholders should always be considered at the start of any new project or service redesign.** **The more information and justification that can be given to them about the need for change, the more supportive they**

	may be. Political stakeholders should always be copied into proactive press releases to ensure they are informed prior to stories hitting the media.
Partner organisations (providers, voluntary sector, local authority etc)	Building an open and trusting relationship with our partners can help ensure their support during times of change. They also play a key role in cascading information to the 'end users'.
Patients and the public	Patients and the general public need to have access to information about issues that will impact upon on them. This can help create a mutual understanding and appreciation for why the change needs to be made. Facilitating two-way communication with patients and the public is essential if we are to uphold our commitment to being a responsive organisation.
Media	We need to build credible links with the media to ensure they view the CCG as a trusted partner – someone they can come to for an expert view on health related matters. This will be achieved by responding quickly to their enquiries and being flexible in our approach to dealing with them. Monitoring media trends will also be important to support the CCG in being proactive on particular issues.

9.0 Positioning and brand values

The emergence of this new organisation brings with it the opportunity for a fresh start.

Although the public perception of the NHS brand is generally positive, there are reputational issues associated with the PCT which the CCG will wish to steer away.

A favourable reputation is often achieved through consistency – both in terms of how the organisation behaves and how it interacts and is seen by people.

Consistency in voice will be achieved through having the communications steering group, as it will essentially act as a gatekeeper for all public facing information relating to the CCG.

However, internal communications within the CCG is paramount to ensuring there is as little dissonance between how the CCG brand is perceived internally and externally.

It should be noted that to build a successful brand externally, it needs to 'cook' from within by staff acting as ambassadors for the brand and fully appreciating its values.

The ultimate vision for the CCG brand is to be recognised as a trusted local leader of the NHS. Its voice must be authoritative, while at the same time showing empathy for local people's needs.

During 2012/13, the communication strategy aims to raise the profile of Vale of York CCG and begin to realise this vision.

10.0 Branding and visual identity

For the foreseeable future, Vale of York CCG should brand itself as a 'non-statutory NHS organisation', therefore using the following logo:

Vale of York
Clinical Commissioning Group

As the CCG is branded under the NHS, all associated correspondence and literature should comply with the NHS branding guidelines, a copy of which can be accessed here: http://www.nhsidentity.nhs.uk/

The organisation should always be referred to as either 'NHS Vale of York Clinical Commissioning Group' or 'Vale of York CCG'. The abbreviation 'VOYCCG' should never be used.

Over time, a 'house style' will be developed that differentiates the CCG from other NHS organisations. This house style should bolster the CCGs brand values and make it instantly recognisable – something which can be challenging in such a complex and multi-faceted environment as the NHS.

A series of corporate templates and corresponding brand guidelines will be produced to ensure proper use of the NHS Vale of York CCG brand.

10.1 Tone of voice

We will aim to communicate in plain English at all times – both in written and verbal communication. The use of acronyms should be kept to a minimum or at least explained within the document.

To support this, communication should follow guidance provided by The Campaign for Plain English, available at http://www.plainenglish.co.uk/free-guides.

11.0 Methods of communication

The following section outlines the key methods of communication we use to communicate with various stakeholders, along with a description of how each will be used.

11.1 Internal communication with GP practices

An online survey of staff working in GP practices was undertaken to establish the most effective way to communicate with them.

The key findings from the 97 surveys received were used to determine the following key methods of communicating with GP practice staff:

Weekly email updates

The purpose of the weekly email update is to ensure practice staff only receive information from the CCG that is relevant to them. This will ensure they are not bombarded with information which increases the likelihood of them reading the information.

The email update will be sent every Monday to Practice Managers and Commissioning Leads with each GP Practice. These updates will include any operational issues and actions that need to be undertaken that week. Where necessary, the email will contain information from third parties too, and third parties should be encouraged to send information in this way rather than directly to individual practices.

The updates will not include any general information about CCG development or wider issues such as feedback from the monthly GP forums. The updates can however include reminders about upcoming events.

Monthly practice updates

A practice update will be created in PDF format and sent to Practice Managers for onward cascade to all practice staff.

The primary objective of this update is to feed back on the monthly GP Forums, as well as to provide an update on the development of the CCG and wider issues affecting GP Practices.

Practice Liaison Representatives

We have identified four CCG Board members to act as GP Practice Liaison Leads.

The role of the Liaison Leads is to act as conduit between GP practices and the CCG Board. Each of the four Leads is responsible for a small number of GP Practices.

Intranet

An intranet is currently being developed which will act as a repository of information for GPs and Practice staff.

The intranet will be part of the CCG website and accessible from anywhere – not restricted to those connected to the N3 network.

Over time, we will look to establish and online forum which will facilitate sharing of best practice and discussion about key issues.

11.2 Media management

The media plays a key role in helping shape a positive reputation and should be treated as partner with which we must build a constructive relationship.

A separate media management protocol has been developed which outlines roles and responsibilities, particularly with regard to reactive media management.

In terms of proactive media management, a forward plan of press releases will be developed taking into consideration the achievement of key milestones in our development and, later on, the implementation/change of new services and initiatives.

Although every effort will be made to sell-in these stories to the media, even if they are not picked up, they will still provide a useful timeline of achievements to be placed on our website.

A key feature of our media approach will be the continual reference to our Patient and Public Engagement Steering Group. Making this group visible will help to demonstrate that decisions have not been in isolation and give a level of ownership to the members of these groups.

11.3 Online presence

Having a strong online presence is important because it:

- **facilitates dialogue;**
- **allows communication in 'real time' and is especially useful in crisis situations;**
- **reaches a range of audiences – both young and old;**
- **enables you to communicate in innovative ways, such as through the use of video;**
- **is an effective way to build a list of contacts who want to be kept informed of information relating to the CCG.**

Corporate website

In the interim, we will have a dedicated section hosted within the existing NHS North Yorkshire and York website.

However, over time, a new standalone website will be launched at: www.valeofyorkccg.nhs.uk

Social media

The role social media can play in reaching those who are deemed 'hard to reach' should not be underestimated.

An official profile for NHS Vale of York CCG will be established on Facebook, Twitter and YouTube. These will be managed by a select number of members from the communications steering group.

Facebook and twitter feeds will be used to further promote stories featured on the proactive media list, and also used to promote upcoming events. YouTube will be used to feature video briefings and films such as the Public and Patient Forum.

11.4 Stakeholder communication

Stakeholders, such as political representatives and partner organisations, will be made aware of issues in a timely manner. The nature of the issue will dictate the level of communication required, for example, they should be informed of a serious incident before it hits the local press.
Timely stakeholder communication will be made possible by maintaining an up to date stakeholder database.

Quarterly stakeholder update

A quarterly stakeholder newsletter will be produced which will act as the main vehicle of communication for keeping a wide range of stakeholders informed of developments within the CCG.

A plan for how and where this will be distributed will be developed.

11.5 Other forms of external communication

Depending on the nature of what needs to be communicated, it may be necessary for us to employ other forms of communication in addition to those detailed above.

The following methods should be considered as part of any communication initiative:

- **Advertising in local press and community magazines such as 'Your Local Link'**
- **Posters and leaflets**
- **PowerPoint presentations**
- **Profiling opportunities in local, regional and national media and events – this will be key to positioning NHS Vale of York CCG as a trusted health expert, thus bolstering the vision to be recognised as the local leader of the NHS.**

12.0 Key communication priorities for 2012/13

The following key communication priorities have been identified for 2012/13:

- **Ensure that the communication requirements contained within the 'CCG readiness for authorisation' checklist are fulfilled;**
- **Develop and launch a dedicated website for the CCG;**
- **Build a positive relationship with local media outlets (such as York Press, BBC Radio York, Selby Times, Pocklington Post), to be achieved through regular briefings and profiling opportunities;**
- **Develop a distinctive visual design style for the CCG to be used across all corporate materials;**
- **Build internal communication networks with GP practices and other organisations to ensure they are kept informed of CCG developments;**
- **Ensure communication protocols are embedded to ensure appropriate and timely communication with stakeholders**
- **Monitor the effectiveness of communication activities to help inform the communication strategy for 2013/14.**

13.0 Evaluating our communications

In order to ensure effectiveness, all methods of communication will require some form of ongoing evaluation.

Surveys, particularly using online solutions such as Survey Monkey, are a good way to collate ongoing feedback on particular methods of communication and brand awareness.

The communications steering group will periodically review each of the aforementioned methods of communication to ensure they are achieving the desired results; for example, by gauging the satisfaction of GPs in terms of how informed they feel.

14.0 Budget

An annual budget will be allocated in order to help plan communication activities and ensure money is spent in the most effective way.

This will be particularly important as the CCG begins to agree strategic priorities as communication is likely to play a key role in achieving them. For example, if the management of long term conditions becomes a key strategic priority, communication materials may be required to explain any changes to patients. This will inevitably have cost implications.

15.0 Progress made so far

Our CCG has made excellent progress so far in this transition year. Below is a description of some of the highlights from our communication and engagement activities.

Public and patient forum

We have so far held two very successful Public and Patient Forums, both of which attracted significant numbers of patients and voluntary sector representatives.

The last Forum, held in June, focussed on giving attendees a feel for how difficult the prioritisation process is and the challenges faced by the CCG in doing this.

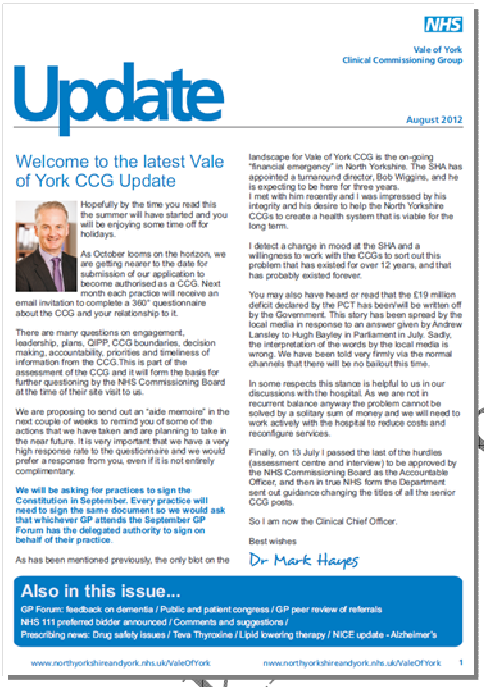
Feedback obtained from attendees was very positive and many said they now appreciate the complexities of commissioning and that there is not an infinite pot of money to pay for all the health services people want.

One aspect of the Forum we hope to improve in the future is encouraging more young people to attend and give their views.

Engaging GP Practice staff

Another aspect of engagement and communication that has been particularly effective over the past 12 months is with colleagues from our constituent GP Practices.

Our monthly GP Forum has been very well attended and has facilitated some very interesting and productive discussions around topics such as Telehealth, non-elective hospital admissions and prescribing.



NHS
Vale of York
Clinical Commissioning Group

Update

August 2012

Welcome to the latest Vale of York CCG Update

Hopefully by the time you read this the summer will have started and you will be enjoying some time off for holidays.

As October looms on the horizon, we are getting nearer to the date for submission of our application to become authorised as a CCG. Next month each practice will receive an email invitation to complete a 360° questionnaire about the CCG and your relationship to it.

There are many questions on engagement, leadership, plans, QIPP, CCG boundaries, decision making, accountability, priorities and timeliness of information from the CCG. This is part of the assessment of the CCG and it will form the basis for further questioning by the NHS Commissioning Board at the time of their site visit to us.

We are proposing to send out an "aide memoire" in the next couple of weeks to remind you of some of the actions that we have taken and are planning to take in the near future. It is very important that we have a very high response rate to the questionnaire and we would prefer a response from you, even if it is not entirely complimentary.

We will be asking for practices to sign the Constitution in September. Every practice will need to sign the same document so we would ask that whichever GP attends the September GP Forum has the delegated authority to sign on behalf of their practice.

As has been mentioned previously, the only blot on the landscape for Vale of York CCG is the on-going "financial emergency" in North Yorkshire. The SHA has appointed a turnaround director, Bob Wiggins, and he is expecting to be here for three years. I met with him recently and I was impressed by his integrity and his desire to help the North Yorkshire CCGs to create a health system that is viable for the long term.

I detect a change in mood at the SHA and a willingness to work with the CCGs to sort out this problem that has existed for over 12 years, and that has probably existed forever.

You may also have heard or read that the £19 million deficit declared by the PCT has been/will be written off by the Government. This story has been spread by the local media in response to an answer given by Andrew Lansley to Hugh Bayley in Parliament in July. Sadly, the interpretation of the words by the local media is wrong. We have been told very firmly via the normal channels that there will be no bailout this time.

In some respects this stance is helpful to us in our discussions with the hospital. As we are not in recurrent balance anyway the problem cannot be solved by a solitary sum of money and we will need to work actively with the hospital to reduce costs and reconfigure services.

Finally, on 13 July I passed the last of the hurdles (assessment centre and interview) to be approved by the NHS Commissioning Board as the Accountable Officer, and then in true NHS form the Department sent out guidance changing the titles of all the senior CCG posts.

So I am now the Clinical Chief Officer.

Best wishes

Dr Mark Hayes

Also in this issue...

GP Forum: feedback on dementia / Public and patient congress / GP peer review of referrals
NHS 111 preferred bidder announced / Comments and suggestions /
Prescribing news: Drug safety issues / Teva Thyroxine / Lipid lowering therapy / NICE update - Alzheimer's

www.northyorkshireandyork.nhs.uk/ValeOfYork

www.northyorkshireandyork.nhs.uk/ValeOfYork 1

Our monthly Practice Update has also been well received and we have now been producing it for 12 months. Each edition includes an update from Dr Mark Hayes, Chief Clinical Officer, about the CCGs progress towards authorisation and the challenges being faced by the local health economy.

The Update also highlights actions GP Practices can take to support the CCGs priorities, and includes a specific section around prescribing.

CCG team building exercise

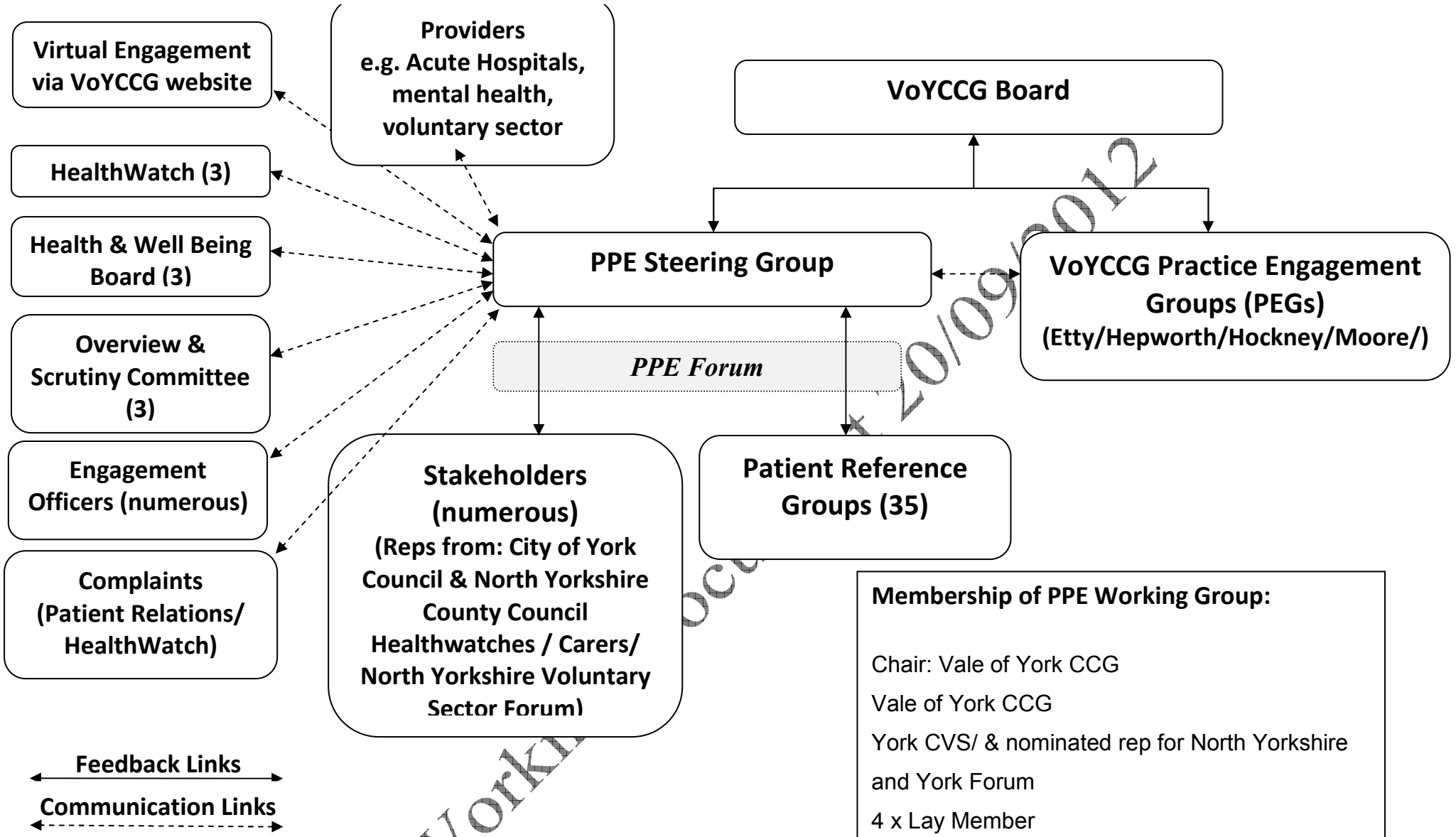
In July, the CCG held a team building exercise to give members and newly aligned CSS representatives the opportunity to meet each other and get everyone thinking about CCG priorities.

The afternoon involved a number of facilitated sessions which aimed to get people thinking about the CCGs vision, how they contribute towards achieving it and also to think about any specific areas that need to be improved.

The session was very productive and resulted in attendees leaving with a shared appreciation for each others' role and feeling more engaged in the vision of the CCG.

APPENDICES

Appendix 1: Structure to delivering public and patient engagement



Membership of PPE Working Group:

Chair: Vale of York CCG

Vale of York CCG

York CVS/ & nominated rep for North Yorkshire and York Forum

4 x Lay Member

North Yorkshire LINk

York LINk

Yorkshire and Humber CSU

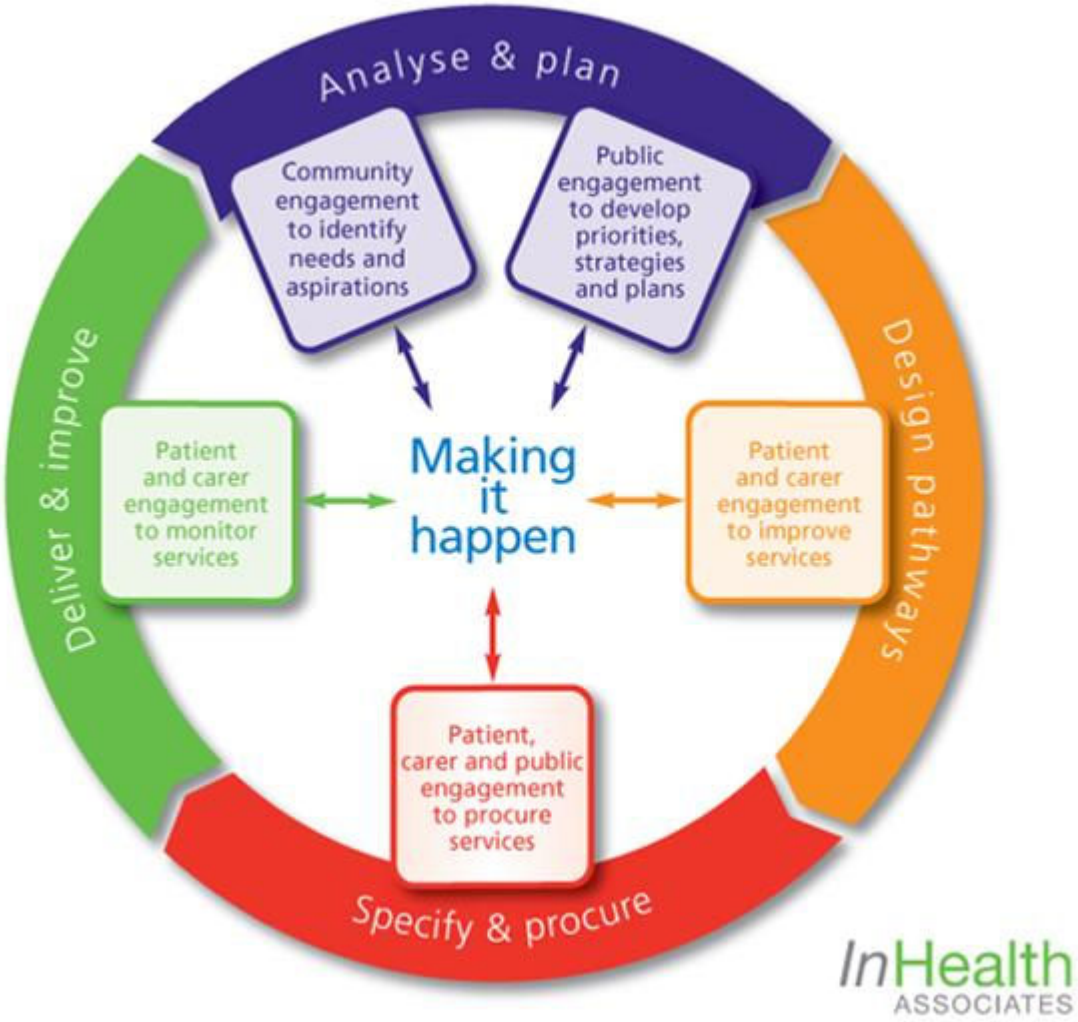
Appendix 2: Patient Engagement Continuum

1. INFORMATION GIVING	2. INFORMATION GATHERING	3. CONSULTATION	4. PARTICIPATION	5. COLLABORATION
Purpose: To provide people with information to assist their understanding	Purpose: To collect information about attitudes, opinions and preferences that will assist understanding and as a consequence decision-making.	Purpose: To obtain feedback on specific policies, business cases or proposals	Purpose: To involve people actively at all stages to ensure their concerns are understood and considered, and to give them some influence on and ownership of decisions.	Purpose: To bring people into active partnership[and agree sharing of resources and decision-making
Examples: Fact Sheets Newsletters Websites	Examples: Surveys Questionnaires Focus Groups	Examples: Consultation papers Public meetings Subject surgeries	Examples: Workshops Stakeholder dialogue	Examples: Local Strategic Partnerships Advisory Panels

Appendix 3: Patient Experience and Engagement Commissioning Cycle

For full details on the cycle visit:

http://www.institute.nhs.uk/tools/the_engagement_cycle/the_engagement_cycle_introduction.html



Appendix 6

Vale of York Clinical Commissioning Group
Draft Financial Strategy
2013/14 – 2015/16

Delivering the CCG's Financial Strategy

Financial Framework

Vale of York Clinical Commissioning Group (CCG) are seeking authorisation to become an NHS body and become operational from 1 April 2013. The CCG is currently operating in shadow form and whilst the financial strategy specifically relates to the CCG some elements are derived from a disaggregation of the NHS North Yorkshire and York (NHSNYY) financial plan. Most importantly NHS NYY operates within a very challenging financial environment and for 2012/13 has submitted a deficit plan of £19m. The CCG strategy assumes a proportionate amount of that deficit will transfer over to the CCG in 13/14.

Due to the challenging financial position of NHSNYY not only does the CCG face the prospect of commencing operations with a requirement to repay a proportion of inherited deficit it also needs to ensure there is sufficient focus on the underlying recurrent position (run rate position). The transformation the CCG aims to achieve will require a shift of resources across the health system; the challenge will be to do this at scale, without significant resources to pump prime initiatives. The overarching vision of the CCG is to take a whole system approach with significant partnership working with all Local authorities within its boundaries and a collaborative approach with its main acute and community provider York Teaching Hospitals NHS Foundation Trust.

Details of CCG level allocations are not expected until autumn 2012 so planning assumptions are currently based on a disaggregation of NHS NYY allocations. Financial analysis is derived from the national data collection baseline exercise, which considered NHSNYY financial accounts outturn for 2011/12 and financial plan for 2012/13. As at the date of publication NHSNYY has not delegated running costs budgets and so assumptions are based on the national running cost maximum expenditure allowance. There will be amendments to the financial data collection in relation to specialist commissioning although the planning assumption is any budgetary or allocation change would be matched with an expenditure change. As such this financial strategy should be seen as an evolving document and will require periodic updates as clarity on the operation, funding and responsibilities within the new NHS architecture is confirmed. It is anticipated a formal review will be conducted once CCG allocations are notified and once the NCB publishes its Charter for 2013/14.

Medium term financial plan 2012/13 – 2015/16

Table 1 Medium term financial plan

Vale of York CCG has developed its outline strategic plan, based on a range of scenarios, it is important to emphasise that the significant financial risk in the local health system means any variance from plan in 12/13 has a material impact on the whole strategic programme. There are three scenarios presented here.

- The base case is a CCG level plan derived from the PCT 12/13 plan of a £19m deficit, this plan assumes full delivery of all QIPP schemes and no contract budget overspends. The planning assumption for the VOYCCG is that a proportion of this deficit will become chargeable against the 2013/14 allocation (£5.3m)
- A revised scenario details the impact of a £5.8 budgetary overspend (this is over and above the CCG's share of the planned £19m deficit), this is based on month 4 VOY dashboard information and assumes the required actions to bring spend back in line are undelivered.
- A revised scenario based on a £10m budgetary overspend, this is based on provider predictions of activity and expenditure growth throughout the remained of 2012/13

The three scenarios are summarised in the table 1 to 3 below and more detailed is provided in Appendix A, B and C. The initial planning assumption (base case)shows a return to recurrent balance in 2013/14.

Table 1 Base Case, achievement of 2012/13 plan including share of £19m PCT deficit

Table 1	2012/13			2013/14			2014/15			2015/16		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Anticipated Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
Anticipated Expenditure	**-382,570**	**-639**	**-383,209**	**-381,114**	**167**	**-380,947**	**-378,497**	**833**	**-377,664**	**-379,698**	**0**	**-379,698**
Surplus/(deficit)	**-28,883**	**6,051**	**-22,832**	**-17,524**	**6,857**	**-10,667**	**-11,271**	**7,523**	**-3,748**	**-8,799**	**6,690**	**-2,109**
Planned efficiencies	17,528	0	17,528	17,781	0	17,781	17,334	0	17,334	18,579	0	18,579
Surplus/(deficit)	**-11,355**	**6,051**	**-5,304**	**257**	**6,857**	**7,114**	**6,063**	**7,523**	**13,586**	**9,780**	**6,690**	**16,470**
Contingeny				0	-913	-913	0	-3,633	-3,633	0	-3,632	-3,632
Defict repayment				**0**	-5,304	-5,304	0	897	897	0	8,850	8,850
Surplus/(deficit)	**-11,355**	**6,051**	**-5,304**	**257**	**641**	**897**	**6,063**	**4,787**	**10,850**	**9,780**	**11,908**	**21,688**

Table 2 Assumed £5.8m in year overspend (in addition to share of £19m deficit)

Table 2	2012/13			2013/14			2014/15			2015/16		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Anticipated Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
Anticipated Expenditure	**-388,376**	**-639**	**-389,015**	**-385,228**	**167**	**-385,061**	**-384,586**	**833**	**-383,753**	**-384,945**	**0**	**-384,945**
Surplus/(deficit)	**-34,689**	**6,051**	**-28,638**	**-21,638**	**6,857**	**-14,781**	**-17,360**	**7,523**	**-9,837**	**-14,047**	**6,690**	**-7,357**
Planned efficiencies	17,528	0	17,528	18,129	0	18,129	18,503	0	18,503	18,916	0	18,916
Surplus/(deficit)	**-17,161**	**6,051**	**-11,110**	**-3,509**	**6,857**	**3,348**	**1,144**	**7,523**	**8,667**	**4,870**	**6,690**	**11,560**
Contingeny				0	-927	-927	0	-3,691	-3,691	0	-3,681	-3,681
Defict repayment				**0**	-11,110	-11,110	0	-10,689	-10,689	0	-7,713	-7,713
Surplus/(deficit)	**-17,161**	**6,051**	**-11,110**	**-3,509**	**-5,180**	**-8,689**	**1,144**	**-6,857**	**-5,713**	**4,870**	**-4,704**	**165**

Table 3 Assumed £10m in year overspend (in addition to share of £19m deficit)

Table 3	2012/13			2013/14			2014/15			2015/16		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Anticipated Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
Anticipated Expenditure	**-392,570**	**-639**	**-393,209**	**-389,644**	**167**	**-389,477**	**-388,984**	**833**	**-388,151**	**-389,328**	**0**	**-389,328**
Surplus/(deficit)	**-38,883**	**6,051**	**-32,832**	**-26,054**	**6,857**	**-19,197**	**-21,758**	**7,523**	**-14,235**	**-18,429**	**6,690**	**-11,739**
Planned efficiencies	17,528	0	17,528	18,381	0	18,381	18,757	0	18,757	19,172	0	19,172
Surplus/(deficit)	**-21,355**	**6,051**	**-15,304**	**-7,673**	**6,857**	**-816**	**-3,001**	**7,523**	**4,522**	**743**	**6,690**	**7,433**
Contingeny				0	-938	-938	0	-3,733	-3,733	0	-3,722	-3,722
Defict repayment				**0**	-15,304	-15,304	0	-19,058	-19,058	0	-20,269	-20,269
Surplus/(deficit)	**-21,355**	**6,051**	**-15,304**	**-7,673**	**-9,385**	**-17,058**	**-3,001**	**-15,268**	**-18,269**	**743**	**-17,302**	**-16,559**

Financial Planning Assumptions

The financial parameters included within this document build on the principles set out in the 12/13 Operating Framework, and supporting documents such as Payment by Results guidance.

The following assumptions have been made

- Allocation uplift at PCT level for 2012/13 was 2.8% this is assumed to continue until 2013/14, the forward projection from 2014/15 has been assumed at 1%
- The CCG control total for 2012/13 will be a deficit of £5,304, this is a % apportionment of the NHSNYY deficit plan of £19m
- The plan is structured to fulfil the requirement to create recurrent headroom of 2% which can only be utilised on a non recurrent basis.
- Inflation on tariff and non tariff is 2.5% and continues at this level for the duration of the plan
- Efficiency on tariff and non-tariff is -4.3% in 2012/13, and assumed to be -4.0% in each future year. The net impact on the tariff and non-tariff from 2013/14 onwards is therefore -1.5%
- The assumptions on tariff inflation and efficiency will be reset annually upon publication of the national tariff guidance.
- Payments for non elective activity will continue at 30% marginal tariff rate for the duration of the plan, similarly any QIPP reductions related to non-elective activity would also be at 30% marginal rate unless activity returns to a level below the 2008/09 threshold
- The financial impact of non payment for readmissions has been built into the plan although the clinical audit to review the baseline is underway
- The locally negotiated financial envelope for CQUINS payments of 1.5% is only assumed for 2012/13, the plan reverts to an assumption of 2.5% from 2013/14 onwards
- Additional health and social care funding for reablement is excluded from this financial plan as resources have transferred to the Local Authority, they will however be referenced in the overall strategy as a key enabler to the redesign of the local health and social care system.
- The assumption for prescribing is that inflationary increases are offset by efficiencies and therefore no uplift in prescribing expenditure is planned for until 2014/15 at which point a 1% increase is assumed.
- At this stage in the planning process there is no assumed investment in strategic developments, and service redesign or QIPP schemes are based on in year pay back and the QIPP plan should be net of any required investment. A strategic review is underway across the wider health economy and decisions on investment will be made in line with the published strategy.
- Demographic growth is assumed to be 2.8% in 2013/14 then increases to 3% from 2014/15 onwards.
- The assumed level of QIPP is 2% in each year of the financial plan
- Specialist commissioning figures submitted as part of the national baseline exercise are subject to change. As at the point of publication no notified changes have been made.

- As at the date of publication no corporate or running cost budgets have been delegated from the PCT cluster, the planning assumption is that budget delegation will match running cost assumptions as detailed in that section.

System Wide External Review

Two of the three scenarios modelled above in the medium term financial plan show that the CCG would not achieve its statutory break even duty until 2015/16 or longer if further corrective action is not taken, This is not a new financial challenge that faces the local heath economy and the former PCT has received in the region of £100m of financial support up to the end of 2011/12. For 2012/13 the PCT will receive no external support and has submitted a deficit plan. The implications for the Vale of York CCG is a brought forward deficit of £5.3m but with a higher underlying recurrent expenditure figure in the region of £11.3m

In order to address the financial challenges the whole system faces an external review has been commissioned and is due to issue its findings at the end of October 2012. No assumptions have been made within this plan of those findings, other than further significant actions will be identified to deliver radical service reconfiguration options that deliver the system wide change required.

All key stakeholders with the health economy have committed to the review including the 3 Acute and community providers within the North Yorkshire Patch one of Which York teaching Hospitals Foundation trust is the major service provider for Vale of York.

Once the North Yorkshire wide review is published and key stakeholders commit to the implementation programme this plan will be revised to take into account those additional savings.

Financial collaboration and risk sharing

NHS North Yorkshire and York has existed in its current geographical structure since 2005/06, prior to that date there were 4 PCT's covering North Yorkshire, at that time there was a strong collaborative working model which has continued through a locality model, although not identical to the proposed CCG's configurations there is a strong commitment across the health economy to maintain this collaboration, there are three key strands to this:

- Functions run at a North Yorkshire Level where there is an intention to continue through commissioning support services, for example continuing care, commissioning for vulnerable people, non-contract activity.

- Host contract arrangements where one CCG will lead on negotiation, in year performance and contract management, for Vale of York this will include York Teaching Hospitals Foundation Trust, Leeds and York Partnerships NHS Foundation Trust, Leeds Teaching Hospital Trust.
- Financial risk sharing, this is proposed to cover three areas, continuing health care, funded nursing care, high cost patients, all 4 North Yorkshire CCGs will pool resources to share risk and benefits of these areas.

Due to the challenging financial position across the whole of North Yorkshire a strategic review is currently underway, where it is beneficial both financially and strategically to collaborate VOY will do so.

Run rate

An important aspect of the financial plan for VOY is the analysis of run rate expenditure. NHS North Yorkshire and York has had historical financial problems and in 12/13 submitted a deficit plan. It is important the CCG fully understand the recurrent underlying rate of spend to ensure it is on a trajectory of improving the position and not heading further into deficit. It is essential that there is a forensic understanding of commissioning decisions, QIPP schemes and efficiency proposals and that these are all mapped to a monthly run rate analysis. This will be routinely monitored by the governing body 2012/13 onwards.

Where does the money go?

The table below details where the CCG expends its resources. The majority of resource is expended with York Hospitals Foundation Trust, following the acquisition of Scarborough and North East Yorkshire, this accounts for 47.2%
.

Table 4 where does the money go

		12/13 £000	%
Commissioned Services			
	York Hospitals Foundation Trust (Acute services)	150,760,703.6	41.2%
	York Hospitals Foundation Trust (Community Services)	17,613,460.3	4.8%
	Harrogate District Foundation Trust (Acute services)	1,292,766.2	0.4%
	Harrogate District Foundation Trust (Community services	8,999,232.8	2.5%
	Scarborough & North East Yorkshire NHS Trust	4,073,884.7	1.1%
	Leeds and York Partnership Trust	29,861,508.3	8.2%
	Yorkshire Ambulance Service	12,342,151.6	3.4%
	Leeds Teaching Hospital Trust	11,639,692.0	3.2%
	Ramsey Hospital - clifton park york	6,510,750.5	1.8%
	Hull & East Yorkshire NHS Trust	4,513,266.9	1.2%
	Nuffield Hospital - York	1,871,680.6	0.5%
	Mid Yorskhire	1,833,405.8	0.5%
	Tees Esk & Wear Valley MH	1,341,471.0	0.4%
	South Tees Foundation Trust	1,296,563.5	0.4%
	Total Major NHS Contracts above £1m	**253,950,537.6**	**69.4%**
	Other NHS Contracts below £1m.	8,136,171.3	2.2%
	NHS Non Contract Activity	6,072,301.1	1.7%
	Private Providers contracts below £1m	1,030,240.3	0.3%
	Other NHS Commissioning	3,092,544.4	0.8%
Total NHS contracts		**272,281,794.7**	**74.5%**
	Partnerships	2,718,070.8	0.7%
	Hospice payments	1,218,226.4	0.3%
	Pooled Budgets	5,049,416.7	1.4%
	Continuing Care	20,014,115.5	5.5%
	Funded Nursing Care	4,400,626.6	1.2%
Total Non NHS Contracts		**33,400,456.0**	**9.1%**
Total Commissioned Services		**305,682,250.7**	**83.6%**
Primary Care			
	Prescribing	46,438,850.0	12.7%
Total Primary Care		**46,438,850.0**	**12.7%**
	Corporate Services	tba	0.0%
	Pocklington practice commissioning to be split	13,560,000.0	
	Deficit Repayment	0.0	0.0%
Total Corporate Services		**13,560,000.0**	**3.7%**
Total Commissioned & Corporate Services		**365,681,100.7**	**100.0%**
	deficit	-5,303,684.2	

Running costs

The NHS commissioning board have set a running cost allowance for each CGG based on registered population adjusted to ONS clusters. For Vale of York this is £8.35m which equates to £24.74 per head of population (unadjusted). This is in line with expectations and the initial management structure ensures the CCG will operate within its running cost total. Throughout the remainder of 2012/13 the CCG will work closely with the PCT cluster to develop its understanding of non-pay expenditure and conclude the business case for HQ location. A significant number of support functions will be provided by the North Yorkshire and Humber commissioning support service.

Table 5 Structure Costs (Pay and Non Pay)

Running Costs	**£000's**
Board of Governors	£1,121
Clinical Engagement	£268
Management Costs	£1,804
Non pay (including CSS)	£4,985
Total	**£8,178**
Population	337,500
Running Cost per Head	**£24.23**
National Running Cost Target	£8,350
National Running Cost Per Head Target	£24.74

Practice Level information

Up to 2010/11 the PCT utilised the DH fair shares toolkit to calculate practice level budgets as part of the practice based commissioning initiative. Once the CCG is established as a statutory NHS body it will be provided with an allocation, PCT level data collection exercises have been conducted in September 2011 and July 2012 to ensure the DH has sufficient information to map expenditure from the current NHS architecture to the new system which incorporates CCGs. In addition a revised allocation formula will be put in place. This will notify the CCG of its Actual allocation and an assessment will be made of its distance from a fair shares allocation. It is also anticipated that a policy on how CCGs may move to a fair shares allocation will be published. In a period of flat growth where uplifts to the overall NHS allocation are only intended to cover inflationary increases any movement towards fair shares will be small, as such the CCG should not anticipate any significant movement from the overall PCT allocation for 12/13, once it has been disaggregated.

Once the overall CCG allocation is known the intention will be to refresh practice level budgets and ensure there is a consistent process for continuing the movement towards fair share practice level budgets**.**

Cash

CCGs will operate in a similar cash regime to PCTs. There will be an annual cash limit within which the CCG must remain. As part of the closedown of the PCT a greater understanding of the anticipated year end position will be sought, as with any business there is a time lag between service delivery and payment for those services, the CCG must ensure sufficient cash is available to meet those year end obligations inherited from the PCT.
Once the CCG is fully functioning in 2013/14 it will be responsible for the direct payment to providers for services. As the vast majority of CCG business is covered by the standard NHS contract 74% of all cash expenditure will flow in equal 12ths. In addition almost 13% is to cover prescribing spend, this means that each month 87% of the CCG cash flow is known. In year adjustments would have to be made for contractual under/overtrades.

Financial governance

As part of its establishment the CCG is considering its requirement to establish robust financial and corporate governance arrangements, there are several key policy and procedure documents that the CCG will adopt prior to establishment, the key ones being:

- Constitution
- Standing Orders and Standing Financial instructions
- Prime financial procedure documents
- Scheme of Delegation

In addition the CCG will be using the SBS ledger system to ensure its obligations for accounting for public funding can be met, a scheme of delegation for authorisation of all expenditure will be embedded within the system.

Committees of the board will be in place to seek assurance that the organisational governance is sound and assurance can be placed on the mechanisms in place, this will be done predominantly through the audit and governance committees.

QIPP

The VOY CCG qipp scheme for 12/13 is £7.3m detail of the schemes are provided below, there will be a mix of new schemes and full year effect of schemes that commenced in 11/12. As 12/13 is the base year for the financial strategy it is essential all schemes are fully delivered.

Table 6 Strategic QIPP plan

	Ref	Workstream	Strategy workstream	Target action	12/13	13/14	14/15	15/16
[redacted]	VOYCC1	3	Elective Care pathways	Dermatology;	£26,378	£18,842		
				Ophthalmology;	£53,769	£38,407		
				Cardiology;	£68,160	£68,160		
				Gynaecology.	£57,040	£0		
	VOYCC2	2	LTC	LOC	£1,162,028	£1,144,424		
	VOYCC3	2	MH - Dementia	Psych liaison	see CE11			
	VOYCC4	2	Urgent care	Urgent care pathway	£100,000			
	VOYCC5	3	MSK expansion	Orthopaedics	£660,339			
				Pain Management	£49,654	£16,551		
				Rheumatology	£47,882	£15,961		
				Orthopaedics	£169,532			
				Pain Management	£67,199	£22,400		
				Rheumatology	£744,079	£35,162		
	VoYCC6	3	Contracting	Effective use of Contract/VFM	£2,135,342	£818,984		
	VoYCC7	x	Lucentis		£1,488,793	£1,488,793	£819,076	
	VoYCCG 8	x	Medicine Management		£485,811			
			unidentified QIPP			£3,749,285	£7,341,980	£7,282,449
	Total				**£7,316,006**	**£7,416,969**	**£8,161,056**	**£7,282,449**

In order to deliver the financial strategy detailed in table 1, QIPP schemes which are 2% of expenditure will be required from 13/14 onwards; these are in addition to any national provider efficiency requirements set in the operating framework and PBR tariff guidance. The medium term QIPP schemes are tabled above. The detailed schemes are a continuation of schemes already commenced. There is still a significant amount of required but unidentified QIPP at this point.

Capital

Once established it is not anticipated the CCG will have any significant assets, buildings within the locality are in the process of transferring to Foundation Trusts or NHS Property Company,

The majority of IM&T infrastructure relates to those buildings or is to support primary care so is assumed not to be on the CCG balance sheet.

Future capital may be required as part of our system redesign aspirations, however it is assumed that the CCG will work with the NHS and other partners to secure any necessary capital.

At this stage the CCG does not anticipate that it will have a baseline capital allocation.

Appendix A Base Case to PCT planned £19m deficit

Category	2012/13 Rec £'000	2012/13 NR £'000	2012/13 Total £'000	2013/14 Rec £'000	2013/14 NR £'000	2013/14 Total £'000	2014/15 Rec £'000	2014/15 NR £'000	2014/15 Total £'000	2015/16 Rec £'000	2015/16 NR £'000	2015/16 Total £'000
RESOURCE AVAILABILITY												
Revenue Resource Limit	334,499	0	334,499	353,687	0	353,687	363,590	0	363,590	367,226	0	367,226
Pocklington Practice	16,512		16,512									
Revenue Growth	9,366	0	9,366	9,903		9,903	3,636		3,636	3,672		3,672
2% Topslice	-6,690	6,690	0	0	6,690	6,690		6,690	6,690		6,690	6,690
assumed return of NEL threshold funding												
Total Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
UNAVOIDABLE EXPENDITURE												
Baseline expenditure	-345,558	-2,784	-348,342	-365,042	167	-364,875	-361,334	833	-360,501	-361,163	0	-361,163
Pocklington Practice	-16,512	0	-16,512	0		0	0		0	0		0
CQUIN	-6,568	2,146	-4,423									
Contract inflation	-6,106	0	-6,106	-6,472		-6,472	-7,050		-7,050	-8,312		-8,312
Demographic Growth	-7,826		-7,826	-7,600		-7,600	-8,114		-8,114	-8,223		-8,223
Cost Pressures				-2,000		-2,000	-2,000		-2,000	-2,000		-2,000
Contingency	0	0	0		-913	-913	0	-3,633	-3,633	0	-3,632	-3,632
Sub Total	**-382,570**	**-639**	**-383,209**	**-381,114**	**-746**	**-381,860**	**-378,497**	**-2,800**	**-381,297**	**-379,698**	**-3,632**	**-383,329**
TOTAL REMAINING FOR INVESTMENT	**-28,883**	**6,051**	**-22,832**	**-17,524**	**5,944**	**-11,580**	**-11,271**	**3,890**	**-7,381**	**-8,799**	**3,058**	**-5,741**
Strategic Investments (Gross)												
Strategic Investments			0			0			0			0
FINANCIAL POSITION BEFORE EFFICIENCIES	**-28,883**	**6,051**	**-22,832**	**-17,524**	**5,944**	**-11,580**	**-11,271**	**3,890**	**-7,381**	**-8,799**	**3,058**	**-5,741**
EFFICIENCY SAVINGS												
Provider Efficiencies	10,212	0	10,212	10,480		10,480	10,067		10,067	11,316		11,316
Quality and Productivity Programme	7,315		7,315	7,301		7,301	7,267		7,267	7,263		7,263
Revised In Year (Deficit) / Surplus	**-11,355**	**6,051**	**-5,304**	**257**	**5,944**	**6,201**	**6,063**	**3,890**	**9,953**	**9,780**	**3,058**	**12,838**
(deficit repayment)/ return of surplus					-5,304	-5,304		897	897		8,850	8,850
	-11,355	**6,051**	**-5,304**	**257**	**641**	**897**	**6,063**	**4,787**	**10,850**	**9,780**	**11,908**	**21,688**

Appendix B Forecast overspend of £5.8m plus share of PCT planned £19m deficit

Category	2012/13 Rec £'000	2012/13 NR £'000	2012/13 Total £'000	2013/14 Rec £'000	2013/14 NR £'000	2013/14 Total £'000	2014/15 Rec £'000	2014/15 NR £'000	2014/15 Total £'000	2015/16 Rec £'000	2015/16 NR £'000	2015/16 Total £'000
RESOURCE AVAILABILITY												
Revenue Resource Limit	334,499	0	334,499	353,687	0	353,687	363,590	0	363,590	367,226	0	367,226
Pocklington Practice	16,512		16,512									
Revenue Growth	9,366	0	9,366	9,903		9,903	3,636		3,636	3,672		3,672
2% Topslice	-6,690	6,690	0	0	6,690	6,690		6,690	6,690		6,690	6,690
assumed return of NEL threshold funding												
Total Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
UNAVOIDABLE EXPENDITURE												
Baseline expenditure	-351,364	-2,784	-354,148	-368,848	167	-368,681	-367,099	833	-366,266	-366,082	0	-366,082
Pocklington Practice	-16,512	0	-16,512	0		0	0		0	0		0
CQUIN	-6,568	2,146	-4,423									
Contract inflation	-6,106	0	-6,106	-6,617		-6,617	-7,197		-7,197	-8,461		-8,461
Demographic Growth	-7,826		-7,826	-7,762		-7,762	-8,290		-8,290	-8,402		-8,402
Cost Pressures				-2,000		-2,000	-2,000		-2,000	-2,000		-2,000
Contingency	0	0	0		-927	-927	0	-3,691	-3,691	0	-3,681	-3,681
Sub Total	**-388,376**	**-639**	**-389,015**	**-385,228**	**-760**	**-385,988**	**-384,586**	**-2,858**	**-387,444**	**-384,945**	**-3,681**	**-382,945**
TOTAL REMAINING FOR INVESTMENT	**-34,689**	**6,051**	**-28,638**	**-21,638**	**5,930**	**-15,708**	**-17,360**	**3,832**	**-13,528**	**-14,047**	**3,009**	**-5,357**
Strategic Investments (Gross)												
Strategic Investments			0			0			0			0
FINANCIAL POSITION BEFORE EFFICIENCIES	**-34,689**	**6,051**	**-28,638**	**-21,638**	**5,930**	**-15,708**	**-17,360**	**3,832**	**-13,528**	**-14,047**	**3,009**	**-5,357**
EFFICIENCY SAVINGS												
Provider Efficiencies	10,212	0	10,212	10,712		10,712	10,302		10,302	11,555		11,555
Quality and Productivity Programme	7,315		7,315	7,417		7,417	8,201		8,201	7,362		7,362
Revised In Year (Deficit) / Surplus	**-17,161**	**6,051**	**-11,110**	**-3,509**	**5,930**	**2,421**	**1,144**	**3,832**	**4,976**	**4,870**	**3,009**	**7,879**
(deficit repayment)/ return of surplus					-11,110	-11,110		-10,689	-10,689		-7,713	-7,713
	-17,161	**6,051**	**-11,110**	**-3,509**	**-5,180**	**-8,689**	**1,144**	**-6,857**	**-5,713**	**4,870**	**-4,704**	**165**

Appendix C Forecast overspend of £10m plus share of PCT planned £19m deficit

Category	2012/13 Rec £'000	2012/13 NR £'000	2012/13 Total £'000	2013/14 Rec £'000	2013/14 NR £'000	2013/14 Total £'000	2014/15 Rec £'000	2014/15 NR £'000	2014/15 Total £'000	2015/16 Rec £'000	2015/16 NR £'000	2015/16 Total £'000
RESOURCE AVAILABILITY												
Revenue Resource Limit	334,499	0	334,499	353,687	0	353,687	363,590	0	363,590	367,226	0	367,226
Pocklington Practice	16,512		16,512									
Revenue Growth	9,366	0	9,366	9,903		9,903	3,636		3,636	3,672		3,672
2% Topslice	-6,690	6,690	0	0	6,690	6,690		6,690	6,690		6,690	6,690
assumed return of NEL threshold funding												
Total Resources Available	**353,687**	**6,690**	**360,377**	**363,590**	**6,690**	**370,280**	**367,226**	**6,690**	**373,916**	**370,898**	**6,690**	**377,588**
UNAVOIDABLE EXPENDITURE												
Baseline expenditure	-355,558	-2,784	-358,342	-373,042	167	-372,875	-371,264	833	-370,431	-370,228	0	-370,228
Pocklington Practice	-16,512	0	-16,512	0		0	0		0	0		0
CQUIN	-6,568	2,146	-4,423									
Contract inflation	-6,106	0	-6,106	-6,722		-6,722	-7,303		-7,303	-8,569		-8,569
Demographic Growth	-7,826		-7,826	-7,880		-7,880	-8,418		-8,418	-8,531		-8,531
Cost Pressures				-2,000		-2,000	-2,000		-2,000	-2,000		-2,000
Contingency	0	0	0		-938	-938	0	-3,733	-3,733	0	-3,722	-3,722
Sub Total	**-392,570**	**-639**	**-393,209**	**-389,644**	**-771**	**-390,415**	**-388,984**	**-2,900**	**-391,884**	**-389,328**	**-3,722**	**-387,328**
TOTAL REMAINING FOR INVESTMENT	**-38,883**	**6,051**	**-32,832**	**-26,054**	**5,919**	**-20,135**	**-21,758**	**3,790**	**-17,968**	**-18,429**	**2,968**	**-9,739**
Strategic Investments (Gross)												
Strategic Investments			0			0			0			0
FINANCIAL POSITION BEFORE EFFICIENCIES	**-38,883**	**6,051**	**-32,832**	**-26,054**	**5,919**	**-20,135**	**-21,758**	**3,790**	**-17,968**	**-18,429**	**2,968**	**-9,739**
EFFICIENCY SAVINGS												
Provider Efficiencies	10,212	0	10,212	10,880		10,880	10,472		10,472	11,727		11,727
Quality and Productivity Programme	7,315		7,315	7,501		7,501	8,284		8,284	7,445		7,445
Revised In Year (Deficit) / Surplus	**-21,355**	**6,051**	**-15,304**	**-7,673**	**5,919**	**-1,754**	**-3,001**	**3,790**	**789**	**743**	**2,968**	**3,710**
(deficit repayment)/ return of surplus					-15,304	-15,304		-19,058	-19,058		-20,269	-20,269
	-21,355	**6,051**	**-15,304**	**-7,673**	**-9,385**	**-17,058**	**-3,001**	**-15,268**	**-18,269**	**743**	**-17,302**	**-16,559**

Appendix 7 QIPP 2012/13

Quality, Innovation, Productivity and Prevention		NHS North Yorkshire and York	
Name of Initiative	Elective Care Pathways (VoYCC1)	High level description of Initiative	Modifying a number of elective care pathways to enable procedures currently provided in a secondary care setting to be transferred to the community and closer to people's homes.
Lead Director	Rachel Potts	Link to National Workstream	Delete as appropriate: ***Commissioning & Pathways*** Planned Care

Overall description/scope	**Resource management**
Description: This initiative is as a direct consequence of work carried out during 2011/12 by Vale of York Clinical Commissioning Group clinicians. The focus is to initialise clinician to clinician discussions about the transfer of service provision that is currently provided in secondary care to a community setting, then taking a partnership approach to developing plans and implementing the transfer. Specialties for consideration during 2012/13 are: Dermatology; Ophthalmology; Cardiology; Gynaecology, In addition practices will be able to take part in a referral review process, whereby they can discuss the appropriateness of specific referrals with secondary care consultants, thereby identifying best practice for future referrals made within GP practices. **Expected outcomes/benefits to patient & commissioner** ➢ More equitable access and treatment of patients for specialties identified ➢ A reduction in referrals to secondary care ➢ Increased patient satisfaction ➢ Improved access to advice and information and increased knowledge and awareness of the management of the specialties identified ➢ Effective and streamlined care pathways minimising the number of patient visits required	**All financial assumptions based on 2010/11 prices** **Contract baseline**. £2,883,710 (annual baseline) **Potential savings from the initiative** £330,000 (cumulative) **Project teams members** Dermatology (Dr Tim Maycock, Andrew Bucklee, Kirsty Kitching) Ophthalmology (Dr Shaun O'Connell, Lisa Barker, Stacey Marriott, Kirsty Kitching) Cardiology (Dr David Hayward, Andrew Bucklee, Kirsty Kitching) Gynaecology (Dr Emma Broughton, Stacey Ransome, Kirsty Kitching) Referral Reviews (Dr Emma Broughton, Dr David Hayward, Stacey Ransome) **Resource End Product** To develop new care pathways within identified specialties that will provide a more streamlined and more accessible service for patients. Improve referral processes at GP practice level.

Programme management

- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach.
- Delivery will take place at locality level where possible and county wide where necessary.
- All QIPP activities will be monitored centrally in the PCT through an approach that will monitor, for each QIPP activity:
    1. Potential savings
    2. The savings trajectory and timeline
    3. Actual savings
    4. Activity levels
    5. Progress towards project outcomes

Lead managers will be accountable for achievement of savings.

- Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.

Timescales and Milestones

Milestones

Description of milestone	Milestone date
Implement changes to the GS018 (Ophthalmology) care pathway.	January 2012
Consider and agree revisions to Post Menopausal Bleeding (Gynaecology) care pathway	January 2012
Develop and agree new specification for Post Menopausal Bleeding	February 2012
Consider and agree revisions to Cardiology (palpitations) care pathway	March 2012
Agree contract changes to existing Post Menopausal Bleeding service	April 2012
Proposal for referral review process presented to CCG membership for consideration	June 2012
Implement agreed changes to Post Menopausal Service	July 2012
Consider and agree revisions to existing Dermatology care pathway.	August 2012
Develop and agree new specification for Cardiology (palpitations)	August 2012
Evaluate changes to the GS018 care pathway and consider revisions as necessary.	August 2012
Referral review process (based on gaining agreement from CCG membership): Agree specialties for reviewing and agree tariff for consultant involvement	August 2012
Consider and agree further revisions to the existing Ophthalmology care pathway	Sept 2012
Consider and agree further revisions to the Gynaecology care pathway (Urogynae/Abnormal Menstrual Bleeding)	Sept 2012
Agree contract changes to existing Cardiology (palpitations) service	Sept 2012
Evaluate changes to Post Menopausal Bleeding care pathway and consider revisions as necessary	Sept 2012
Implement referral review process	Sept 2012
Develop and agree new specification for Dermatology	October 2012
Develop and agree new specification for Ophthalmology	Nov 2012
Agree contract changes to existing Dermatology service	Nov 2012
Develop and agree new specification for Gynaecology (Urogynae/Abnormal Menstrual Bleeding)	Nov 2012

Agree contract changes to existing Ophthalmology service	Dec 2012
Implement agreed changes to Cardiology palpitations care pathway	Dec 2012
Agree contract changes to existing Gynaecology service re Urogynae/Abnormal Menstrual Bleeding	Feb 2013
Implement agreed changes to Dermatology service	March 2013
Implement agreed changes to Ophthalmology service	April 2013
Implement agreed changes to Urogynae/Abnormal Menstrual Bleeding	April 2013
Evaluate effectiveness of referral review process (based on 3 months data)	April 2013
Evaluate changes to Cardiology (palpitations) care pathway and consider revisions as necessary	May 2013
Evaluate changes to Gyanecology (Urogynae/Abnormal Menstrual Bleeding) care pathways and consider revisions as necessary	Sept 2013
Evaluate changes to Dermatology and Ophthalmology care pathways and consider revisions as necessary	Sept 2013

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Lack of support from acute sector colleagues.	• Maintaining a partnership approach throughout the whole development and implement stages. • Escalate to VoYCCG Board/ NY Review Board	Ongoing
New pathways do not enable improvements in patient flows, therefore not reducing the cost base	• Build in evaluation process and allow for remedial actions to be undertaken	Ongoing
Lack of management capacity to implement milestones within agreed timescales	• Escalate to the VoYCCG Board for recommendations for remedial action	Ongoing
Lack of clinical leadership capacity to move the various projects within this scheme forward.	• Escalate to VoYCCG for recommendations for remedial action	Ongoing

Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
York Hospital as the main provider are a key partner in ensuring a partnership approach	Monthly meetings of the CMB performance/quality sub-group	Meetings, reports
GP Practice are key supporters of the new approach	Monthly meetings of VoYCCG GP Forum.	Meetings, reports
Patients and public need to be assured that the future care pathways will meet their needs.	As required	Local media, websites, VoYCCG Patient/Public Congress

£'000	FY12/13	FY13/14	FY114/15	Total
Expenditure	0	0	0	0
Saving	205	125	0	330
Total net savings	**205**	**125**	**0**	**330**

Note the savings have been assumed based on pathway changes to deliver the net impact of 10% savings. The calculations are on outpatient first attendances at the moment, so as to not duplicate the savings assumed on the First to Follow Up QIPP.

Quality, Innovation, Productivity and Prevention		NHS North Yorkshire and York	
Name of Initiative	Long Term Conditions (VoYCC2)	High level description of Initiative	Providing a health system where people receive care and support in the least dependent setting (based on the levels of care system theory) enabling them to reach their optimum level of health.
Lead Director	Rachel Potts	Link to National Workstream	Delete as appropriate: ***Commissioning & Pathways*** Long Term Conditions ***Provider Efficiency*** Clinical Support Rationalisation
Overall description/scope		**Resource management**	
Description: The focus of this scheme is to utilise the Levels of Care theory with particular relevance to those people with long term conditions. We specifically expect to implement a method of risk stratification within each GP practice, embed Levels 3 (intermediate care – facility based) and 4 (intermediate care - home based) in the community via Neighbourhood Care Teams and an integrated approach to a single point of co-ordination. We also aim to optimise people's level of health through encouraging self management of their conditions, aided by embedding the use of technology where there is sufficient evidence to support its use in the community. **Expected outcomes/benefits to patient & commissioner** ➢ Improved access to services. ➢ Increased number of people remaining in their own home and maintaining their independence ➢ Improved service user and carer experience, satisfaction and quality of life ➢ Reduction in admissions to acute settings ➢ Reduction in length of stay in acute settings ➢ Reduction in current levels of acute bed base.		**All financial assumptions based on 2010/11 prices** **Contract baseline**.£34,479,300 (12/13 estimate based on 11/12 actual) **Potential savings from the initiative**: £2,306,000 cumulative **Project team members** Dr Tim Hughes, Andrew Bucklee, Kirsty Kitching, Janna Bridgeman **Resource End Product** See description	

Programme management

- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach.
- Delivery will take place at locality level where possible and county wide where necessary.
- All QIPP activities will be monitored centrally in the PCT through an approach that will monitor, for each QIPP activity:
    1. Potential savings
    2. The savings trajectory and timeline
    3. Actual savings
    4. Activity levels
    5. Contracting changes and/or notifications
    6. Progress towards project outcomes

Lead managers will be accountable for achievement of savings.

- Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.

Timescales and Milestones

Milestones

Description of milestone	Milestone date
Neighbourhood Care Team specification first draft completed	Jan 2012
Early implementer (phase 1) sites for NCTs agreed	Jan 2012
Agree reduction in non-elective threshold baseline	March 2012
Practices trained in use of risk stratification tool	April 2012
Neighbourhood Care Team specification agreed with partners	June 2012
Neighbourhood Care Team specification requirements embedded into YHFT Service Improvement Plan	June 2012
Remaining NCT practice clusters agreed	July 2012
Initiate roll out of Early Implementer Neighbourhood Care Teams	July 2012
NCT (early implementers) commence training/development programme	Aug 2012
NCT (early implementers) commence MDT process for risk profiled patients	Aug 2012
Commence first draft of specification for Single Point of Co-ordination drafted with local authority partners	Sept 2012
NCT (early Implementers) share learning with Phase 2 NCTs	Sept 2012
Consider and agree revisions to existing Diabetes care pathways (Type I & II)	Sept 2012
Consider and agree revisions to existing COPD care pathway	Sept 2012
Initiate roll out of phase 2 of Neighbourhood Care Teams	Oct 2012
NCT (Phase 2) commence training/development programme	Nov2012
NCT (Phase 2) commence MDT process for risk profiled patients	Nov 2012
Agree amendments to existing specification for Diabetes	Nov 2012
Agree amendments to existing specification for COPD	Nov 2012
Phase 1 & Phase 2 NCTs to share learning with Phase 3 NCTs	Dec 2012
Agree contract changes (if required) to existing Diabetes service	Dec 2012
Agree contract changes (if required) to existing COPD service	Dec 2012
Single Point of Co-ordination specification agreed	Jan 2013
Initiate roll out of remaining Neighbourhood Care Teams (Phase 3)	Jan 2013
NCT (Phase 3) commence training/development programme	Feb 2013
NCT (Phase 3) commence MDT process for risk profiled patients	Feb 2013

	Implement changes to existing Diabetes & COPD service in accordance with care pathway changes	March 2013
	Single Point of Co-ordination implemented	April 2013
	Evaluate changes to Diabetes care pathways (Type I & II) and consider revisions as necessary	Sept 2013
	Evaluate changes to COPD care pathway and consider revisions as necessary	Sept 2013

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Lack of support from acute sector, community services and local authorities re neighbourhood care and neighbourhood care teams	• Maintaining a partnership approach throughout the whole development and implement stages	Ongoing
New pathways does not enable improvements in patient flows, therefore not reducing the cost base	• Iterative approach to the cost based modelling	Ongoing
GP practices not engaged in the implementation of telehealth/smoking cessation	• Escalate to the VoYCCG Board for recommendations for remedial action	Ongoing
Unable to reach agreement for the reduction of the non-elective threshold baseline	• Escalate to the VoYCCG Board for recommendations for remedial action. • Escalate to the SME for recommendations for remedial action.	Ongoing
Lack of management capacity to implement milestones within agreed timescales	• Escalate to the VoYCCG Board for recommendations for remedial action	Ongoing
Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
Hospital providers (acute and community) are key partners in ensuring a whole systems approach	Monthly meetings of the TCS Board	Meetings, reports
Local Authorities (NYCC/CYC) are key partners in the design and implementation of this integrated approach	Monthly meetings of Adult Commissioning Group. Regular meetings with key personnel engaged with the process	Meetings, reports
GP Practice are key supporters of the new approach	Monthly meetings of VoYCCG GP Forum. Meeting with practice personnel as and when required	Meetings, reports
Patients and public need to be assured that the future model will meet their health and social care needs.	As required	Local media, websites, VoYCCG Patient/Public Congress

£'000	FY12/13	FY13/14	FY14/15	FY15/16	Total
Expenditure	0	0	0	0	0
Saving	1,162	1,144	0	0	2,306
Total net savings	**1,162**	**1,144**	**0**	**0**	**2,306**

Quality, Innovation, Productivity and Prevention		NHS North Yorkshire and York	
Name of Initiative	Urgent Care (VoYCC4)	High level description of Initiative	Modifying a number of elements within the urgent care pathway.
Lead Director	Rachel Potts	Link to National Workstream	Delete as appropriate: ***Commissioning & Pathways*** Urgent Care

Overall description/scope	**Resource management**
Description: Our first initiative is as a direct consequence of work carried out during 2011/12 by Vale of York Clinical Commissioning Group clinicians. The focus is to initialise clinician to clinician discussions about revising the existing adult and paediatric assessment process and care pathways associated with ambulatory care, falls and catheterisation. It will also include the elements within the previous QIPP initiative for the integrated unscheduled care service. **Expected outcomes/benefits to patient & commissioner** ➢ All patients who access the service will receive a clinical response and outcome that is appropriate to their clinical needs. ➢ Patients will feel fully informed of the outcome of their clinical assessment and treatment plan and where clinically appropriate will receive advice on self care. ➢ Improve integration with Out-of-Hours. ➢ Safer and more efficient care and treatment. ➢ Fewer inappropriate ED attendances. ➢ Patients are streamed to the appropriate service for their health need. ➢ Reduce ED re-attendances and re-admissions. ➢ Reduce length of stay. ➢ Shorter waiting times. ➢ Improve throughput. ➢ Patients are treated with dignity and respect.	**All financial assumptions based on 2010/11 prices** **Contract baseline** : £6,280,000 **Potential savings from the initiative** : £100,000 (cumulative savings) **Project team members** Dr David Hayward, Stacey Ransome, Kirsty Kitching **Resource End Product** To initialise clinician to clinician discussions about revising the existing adult and paediatric assessment process and care pathways associated with ambulatory care, falls and catheterisation Ensuring that the wishes of residents within Nursing Homes are sought and recorded and with consent shared with the right people to ensure that those expressed wishes are realised. A consequence of this is an expected reduction in non-elective admissions.

- Improve patient experience and satisfaction..
- Improved competencies between primary care and secondary care practitioners and create a more integrated workforce.

A further initiative will be to work with Nursing Care homes to ensure a consistent approach to the quality of the care that residents receive. Vale of York CCG will analyse what its contribution to this system issue is and then work through a partnership approach with the Nursing Care Home providers

Programme management

- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach.
- Delivery will take place at locality level where possible and county wide where necessary.
- All QIPP activities will be monitored centrally in the PCT through an approach that will monitor, for each QIPP activity:
    1. Potential savings
    2. The savings trajectory and timeline
    3. Actual savings
    4. Activity levels
    5. Progress towards project outcomes

Lead managers will be accountable for achievement of savings.

- Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.

Timescales and Milestones

Milestones

Description of milestone	Milestone date
Analyse Nursing Home non-elective admission data	June 2012
With partners develop templates for Advance Care Plans (ACPs), End of Life Plans(EoLCPs) and Emergency Care Plans(ECPs)	Aug 2012
Agree reduction in non-elective threshold baseline	Aug 2012
Consider and agree revisions to Cellulitis care pathway (Ambulatory Care)	Aug 2012
Consider and agree revisions to Falls care pathway	Sept 2012
Review existing contractual processes for adult and paediatric assessment	Sept 2012
Agree revisions to existing contract for adult and paediatric assessment	Oct 2012
Consider and agree revisions to Catheterisation care pathway	Oct 2012
Develop and agree new specification for Cellulitis care pathway	Oct 2012
Visit Nursing care Homes with most non-elective admissions, promoting use of ACPs, EoLCPs and ECPs. In addition also promote use of flu jabs. Also promote use of SBAR referral form.	Oct 2012
Agree contract variations required to implement Cellulitis care pathway	Nov 2012
Develop and agree new specification for Falls care pathway	Dec 2012
Evaluate changes to adult and paediatric assessment and consider revisions as necessary	Jan 2012
Agree contract variations required to implement Falls care pathway (YAS)	Dec 2012
Develop and agree new specification for Catheterisation care pathway	Jan 2013
Agree contract variations required to implement Catherisation care pathway	Feb 2013
Implement agreed changes to Cellulitis service	Apr 2013
Implement agreed changes to Falls service	Apr2013
Analyse non-elective admissions from Nursing Homes and evaluate success	Apr 2013

	of VoYCCG initiative and consider revisions to approach as necessary.	
	Implement agreed changes to Catheterisation service	June 2013
	Evaluate changes Cellulitis care pathway and consider revisions as necessary	Sept 2013
	Evaluate changes Falls care pathway and consider revisions as necessary	Sept 2013
	Evaluate changes Catheterisation care pathway and consider revisions as necessary	Nov 2013

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Lack of support from acute sector colleagues.	• Maintaining a partnership approach throughout the whole development and implement stages. • Escalate to VoYCCG Board/ NY Review Board	Ongoing
New pathways do not enable improvements in patient flows, therefore not reducing the cost base	• Build in evaluation process and allow for remedial actions to be undertaken	Ongoing
Unable to reach agreement for the reduction of the non-elective threshold baseline	• Escalate to the VoYCCG Board for recommendations for remedial action. • Escalate to the SME for recommendations for remedial action.	Ongoing
Lack of management capacity to implement milestones within agreed timescales	• Escalate to the VoYCCG Board for recommendations for remedial action	Ongoing
Lack of clinical leadership capacity to move the various projects within this scheme forward.	• Escalate to VoYCCG for recommendations for remedial action	Ongoing

Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
York Hospital as the main provider are a key partner in ensuring a partnership approach	Monthly meetings of the CMB performance/quality sub-group	Meetings, reports
GP Practice are key supporters of the new approach	Monthly meetings of VoYCCG GP Forum.	Meetings, reports
Patients and public need to be assured that the future care pathways will meet their needs.	As required	Local media, websites, VoYCCG Patient/Public Congress

£'000	**FY12/13**	**FY13/14**	**FY14/15**	**FY15/16**	**Total**
Expenditure	97.0	0	0	0	97.0
Saving	197.0	0	0	0	197.0
Total net savings	**100.0**	**0**	**0**	**0**	**100.0**

Quality, Innovation, Productivity and Prevention		NHS North Yorkshire and York	
Name of Initiative	MSK Development	High level description of Initiative	Clinical Assessment, Triage and Treatment Service within a community setting covering the Orthopaedic and musculoskeletal needs of the York and Selby Locality.
Lead Director	Rachel Potts,	Link to National Workstream	Delete as appropriate: ***Commissioning & Pathways*** Planned Care
Overall description/scope		**Resource management**	
An expansion to the existing community based Orthopaedic/MSK service across the York and Selby locality, to include Pain Management and Rheumatology. The overarching objective will be to meet the needs of all patients with musculoskeletal symptoms and allow GP's clear access to a more efficient and effective care pathway. It will also embrace the principle of innovation in healthcare delivery, whilst maintaining robust clinical governance and risk management strategies. This will be underpinned by robust financial plans. **Expected outcomes/benefits to patient & commissioner** ➢ Transfer activity from acute hospital setting to the community ➢ Improve the clinical pathway by developing joint working between primary and secondary care providers and clinicians ➢ Reduce health inequalities by improving access to the service ➢ Improvement in patient and referrer experience ➢ Help to reduce long term disability ➢ Achievement of 18 week targets for all referrals relevant to the service: o Achieve maximum of 4 weeks from GP referral to assessment and commencement of treatment.		**All financial assumptions based on 2010/11 prices** **Contract baseline**.£ 2,926,676 (YFT only costs shown elsewhere) **Potential savings from the initiative** £1,828,800 (cumulative) **Project team members** • Andrew Bucklee • Kirsty Kitching • Dr Shaun O'Connell **Resource End Product** To further enhance the existing community MSK service to encompass service elements of Pain Management and Rheumatology	

Programme management	Timescales and Milestones
- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach. - Delivery will take place at locality level where possible and county wide where necessary. - All QIPP activities will be monitored centrally in the PCT through an approach that will monitor, for each QIPP activity: 1. Potential savings 2. The savings trajectory and timeline 3. Actual savings 4. Activity levels 5. Contracting changes and/or notifications 6. Progress towards project outcomes Lead managers will be accountable for achievement of savings. • Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.	**Milestones** Description of milestone / Milestone date Review use of Informed Decision Making Tools within MSK service, make recommendations and consider revisions to contract as necessary. — Feb 2012 Annual review of MSK service provision and consider revisions as necessary. — Sept 2012 Consider and agree revisions to existing Pain Management care pathway — Oct 2012 Consider and agree revisions to Rheumatology care pathway — Dec 2012 Agree amendments to existing service specification for Pain Management — Dec 2012 Agree amendments to existing service specification for Rheumatology — Feb 2013 Implement changes to existing Pain Management service in accordance with changes to existing care pathway — Mar 2013 Implement changes to existing Rheumatology service in accordance with changes to existing care pathway — May 2013 Evaluate changes made to the Pain Management care pathway and consider revisions as necessary. — Sept 2013 Evaluate changes made to the Rheumatology care pathway and consider revisions as necessary. — Nov 2013

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Previously unmet demand	GP education / awareness Implementing and monitoring compliance with PCT thresholds Negotiate risk management arrangements above threshold levels	ongoing
Assumptions based on national evidence not realised	Implementing and monitoring compliance with PCT thresholds Clinical audit to measure appropriateness of onward referrals	ongoing

Increased demand affecting delivery of 18 weeks	Tolerances included within contract around demand (capacity review)	ongoing

Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
York Hospital as the main provider are a key partner in ensuring a partnership approach	Monthly meetings of the CMB performance/quality sub-group	Meetings, reports
GP Practice are key supporters of the new approach	Monthly meetings of VoYCCG GP Forum.	Meetings, reports
Patients and public need to be assured that the future care pathways will meet their needs.	As required	Local media, websites, VoYCCG Patient/Public Congress

+

£'000	FY12/13	FY13/14	FY14/15	FY15/16	Total
Expenditure	**0**	**0**	**0**	**0**	**0**
Saving	**1,738.7**	**90.1**	**0**	**0**	**1,828.8**
Total net savings	**1,738.7**	**90.1**	**0**	**0**	**1,828.8**

Note 1 – This has been calculated based on the full year cost of the service, less the part year cost already assumed in the financial plan. Also included is the part year cost assumption for the expansion for Pain Management or Rheumatology.

Note 2 – The savings are assumed as the full year effect less the part year assumed in the forecast outturn. The expansion into Rheumatology and Pain Management is calculated with a start date of 1st July 2012.

Note 3 – all calculations are based on 11/12 prices.

Quality, Innovation, Productivity and Prevention

NHS North Yorkshire and York

Name of Initiative	Effective use of Contract / VFM (VoYCC6)	High level description of Initiative	Effective use of contract to ensure value for money within existing resources.
Lead Director	Rachel Potts	Link to National Workstream	Delete as appropriate: ***Provider Efficiency*** Back office Efficiency and Optimal Management / Procurement / Clinical Support Rationalisation / Supporting Staff Productivity / Medicines Use and Procurement

Overall description/scope

Using the contract mechanisms available, the following areas will be targeted to ensure VFM and improve clinical quality within the local health community:

1) Outpatient First : Follow Up Attendances
Work towards achieving national best practice first to follow up rates of 1.89 over 4 years with York Hospitals NHS Foundation Trust.

	2012/13	2013/14	2014/15
Ratios	2.10	2.00	1.90
Saving	£820,853k	£818,984	£819,076k

Use national benchmarking data to work with Provider to target specialties which are above best practice, but manage as a capped ratio for total follow up to enable operational flexibilities.

2) Consultant to Consultant Referrals
To ensure that only appropriate consultant to consultant referrals are made, York FT will be given a target to deliver consultant to consultant proportions back to the 09/10 outturn position.

Of the total outpatient activity seen at York FT 21% is generated by a consultant to consultant referral.

£118,253 saving in 12/13

Resource management

All financial assumptions based on 2010/11 prices

Contract baseline.£20,437,246

Potential savings from the initiative

	2012/13	**2013/14**	**2014/15**
Outpatient First to Follow Ratios	£820.8k	£819K	£819.1
Consultant to Consultant Referrals	£118.3k	0	0
Total	£939.1	£819k	£819.1k

Project team members

- Kirsty Kitching
- Kathryn Brewin
- Angie Richards
- GP Lead

3) Agree different tariffs for treatment for ARMD
- OP Procedures for treatment rather than local tariff
- Discussions around assessment tariffs year 2

Identify how you are going to measure improvement / delivery:

The performance management arrangements are as follows :

1) Outpatient First : Follow Up Attendances

The capped ratio would be included within Schedule 3 part 4A of the contract and would be monitored via the Finance and Activity sub group. A financial adjustment would be made at reconciliation where appropriate to bring the provider back in line with the target.

2) Consultant to Consultant Referrals

The proportionate level of referrals would be included within Schedule 3 part 4A of the contract and would be monitored via the Finance and Activity sub group. A financial adjustment would be made at reconciliation where appropriate to bring the provider back in line with the target.

3) ARMD

Tariffs agreed in the contract

Expected outcomes/benefits to patient & commissioner

- Improved value for money
- A reduction in the number of follow-ups across all levels of care

Resource End Product

See description

Programme management

- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach.
- Delivery will take place at locality level where possible and county wide where necessary.
- All QIPP activities will be monitored centrally in the PGT through an approach that will monitor, for each QIPP activity:
    1. Potential savings
    2. The savings trajectory and timeline
    3. Actual savings
    4. Activity levels
    5. Contracting changes and/or notifications
    6. Progress towards project outcomes

Timescales and Milestones

Milestones

Description of milestone	Milestone date
Agree ratios and consultant to consultant proportions	15th March 2012
Agree tariff arrangements for ARMD	15th March
Sign Contract	16st March 2012
April Freeze data to assess full month final impact	June 2012
Quarter 1 to assess impact on estimate against target	Sept 2011
Discuss options around tariffs for assessments	December 2012

Lead managers will be accountable for achievement of savings. • Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.	

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Failure to agree KPI's and changes to pathway	• Early discussions and negotiations. Identify Provider benefits and savings to incentivise movement to new model	31/03/12
OP Follow ups discharged from hospital and referred incurring OP First Attendance (additional cost)	• Identify practices and escalate to GPCC board	Sept 2012
OP Follow ups discharged from hospital, resulting in additional primary care workload	• GPCC leadership and direction	April 2012
	•	

Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
Contract Management Board	Monthly - Ongoing	Meeting
Finance and Activity Sub Group	Monthly	Meeting
Performance and Quality Sub Group	Monthly	Meeting
Locality Team	Monthly	Meeting
SME	Fortnightly - ongoing	Meeting / Report

£'000	FY12/13	FY13/14	FY14/15	FY15/16	Total
Expenditure				**0**	**0**
Saving	**2,135**	**819**	**819**	**0**	**0**
Total net savings	**2,135**	**819**	**819**	**0**	**0**

Quality, Innovation, Productivity and Prevention		NHS North Yorkshire and York	
Name of Initiative	Lucentis to Avastin for ARMD (VoYCC7)	High level description of Initiative	Transfer of Lucentis to Avastin.
Lead Director	Rachel Potts	Link to National Workstream	Delete as appropriate: ***Commissioning & Pathways*** Elective care

Overall description/scope	**Resource management**
Description: This initiative is to oversee the transfer from Lucentis to Avastin for the treatment of Age Related Macular Degenerative Conditions. **Expected outcomes/benefits to patient & commissioner** ➢ Improved value for money	**All financial assumptions based on 2010/11 prices** **Contract baseline**. £4,187,232 **Potential savings from the initiative**: £1,488,000 (cumulative) **Project team members** Dr Mark Hayes Rachel Potts Kirsty Kitching **Resource End Product** See description

Programme management	**Timescales and Milestones**
- Delivery of all QIPP opportunities and enabling projects will be monitored through our corporate programme management approach. - Delivery will take place at locality level where possible and county wide where necessary. - All QIPP activities will be monitored centrally in the PCT through an approach that will monitor, for each QIPP activity: 1. Potential savings	**Milestones** Description of milestone — Milestone date Include discussions to transfer in contracts — March 2012 Agree governance / risk process — June 2012

2. The savings trajectory and timeline 3. Actual savings 4. Activity levels 5. Progress towards project outcomes Lead managers will be accountable for achievement of savings. • Whole health economy activities (as agreed by the SME) will also be monitored on a monthly basis by the SME.	

Develop communications/engagement plan	June 2012
Implement communications/engagement plan	July 2012
Initiate transfer	August 2012
Complete transfer	Ongoing
Evaluate use of Avastin	December 2012

Risks		
Risks identified	**Mitigating actions**	**Timescale**
Lack of support from acute sector colleagues.	• Maintaining a partnership approach throughout the whole development and implement stages. • Escalate to VoYCCG Board/ NY Review Board	Ongoing
New pathways do not enable improvements in patient flows, therefore not reducing the cost base	• Build in evaluation process and allow for remedial actions to be undertaken	Ongoing
Unable to reach agreement for the reduction of the non-elective threshold baseline	• Escalate to the VoYCCG Board for recommendations for remedial action. • Escalate to the SME for recommendations for remedial action.	Ongoing
Lack of management capacity to implement milestones within agreed timescales	• Escalate to the VoYCCG Board for recommendations for remedial action	Ongoing
Lack of clinical leadership capacity to move the various projects within this scheme forward.	• Escalate to VoYCCG for recommendations for remedial action	Ongoing
Stakeholder engagement		
Stakeholder group and purpose	**Start date and frequency**	**Method of engagement**
York Hospital as the main provider are a key partner in ensuring a partnership approach	Monthly meetings of the CMB performance/quality sub-group	Meetings, reports
GP Practice are key supporters of the new approach	Monthly meetings of VoYCCG GP Forum.	Meetings, reports
Patients and public need to be assured that the future care pathways will meet their needs.	As required	Local media, websites, VoYCCG Patient/Public Congress

£'000	**FY12/13**	**FY13/14**	**FY14/15**	**FY15/16**	**Total**
Expenditure	0	0	0	0	0
Saving	1,488	1,488	0	0	1,488
Total net savings	**£1,488**	**£1,488**	**0**	**0**	**1,488**