Notice of a public meeting of

Health and Adult Social Care Policy and Scrutiny Committee

To: Councillors Doughty (Chair), Cullwick (Vice-Chair), Derbyshire, S Barnes, Craghill and Richardson

Date: Wednesday, 29 March 2017

Time: 5.30 pm

Venue: The George Hudson Board Room - 1st Floor West Offices (F045)

A G E N D A

1. Declarations of Interest (Pages 1 - 2)
At this point in the meeting, Members are asked to declare:

- any personal interests not included on the Register of Interests
- any prejudicial interests or
- any disclosable pecuniary interests

which they may have in respect of business on this agenda.

2. Minutes (Pages 3 - 10)
To approve and sign the minutes of the last meeting of the Committee held on 27 February 2017.

3. Public Participation
At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **5:00 pm** on **Tuesday 28 March 2017.**

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4. **Bootham Park Hospital: Update of Action Plans following NHS England Review** (Pages 11 - 30)
This report provides the Committee with an update of the action plans of partner organisations following the NHS England Reflections, Learning and Assurance Report into the Transfer of Services between Leeds & York Partnership NHS Foundation Trust and Tees, Esk & Wear NHS Foundation Trust following the closure of Bootham Park Hospital.

5. **Vale of York Clinical Commissioning Group Operational Plan 2017-19 and Medium Term Financial Strategy** (Pages 31 - 202)
This report introduces two Vale of York Clinical Commissioning Group reports requested by the Health & Adult Social Care Policy & Scrutiny Committee at their 30 January 2017 meeting – the Operational Plan 2017-19 and the Medium Term Financial Strategy.

6. **Public Health Services Commissioned by NHS England - Vaccinations, Immunisations and Screening** (Pages 203 - 212)
This report focuses specifically on the screening, vaccination and immunisation responsibilities of the local authority and does not cover the other elements of Health Protection which were presented to the Health and Wellbeing Board in November 2016.

7. Council Motion - Access to NHS Services (Pages 213 - 242)
This report responds to the motion on Access to NHS Services which was passed at the Council meeting on 15 December 2016. It also updates the Committee on subsequent discussions with the Vale of York Clinical Commissioning Group.

8. Public Health Grant Spending Draft Final Report
(Pages 243 - 288)
This report provides the Committee with all the information gathered in support of the scrutiny review into Public Health Grant Spending, together with a review analysis and draft recommendations.

9. Work Plan 2016/17 (Pages 289 - 292)
Members are asked to consider the Committee's work plan for the municipal year.

10. Urgent Business
Any other business which the Chair considers urgent.

Democracy Officer:

Name- Judith Betts
Telephone – 01904 551078
E-mail- judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

This information can be provided in your own language.

我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja może być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almanız mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

☎ **(01904) 551550**

Agenda Item 1

Health and Adult Social Care Policy and Scrutiny Committee

Agenda item 1: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor S Barnes	Works for Leeds North Clinical Commissioning Group
Councillor Craghill	Member of Health and Wellbeing Board
Councillor Doughty	Member of York NHS Foundation Teaching Trust.
Councillor Richardson	Niece is a district nurse. Ongoing treatment at York Pain clinic and ongoing treatment for knee operation.

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City of York Council	Committee Minutes
Meeting	Health and Adult Social Care Policy and Scrutiny Committee
Date	27 February 2017
Present	Councillors Doughty (Chair), S Barnes, Craghill and Richardson (except Minute Items 58-60)
Apologies	Councillor Derbyshire

58. Declarations of Interest

Members were asked to declare, at this point in the meeting, any personal interests, not included on the Register of Interests, or any prejudicial or disclosable pecuniary interests that they might have had in respect of business on the agenda. None were declared.

59. Minutes

Resolved: That the minutes of the Health and Adult Social Care Policy and Scrutiny Committee held on 30 January 2017 be approved and then signed by the Chair as a correct record.

60. Public Participation

It was reported that there had been three registered speakers under the Council's Public Participation Scheme.

Sue Snelgrove from Mental Health Action York spoke in regards to Agenda Item 6 (Developing a new mental health hospital for the Vale of York) about the reduction in specialist mental health facilities in the city. She commented on how the Vale of York used to have 8 units and 121 inpatient beds for elderly people. With the redevelopment of the Peppermill Court, which specialised in treating challenging behaviours in men, she wondered where the service users who previously had used these facilities had ended up. She felt that the proposed service could not replace skilled medical care.

Two speakers spoke in regards to Agenda Item 7 (Update Report on Implementation of Recommendations from Bootham Park Hospital Scrutiny Review):

Ann Weerakcoombe, also represented Mental Health Action York and informed Members of the group's concerns over the closure of Bootham Park Hospital. The main concerns related to the movement of service users away from York, which they felt increased distress and risk, why the repairs were not carried out.They also felt that the CQC's written response to the Committee was lacking in responsibility.

Joanne Lazenby was concerned that the closure of Bootham Park Hospital suggested that profits were being put before patients, while querying the land value of Bootham Park Hospital itself.

61. 2016/17 Third Quarter Finance & Performance Monitoring Report - Health & Adult Social Care

Members received a report which analysed the latest performance for 2016/17 and forecasted the financial outturn position by reference to the service plans and budgets for the relevant services falling under the responsibility of the Corporate Director of Health, Housing & Adult Social Care and the Director of Public Health.

The Finance Manager, Adults, Children and Education and the Assistant Director Adult Social Care presented the report and were in attendance to answer Members' questions.

Members were informed that the Care Act Reserve had been created by underspends from previous years and had been built up over four years. This money had now gone into the Adult Social Care grant. The largest spend in the Adult Social Care grant was the Assessment Care Management team.

Questions from Members to Officers related to;

- Why the Better Care Fund was not included in projections.
- The pilot to speed up Delayed Discharges
- Which vacancies were held prior to the public health restructure?
- The suitability of a zero tolerance approach to suicide as an STP approach

It was reported that the BCF was not included in the projections as budget discussions were continuing with the Clinical Commissioning Group (CCG).

CCG data on schemes would be included within CYC's data. Members expressed concern that the public would not know who was funding what scheme.

Work to speed up discharges took place with York Hospital and focused on an acute pathway. This allowed for a 32% reduction in discharges. However, there still remained issues in delayed transfers from mental health facilities.

The posts that had been held vacant in Public Health were an Assistant Director and a Suicide Prevention post. Work was underway to arrange a tariff cost for Out of Area treatment with Yorkshire and Humber.

The Director of Public Health commented that through the Suicide Safer City status and the Suicide Surveillance Group, relatives could be supported and lessons learnt. There was an intention to develop a Suicide Prevention Strategy for the city and this would be put on the Council's Forward Plan.

The Chair thanked the Finance Manager, Adults, Children and Education and the Assistant Director Adult Social Care.

Resolved: That the report be received and noted.

Reason: To update the Committee on the latest financial and performance position for 2016/17.

62. Yorkshire Ambulance Service Inspection Cover Report

Members received a report and Powerpoint Presentation which provided them with details of the Care Quality Commission's (CQC) findings following its inspection of the Yorkshire Ambulance Service NHS Trust (YAS).

The Chair congratulated YAS on their good inspection and improvement that had been made since the last CQC inspection.

Karen Warner, Deputy Director of Quality and Nursing and Mark Inman, Locality Director, Emergency Operations were in attendance to introduce the report and answer any questions.

One Member asked what York could improve on in regards to other areas of the Yorkshire Ambulance area.

Improvement was needed in the better use of volunteers, and the opportunity to work together across the area. In addition, ongoing work with hospitals to send urgent care practitioners out to homes instead of sending patients to Accident &Emergency departments.

The Director of Public Health requested that YAS share information on falls prevention and alcohol with the Health and Wellbeing Board for further discussion. They confirmed that they would discuss this with the Scrutiny Officer, or attend themselves.

In regards to the role played by CYC in delivering and developing volunteers for YAS, it was reported that they could encourage people to become first responders or help with Patient Transport and help train, give kit or fit defibrillators.

The Chair thanked the YAS representatives for their attendance.

Resolved: (i) That the information provided in the annexes to the report be noted.

(ii) That the Trust be congratulated on the work it has been undertaken to raise its rating from Requires Improvement to Good.

(iii) That the Trust be encouraged to sustain the improvements that have been made.

Reason: (i) To keep the Committee up to date with the work of the Trust.

(ii) To recognise the improvements made by YAS.

(iii) To ensure residents of York and the wider Yorkshire region receive the best possible emergency and healthcare services.

63. Developing a new mental health hospital for the Vale of York: Public Consultation Outcome Report

Members received a report which included information from the formal public consultation into the creation of a new mental health hospital for the Vale of York.

In attendance to present the report and answer Members' questions were Ruth Hill, Director of Operations for York and Selby, Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) Martin Dale, Project Manager, (TEWV) and Elaine Wyllie, Interim Executive Director of Joint Commissioning, Vale of York Clinical Commissioning Group (CCG).

Members were informed that the new mental health hospital would also be the central point for a Section 136 assessment suite and a base for an adults crisis home liaison team.

It was reported that during the consultation for the new mental health hospital the main concern raised had been the number of beds, particularly with an ageing population, and if community services were robust enough to cope with a proposed reduction in beds.

It was noted that the CCG Governing Body would meet again in March to receive an options appraisal, and in April to receive an update on progression of the business case.

The Chair commented that in his appraisal of the report it appeared there was a favouring of using the Bootham Park Hospital site for the new Mental Health Hospital. He wondered whether the concerns raised by the public speakers in regards to the adequacy of community services following the reduction in bed numbers could be answered.

In regards to the level of current community services, the Director of Operations for York and Selby, Tees, Esk and Wear Valley NHS Foundation Trust informed Members that she was aware that crisis liaison teams were working with patients who would previously need to have been admitted into hospital. Members were informed that TEWV were considering increasing bed numbers and whether the gender mix was correct. Consideration would be given to the optimum size for more beds and more space. In response to a Member's question, it was confirmed that no patients would be treated out of area.

In regards to the building constraints, such as flooding and land costs, TEWV confirmed that this had been discussed with planners. In addition, any solutions would need to be Disability Discrimination Act (DDA) compliant.

Members asked if the weighting criteria, with comments, for each proposed hospital site would be shared with the Committee. It was

confirmed that a business case document would be made available but further details would need to be clarified before being released to Members. It was felt that the hospital should be deliverable.

The Chair thanked Ruth Hill, Martin Dale and Elaine Wyllie for their report.

Resolved: That the report be received and noted.

Reason: So that Members are kept informed on the details of the formal public consultation into the creation of a new mental health hospital for the Vale of York.

64. Update Report on Implementation of Recommendations from the Bootham Park Hospital Scrutiny Review

Members received a report which provided them with an update on the implementation of recommendations from the previously completed scrutiny review into the closure of Bootham Park Hospital (BPH).

The Chair shared his thoughts with the Committee about the lessons that had been learnt following the scrutiny review. He felt that all organisations wanted to blame one another, and avoid responsibility.

The Scrutiny Officer informed the Committee that the action plan which had been produced by NHS England following the Lessons Learnt Review, which had been agreed by all partner organisations involved in the review, would be available to Members at the next Health and Adult Social Care Policy and Scrutiny Committee.

Discussion took place in regards to whether Members should sign off the recommendations as completed or whether they should continue to receive updates.

Some Members questioned the response to the recommendation to NHS England to name the nominated person to be responsible for sustained improvements to mental health in the city as the Accountable Officer from the Vale of York CCG.

Following further discussion it was suggested that Members might wish to request and see sight of the joint working protocol when they received the action plan.

Resolved: (i) That the report be noted and that all recommendations from the Bootham Park Hospital Scrutiny Review that have been fully implemented be signed off as completed.

(ii) That Members have sight of the joint working protocol within the updated action plan.

Reason: To complete this scrutiny review.

65. Work Plan

Consideration was given to the Committee's work plan for the rest of the municipal year.

Discussion took place on the presentation of a strategic overview of mental health services in the city to Members. The Director of Public Health informed the Committee that the Health and Wellbeing Board would appoint a lead to be shared between two named people, Phil Mettam, the Vale of York CCG Accountable Officer, and Martin Farran, CYC's Corporate Director of Health, Housing & Adult Social Care, to take responsibility for mental health needs and that they could report to Members.

Resolved: That the work plan be noted with the following amendments;

- That the Public Health Grant Spending Scrutiny Review Draft Final Report be received at the March meeting.

- NHS England present the updated action plan following the Lessons Learnt Review into the closure of Bootham Park Hospital at the March meeting.

Reason: To ensure that the Committee has a planned programme of work in place.

Councillor P Doughty, Chair
[The meeting started at 5.30 pm and finished at 8.00 pm].

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Health & Adult Social Care Policy & Scrutiny Committee **29 March 2017**

Report of the Assistant Director – Legal & Governance

Bootham Park Hospital: Update of Action Plans following NHS England Review – Cover Report.

Summary

1. This report provides the Health & Adult Social Care Policy & Scrutiny Committee with an update of the action plans of partner organisations following the NHS England Reflections, Learning and Assurance Report into the Transfer of Services between Leeds & York Partnership NHS Foundation Trust and Tees, Esk & Wear NHS Foundation Trust following the closure of Bootham Park Hospital.

Background

2. Bootham Park Hospital was closed following an unannounced inspection of the psychiatric inpatient services by the Care Quality Commission (CQC) in September 2015. The CQC reaffirmed that the service being provided to patients from Bootham Park Hospital (BPH) at this time was not fit for purpose and that all clinical services had to be relocated from 30 September 2015.

3. In November 2015 this Committee agreed to carry out its own review of the BPH closure, working with NHS England, who were carrying out their own lessons learned review.

4. As part of the NHS England review health partners including the Care Quality Commission (CQC), NHS Property Services, Leeds & York Partnership FT, Vale of York Clinical Commissioning Group (CCG), Tees, Esk & Wear Valleys FT and the Partnership Commissioning Unit agreed to develop an action plan around governance arrangements for the management of situations such as Bootham Park Hospital with organisations with responsibility for actions being held to account.

5. In February 2017 the Health & Adult Social Care Policy & Scrutiny Committee considered an update report on the implementation of recommendations from the Bootham Park Hospital Scrutiny Review. While the Committee were happy that several of the recommendations had been fully implemented they agreed not to sign off the report until they had considered the update of the action plans of partner organisations following the NHS England Transfer of Services review.

Consultation

6. No consultation was required in the production of this report. As part of the Bootham Park Hospital Scrutiny Review there was extensive consultation with NHS England who have continued to be involved in consultations with partner organisations. A representative from NHS England will be at the meeting to answer any questions on the report into the updated action plan.

Options

7. Members can:

- Consider the information provided around the update of the action plans and request any further information deemed appropriate;

- Request further updates and the attendance of relevant officers at a future meeting to clarify any outstanding recommendations in the Bootham Park Hospital Scrutiny Review;

- Agree to sign off the outstanding recommendations in the Bootham Park Hospital Scrutiny Review as having been fully implemented and to receive no further updates.

Analysis

8. There is no analysis in this report.

Council Plan

9. This report is linked to the Focus on Frontline Services and A Council That Listens to Residents elements of the Council Plan 2015-2019.

Risks and Implications

10. There are no risks or implications associated with this report. The risks and implications associated with the scrutiny review recommendations were detailed in the Bootham Park Hospital Scrutiny Review Final Report.

Recommendations

11. Members are asked to note the content of this report and its annex and:

    i. Agree what, if any, further information is required;

    ii. Sign off the remaining recommendations of the Bootham Park Scrutiny Review that have been fully implemented.

    Reason: To raise awareness of any recommendations which are still to be fully implemented.

Contact Details

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Report Approved ✓ **Date** 20/03/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Transfer of Services between Leeds York Partnership FT and Tees, Esk and Wear Valleys NHS FT Reflections, Learning and Assurance Report

http://modgov.york.gov.uk/ieListDocuments.aspx?CId=671&MId=9652&Ver=4

Annexes
Annex 1 – Actions Plan Summary
Annex 2 – Update of Action Plan

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ANNEX 1

Transfer of Services between Leeds York Partnership FT and Tees, Esk and Wear Valleys NHS FT: Reflections, Learning and Assurance

Final Report to the Health & Adult Social Care Policy & Scrutiny Committee, City of York Council Meeting 29th March 2017

Summary

A lessons learnt review, following the closure of Bootham Park Hospital, York, was presented to the City of York Council, Health and Adult Social Care Policy and Scrutiny Committee on the 25th April 2016. The review and development and monitoring of the resulting action plan have been led by Margaret Kitching, Chief Nurse, NHS England (North).

All actions are now complete with the exception of the following which are on track to deliver by the end of April:

	Recommendation	Lead organisation	Anticipated completion date
h	Commissioning and procurement processes should recognise the timeframes required for adequate due diligence requirements to be completed around premises and identify any risks around this to mobilisation and delivery.	Vale of York CCG	April 17
l	The roles of both the inspection and registration teams in this process needs to be understood by commissioner and provider organisations.	Vale of York CCG	April 17
	In order to ensure that the lessons are learnt and mistakes are not repeated it is recommended that NHS England take the lead in developing a memorandum of understanding for the sudden closure of hospital facilities on the grounds of serious quality or safety concerns.	NHS England (North)	March 17

Recommendations

Committee members are asked:

- To note that the actions from the lessons learned review are complete with the exception of 3 elements of the plan listed above.

Ruth Holt

Director of Nursing/Independent Care Sector Regional Lead

NHS England (North)

21st March 17

Transfer of Services between Leeds York Partnership FT and Tees, Esk and Wear Valleys NHS FT
Reflections, Learning and Assurance Report

Action Plan Update March 2017

Code:

Complete	
On track	
Delayed but recoverable	
Delayed/not started	

Recommendation	Organisation	Objective	Action	How will this be evidenced	Update March 2017	Lead
Managing safe services in an unsuitable environment						
a) Governance arrangements for the management of action plans such as the Bootham Park Hospital action plan following the CQC review need to include clear reporting arrangements with organisations with responsibility for actions being held to account.	Vale of York CCG	Effective governance arrangements. Completion to time of action plans and resulting outcomes achieved.	The CCG has undertaken an independent external review of the Partnership commissioning Unit (PCU) who are responsible on our behalf, for the assurance of the mental health contract during its lifetime, in order to see if joint commissioning arrangements and the model over 4 CCGs is effective – report awaited. All contracting arrangements now have CCG representation. All new contracts have levers to incentivise quality improvement such as CQUIN. In addition we have undertaken a deep dive into estates provision and have a Strategic Estates Plan agreed with partners following stakeholder engagement	Minutes from contract management meetings. Completion of action plans	PCU external review completed. PCU functions to be shared amongst member CCGs. First phase completed by 31st March and second phase completed by 30th June when Sovereign House will be vacated.	Chief Nurs
b) The regulatory remit and expertise of the CQC do not currently allow the CQC to take part in programme boards where safety issues have been identified and the environment is considered to be potentially unsuitable for care. The CQC should consider whether this should be part of their remit adding to the expert advice that a programme board seeks and utilises. The commissioner, provider and NHSPS should ensure that they have access to the appropriate expertise to ensure that building work meets CQC minimum standards. The CQC may want to consider providing additional assurance to this process.	NHS Property Services Ltd	NHSPS ensures that they have access to the appropriate expertise to ensure that building work meets CQC minimum standards.	Ensure that all consultants appointed are competent in healthcare design and fully aware of CQC compliance issue for relevant premises.	Request details of experience and confirmation that each consultant is competent as part of tender return included in all tender specification	Process in place to ensure contractors have knowledge of both NHS and CQC requirements	Head of Construction Programme Management
	CQC	Consideration of whether CQC should take part in programme boards as part of its regulatory remit, and whether CQC should provide additional assurance to the process of ensuring that building work meets CQC standards.	No further action is required from CQC. As part of our ongoing relationship management between the provider and CQC we may attend programme boards or oversight group meetings as an observer to assess progress and to encourage improvement. However, we would not consider the CQC	Complete		

			relationship owner to be part of formal governance, or to be there to sign off plans or to provide internal assurance. It is essential that CQC remains independent, and is able to make independent regulatory judgements in which both the provider and the public can have confidence. To do otherwise could blur the accountabilities for quality at a local level.			
c) Delays in the critical path for the redevelopment of the buildings (Bootham Park and Cherry Tree House) were caused, in part, by contractor delays. These were identified to the BPH Programme Board. Where building programmes are significantly delayed alternative provision should be considered with a view to maintaining safety.						
d) Contingency or business continuity plans should be written to cover the loss of estate and re-provision of services. LYPFT enacted their business continuity plans following notification by the CQC that all regulated activity must cease at BPH.	NHS Property Services Ltd	NHS PS to support providers when the provider develops their Business continuity plans and provide potential options for other sites and landlord information	Information supporting business continuity planning is provided on request	Guidance issued to NHSPS FM and H&S staff to assist with information and advice	Document written to underpin the development of business continuity plans	Head of Facilities Management and Head of Safety
	York of Vale CCG	Effective and robust business continuity planning	Robust contracting arrangements must include the provider having effective contingency and business continuity plans and to invoke those plans should the need arise. The CCG will ensure the requirement for effective plans are in the service specification for contracts and are part of the contract going forward to hold providers to account.	Evidence in contracts. Minutes from contract management meetings. Escalation procedures.		Chief Finance Officer
			The CCG will ensure it has business continuity plans which cover the failure of provider business continuity plans preferably over a larger geographical area where appropriate.	Business continuity plans.	As part of the developing STP footprint this would be the effective unit of planning to create and consider wider strategic impact of sudden provider failure as part of a strategic EPRR response and will be played into emerging discussions. The CCG is in the process of incorporating provider failure into its business continuity plans	Chief Operating Officer

e) The CQC should consider sharing reports of specialist advisors where the content of those reports may impact on the safety of patients or the public and where this is permitted by the relevant information governance, legislation and codes of practice.	CQC	Consideration of whether CQC should share reports of specialist advisors.	No further action is required from CQC. We do not routinely release individual inputs or pieces of evidence gathered at inspection, as such documentation in isolation would be only a partial representation of the full inspection, and could be misleading. Our policies and internal guidance do allow for the sharing of information (such as specific reports) in certain circumstances where it is considered necessary and proportionate to do so to protect the safety and welfare of patients and the public. Our internal guidance already supports our staff in doing this within the constraints of relevant legislation and best practice.	Complete	Complete	Complete
f) Closing premises and relocating patients can be concerning in its own right – the risks of continuing in premises which are not fit for purpose and closure need to be carefully considered, by all parties, commissioner, provider and the CQC, before a decision to close is made.	NHS Property Services Ltd	NHSPS support active review and clear strategic plans for poor quality premises with health commissioners	NHSPS FM team collates results of 3 facet surveys and highlights to strategy team. NHSPS strategy team highlights properties falling into D or DX[1] in our portfolio. [1] *6 facet survey rating of property, or other similar system of evaluating the quality and suitability of healthcare premises which is in operation from*	List of D & DX properties supplied to Strategy Team NHSPS identify all D and DX properties in strategic estates planning process with CCG and include in SEP documents	All surveys complete and available to strategy teams for review.	Head of Facilities Management

			time to time.			
	CQC	Ensure that CQC fully considers the risks of continuing in unsafe premises against the risks associated with closure.	No further action is required from CQC. It is essential that the balance of risks is taken into account when considering any enforcement action and our published enforcement policy sets out our approach. When CQC takes urgent action to suspend, vary or cancel a registration we make a balanced decision that takes into consideration the vulnerability of the people using the service, the seriousness of the shortcomings and the severity of the risks posed to service users against the risks and benefits that arise as a result of taking urgent enforcement action. We also consider how long it would take the provider to put right the serious risks we have identified, whether they are able to put it right, and whether commissioners are involved in supporting the service. CQC is working with NHS England and others on a shared protocol on unplanned or rapid closures, intended to be used by the relevant statutory bodies in partnership with providers to help them support people using care services when care provision fails or closes unexpectedly. It includes a checklist of actions that each organisation should take in closure situations. The remit for this work is initially for care homes. We will work with partners to ensure that an equivalent protocol is developed for full and partial closures in the hospitals sector, including mental health.	We will publish the protocol on our website when it is complete.	**published Jan 17**	Mike Richards

The safe transfer of services between organisations							
g) The time frames for the transfer of services between organisations should be appropriate to the action which needs to be taken to ensure a safe transfer. This is a recommendation which applies equally to the organisations transferring services and the CCG with responsibility for these services.	York of Vale CCG	Appropriate and robust procurement and mobilisation processes to allow for safe transfer of services.	The CCG abided by procurement guidance by allowing 4-6 months for mobilisation after contract awarded. However given the complexity of the situation the CCG will allow for longer, more flexible timeframes in future procurement as required.	Procurement and mobilisation documentation. Reduction in adverse incidents aligned to procurement and mobilisation	Chief Finance Officer	Only very small procurements have occurred since closure of Bootham not requiring longer or more flexible time frames. Procurement specialist considers requirements and robustness of mobilisation timescales into project plans.	On-going as contracts arise
h) Commissioning and procurement processes should recognise the timeframes required for adequate due diligence requirements to be completed around premises and identify any risks around this to mobilisation and delivery.	NHS Property Services Ltd	Recognise the timeframes required for adequate due diligence requirements to be completed around premises and identify any risks around this to mobilisation and delivery.	Develop a standard set of due diligence questions for procurement processes on estates and property issues	Estates Readiness Checklist developed and made available to CCGs	Director of Asset Management	Dissemination of lessons learnt via NHS England and NHS Clinical Commissioners	30 November 2016
	York of Vale CCG	Appropriate and robust procurement and due diligence processes to allow identification of risk.	A full look back exercise on the procurement will occur within 6 months by the project team in order to ensure full learning for future is captured	Procurement and mobilisation documentation. Reduction in adverse incidents aligned to procurement, mobilisation and delivery	Chief Finance Officer	This was delayed due to an internal audit review of procurements and corporate decision making and then availability of key staff due to annual leave. Changes in structure and governance of CCG – Paper advising of lessons learnt to go to Executive committee in April 2017 and then to Finance and Performance. Copy to be submitted to the CNO (North) In the meantime other procurements (since the MH&LD contract and not of that size and scale) led, on and behalf of the CCG, by the embedded procurement specialist have been progressed with the learning from the MH & LD procurement Partial mitigation due to the retention of the embedded procurement specialist which has informed and advised procurements since 2015.	CFO April 2017
i) As the organisation receiving services it is essential that the new provider ensures that premises are suitable before the services are accepted. Where this is not possible a plan should	Tees, Esk and Wear Valleys NHS Foundation Trust	Tees, Esk and Wear Valleys NHS Foundation Trust have no specific	Tees, Esk and Wear Valleys NHS Foundation Trust have no specific actions to address from this report but will be taking into consideration	This check of premises will form part of the tendering process for any future	Chief Operating Officer	Tees, Esk and Wear Valleys NHS Foundation Trust have reviewed this action and ensured that this will be considered in any future	Complete

be enacted to mitigate risk.		actions to address from this report but will be taking into consideration this recommendation any future work streams.	this recommendation any future work	service acquisitions from other providers.		business developments.	
j) A clear plan needs to be developed to ensure that services are safely maintained in the period leading up to the transfer of services.							
k) The balance of risk to patient safety should be considered when deciding to close services. Time frames should be proportionate to this risk.	CQC	Ensure that CQC fully considers the risk to patient safety when deciding to close services, and works to ensure that time frames are proportionate.	We agree that the balance of risk to patient safety should be considered, and that time-frames should be proportionate to that risk. The closure of an NHS service is a rare occurrence, and the evidential threshold to show that the risk of harm to people necessitates such enforcement action is very high. As noted above, CQC's enforcement policy sets out the considerations we take in coming to a decision on appropriate action. We will work with partners to ensure that a protocol is developed for full and partial closures in the hospitals sector, including mental health.	We will publish the protocol on our website when it is complete	Mike Richards	published Jan 2017	
l) The roles of both the inspection and registration teams in this process needs to be understood by commissioner and provider organisations.	York of Vale CCG	Good understanding of inspection and registration processes and appropriate actions relating to this.	The CCG had a lack of organisational history and experience of awarding contracts where deregistration and reregistration was involved. The CCG will ensure the registration process is well understood by commissioners and procurements managers.	Procurement and mobilisation documentation. Reduction in adverse incidents aligned to procurement, mobilisation and delivery. Evidence in contract management minutes to demonstrate appropriate application of guidance where appropriate by provider and commissioners including any clinical visits	Chief Officers	See item h) above	CFO – April 2017
		Facilitate	We agree that it is essential that	Data from post	Sally Warren, DCI	We have a shared a video about	Improvements will

	CQC	commissioner and provider understanding of the regulatory environment.	commissioners and providers understand the regulatory environment in which they operate. An open and honest dialogue between lead inspectors and providers operating in local areas is important in facilitating this understanding. Where we find unsafe care we will use local relationship management to support providers to improve, using our registration, inspection and if necessary enforcement processes. We are working to improve the robustness, efficiency and effectiveness of registration, as set out in our August 2015 publication A fresh start for registration. This includes what providers can expect from the registration process, how we will make the experience as user-friendly and efficient as possible and what our expectations are of them when they are registered. We are committed to working with our partners to develop further information resources to improve understanding of CQC's role and processes.	registration provider survey	National Functions	registration with the NHS England New Models of Care team.	be made on an ongoing basis, as detailed in our publication, A fresh start for registration.
m) Clear escalation between organisations around dispute resolution between commissioner and provider (mental health and property services) when dispute resolution is required. Initially this should utilise the contractual mechanisms available to commissioners and providers – in this case the lease or contract for services.	Vale of York CCG	Robust contract management and dispute resolution / escalation processes	Escalation to be built in to terms of reference for programme boards	Evidence in terms of reference	Chief Finance Officer	As most of the interim estates solutions are in operation, pending the opening of Peppermill Court, the Estates Programme Board has been dissolved and Estates (including the new mental health facility) will be a standing item on the Contract Management Board agenda. Mental Health Programme Board now dissolved and multi-agency mental health commissioner forum established	September 2016
n) A lead body should be nominated at the outset to take charge of the process of closure (this would normally be the commissioner). The process of varying the registration of the outgoing and incoming trust with the Care Quality Commission where services are transferring						To be included in 1.14	

o) Where concerns regarding safety standards are identified by the CQC the Trust and commissioner must seek the appropriate expertise and professional advice urgently to ensure that premises are refurbished to the required standard.	York of Vale CCG	Appropriate use of expertise to ensure safe service provision	The CCG will ensure, as part of its contracting and procurement arrangements going forward (and Strategic Estates Plan), that processes for seeking expertise are described within. The CCG has since recruited an estates advisor in order to coordinate the estates strategy and liaise with experts to inform the implementation of the Strategic Estates Plan	Evidence in contracts. Minutes from contract management meetings. Escalation procedures.	Chief Finance Officer Chief Nurse	Only very small procurements have occurred since closure of Bootham not requiring input from estates Process established through CCG Estates advisor	Complete June 2016
p) Commissioners and providers need a clear understanding of the time frames for registration and deregistration. These must be considered as part of the plans for the transfer of services between provider organisations.	York of Vale CCG	Good understanding of registration and deregistration processes and appropriate actions relating to this.	The CCG had a lack of organisational history and experience of awarding contracts where deregistration and reregistration was involved. The CCG will ensure the registration process is well understood by commissioners and procurements managers	Procurement and mobilisation documentation. Reduction in adverse incidents aligned to procurement, mobilisation and delivery.	Chief Officers	See item h) above	CFO – April 2017
	CQC	Facilitate commissioner and provider understanding of the timeframes involved in registration applications.	We agree that commissioners and providers should have a clear understanding of the time frames for registration processes. Currently providers are asked to submit their registration applications 10 weeks ahead of service commencement. This information is contained in the application forms available on our website. We are working to improve the information for providers on our website. The actions we have outlined in our response to recommendation (l) above, will help commissioners and providers to be clear about the processes involved, and to factor the likely time frames into their programme plans for service transfers.	Data from post registration provider survey	Sally Warren, DCI National Functions	We have a shared a video about registration with the NHS England NMoC team. if this proves helpful in improving understanding,, we will share further The Registration team (CQC) are awaiting feedback from the NHS England New Models of Care team to ensure it is helpful before any wider dissemination takes place across CCG's	Improvements will be made on an ongoing basis, as detailed in our publication, A fresh start for registration
	Tees, Esk and Wear Valleys NHS Foundation Trust	Tees, Esk and Wear Valleys NHS Foundation Trust have no specific actions to address from this report but will be taking into consideration this recommendation	For any future service acquisitions the compliance team in TEWV will ensure they continue to liaise with CQC in a timely manner to ensure due process is followed.	This cannot be evidenced until such a time as a similar transfer of service process is instigated within the Trust.	Director of Nursing/Director of Quality Governance	Tees, Esk and Wear Valleys NHS Foundation Trust have reviewed this action and ensured that this will be considered in any future business developments.	Complete

		any future work streams.					
q) The CQC should be involved at the earliest possible opportunity when services are being transferred between provider organisations.	CQC	CQC support for this recommendation	We support this recommendation. It is good practice for providers to inform CQC when they are planning transfers or changes in their regulated activities. CQC deals regularly with changes in ownership of services between providers across the health and social care sector, and it is useful for us to be aware as early as possible of any plans. This enables us to ensure that providers have the information on the likely registration processes and timetables, and are aware of the link between our registration processes and our monitoring, inspection and rating of services. We have the right to refuse applications for registration, including adding an additional location, where providers are unable to satisfy us that the regulations will be met.				
r) Where the CQC have significant concerns about the safety of services delivered by provider organisations these should be raised with the commissioning organisation and, if necessary, NHS England.	CQC	Ensure that significant concerns are raised with commissioners and NHS England where appropriate.	CQC already does raise significant concerns about the safety of services with the commissioning organisations. CQC is required to notify a number of third parties of a Notice of Proposal, Notice of Decision, warning notices and urgent procedures for suspension, variation etc. This includes the commissioning organisation and NHS England in some circumstances. We may also inform any other organisations that we consider appropriate, where this assists in protecting people who use services. Following all comprehensive inspections of NHS Trusts we hold a Quality Summit, to develop a high level plan of action and recommendations based on the inspection team's findings. Attendees would normally include representatives from the CCG, NHS	Our template letter will be amended, and the change will be communicated to inspection teams.	Mike Richards	We share information of particular concern with NHS England and NHS Improvement by copying them the letter shortly after inspection. This includes example relating to Staffordshire & Stoke on Trent Partnership, Wye Valley 7 South Warwickshire, EEast, SECAMB, Brighton, Addenbrookes.	October 2016

			England Area Team, and NHS Improvement. Similarly, focussed inspections which raise concerns can trigger a Risk Summit as required. Risk Summits may be convened at any time outside of the inspection programme by any statutory organisation that has concerns about the quality or safety of care being provided. Immediately following all our inspections of Trusts we write to the provider to set out any concerns we may have. In future we will copy the commissioning organisation local to the provider into these letters where appropriate.				
Learning for individual organisations							
1.11 Vale of York CCG Commissioning from unsafe buildings – the provision of services from BPH should have ceased when concerns were first raised by the CQC (if not before) Management of actions plans and holding to account on time frames specifically for LYPFT and NHSPS should have been more robust.	Vale of York CCG	Robust contracting arrangements to ensure arrangements for alternative provision, should serious or significant concerns arise	The CCG sought an alternative to provision once the CQC concerns were known – any suitable alternatives could not occur within a short time frame. The CCG will ensure the requirement for seeking alternative provision, should serious or significant concerns arise, are in the service specification for contracts and are part of the contract going forward to hold providers to account	Evidence in contracts	Chief Finance Officer Chief Nurse	only very small procurements have occurred since closure of Bootham not requiring input from estates or specialist advice Further information in NHS Standard Contract 16/17: https://www.england.nhs.uk/wp-content/uploads/2016/03/nhs-contrct-full-length-1617.pdf. Section 17.10 refers to Termination: Provider Default Section 18 refers to Consequence of Expiry or Termination. The CCG has incorporated provider failure into its business continuity plans include escalation procedures.	
	Vale of York CCG	Robust contract management arrangements and escalation processes in place	Robust contracting arrangements must include the provider having effective contingency and business continuity plans and to invoke those plans should the need arise. The CCG will ensure the requirement for effective plans are in the service specification for contracts and are part of the contract going forward to hold providers to account. In this instance the CCG accepts it	Evidence in contracts. Minutes from contract management meetings. Escalation procedures.	Chief Finance Officer Chief Nurse	Lessons learned report to be produced for CCG SMT in October and shared with CNO (North).	CFO – mid-October 2016. CNO (North) 31/10/2016

			could have escalated issues to CEO NHSPS and NHSE when the position was deteriorating and will ensure escalation processes describe this effectively. The CCG accepts that it could have taken independent specialist advice with regards to grade 1 listed buildings, and will ensure processes are built in to any further procurements. The CCG has since recruited an estates advisor in order to coordinate the Strategic Estates Plan and liaise with experts to inform the implementation of the estates strategy				
1.12 Leeds York Partnership FT Should not have delivered services from unsafe premises – concerns were raised but action should have been taken to move out sooner	Leeds York Partnership FT	To maintain safe and suitable premises at all times.	CQC Fundamental Standards Group – tracking of all CQC compliance issues Clinical Environments Operational Group Escalation procedure in place for all staff	• CQC action plan and tracker • Minutes and action log from CEOG. • Escalation procedure available in all services and via the trust intranet.	Director of Nursing, Professions and Quality	Complete	30 June 2016
			Developing reciprocal decant options with partners organisations as part of our Business Continuity Plan.	• Revised Business Continuity plan	Chief Financial Officer	**Complete** The Trust has developed a series of action cards covering evacuation and internal resettlement following the loss of a ward – which for planning purposes (based on our design of PFI units) is the reasonable worst case scenario we face. These action cards describe the process for evacuating service users following any emergency requiring this and how we would resettle over a period of days into other accommodation within the Trust. **On-going**	30 June 2017

						Work with partners continues to be work in progress as part of the West Yorkshire Mental Health Trust collaborative workstream,	
1.12 Leeds York Partnership FT LYPFT should have been more forceful in taking action in line with their accountabilities as a provider.	Leeds York Partnership FT	To ensure that where patient safety risks are present and their resolution subject to third party decisions, serious risks and concerns are escalated at the earliest opportunity to all relevant parties including commissioners	• Reviewed and clarified the governance arrangements with third party organisations • Ensure any quality actions, including proposals to close or relocate a service are addressed to commissioners through the Quality Review process.	• Revised SLA with NHS Property Services and PFI providers • Minutes and actions from Quality Review meetings	Chief Financial Officer Director of Nursing, Professions and Quality	**complete by 31 March 2017**	31 March2017
1.13 NHS Property Services Robust management of contractors to agreed timeframes. Assurance was given that refurbishments would be delivered to timeframes when this was not the case.	NHS Property Services Ltd	Review of all programmes submitted for work via contractors and evaluation of potential risks including design. Ensure adequate float programme and suitable levels L&D	Standard process for programme and risk review on all schemes including float allowance and review and sign off via principal project manager.	Sign off matrix on all schemes at each stage and prior to issue of programmes to tenants and commissioners	Head of Construction Programme Management	Process for tracking decision points developed. Further workshop 9th Sept	31 Sept 2016
Due diligence is essential before taking the ownership of properties to ensure an understanding of the issues associated with the building.	NHS Property Services Ltd	NHSPS document the due diligence process required prior to acquisition of new sites and agree this with Department of Health	A standard process is in place for due diligence and handover of property where all parties understand associated risks and liabilities.	Due Diligence process agreed	Director of Asset Management	On track	By end March 2017
NHS England In order to ensure that the lessons are learnt and mistakes are not repeated it is recommended that NHS England take the lead in developing a memorandum of understanding for the sudden	NHS England	Safe closure of hospital facilities following serious concerns about quality or safety	MOU to be written by multi-organisational working group (to be established). Membership, governance and reporting arrangements to be	Memorandum of understanding written and agreed by all stakeholders including patient	Ruth Holt, Director of Nursing - NHS England, North	Joint Protocol written, gateway anticipated as April 2017	

closure of hospital facilities on the grounds of serious quality or safety concerns.			confirmed	representatives			

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Health & Adult Social Care Policy & Scrutiny Committee **29 March 2017**

Report of the Assistant Director – Legal & Governance

Vale of York Clinical Commissioning Group Operational Plan 2017-19 and Medium Term Financial Strategy – Cover Report

Summary

1. This report introduces two Vale of York Clinical Commissioning Group reports requested by the Health & Adult Social Care Policy & Scrutiny Committee – the Operational Plan 2017-19 and the Medium Term Financial Strategy.

Background

2. At the 30 January meeting of the Health & Adult Social Care Policy & Scrutiny Committee the Vale of York Clinical Commissioning Group (VoY CCG) Accountable Officer shared information on a range of issues, including the VoY CCG's revised forecast deficit of £28.1 million.

3. However, he was not able to present details of the Operational Plan as the VoY CCG is under legal direction from NHS England and the plan would not be made public until March.

4. The Operational Plan remains unapproved based on the national requirements of NHS England (NHSE), but the regional NHSE team is sufficiently assured to support the presentation in public at this meeting.

5. The plan represents how the CCG will address and deliver improvements in health and wellbeing, care and quality and financial outcomes over the next two years.

Consultation

6. The CCG has engaged widely with all system partners in relation to developing its Operational Plan. Further to confirmation from NHSE on 10th February 2017 the CCG can now present the Operational Plan in

public while it remains unapproved. The CCG is working to develop an Accountable Care System (ACS) with its local partners and the Operational Plan with its four emerging programmes of work and six priorities has provided a framework for the locality groups within this ACS to start prioritising work at a locality level. Members of all our local Health and Wellbeing Boards are on each of these ACS locality delivery groups.

Options

7. Members can consider the information provided in the CCG Operational Plan and Medium Term Financial Strategy and direct any queries or requests for further information to CCG representatives at the meeting.

Analysis

8. This section is not applicable.

Council Plan

9. This report and its annexes are linked to A Focus on Frontline Services element of the Council Plan.

Implications

10. There are no implications attached to the recommendations in this report. As with all CCG plans there is an equality impact assessment and a quality impact assessment on-going which will be finalised to augment the plan when full NHSE approval is given.

Risk Management

11. There are no risks attached to the recommendations in this report. However, the CCG is considering the full risk assessments for each work stream within each Programme for 2017/18 as part of its mobilisation. This will be incorporated into the CCG risk register if/ as required.

Recommendation

12. Members are asked to consider and comment on the Operational Plan and Medium Term Financial Strategy.

    Reason: To continue to inform members of the progress of the CCG Operational Plan and Financial Strategy.

Contact Details

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Assistant Director – Legal & Governance
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Report Approved ✓ **Date** 17/03/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Annexes

Annex 1 – Operational Plan Briefing Note
Annex 2 – Operational Plan 2017-19
Annex 3 – Finance Slides
Annex 4 – Financial Strategy

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ANNEX 1

Vale of York Clinical Commissioning Group

Briefing Note to support presentation of the NHS Vale of York CCG Two Year Operational Plan to the Health & Adult Social Care Policy & Scrutiny Committee on 29 March 2017

Approvals & Engagement

The Operational Plan is shared in full with the Health & Adult Social Care Policy and Scrutiny Committee today to allow further engagement and to clarify how the Committee and CCG can work together to support the development and delivery of the programmes of work required.

The Operational Plan remains unapproved based on the national requirements of NHS England but the regional NHSE team is sufficiently assured to support the presentation in public of the plan at Health Scrutiny. The plan was presented in public at the CCG Governing Body on the 2nd March and endorsed by the Governing Body to move into delivery while awaiting formal approvals.

The CCG recognises the critical importance of engaging with our local population alongside our partners in order for local people to clearly understand the challenges faced in their health and care system and how they can support and shape future service delivery. This will include how we all improve prevention, self-care, education and signposting around the services locally as they transform.

A new approach to planning and commissioning

The CCG is planning as part of the NHS Five Year Forward View and in the context of being one of the most challenged health and care systems in England. The starting point for planning for 2017/18 & 2018/19 is to address the gaps in outcomes (pages 4-5) in the Vale of York system:

- Our health and wellbeing outcomes
- Our care & Quality outcomes
- Our financial gap

The financial gap

The CCG is planning with its partners within the context of a fixed financial allocation through to 2020/21 and a forecast financial deficit of £44.1million in 2017/18 (pages 9-10 and updated finance plan tabled pages 1-4). This allocation is low as the Vale of York population overall has a low level of need and low levels of unmet need based on the national funding allocation formula. We have 11% less than other CCGs on average to spend on our services and currently as a system we spend more on health and care than we can afford.

The system has to live within its means and the CCG and its partners are therefore planning for a different way for our population to access their services and our services to be organised and delivered.

The CCG has identified the areas where the Vale of York system is using and spending too much compared to other populations nationally and comparable systems, including the Right Care analysis of evidence of where our population are not achieving the best possible outcomes for our patients from accessing those services.

This is captured in our Medium Term Financial Strategy (pages 43-48 and updated finance plan tabled page 1-4) and gives a clear indication of where the system needs to explore first to address improving the value for money for every pound of Vale of York in our allocation, and to drive up the health outcomes of those services.

The plan in summary

Based on the context above the plan captures six key priorities which represent the priorities of the system for all our health and care partner organisations (pages 24-25). All of these aim to improve how resilient our system is to delivering accessible services seven days a week for the increasing demand and acuity of need of our population. The focus for us and our partners is on the most frail, vulnerable and complex people locally and how they can best access the right services in the right place.

To deliver service improvement and system change which will address these gaps in outcomes and drive these six shared priorities means the CCG has to plan and prioritise programmes of work in a completely different way. Our role as a CCG is to enable our partners to come together and plan based around place and the population needs, and not as separate organisations.

The plan therefore presents four emerging programmes of work which would drive improvements in local outcomes (page 26). The majority of these programmes need to be joint and collaborative with our partners in order to drive improvements and address our gaps in outcomes.

Moving into delivery

The CCG is now working to develop the specific work streams within these programmes which will start delivering from the 1st April 2017. It is doing this with its local authority, general practice, provider and voluntary sector partners and using the now established Accountable Care System (ACS) in the Vale of York and the three emerging locality delivery groups (North, South and Central) within that ACS to identify joint priorities for service transformation based around the needs and pressures in those localities. These locality delivery groups will all have met twice by the 1st April and the ACS Partnership Board met for the first time on the 1st March.

The detailed work streams to be included in these programmes of work, and the supporting governance, resourcing and approach to risk management will be discussed with NHSE before the 31st March. The CCG would welcome the opportunity to provide regular updates to the Health and Wellbeing Board and Overview & Scrutiny Committee each time it meets on our joint programmes of work in the ACS and CCG and progress with NHSE approval.

The CCG is also developing an Engagement Programme for our joint work with our partners and our local population ('Better Together') and we would also welcome an opportunity to launch and discuss this engagement plan with the Health and Wellbeing Board when it next meets.

A public-facing version of our Operational Plan is being developed to support engagement and will be available in April 2017.

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Operational Plan 2017-19

for the Vale of York locality

Commissioning as part of the Humber, Coast and Vale Sustainability and Transformation Plan

Final Submitted on: 23.12.16

Update on 22/2/17: the CCG Operational Plan 2017/18 -2018/19 remains unapproved by NHSE until after the final submission of finance and activity plans on the 27/2/17, but is available for presentation to public at Health & Wellbeing Boards and CCG Governing Body.

NHS
Vale of York
Clinical Commissioning Group

Foreword

Phil Mettam, Accountable Officer

NHS
Vale of York
Clinical Commissioning Group

Welcome to our Operational Plan. It is an outline of how we propose to improve the Vale of York Health and care system over the next two years.
The CCG is moving to a new phase with collaboration being the underlying principle, transparency and engagement key values.
We look forward to working with partners to help us deliver services that local people deserve whilst recognising the limitations of our fixed financial allocation when compared to the choices and decisions being made by our patients and clinicians.

Organisational Fitness For Purpose

- Our Improvement Plan is the Governing Body response to Directions. It addresses five challenges these are capability, capacity, leadership, governance and the financials.
- We are also delivering our Improvement Plan and transformation programmes within our wider HCV STP system and emerging local Accountable Care System (ACS) and this is pivotal in how we are looking at commissioning for outcomes through new lenses
- We are taking a fundamentally different approach to the deployment of our allocation so it meets population need at a local level
- There is a focus on outcomes and embedding these in frameworks and models for transformation and transacting in a consistent way
- We can only fulfil our ambition for improving health and reducing inequalities if we can optimise the way resources are used

System and Partnership working – we are:

- Unlocking the system and enabling all partners – population and place always taking precedent over organisations
- Galvanising partners to come together as equals and build trusting, respectful and cohesive alliances based on common gain
- Taking our population (they are our patients, our workforce, our carers and their elected members) with us as equal partners
- Developing robust governance structures which support and formalise joint decision-making and accountability for delivery at organisation, local place and system-wide levels
- Doing things once – analysis, planning, making decisions, delivery, contracting
- Making decisions quickly, effectively and using gateways & an emerging governance framework to make sure we stick to them
- Sharing the leadership for delivering
- Understanding the resources, leverage and 'cover' required to truly transform and deliver – from partners, from NHSE and NHSI, from the HCVSTP partners and STP funds and sharing our scarce resource
- Efficiency through streamlining (back office, estates, technology)
- Aligning the local place with the wider system – consistent narrative and one set of programmes and contracts for achieving transformed services

Leadership & Corporate Priorities – we want to be:

- While place supersedes organisation, our CCG needs to be fit for purpose to come out of Legal Directions
- Strong, proactive and focused on delivering improvement at pace and first in the system when we need to go fast
- Strategic and ambitious – while rigorous in delivering performance and transformation day in day out
- Focus on new ways of doing things – CCG to lead in the HCVSTP for priority areas where it will deliver the improvement plan (e.g. development and use of new funding and contracting mechanisms)
- Clinically-led, informed and committed community of members
- Collaborative in all we do and building trust & respect
- Resilient and building resilience in our teams and services

Contents

NHS
Vale of York
Clinical Commissioning Group

Our Triple Aim: addressing our 3 gaps

We need to ensure our patients gain the most benefit from the health care interventions they receive and we support people to take responsibility for their own health – **there needs to be a fundamental shift in the way local people access care**.

Our **financial gap (£24.1m)** provides the framework for targeting our resources in a completely new way to drive improvement in all our outcomes and achieve Value for Money in every York £ spent on care.

Our Triple Aim: addressing our Three Gaps

NHS
Vale of York
Clinical Commissioning Group

GAP 1: Health & Wellbeing Outcomes

- Smoking, alcohol and obesity rates are higher than average – CVD and stroke outcomes are poor
- Cancer is the leading cause of death in U75s but diagnosis rates are lower than national average
- Mental health – 14% of people aged 16-74 yrs have a mental health disorder

Opportunities to improve how we address:

1. people with complex care needs who attend hospitals multiple times each year
2. prevention of and self-care for people
3. reduce inequalities through changing the way that CCG resources are currently used

GAP 2: Care & Quality Outcomes

- Many people who are in our hospital beds do not need to be there
- Many people can't see their GP when they need to do so to go to A&E and out of hours services 27% of people seen by GPs could have their issue resolved in another way
- Significant waiting times to access some of our services
- Not consistently meeting our Constitutional targets in IAPT, RTT, A&E 4 hour waits, CAMHS and dementia
- Our estate is not fit for purpose or efficiently utilised – this hinders our ability to deliver integrated services in the community and to strengthen primary care and patient access to services 7 days a week
- There are increasing workforce pressures in the healthcare and domiciliary care

GAP 3: Financial Gap

- There is a significant local deficit and unsustainable finances across both our CCG and the HCV STP
- Locally there is a financial deficit forecast of £24.1m in 16/17 and £45.5m in 17/18
- We are currently delivering an Improvement Plan to address this financial gap and must achieve the challenging efficiency targets we have agreed with NHS England

Our operational plan focuses on:

- delivery of this financial improvement in the short-term,
- our programmes for transforming the system in the longer-term to provide the platform for delivering more efficient and integrated services and financial sustainability by 2020/21

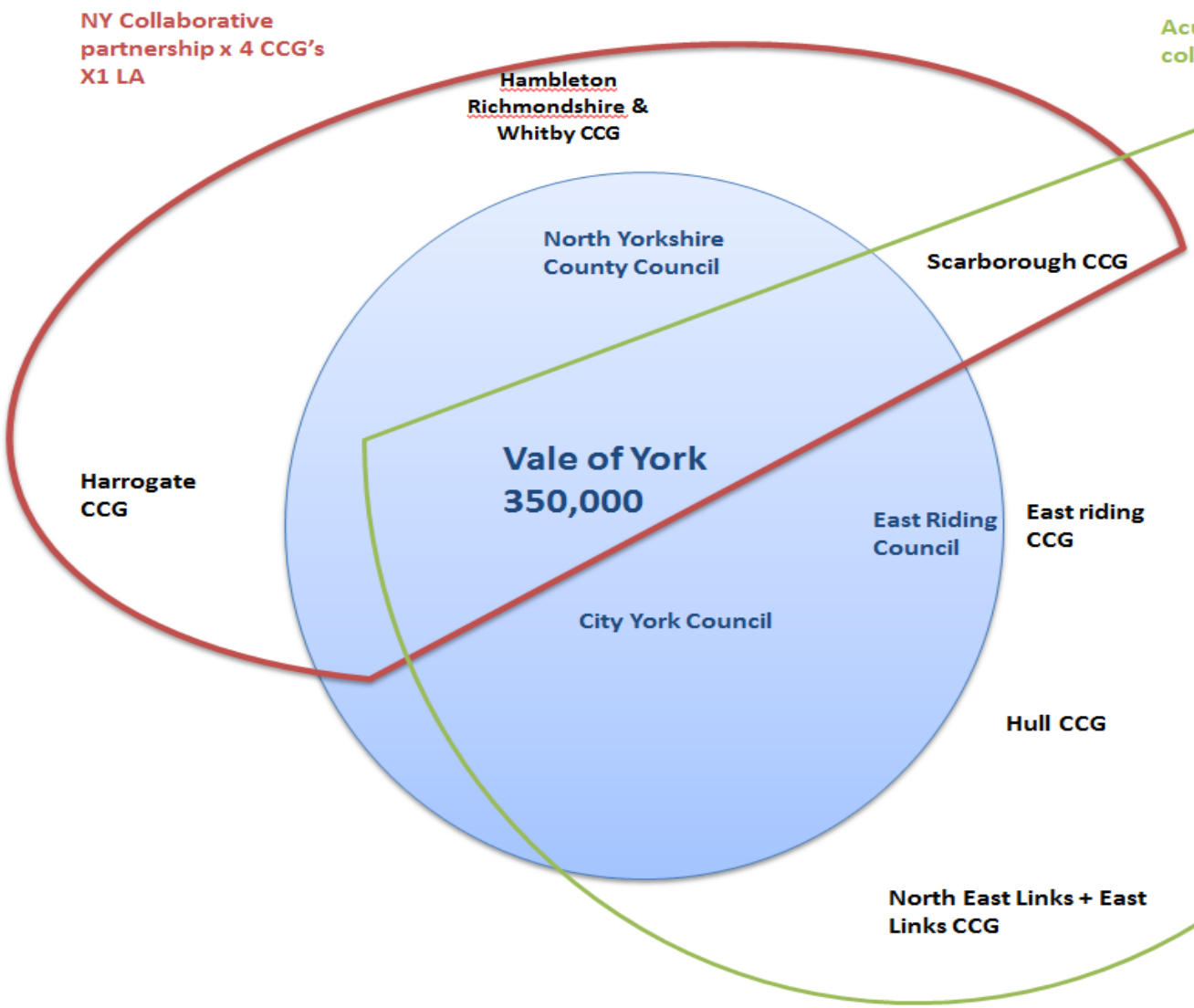
Our Population Needs

We are planning in a system based on the needs of our population in each locality within the Vale of York.

The system is complex and aligning planning with all our partners is challenging. **A focus on population and 'place'** allows us to plan together, challenge where things don't work for patients and move away from some of the limitations of working in one organisation.

Our Vale of York system: complexity and boundaries

NHS
Vale of York
Clinical Commissioning Group



The geography of the Vale of York has always provided significant barriers (boundaries and numbe of organisations) to planning an delivering as a system.
This has not benefited patient flow, access and navigation of the system or utilised the system resources (back office, estates etc) in planning and delivering the services required for patients.
Transforming as part of a wider STP, and most importantly driving the development of a local Accountable Care System (ACS) to deliver the transformation needed based on population need in each locality, is critical to manage this geography.

Our population: key health and well being features and outcomes

NHS Vale of York Clinical Commissioning Group

Overarching population needs

Population of 350,000 (including York 204,000, Selby 85,000 and main population centres include Tadcaster, Easingwold and Pocklington) Fluctuating population – York has two universities, 6.8m tourists pa Commissioning budget £435.3m in 2016/17	We have three local authority areas – City of York Council, East Riding of Yorkshire Council and North Yorkshire County Council (upper tier authority, with 7 district councils, 3 of which overlap with the CCG boundary Selby, part of Ryedale and Hambleton). There are 27 GP practices as at September 2016
People within York have good health overall with above national average life expectancy but with considerable variation in this life expectancy across our patch (up to 6.5 years in men and 5.5 yrs in women), closely linked to the seven areas ranked in the 20% most deprived in England.	Ageing population: Over-85s represent 5% of the population and 20% of non-elective hospital admissions and an increasing acuity of need and demand for healthcare and domiciliary care.
Cancer is the most significant cause of premature death (death under 75 years) in York but not significantly higher than the England average	High numbers of admissions for: myocardial infarctions, respiratory disease, stroke, stage 5 kidney diseases in people with diabetes, chronic ambulatory care sensitive conditions (808-v-778/ 100000 in similar CCG
Significantly higher rates of excess weight in Selby (70% compared to 65%) including children in reception and Year 6 being above the national average	Stroke mortality rates in those aged >75 years are significantly higher than the England average (708-v-608 per 100,000)
Binge drinking 28.8% adults compared to 20% nationally and rates of alcohol related cancers conditions is higher than the England average and regional average (207.8 –v- 176.5 / 100,000	Chronic obstructive pulmonary disease has been steadily rising to 1.4% in 2010/11 but remains below the England average of 1.57%
Smoking quit rates are significantly worse than in similar CCGs (480-v-818/ 100,000) and there is a need to address rates of smoking, particularly in people with mental health conditions who represent a disproportionately high number of people who smoke.	The CCG has poorer outcomes for CVD than other comparable CCGs. MSK spending and rates of major joint replacement surgery are significantly higher than for comparable CCGs and yet health gain per patient is lower.
There are 950 complex patients (3+ different conditions) resident in CCG who are admitted to hospital on average >6 times per year and 75% of them had an 3 A&E attendances per year. 44% of these are over 75 years. The most common conditions are circulatory, neurological, respiratory with co-morbidities in gastro-intestinal. CCG expenditure on these patients is 0.2% above the England 15% av.	Parity of esteem for people with mental health conditions through better physical disease management. is an area of need we need to focus on in order to reduce rates of death from cancer, heart disease, respiratory disease and diabetes in this population group.

Our Financial Context

We are planning to deliver **financial** recovery – there is no additional NHS funding allocation for the Vale of York in 2017/18 and 2018/19 and a forecast £24.1m deficit.

It is our responsibility to deliver the services patients most need within that allocation and for all partners to work together to drive out inefficiency, duplication and unwarranted variation in our system.

Financial context: Financial Recovery

NHS Vale of York Clinical Commissioning Group

BASELINE 2016/17: commissioning budget of £435.6m. The Vale of York CCG baseline of 2.1% is above the national target allocation but not greater than 5% and therefore viewed as reasonable. As such the CCG received minimum growth in 2016/17.
Allocations, albeit indicative for future years, suggest the CCG will remain over target and therefore can expect to receive minimum growth until 2020/21.
Expenditure on out of hospital care (voluntary sector, community, BCF schemes, winter pressures, system resilience schemes) compared with In hospital care: 15% (£40,575,000) compared to 85% (£228,649,000)


NHS Vale of York Clinical Commissioning Group

Improvement Plan
in response to NHSE Legal Directions (issued 1 Sept 2016)
Detail pack
6 October 2016

IMPROVEMENT PLAN TO 17/18: Current Financial Recovery Plan ("FRP") to deliver an in-year deficit of no more than £7m (£13.3m cumulative). The CCG currently forecasts to end 2016/17 with a £24.1m deficit (before further mitigations). Further mitigating actions totalling £1.1m have been identified but the CCG will need to generate a further £5.4m from development of pipeline ideas and system support proposals.
It also sets out an intention for 2017/18 to operate within the annual allocation.
Monthly refresh of financial recovery plan based on validation of agreed and further deliverable mitigations, pipeline QIPP ideas and system support schemes

Forecast outturn 2016/17	(£m)
Forecast deficit	(17.3)
Net unmitigated risks	(4.2)
Risk adjusted forecast deficit at M5	**(21.5)**
Update to risk since M5	(2.
Revised risk adjusted deficit	**(24.**
Removal of capital support assumption in m5	(1.
Potential further mitigations	1
Pipeline ideas and system support actions	5.
Revised risk adjusted deficit	**(18.6)**
Potential capital support	1.0
Potential release of 1% non-recurrent headroom	4.3
Forecast outturn (after further mitigations)	**(13.3)**
Target to meet legal directions	(13.3)

MEDIUM-TERM FINANCIAL STRATEGY 17/18 ONWARDS: Development and agreement of MTFP and associated financial strategy – in development and to be finalised by 23/12/16.
Refreshed and augmented QIPP programme to deliver efficiencies required to stay within allocation development of activity modelling, funding arrangements and contracting options for out of hospital model. increasing contract grip and control and supporting the system wide reallocation of financial resources and risks and driving wider system planning.


NHS Vale of York Clinical Commissioning Group

Vale of York Medium Term Financial Strategy

A new approach to commissioning
DRAFT

Our Improvement Plan

We are working under **Legal Directions** with the support of NHS England.

Our operational planning and financial recovery are at the core of our CCG Improvement Plan as we transform internally as a CCG (‘organisation’) at the same time as leading system change alongside our partners (‘place’).

We are working **transparently and at pace** to deliver the improvements needed to come out of Legal Directions.

The CCG Improvement Plan: Five key steps 2016/17

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Clinical Commissioning Group

Stabilisation of finances	• Financial Recovery – Investment and Risk share 2017/18 and 2018/19 • Scoping new models of funding and contracting arrangements (Oct 16) • Director to drive forward contracting reforms (Dec 16) • Addressing 'system opportunity cost' in Out of Hospital Care
Headline our deliverables – key performance delivery	• Constitutional Delivery • A&E Delivery and stabilisation • Improved mental health performance
Clear priorities and purpose for the CCG	• End October - agree 18 month recovery programme setting out the organisational priorities • Internal refocus of capacity and capability focussed on priorities Dec 16 • New Executive Team to strengthen CCG leadership and capability Dec 16
Building key relationships and joint commissioning opportunities	• Director for Joint Commissioning to drive CCG Commissioning arrangements • Multiplicity of collaborative approaches - commissioning across specific geographies and population groups • Risk share across CCGs on complex cases 17/18 – 18/19
Positioning the system for sustainability	• Progressive direction to Accountable Care Systems – Mar 17 • Regaining confidence and trust from the Council of Representatives • Collaborative philosophy- engaging with stakeholders across the system and the local population to set the platform for the future

The CCG under Legal Directions: Improvement Plan

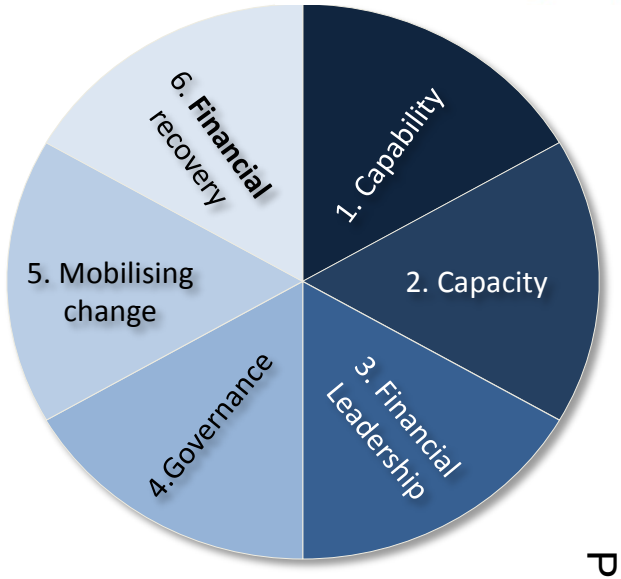
NHS Vale of York Clinical Commissioning Group

- The CCG understands the scale of the challenge and requirement to comply with the legal directions and has a greater understanding of the true underlying financial position to form the basis for immediate financial stabilisation through the Financial Recovery Plan and development of a robust medium-term financial strategy. The top priorities are:

- Develop strategic partnership working and building trust in local partners alongside strength in financial decision making

- Ensure that the capacity, capability and governance is strengthened in line with the Capability and Capacity Review of 28 January 2016 to deliver sustainable system wide improvement and provide effective commissioning and clinical leadership

- Focus on addressing its immediate challenges and leading a credible longer term programme of sustainable improvement, both internally and for the wider health economy



- Refocus the capacity in the organisation to deliver change at pace

- Develop local services solutions and strengthening support into general practice

- Additional lay support with a focus on finance to enhance scrutiny and challenge

- Continue to deliver against the NHS Constitution and national pledges

- Move to strategic commissioning across both the City of York and the North Yorkshire footprints:
  - New executives with clearly defined roles and responsibilities over: joint commissioning; transformation and delivery; system resources; and performance
  - Prioritising activities to support delivery of the plan
  - shared posts and functional convergence with other CCGs

- Strengthening partnerships to share capacity:
  - Formulation of clear and consistent priorities with partner organisations to reduce wasted time
  - Proactive engagement with the public, patients and key stakeholders through improved direct relations and communications

The CCG Improvement Plan: Progress

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Clinical Commissioning Group

	October – December 2016	January - March 2017
Stabilisation of finances	Strengthened financial decision making: ▪ Financial recovery plan in place (see M8 finance performance) ▪ Exec Director of Systems and Resources in place ▪ Contracting reform – Heads of Terms to manage contract and risks, negotiation & agreement – linked to emerging priorities and programmes of work across system (see Plan on Page and local place based plan)	1. Delivery of contract in line with Heads of Terms 2. Explore hybrid PbR opportunities 3. Further QIPP delivery 16/17 4. Further QIPP pipeline 17/18 development 5. Operationalise programmes in prim / care, unplanned care and planned care to support delivery of system o of hospital opportunities
Headline our deliverables – key performance delivery	▪ Improvement in cancer standards (31 day recovery) and local Trust Action Plans for RTT and cancer December 2016 ▪ Developed and refreshed Action Plans for IAPT, CAMHS and dementia utilising NHSE funding support ▪ Review of PCU commissioning support to ensure local grip on mental health performance ▪ Winter planning and assurance through A&E Delivery Board ▪ STP work on Right Care and clinical thresholds	1. Rapid mobilisation of provider and wider system recovery plans for cancer and RTT through establishment of planned care task & finish – evolve into ACS unplanned and planned care programmes 2. A&E Delivery Board plans with focus on streaming, hospital flow and discharge 3. Work with primary care through CoR to formulate and deliver the collective 'ask' to support management of growth in demand

The CCG Improvement Plan: Progress

Vale of York Clinical Commissioning Group

	October – December 2016	January - March 2017
Clear priorities and purpose for the CCG	▪ Approved Improvement Plan for CCG in implementation ▪ Consultation on proposed future structure of CCG and new Exec team recruited to (capacity & capability) ▪ Revised and strengthened governance structure including: new Clinical Executive, Executive Committee, refreshed Primary care Committee ▪ Additional lay support with a focus on finance ▪ Refreshed GPFV plan, practice visits and work with CoR & LMC to understand local services solutions and strengthening support into general practice ▪ Clinical Summit for system and v successful	1. Prioritisation and strategic refresh in January 2017 based on system work and engagement 2. Link this to resourcing and shared resources across ACS and STP 3. Linking this to individuals' and teams' medium-term objectives in CCG 4. Linking this to comms & engagement – focus on **coproduction** with local populatio at locality level
Building key relationships and joint commissioning opportunities	▪ Exec Director of Joint Commissioning appointed ▪ Emerging ACS (focus on population and place) and CCG leadership to driving this forward ▪ Develop strategic partnership working and building trust in local partners – primary care and CoR, STP, Local Authorities, MPs, DPHs – engage with ACS and Operational Plan ▪ Focused 'deepdive' on CHC, joint packages of care and complex care ▪ PCU as commissioning support review ▪ Development of collaborative commissioning intentions, acute contract and thresholds as STP	1. ACS Partnership Board to meet in Feb 2017 along with shadow locality boards. In delivery from April 2017. 2. Strengthening partnerships to share capacity: BI, PMO, back office, governance 3. Formulation of clear and consistent priorities with partner organisations and populations through locality boards and longer-term programmes of work
Positioning the system for sustainability		

Our transformation to date

The work we and partners have delivered during years 1 and 2 of the Five Year Forward View have had a positive impact in our locality and for our patients.

This provides a **strong foundation** for the further system change now needed.

Transformation and success

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The CCG has worked with its partners to deliver transformation in the local care system during the past two years which will provide a strong foundation to the system change now required. These have focused on:

- Demand management through RSS
- Resilience around urgent and emergency care to reduce avoidable admissions and A&E attendances
- Piloting the care hub model
- Addressing poor mental health estates and engagement around mental health strategy

Redesigned diabetes pathways to better support management of diabetes in the community and prevent hospital admission **1**

Referral Support Service (RSS) **2**

Health Navigator Proactive health coaching **3**

Urgent Care Practitioners **4**

Integrated Care: Pioneer for Care Hubs

5

Reprocurement of mental health services and associated estates modernisation in progress **6**

Implementation NICE approved guidance on 2 week wait pathways for the different types of cancer **7**

Discover engagement programme for Mental health to inform future strategy **8**

Prescribing – lowest per capita prescribing frequencies and costs in the region **9**

Impact in the Locality: Managing Demographic Growth

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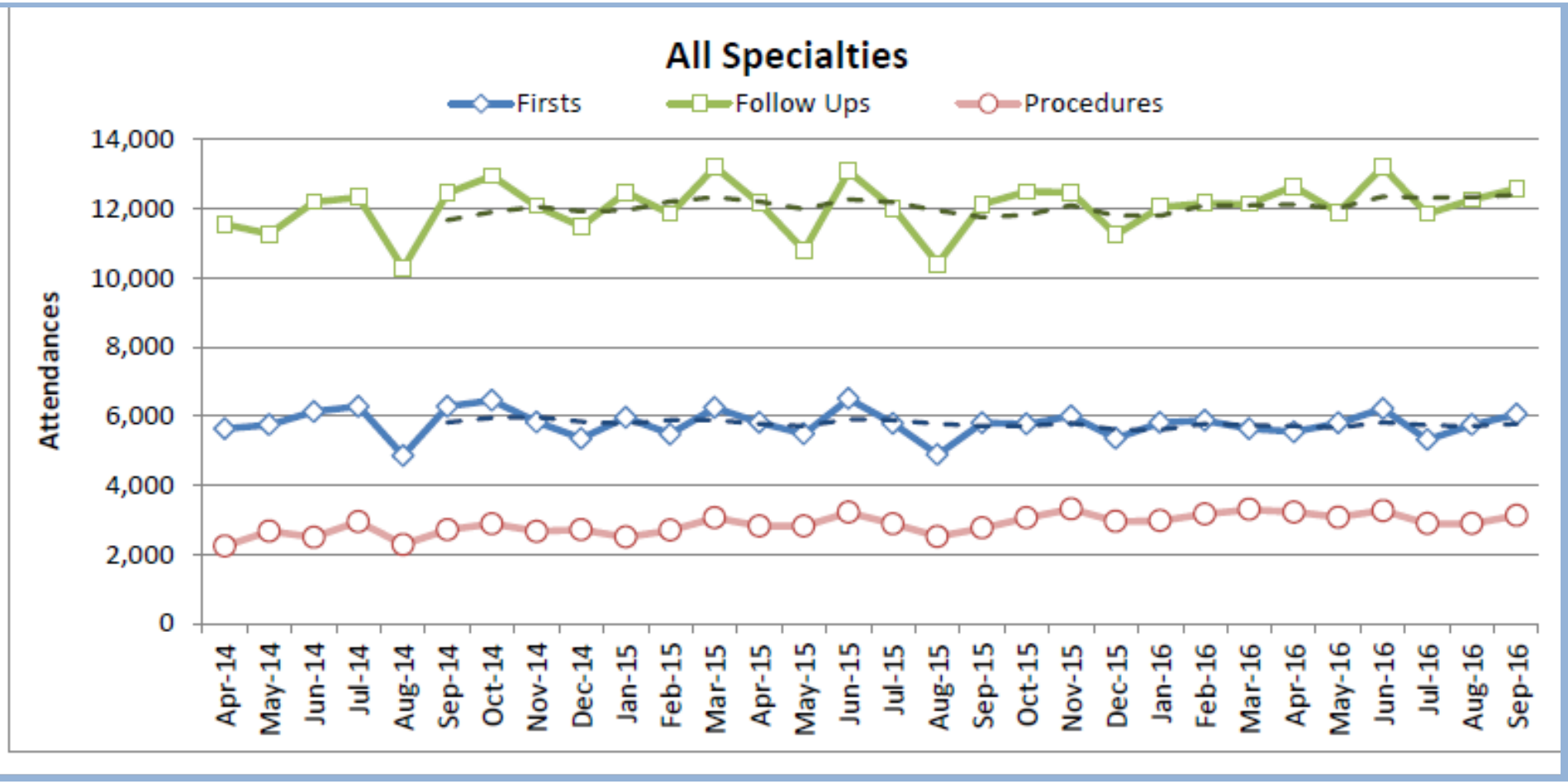
Referral Support Service (RSS): managing demographic growth to keep outpatient activity stable



Impact in the Locality: Managing Demand on the System

NHS Vale of York Clinical Commissioning Group

Improvement/ Transformation	Impact
Emergency Department (ED) Front Door schemes	ED attendances for the York Hospital went down 6.8% compared to 12 months previous (Nov 2016) against a rising population
Integration hubs: York Integrated Care Team (YICT) The YICT is in the process of being rolled out to other practices in the City of York during December 2016 and January 2017.	In Priory Medical Practices (part of the York Integrated Care Team) attendances are down 8.7%, admissions are static and excess bed days are down by 13.3%
OptimiseRx software	Supporting nearly £300,000 of efficiencies i prescribing being delivered through the medicines management team
Oral Nutritional Supplements (ONS) – VoY has led work to optimise nutritional care for patients and interventions through the formulary and using OptimiseRx in the past 18 months. Other CCGs have been in touch wanting to replicate our schemes - their ONS prescribing trends have remained high despite some ONS price reductions over the past year.	Quality benefits for patients by optimising their nutritional treatment to reverse/stabilise malnutrition. Downward trend in expenditure and achieving regular monthly 'savings' (approx £12,000 per month)
Dermatology indicative budgets in general practice Supported by further expansion of dermascopes into practices and impact on 2WW Cancer (skin)	YTD the CCG can evidence savings of £68,000 with £23,000 of this going to alliances

Impact in the Locality: Driving Integration in the Community

NHS Vale of York Clinical Commissioning Group

Integration

Arc Light	Works with homeless people to support them and hence prevent re-attendances after initial contact across the system. Commenced 2014.
Fulford Care Home Beds	Commissioned 4 beds for step up and step down; has links to the UCP service and primary care for direct admission to the care home rather than requirement for attendance at ED first. Commenced 2015.
York Integrated Care Team	Reviews all patients identified by risk stratification and/or discharged the previous day from hospital to provide pro-active support for that group of patients going forward. Shows a clear reduction in attendances for the target population. Covers 1/3 of VoY population currently and being rolled out further. Commenced in a limited way in 2014, major expansion in Summer 2015.
Pocklington Integrated Care Team	Manages step up and step down patients in a local dedicated bed base; coordinates pro-active care from community teams in the local area. Shows a clear reduction in attendances for the target population. Commenced 2015.
Selby Integrated Care Team	Provides a community response team that supports a caseload including LTCs and aims for attendance/admission prevention. Ongoing wor and monitoring at present. Commenced 2015.
Priory Outreach	Scheme makes the link between the hospital and community and has a 3-5 day rapid input of care to avoid attendance/admission for step up and primary care patients. Commenced 2015.
UCPs	Urgent Care Practitioners (advanced paramedics) provide cover from 7am to 2am, 7 days a week, for see and treat of appropriate patients and support non-conveyance where appropriate. Commenced 2014, signficant expansion in 2015.
Hospice @ Home	Extended hours for evenings and weekends for H@H team to attend patients with an EOL care requirement, to avoid attendance and admission where requested and possible. Commenced 2014.
GP in hours referrals	YAS paramedics have the option to call to a GP practice for advice/review and transport to clinic rather than direct conveyance to ED. Commenced 2014.
Ambulatory Care Unit	Unit was trialled for 6 weeks at the end of 2014-15 and then put into place permanently from November 2015; approximately 1/3 of attendees are direct admissions from GPs.

Integration

York Integrated Care Teams – Phased Roll out/ Population

Vale of York CCG GP Practices Total* Population: 350,723

GP Practice	Timeline	Population	% of total*	Rolling
Priory Medical Group	Phase 1	55,499	15.82	**15.82 %**
Unity Health	Phase 2	22,600	6.22	22.04 %
Haxby	Phase 2	32,868	9.37	31.41 %
MyHealth	Phase 2	18,741	5.34	36.75 %
Kirkbymoorside	Phase 2	5,937	1.69	**38.44 %**
York Medical Group	Phase 3	43,418	12.38	50.82 %
Dalton Terrace	Phase 3	7,646	2.18	53.00%
Jorvik Gillygate	Phase 3	19,695	5.87	58.87%
East Parade	Phase 3	2,097	0.63	**59.50%**
Selby Integrated Care Team		76,015	22.67	82.17%
Pocklington Integrated Care Team		15,510	4.42	86.59%

End of Phase 3 = 86.59 % of Vale of York practice population covered by Integrated Care Teams

GPs, nursing, physio, OT, Social Care, housing, social prescribing, DNs, UCPs

Our Plan on a Page

We have worked with our partners to capture our system and the **joint priorities for delivering care** for our population.

We want to provide a **common framework** for all partners to come to our emerging Accountable Care System and start planning how we transform locally.

This plan is not prescriptive or limiting; it aims to help us find commonality in the way we see and work in our system together **at this point in time**.

Vision	To create fully integrated care for all our communities and support the best possible health outcomes for all people	
Goals	Safe, resilient services working across 7 days that can deliver: • All NHS Constitution standards • A sustainable acute hospital delivery system • Out of hospital services joined up in a way so people only need to go to hospital when no other option is available • A financially sustainable system which provides VFM for every Vale of York £ spent on health and care • Access to good services for people with mental and physical health needs, especially those that are vulnerable	
Population Outcome and Prevention Priorities	Reducing LTCs prevalence – Smoking cessation, Obesity, alcohol, Frail elderly and vulnerable people including falls reduction Addressing isolation and quality of life – individual and rural Child health & Early Years – CAMHS, obesity (in utero maternity), SEN & LAC assessment Mental health access and early intervention – IAPT, dementia, smoking cessation, physical health & complex specialised services Holistic care for people with learning disabilities: physical health checks Cancer detection and diagnosis improvement	**Outcomes** **Improved patient outcomes:** • Morbidity reduction • Mortality reduction • Improved quality of life for patients **Acute activity maintained at sustainable levels:** • Reduce avoidable A&E attendances • Reduce avoidable emergency admissions • Reduce LOS and excess bed-days • Reduce outpatient attendances
Sustainability Priorities	1. Legal Directions - improvement plan and return to financial sustainability 2. Reducing demand on acute hospital care 3. Resilient urgent and emergency care networks working across in- and out of hospital care 4. Transformed primary and community care provision – fully integrated out of hospital care at or close to home 5. Transformed workforce across health and social care – Bands 1-4 and practitioner roles across health and care 6. Addressing unsustainable specialised commissioned services across the HCV and wider Y&H footprint (NHSE) 7. Fit for purpose estates and improved utilisation	
	Local	**STP wide**
STP Plans aligned with our 3 Health & Well Being Plans	 1. Strengthened primary care – capacity and resilience, estates improvement, workforce, integration, specialisation 2. Self care, Empowerment & Prevention – education, information, navigation, decision-aids and clinical advice 3. Integrated out of hospital care and Accountable Care System (ACS) with all partners to support place-based services which target the most frail, complex and vulnerable 4. Transformed mental health and learning disability (LD) services including complex healthcare (CHC) and CAMHS improvements 5. Sustainable acute hospital – outpatients and pathway redesign (RightCare; cancer); shared diagnostics, back office and estates	 <u>3 priority collaborative programmes:</u> 1. Strategic commissioning 2. Mental health and joint commissioning 3. In-hospital care and single acute contract <u>Through existing networks:</u> 1. Urgent care and networks 2. Cancer Alliances and diagnostics 3. Maternity strategy and clinical network 4. Specialised commissioning – neuro rehab/ Weight Mgt

Our Priorities and emerging Programmes

Our priorities focus on how we can drive **system outcomes** that address our triple aims.

Some of those priorities will be driven by our work internally as a CCG as a commissioner – strengthening primary care is our number one priority.

Everything else will require us to **work as a system** – in an Accountable Care System and as part of the Humber, Coast & Vale STP.

Our Six Priorities

NHS Vale of York Clinical Commissioning Group

FINANCIAL RECOVERY AND FINANCIAL SUSTAINABILITY

PRIORITY 1
Strengthening Primary Care

PRIORITY 2
Reducing Demand on the System

PRIORITY 3
Fully Integrated Out of Hospital (OOH) Care

PRIORITY 4
Sustainable acute hospital and single acute contract

PRIORITY 5
Transformed mental health , LD and Complex Care services

PRIORITY 6
System transformations

IMPACT on Three Outcomes Gaps:

Finance: best value for Vale of York £ spent

- Single acute contract & strategic commissioning
- Consistent demand management and reduction in unnecessary activity in acute hospital
- Reduction in variation in reference costs
- Reduction in waste and duplication: diagnostics, medicines
- Right sized for elective care capacity and optimised utilisation of local estates
- Shared informatics, reporting and back office resources

Health & Well-Being: Population needs are met

- Whole population and targeted cohorts (most vulnerable) outcomes improvement: mortality, morbidity and quality of li
- Patients taking responsibility for their own health and budge for care
- Improvement in physical health of people with mental health conditions and learning disabilities
- People having the best possible start in life with prevention, early detection rates and survivorship improvement

Care & Quality: Patient experience and rights are met

- Consistent delivery of NHS Constitutional targets
- Improved access, resilience and 7 day working
- Standardisation of clinical practice to 'best in class'
- Evidence-based clinical thresholds
- Fit for purpose estate for delivering care (mental health, integrated primary and community care)
- Sufficient and right workforce to deliver the care required

Our Emerging Joint 'Local Place' Programmes: 2017-2019

PRIORITY 1

Strengthening Primary Care

PRIORITY 2

Reducing Demand on the System

PRIORITY 3

Fully Integrated Out of Hospital (OOH) Care

PRIORITY 4

Sustainable acute hospital and single acute contract

PRIORITY 5

Transformed mental health , LD, Complex Care & CHC services

Primary Care:

- ✓ Driving prevention and self-care
- ✓ Driving demand management
- ✓ Prescribing optimisation

Supported by:

- GPFV – developing support for practices: capacity, access & capability
- Development of localities in ACS
- RSS
- Devolvement of budgets
- Development of reporting and monitoring

Unplanned Care (Out of Hospital):

- ✓ Proactive management of:
  - Frail elderly
  - LTCs/ complex
  - vulnerable
  - children

Supported by:

- ACS & locality structure
- Risk stratification
- Urgent care stabilisation
- New models of integrated care
- Community hubs
- Review of community beds & care homes
- Personal Health Budgets
- Estates investment

Planned Care:

- ✓ Right Care: Gastro; MSK (ortho); Circulatory
- ✓ Outpatients redesign
- ✓ RTT Recovery
- ✓ Clinical thresholds
- ✓ Networked services:
- Cancer redesign
- Shared Diagnostics, pathology
- Maternity & neonatal
- Specialised commissioned services

Mental Health, LD, Complex Care & CHC:

- ✓ Access, early intervention & crisis avoidance: CAMHS, IAPT, dementia diagnosis
- ✓ Physical health
- ✓ Targeted prevention: smoking, alcohol, obesity
- ✓ CHC redesign

Supported by:

- CHC review joint packages of care
- Personal Health Budgets
- MH consultation
- Modernised MH estate

PRIORITY 6

System transformations

ACS & HCVSTP Shared resources – PMO & BI

HCV STP Collaborative programmes

Shared care record & LDR

Workforce transformation

Shared back office and estate

Better Care Fund

Governance and accountability frameworks

Communications and targeted engagement

Our Existing Work

We are already working in many areas to drive improvement and transformation with our partners.

These include the **GP Forward View, Urgent & emergency care, cancer** and **mental health –** highlights are outlined in Annex 1.

Not all our work is captured in coherent strategies or system-wide programmes, however, which means not everyone understands our work in a consistent way.

Our operational plan will take this work and develop it further as part of the **system-wide programmes** with our ACS and STP.

Getting Started

Our operational plan is a **high level plan** which captures emerging priorities and programmes of work in our care system.

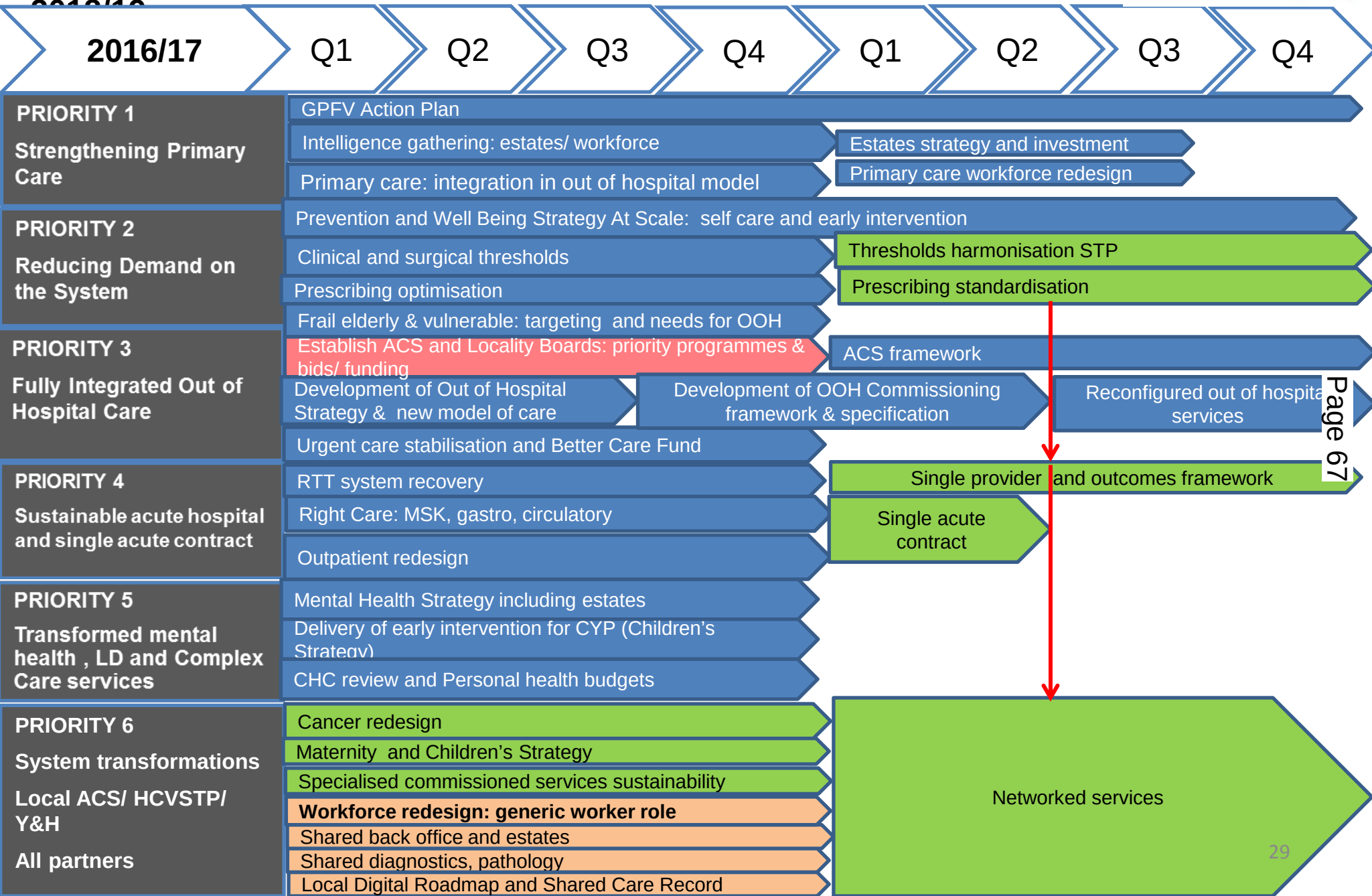
We will work to **scope and mobilise** these programmes with our partners through our emerging ACS and locality boards.

We need each locality to focus on a **few priorities to start working and target improvements** for those people who are most in need and vulnerable.

We will co-ordinate **bids for STP funding** to support transformation wherever possible.

Proposed Two Year Timeline for Delivery 2017/18

NHS Vale of York Clinical Commissioning Group



Our Governance

We need the appropriate shared resource and consistent frameworks for managing **governance and risk** if our programmes are to deliver at pace and scale.

We are strengthening our governance internally as a CCG as part of our Improvement Plan.

At the same time we are working as an emerging ACS and STP to understand how we can build trust and make decisions as a system. **Principles** and governance which focus on population and place are critical.

CCG Organisational Governance and Strengthening Delivery

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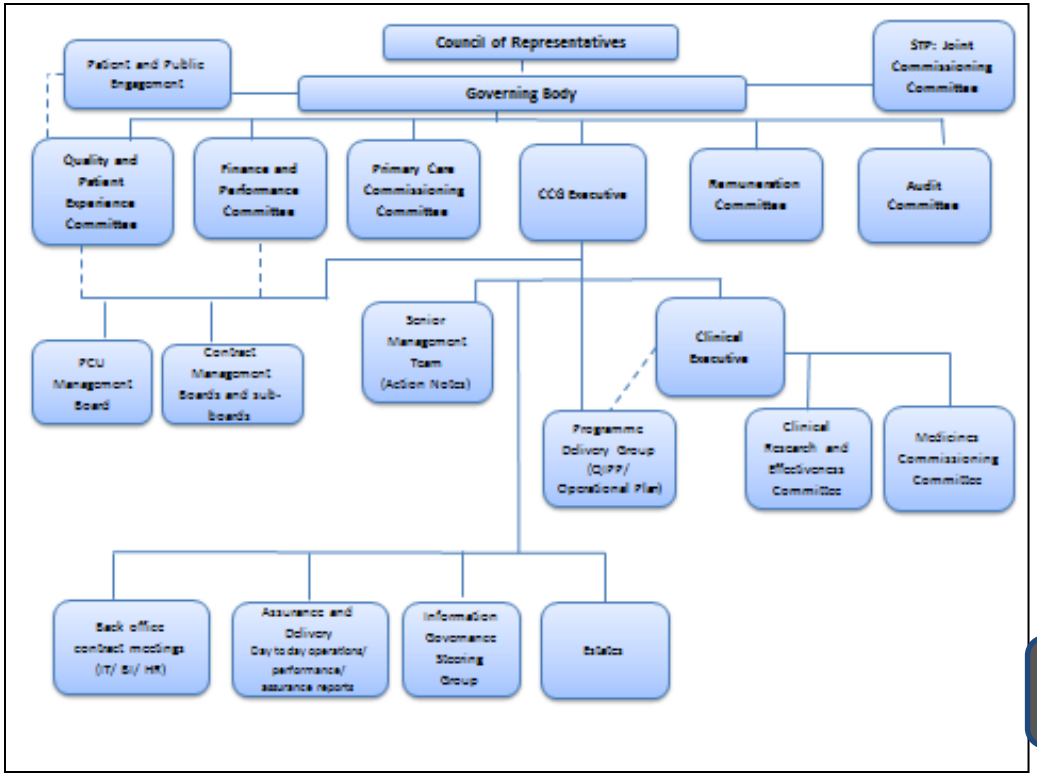
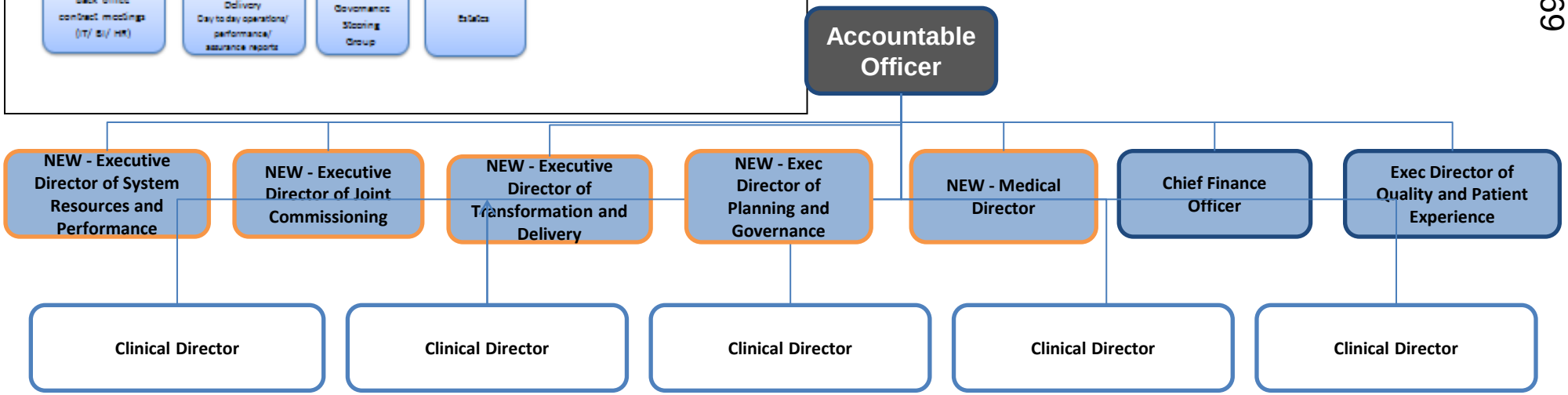


Aims:

1. Strengthened executive leadership to drive transformation
2. Clearer accountability and locked in decision-making
3. Focus on performance and rapid escalation if deterioration
4. Leaner reporting process and outputs: focus on delivery of improvement plan, IAF and constitutional standards



Accountable Care System (ACS) – Emerging Governance Framework (to be discussed in February 2017)

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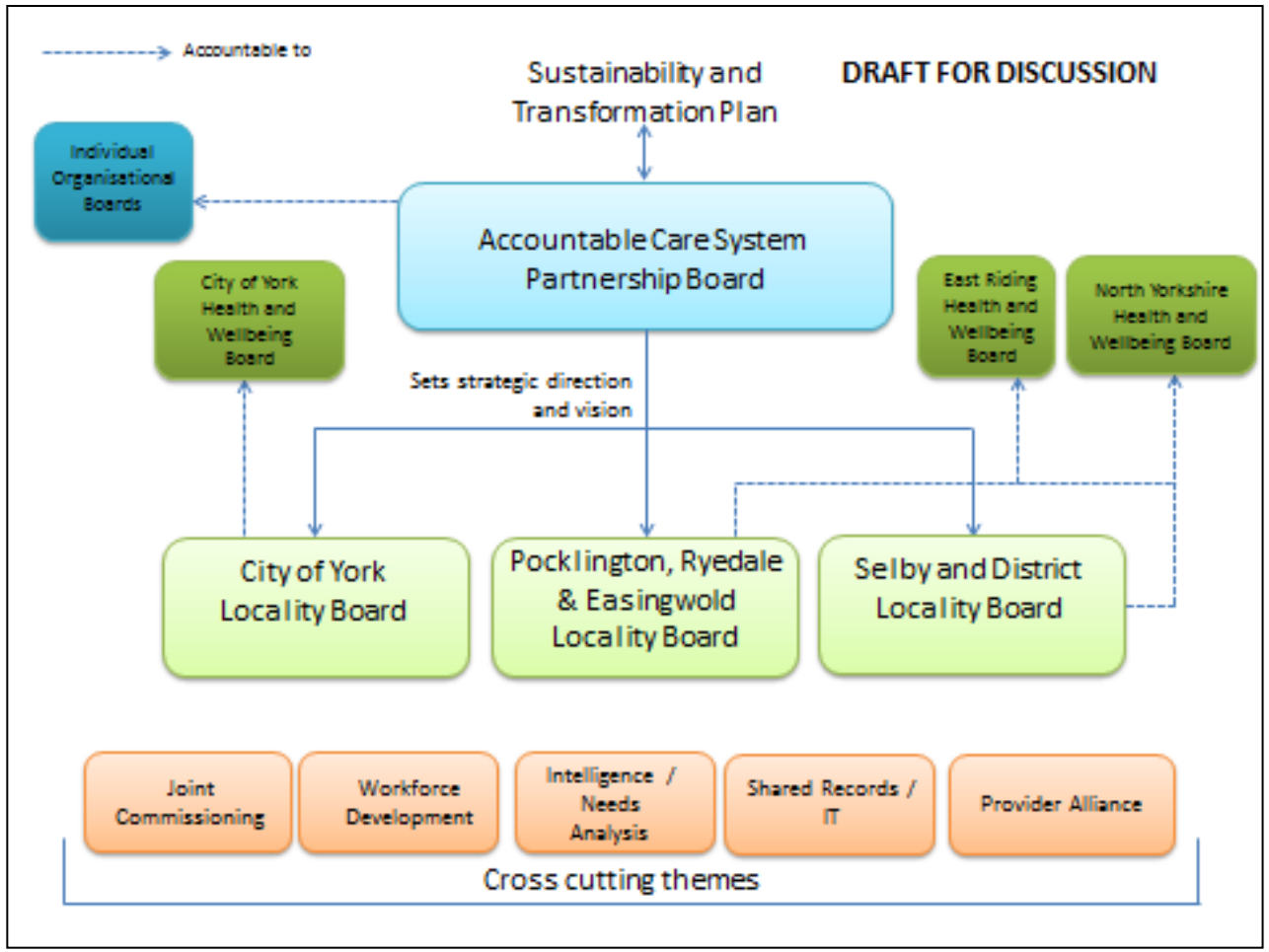

Emerging principles:

Working together our system will:

1. Be person-centred, holistic and individual, involving people in their decisions
2. Promote independence
3. Be underpinned by effective communication and integration software to connect information systems
4. Offer value-for money and be cost-effective, rebalancing investment towards prevention and early intervention and removing/disinvesting in duplication
5. Support increased multi-disciplinary working and empower the front-line, thereby increasing professional satisfaction
6. Give a timely and unambiguous response to need

HCVSTP System Governance (indicative)

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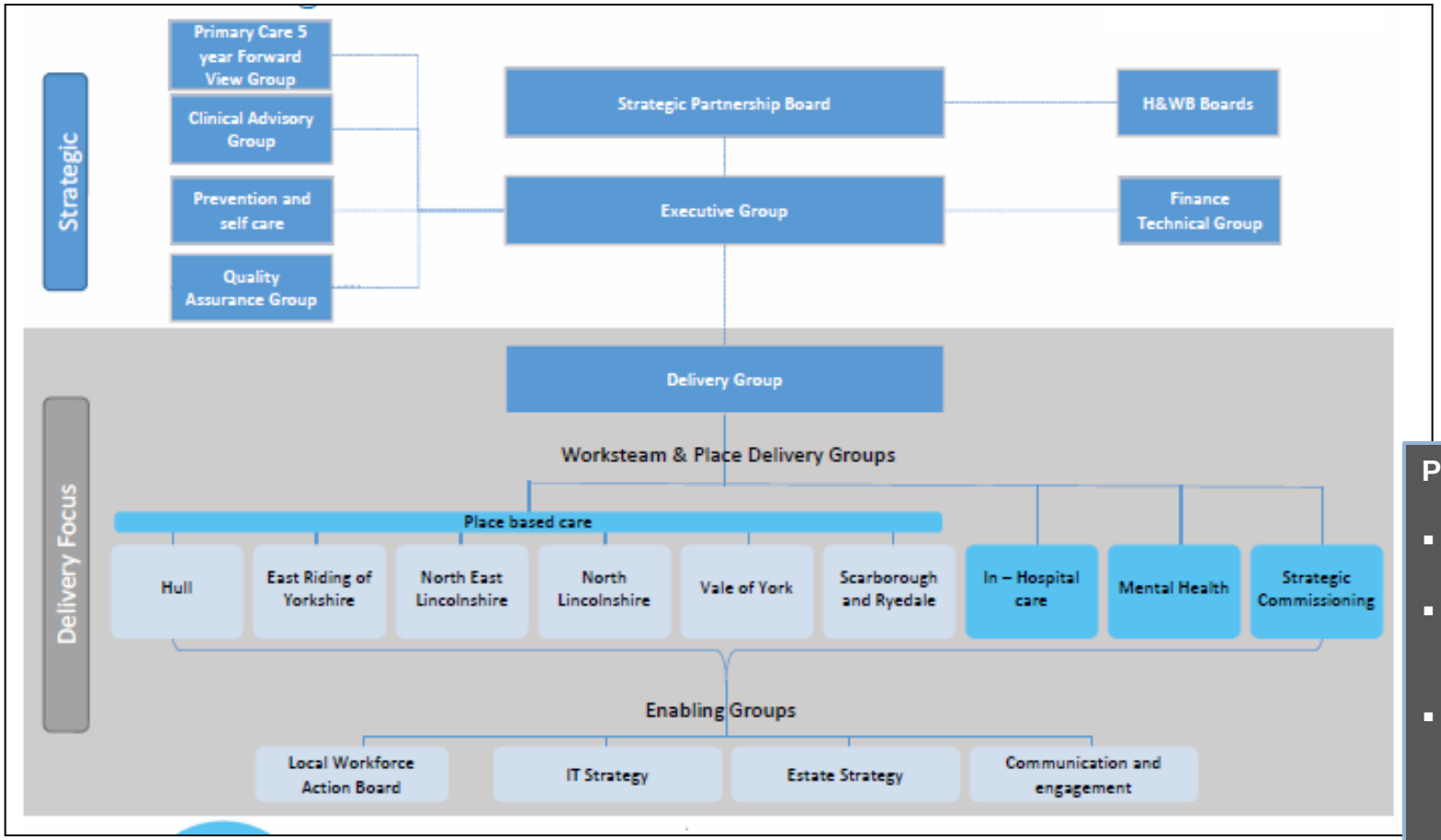

Principles & Aims:

- System first, organisatic second
- Moving from a reactive system to a proactive future system
- Work closely and collaboratively together to ensure the resources available are used in the most appropriate way for our communities
- System governance to provide rigour and challenge

Our Must Dos

We and our NHS partners have a **statutory duty** to deliver the rights and pledges of our patients in line with the NHS Mandate and **NHS Constitutional targets**.

Financial and workforce pressures in our system mean these targets are not being delivered in all areas or consistently.

We plan to work as a system to ensure we recover our delivery of all targets and can do so in a **sustainable** way – **managing demand on our services and prevention** will be critical to sustainable delivery.

Our STF trajectories have been triangulated with all our partners and represent the current system trajectory.

A&E 4 hour wait

Vale of York Clinical Commissioning Group

Q2 PERFORMANCE:
Sept 2016: 91% (CCG) & 90.9% (YHFT)
LATEST PERFORMANCE:
October 2016: 85.5% (CCG & YHFT) – 4th consecutive monthly fail
WE 4th Dec: 81.8% (lowest daily to date 59.7%)

Front door (FD) ED schemes have seen a reduction in attendances in ED of 2.1% between July 2015- July 2016.

SYSTEM BOARD & MECHANISMS:
Local Place: Unplanned care programme in ACS
COG: A&E Delivery Board & Steering Group
STP: Y&H UEC network
CCG: Finance & Performance Committee

SYSTEM LEADS:
SRO: Pat Crowley, CE, YHFT
Clinical Lead (CCG): Andrew Phillips, MD
Exec lead (CCG): ED Transformation & Jim Hayburn, ED Systems & Resources
Programme Lead (CCG): Becky Case

Confirmed 2 year trajectory:
Return to 93% in Q3 2017 (September) within forecast activity model. Maintenance at 93% throughout rest of 2017/18 and 2018/19.

RECOVERY PLAN:
Short-term (Q4 2016/17)

- Continued delivery of provision of FD schemes and Ambulance handover concordat action plan: a separate Ambulatory Care, see and treat via Urgent Care Practitioners, e-procurement of Out of Hours services to integrate with NHS111, Community Integrated Care Team rollout, Discharge to Assess pathways, Primary Care services in A&E to support minor ailment streaming, clinical navigator and ensuring staffing levels in ambulance assessment area
- Decision by A&E Delivery Board (7/12/16) to focus on FLOW in hospital and address high bed occupancy with ECIP support to implement SAFE bundles of actions (focus on AMUs, acute elderly, discharge status and lounge) to address 11% increase in NE admissions, and the 28% of those admissions with LOS <24 hrs
- Address high levels of stranded patients (over 7 days in hospital) to reduce from 58% to national average of 30%
- Winter plan assurance and primary care access

Medium-term (Q1&2 2017/18)

- Delivery of full A&E Board Delivery Plan based on national 5 Imperatives
- Agree impact of S&R ED Medical Assessment Model on reporting and delivery of 4 hour target
- STP funding bid for liaison psychiatry

Resources and mitigations required/ to be agreed:

1. System decision on funding/ supporting medical and surgical assessment units and further utilisation of Ambulatory Care Unit from December 2016
2. Approach to delivering and impact of the new NHSI provider A&E scorecard from April 2017

RTT: Performance Summary October 2016

NHS Vale of York Clinical Commissioning Group

Summary: RTT performance is below constitutional target of 92% - YTHFT is responsible for 79% of the 8.49% under performance which equates to 6.71%. York tends to be the main driver of the measure in each specialty – except for T&O and Plastics (Leeds TH).

Commissioner Org Name	Provider Org Name	Total	Breach	%	Impact
NHS VALE OF YORK CCG	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	13040	1077	91.74%	6.71%
	LEEDS TEACHING HOSPITALS NHS TRUST	927	104	88.78%	0.65%
	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	274	38	86.13%	0.24%
	MID YORKSHIRE HOSPITALS NHS TRUST	183	36	80.33%	0.22%
	NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	138	28	79.71%	0.17%
	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	453	27	94.04%	0.17%
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	162	9	94.44%	0.06%
	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	43	5	88.37%	0.03%
	CLIFTON PARK HOSPITAL	395	5	98.73%	0.03%
	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	14	3	78.57%	0.02%
	SPIRE HULL AND EAST RIDING HOSPITAL	8	3	62.50%	0.02%
	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	17	3	82.35%	0.02%
	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	6	2	66.67%	0.01%
	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	7	2	71.43%	0.01%
	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	11	2	81.82%	0.01%
	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	11	2	81.82%	0.01%
	NUFFIELD HEALTH, YORK HOSPITAL	141	2	98.58%	0.01%
	THE ROTHERHAM NHS FOUNDATION TRUST	2	1	50.00%	0.01%
	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	1	1	0.00%	0.01%
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	14	1	92.86%	0.01%
	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	2	1	50.00%	0.01%
	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	2	1	50.00%	0.01%
	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	1	1	0.00%	0.01%
	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	3	1	66.67%	0.01%
	FRIMLEY HEALTH NHS FOUNDATION TRUST	1	1	0.00%	0.01%
	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	1	80.00%	0.01%
	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	4	1	75.00%	0.01%
	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1	1	0.00%	0.01%
	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	13	1	92.31%	0.01%
	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6	1	83.33%	0.01%
	NORTH BRISTOL NHS TRUST	2	1	50.00%	0.01%

Split by specialty as follows October 2016:

Provider Org Name	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST			
RTT Part Description	Incomplete Pathways			
Commissioner Org Name	**Treatment Function Name**	**Sum of Total All**	**Sum of Breaches**	**Sum of %**
NHS VALE OF YORK CCG	Cardiology	790	48	93.92%
	Dermatology	959	62	93.53%
	ENT	1121	62	94.47%
	Gastroenterology	927	61	93.42%
	General Medicine	192	3	98.44%
	General Surgery	2032	232	88.58%
	Geriatric Medicine	168	0	100.00%
	Gynaecology	717	77	89.26%
	Neurology	345	13	96.23%
	Ophthalmology	1864	141	92.44%
	Other	1157	53	95.42%
	Plastic Surgery	92	5	94.57%
	Rheumatology	377	31	91.78%
	Thoracic Medicine	481	73	84.82%
	Trauma & Orthopaedics	866	49	94.34%
	Urology	952	167	82.46%
NHS VALE OF YORK CCG Total		13040	1077	91.74%

RTT

NHS Vale of York Clinical Commissioning Group

Q2 PERFORMANCE:
July 2016: 91.8%/ August 2016: 91.5%
Sept 2016: 91.6%
LATEST PERFORMANCE:
October 2016: 91.5%
Current non-admitted backlog at YHFT is 3,500 patients more than same time last year (Aug 2015-6) of which 900 patients have now waited more than 18 weeks. Admitted backlog is 1280 (IMAS model identifies sustainable backlog 240)
Key causes:
- Bed pressures (43 cancellations October)
- Theatre list cancellations (6-10 sessions per week/ 102 cancelled in Q2)

SYSTEM BOARD & MECHANISMS:
Local Place: Planned care programme in ACS
COG: TBC – re-establish 'planned care group'
STP: Strategic Collaborative Commissioning workstream (includes thresholds/ Outpatients)
CCG: Finance & Performance Committee

SYSTEM LEADS:
SRO: TBA
Clinical Lead (CCG): Shaun O'Connell
Exec lead (CCG): ED Transformation & Jim Hayburn
Programme Lead (CCG): Andrew Bucklee

Confirmed 2 year trajectory:
Return to sustainable position at 92%: April 2017 within forecast activity model (growth related to managing the current backlog will be excluded and managed discretely through system RTT recovery plan)
Maintenance throughout 2017/18 and 2018/19

RECOVERY PLAN:
Short-term (Q4 2016/17)
- ✓ YHFT internal recovery plan – recruitment to theatre and key specialties in progress; improved theatre capacity planning; roll validation 14 wks+ non-admitted waiting lists; streamlining validation; additional OP clinics; RTT management tightening; subcontracting to Nuffield (urology), Ramsay (gynae & MaxFax) and Clifton (ortho); specific ophthalmology action plan
- ✓ Work with Clinical Exec at CCG to drive any further primary care-led demand management (e.g. dermatology)
- ✓ Establish system task and finish group as precursor to ACS planned care programme – develop system RTT recovery plan in Q4
- ✓ On-going impact/ expansion of RSS and reduction on referrals and OPAs wi focus on 2WWs (link to cancer recovery)
- ✓ NHSE support: additional demand and capacity planning capacity available
- ✓ Discussion with NHSE re: maxfax (dental) – shortages of capacity region

Medium-term (Q1&2 2017/18)
- Management of growth in demand through impact of clinical thresholds policy from April/ May 2017
- Pathway review (local & STP) including STP funding bid for diabetes
- Rightcare (local & STP): MSK, gastro, circulatory, neuro, resp med
- Outpatients review
- Establishment of ACS and programme for planned care
- Explore extension of devolved budgets to primary care - gynaecology, ENT and gastroenterology

Resources and mitigations required:
1. Some additional funding via NHSE to support subcontracting out to other regional providers (process TBC by NHSE)
2. System review of YHFT of RTT backlog modelling by speciality to inform system RTT recovery plan.

Cancer

NHS Vale of York Clinical Commissioning Group

Q2 PERFORMANCE:
Sept 2016:
31 days subsequent surgery - 92.1% (2 derm & 1 H&N)
62 days to treatment – 71.8% (demand increase in derm/H&N/colorectal/upper GI)
LATEST PERFORMANCE:
October 2016:
14 days: 88.1% (102/ 854 patients – dermatology & colorectal)
62 days: 75% (21/ 84 patients)
31 days: recovered to 97.5%

SYSTEM BOARD & MECHANISMS:
Local Place: Planned care programme in ACS
COG: York & Scar Cancer Locality Group
STP: Cancer Alliance Board; Y&H Cancer network
CCG: Finance & Performance Committee

SYSTEM LEADS:
SRO: TBC
Clinical Lead (CCG): Dan Cottingham
Exec lead (CCG): ED Transformation & Jim Hayburn
Programme Lead (CCG): Paul Howatson
STP: TBC

Confirmed 2 year trajectory:
Return to sustainable position: Q1 2017 within forecast activity model
Maintenance throughout rest of 2017/18 and 2018/19

RECOVERY PLAN:
Short-term (Q4 2016/17)

- 2WWYork hospital site now back on track with dermatology workload management Locum capacity now in place but Scarborough still experiencing delays
- YHFT recovery plan new being developed – final for approval end Dec 2016 (part of wider Trust performance mgt framework):
  - 62 days:
    - RCA work with Hull around theatre cancellations
    - RCA work with tertiary centres re: delays in diagnostics
    - Internal YHFT work to reduce pathway from 31 days to 28 days and validati
    - Breach analysis weekly
- Continued demand mgt schemes (RSS both VoY & S&R), improving digital images and work with Clinical Exec at CCG to drive any further primary care-led demand management
- Regional Cancer Alliance Work plan for approval 18/1/17
- Establish system task and finish group as precursor to ACS planned care programme – develop system RTT recovery plan in Q4

Medium-term (Q1&2 2017/18)

- Establish ACS planned care programme to include RTT and cancer
- Start delivery of Cancer Alliance work plan through ACS and STP – includes regional diagnostics capacity model including shared radiology; pathway streaming
- STP transformation fund bids x 3:early diagnosis, recovery, & risk strat

Resources and mitigations required:
1. Approval of final Cancer Alliance workplan after 18/1/17 and rapid mobilisation in VoY locality

Mental Health: IAPT

NHS Vale of York Clinical Commissioning Group

LATEST PERFORMANCE: October 2016:

☐ Access levels 14.1%, up from 12.7% in Sept & above the planned trajectory of 13.1% but below the 15% target

☐ Recovery rates 45.9% down from 46.1% in Aug, below the planned trajectory of 47% against a national target of 50%

☐ 6 week finished treatment 77.6% down from 79.6% in Aug, above the planned trajectory of 69.0% & nat target of 75.0%

❑ 18 week finished treatment 98.2% above 95% target

Improvement has been variable but now approaching the 2016/17 targets

Reasons for poor performance:

- historic lack of funding and access
- new patient administration system (PARIS) was implemented & this led to a number of data quality issues
- data quality has been improved
- workforce development issues/ counsellor contracts

SYSTEM BOARD & MECHANISMS:
Local Place: MH programme in ACS
STP: Collaborative STP MH programme
CCG: Finance & Performance Committee
SYSTEM LEADS:
SRO/ STP: TBC
Clinical Lead (CCG): Louise Barker
Exec lead (CCG): Elaine Wyllie
Programme Lead (CCG): Paul Howatson

Confirmed 2 year trajectory:

Access: 16.8% 17/18 and 19% in 18/19
Recovery: 50% from Q1 17/18 and throughout 18/19
6 weeks access: 75% from Q1 17/18 and throughout 18/19
18 weeks access: 95% throughout 17/18 and 18/19

RECOVERY PLAN:

Short-term (Q4 2016/17)

- CCG to prepare General Practice & primary care MH special bulletin 19th Dec
- New contract with clear expectations, outcomes and KPIs to work towards sustainable delivery of improved performance & managed robustly through CMB and Q&P, with clear commitment by the provider executive team to drive system improvements & ensure sustainable delivery of all metrics/KPIs
- Increased collaboration with the provider to develop and agree joint plans to address the non-achievement of KPIs and trajectory
- Initiatives include:
  - more straightforward referral forms, clearer referral criteria are driving the number of increased referrals and the provider now actively encourag self-referrals
  - using a combination of different channels and methods of delivery to increase the choice and uptake for service users, including one-to-one, group and web-based sessions
- The provider reviews workforce, workload and distribution by practice to ensure any variability is understood and referral patterns are acted upon
- The local services are monitored by the CCG & supported by additional inputs from the Assurance & Delivery, Clinical Strategy and Intensive Support Teams
- The Intensive Support Team to be involved in a local review of service delivery with CCG and TEWV. Findings from this review will be rapidly acted on to ensure that improvements in delivery are implemented asap. IST starts19/12/16

Medium-term (Q1&2 2017/18)

- Development of VoY Locality/ population based mental health plans

Resources and mitigations required:

1. Impact of/ on current option appraisal of PCU/ joint commissioning for NY CCGs
2. Seasonal referral variations/ workforce pressures in counselling capacity in locality

Mental Health: CAMHS

NHS Vale of York Clinical Commissioning Group

LATEST PERFORMANCE - October 2016:

- Access 14.1% against target 15%
- Recovery 43.6% against target 50%
- 257 patients awaiting their initial assessment or first treatment appointment
- CQC request validation of no. of looked after children- confirmed none on the validated waiting list

Reasons for poor performance

- increased rates of referrals to services from across the children and young people's age ranges &higher degrees of acuity
- a new patient administration system (PARIS) was implemented & data quality issues
- workforce challenges due to there now being two different providers fulfilling the two commissioned contracts - TEWV now fulfils the CCG contract whereas Leeds York Partnership Foundation Trust fulfils the NHS England inpatient CYPMHS contract

SYSTEM BOARD & MECHANISMS:

STP: Collaborative STP MH programme
CCG: Finance & Performance Committee

SYSTEM LEADS:

SRO: TBC
Clinical Lead (CCG): Louise Barker
Exec lead (CCG): Elaine Wyllie
Programme Lead (CCG): Paul Howatson
STP: TBC

Confirmed 2 year trajectory:

Access target 15% from Q1 17/18 and maintenance in 18/19
Recovery target 50% from Q1 17/17 and maintenance in 18/19

RECOVERY PLAN: **Short-term (Q4 2016/17)**

Vale of York CCG Waiting List Initiative with CAMHS TEWV

CCG have requested that TEWV lead on and provide capacity to reduce the waiting list and improve access for children and young people.
TEWV to ensure that the range of interventions offered to reduce the waiting list are in line with the Thrive model in providing services for 'getting help' and 'getting more help' cohorts. Project plan in development as follows:
1. York MIND to offer those children and young people on the waiting list with a lower level of need, eg, low mood, anxiety, in the form of 1:1 counselling or group work. 35 cases identified cost of £15,000
2. Focus – ADHD assessments and interventions. 24 cases cost of £25,200.
Private provider 1: 26 cases cost of £20,748 over 13 weeks (from 1st Jan – 31st Mar)
Private provider 2: 26 cases cost of £15,975 over 13 weeks (from 1st Jan – 31st Mar)
Total cost of interventions: £76,923 & Reduction from waiting list: 111

Other:

- new contract clear expectations, outcomes and KPIs included to drive performance through CMB and Q&P
- clear commitment by the provider's executive team to drive system improvements thereby ensuring sustainable delivery of all metrics and KPIs
- increased collaboration with the provider with jointly agreed plans to address the non-achievement of the KPIs
- development of a single point of access early in 2017
- additional inputs from NHSE Assurance & Delivery and Clinical Strategy
- CCG to prepare General Practice & primary care MH special bulletin 19th Dec

Medium-term (Q1&2 2017/18)

- Development of VoY Locality/ population based mental health plans

Resources and mitigations required:

1. Additional funding for action plan to support further cohorts of children on waiting list
2. Impact of/ on current option appraisal of PCU/ joint commissioning for NY CCGs

Mental Health: Dementia

NHS Vale of York Clinical Commissioning Group

Q2 PERFORMANCE:
Sept 2016: 54.7%

LATEST PERFORMANCE:
October 2016: 55.3%
November 2016: 55.69%
Against target 67%

Confirmed 2 year trajectory:
Achieve target 67% Q1 17/18
Maintenance throughout rest of 2017/18 and 2018/19

SYSTEM BOARD & MECHANISMS:
Local Place: MH programme in ACS
STP: Collaborative STP MH programme
CCG: Finance & Performance Committee

SYSTEM LEADS:
SRO: TBC
Clinical Lead (CCG): Louise Barker
Exec lead (CCG): Elaine Wyllie
Programme Lead (CCG): Paul Howatson
STP: TBC

RECOVERY PLAN:
Short-term (Q4 2016/17)
- Existing dementia action plan (see Annex 1)
- Push to drive up primary care coding targeting practices with greatest potential
- Address system toolkit technical difficulties to support Q4 next wave of practices to be targeted
- CCG to prepare General Practice & primary care MH special bulletin 19th Dec

Medium-term (Q1&2 2017/18)
- Development of VoY Locality/ population based mental health plans
- Incorporate dementia as part of a wider 'ask' of primary care for support in prevention, access and early diagnosis

Resources and mitigations required:
1. Access and target additional funding to support this additional coding
2. Engagement with primary care including via CoR and practice visits
3. Resources and mitigations required:
4. Impact of/ on current option appraisal of PCU/ joint commissioning for NY CCGs

Transforming Care: Progress against 2016/17 plan

LATEST PERFORMANCE: December 2016:
The CCG has already worked with its provider and closed one inpatient facility with TEWV reinvesting funding in community services including crisis.
VoY CCG had 6 clients out of area, all of whom are jointly funded (led by HAS) and one has recently returned to the locality. The 5 remaining clients are in non-secure hospital beds as follows:

Client:	Inpatient unit:	Progress with discharge and transfer to community/ home care:
1 (long-term)	Lincoln (independent hospital)	CTR April 2016 – decision to proceed with discharge planning. Significant delays due to providers being unable to offer packages and unable to source appropriate accommodation Brokerage also sent out to increase options Clinical team reservations on discharge but family sought legal advice to support discharge ACTION: Local CLDT to review
4	Oak Rise LD acute admission unit	1 x planned discharge confirmed 3 x mental health issues limiting discharge and further MDTs in December (1 x CTR completed April 2016)

RECOVERY PLAN:
- Case managers attending reviews
- Weekly updates from clinical teams
- RPIW discharge planning improvement support to Oak Rise to incorporate CTR process

Confirmed 2 year trajectory: The CCG is currently meeting its trajectory to reduce CCG commissioned beds. However, the TCP area as a whole is slightly off trajectory due to increased activity in specialist commissioned beds. Work to progress achievement of the combined bed reduction trajectory is being managed through the TCP with support from NHSE Area team. Work is ongoing (as described above) to ensure the community support is in place to facilitate discharge from hospital settings and ensure re-admission rates are minimal.

SYSTEM BOARD & MECHANISMS:
Local Place: MH & LD/ complex programme in ACS
STP: Transforming Care Partnership Board (TCP) has been established to manage and deliver the 'Building the Right Support' (BTRS) agenda
CCG: Quality & Patient Exp Committee; PCU

SYSTEM LEADS:
SRO: TBC
Clinical Lead (CCG): Louise Barker
Exec lead (CCG): Michelle Carrington
Programme Lead (CCG): Paul Howatson

Resources and mitigations required:
1. Impact of/ on current option appraisal of PCU/ joint commissioning for NY CCGs

Our Financial Modelling

We are working to deliver **financial recovery** through our CCG Improvement Plan with an immediate focus on the 2016/17 financial deficit.

As part of a **longer-term approach** to financial recovery we have undertaken a different strategic approach to financial modelling.

Medium Term Financial Strategy: New system of care

NHS
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Clinical Commissioning Group

- VoY CCG recognises that it will need to take a new approach if it is to become financially sustainable. Up until now, the health and social system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings

- VoY's strategy for delivering change is grounded in the work of the Humber, Coast and Vale STP and includes a vision for commissioning based around the development of an accountable care system for the population of VoY

Characteristics of the new system of care will include:

- Realigning resources within the system through an outcomes-based approach to commissioning
- Supporting the right care and the right workforce to be delivered in the most efficient cost settings
- Incentivising and implementing a whole system approach to prevention
- Employing new contracting models and payment structures, including a phased move away from PbR, to deliver the right incentives and behaviours

- Successfully implementing an **Accountable Care Model** will require the VoY system to demonstrate a series of capabilities and work closely with its STP partners to deliver on this significant programme of change

Medium Term Financial Strategy – a new approach to commissioning

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Executive Summary from the Draft MTFS

VoY's current situation

- Vale of York CCG commissions health services on behalf of a population of 350,000
- The CCG has had an underlying financial deficit since its creation in 2014 and reported a deficit position of £6.3m at the end of 2015/16
- The CCG is one of nine to have recently been put into Special Measures by NHS England and received Legal Directions on 1st September 2016
- VoY responded with the development of a Financial Recovery Plan ('FRP'), submitted to NHSE on 6th October 2016, and including a plan to achieve an in-year deficit of no more than £7m (£13.3m cumulative)[1]
- A new Accountable Officer has also been appointed (in post from 3rd October) to oversee the rapid organisational change required and inject challenge

Purpose of financial strategy

- The CCG recognises the need to articulate a strategic plan which addresses the underlying causes of financial deficit and identifies a path to sustainability
- VoY spends less per head of population than any other CCG within the STP footprint yet receives the lowest allocated spend per head from NHSE (a function of how the allocation formulae recognises the health needs of the population)
- This means that the CCG needs to spend 11% less per person than the STP average in order to live within its means

- The Medium Term Financial Strategy seeks to:
  - **outline a plan** for how the CCG can reach a balanced and sustainable financial position
  - **align with existing system plans**, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan (which VoY is a partner to)
  - **meet key statutory financial targets and business rules**
  - **be consistent with the CCG's vision** and support the delivery of the CCG objectives
  - recognise and **meet the scale of the challenge** in the Five Year Forward View
  - **deliver operational and constitutional targets**
- VoY has taken a fundamentally different approach to the development of its strategy based on a detailed understanding its local population needs which has allowed it to pinpoint a number of areas it needs to focus on

A new approach to commissioning

- The CCG believes that, in order to deliver real change, a radical new approach to system leadership, commissioning and delivery is now required
- Up until now, the health and social care system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings

Medium Term Financial Strategy – a new approach to commissioning

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Executive Summary from the Draft MTFS

This is evidenced by the fact that only 24 to 29% of the CCG's targeted QIPP cost savings have been achieved over the past two years

Moving forward, VoY needs to play its part in redesigning and delivering a new health and social care system which is better able to care for patients, whilst also delivering financial sustainability

VoY's strategy for doing this is embedded in the work of the STP and includes a vision for new models of accountable care in VoY, strategic commissioning across the system and new approaches to system governance and risk sharing

This builds on the ideas put forward in the Five Year Forward View and best-practice national and international examples of whole population management and outcomes-based commissioning

VoY has already made progress in a number of areas, for example in articulating a vision for a VoY Accountable Care System

Financial opportunity

The CCG has identified 6 areas of immediate financial opportunity to focus on: Elective Orthopaedics, Out of Hospital, Outpatients, Continuing Healthcare, Prescribing and High-cost Drugs

- Combined, these 6 opportunities have the potential to release savings to the CCG in the order of £50m by 20/21
- This would allow the CCG to reach in-year surplus by 19/20 although a cumulative financial deficit of approximately £24m at 20/21 would still remain
- A number of additional "pipeline" opportunity areas have also been identified but these are at an early planning stage only. If delivered in full, these additional opportunities would take the CCG's financial position to in-year financial balance by 18/19 and cumulative balance by 20/21
- The CCG has agreed delivery plans, next steps and work with stakeholders to progress each of the 6 major opportunities. 5 of these opportunities have the potential to deliver cost savings from 16/17
- Further work to firm up the size and potential for delivery of the additional pipeline opportunities is ongoing

- Next steps
- Moving forward, VoY recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals
- Development of the financial strategy will require close collaboration with providers and other STP partners, as well as a strong and realistic understanding of the capabilities required to deliver the new vision articulated

Medium Term Financial Strategy – a new approach to commissioning

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VoY's approach to understanding how we currently spend our population allocation based on population need

Report sections	Key activities
3 ***Population analytics and benchmarking***	• Reviewed weighted population allocation to understand areas where VoY does and does not "live within its means" • Conducted benchmarking with other STP commissioners to understand areas of VoY over- and under-spend • Reviewed VoY population characteristics to identify underlying cause of the deficit • Reviewed Right Care analysis to identify potential areas of saving • Reviewed other literature/best practice to identify
4 ***Financial opportunity***	• Identified specific financial opportunities based on population analytics/benchmarking analysis undertaken • Quantified opportunities based on evidence available • Phased savings over four year period to 20/21 • Calculated residual financial "gap" for VoY CCG under different scenarios • Reviewed delivery plans and enablers for each opportunity identified • Agreed approach to working with stakeholders and immediate next steps

Medium Term Financial Strategy – a new approach to commissioning

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We have identified 6 specific financial opportunities which we are taking forward to delivery immediately

- The CCG has identified 6 key areas of financial opportunity based on the population analytics and health benchmarking findings
- The annual potential planned savings for these until 20/21 are detailed below and are evidenced in further detail in the following slides
- This chapter also includes VoY's agreed approaches to delivering the opportunities identified, driven by the CCG's overarching new approach to commissioning, described in Section 2

Section reference	Opportunity	Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)
(4.2)	***1) Elective orthopaedics***	**4.2**	1.3	1.0	1.0	1.0
(4.3)	***2) Out of hospital care***	**21.3**	0.0	9.1	7.2	5.0
(4.4)	***3) Contracting for outpatients***	**5.0**	3.0	2.0	0.0	0.0
(4.5)	***4) Continuing healthcare and funded nursing care***	**9.3**	3.1	2.5	2.5	1.2
(4.6)	***5) Prescribing***	**6.2**	1.7	1.5	1.5	1.5
(4.7)	***6) High cost drugs***	**2.0**	0.2	0.6	0.2	1.0
	Total	**50.0**	**9.4**	**16.7**	**12.4**	**9.6**

Detail and evidence to support the proposed reduction of spend on each of these areas is included in the draft Medium Term Financial Strategy. This is starting a period of engagement and refinement to ensure the messages are clear to everyone in the CCG, partners and stakeholders. A summary stakeholder document has been prepared for this purpose.

2017/18 Financial Plan Summary

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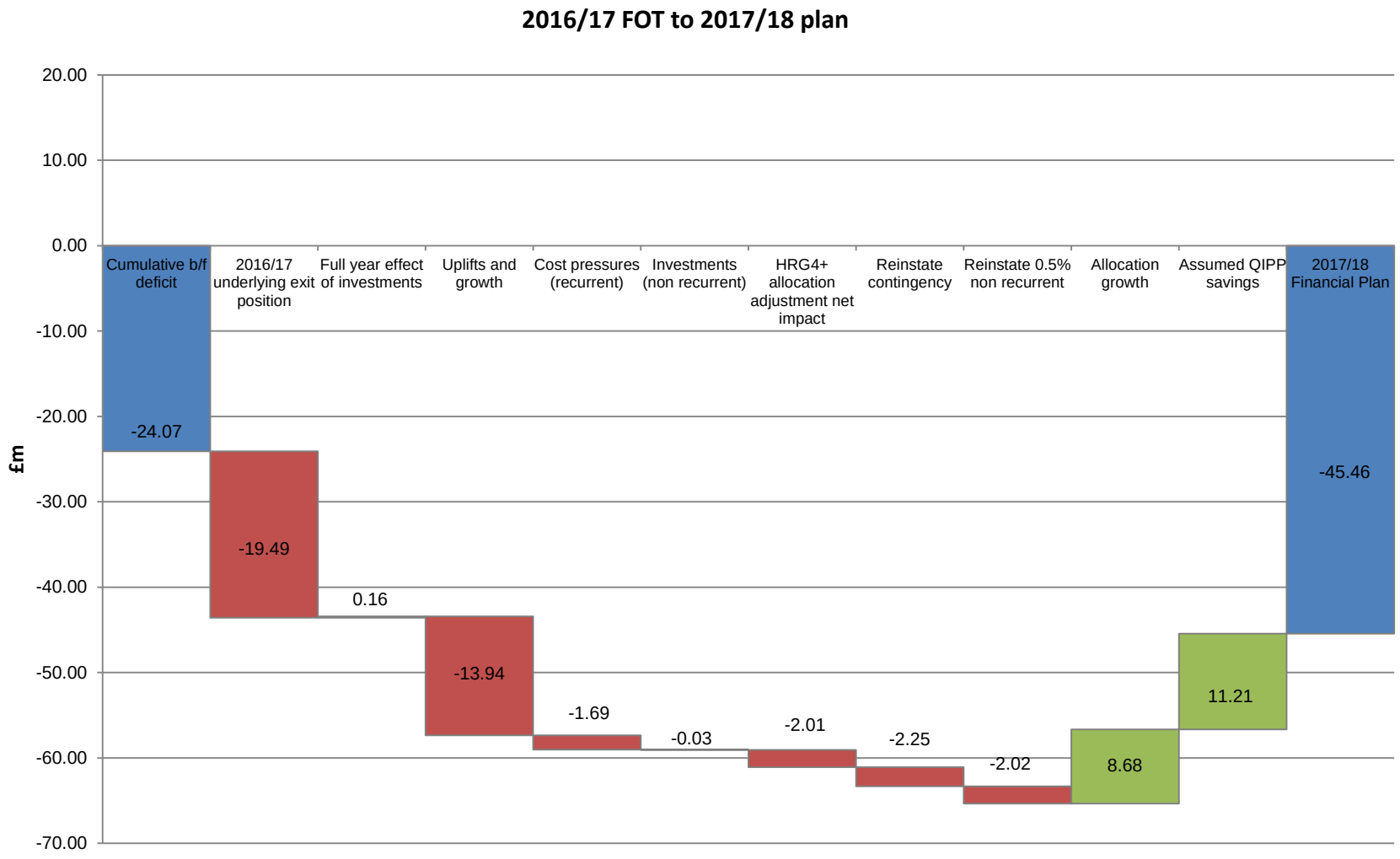
Headlines

- The Plan assumes a 2016/17 position of £24.1m deficit in line with the CCG Improvement Plan submission.
- The underlying deficit position of £19.5m along with inflation and growth of £13.9m have been applied.
- Allocation growth of £8.7m is included.
- A QIPP saving of £11.2m (2.5%) has been applied to the plan.
- This results in a 2017/18 cumulative deficit of £45.5m

Business Rules

- CCGs should plan for in-year break-even ✗
- CCGs should plan to spend 1% of allocation as non-recurrent expenditure ✗
- Deficit CCG to delivery a in-year breakeven position or deliver 1% of allocation improvement ✗
- 0.5% of non-recurrent expenditure should be uncommitted as a risk reserve ✓
- CCGs should plan for 0.5% Contingency ✓

Bridge chart - 2016/17 Forecast Outturn to 2017/18



Underlying position 2016/17 to 2017/18

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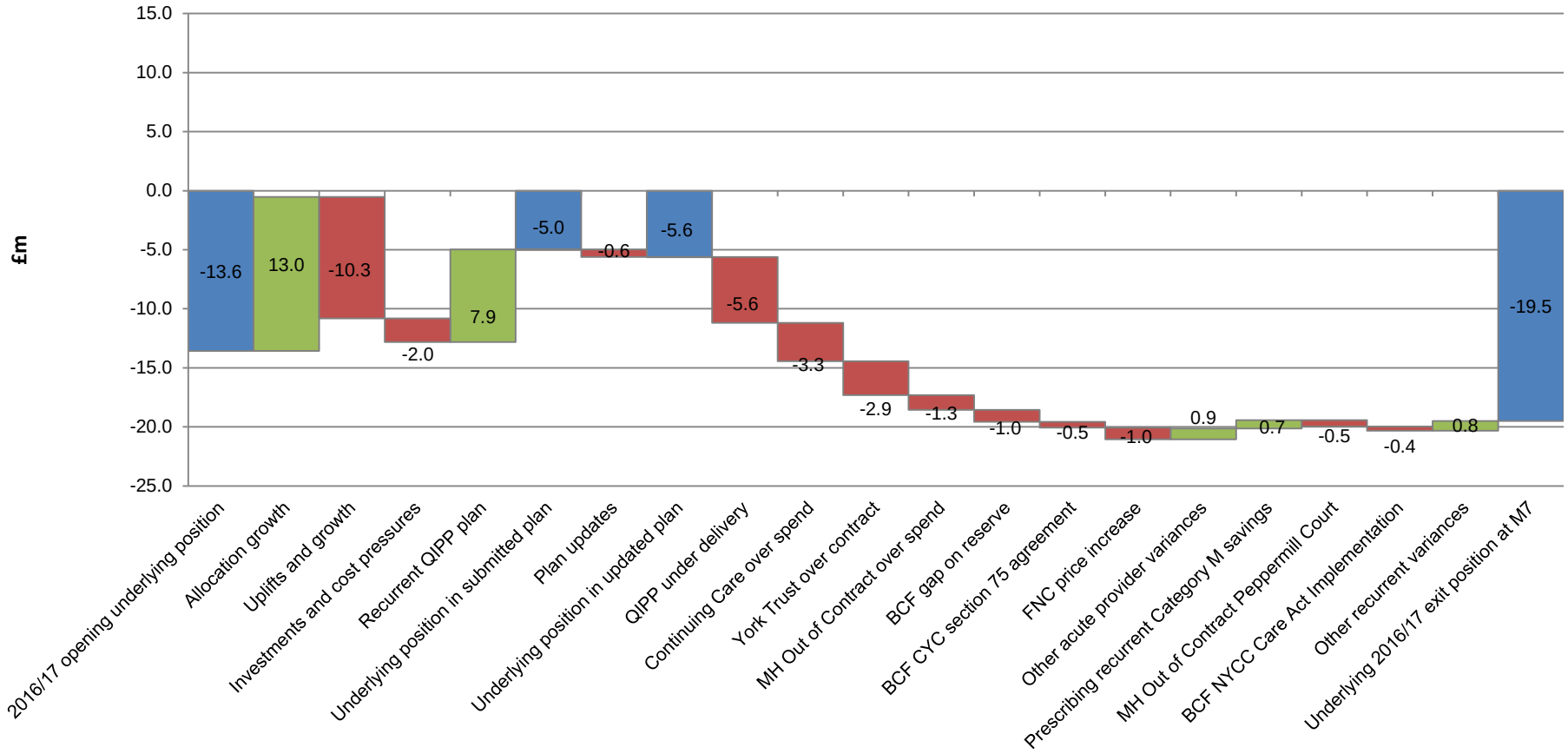

- The underlying deficit has deteriorated by £5.9m in 2016/17. The main drivers for this are an increase in acute activity, an increase in continuing care activity along with lower than planned delivery of QIPP.
- A review of the underlying position has taken place between the CCG and NHS England since the 1st draft submission of the 2017/18 plan.
- Assumptions around the treatment of recurrent and non-recurrent expenditure and savings and some assumptions were changed as a result of this.

Planning assumptions

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Inflation & growth assumptions

- Inflation accounts for £5.2m of the overall £13.9m Inflation and growth.
- Inflation has been applied in line with national tariff inflation. With the exception of continuing care and Primary care where PCU levels and nationally assumed primary care levels have been used.
- The growth levels that account for £8.8m are based on STP assumptions for growth levels, with the exceptions of continuing care and primary care where PCU levels and population growth have been used.
- An extensive process of challenge and review took place between NHS England and the CCG on the STP and PCU growth assumptions.

Cost Pressures, Investments & Contingencies

Cost pressures:

- Property Services move to market rent £1.7m
- Increase in Running Costs £0.2m

Investments:

- The CCG has been able to include the £3 per head for primary care but this is reliant on additional savings being made to generate it
- Contingency of 0.5% of allocation has been provided for.
- Non Recurrent risk reserve of 0.5% has also been provided

QIPP 2017/18

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- A QIPP target of £11.2m has been built into the plan which equates to 2.5% of the overall allocation.
- The critical areas for focus are derived from the Medium Term Financial Strategy and support delivery of the organisation's priorities.
- These sit alongside a number of other schemes delivering better value for the resources available.
- A joint CCG and NHS England confirm and challenge event has been held to confirm the QIPP target and determine executive responsibility for all areas of programme spend. This event reviewed the full value of the schemes identified in the pipeline and the FYE of schemes that commenced or that are due to commence in 2016/17 alongside new schemes planned for 2017/18 and 2018/19.

Risks to delivery of 2017/18 Financial plan

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- **Contracting** – the CCG are in discussion with York Foundation Trust regarding a non-PBR funding mechanism for 2017/18 as well delivering a single contract with the trust across all commissioning partners.
- **Activity and growth assumptions** – based on STU & PCU and also have been subject to challenge but could prove to be incorrect.
- **NHSPS** – increased market rent is built into cost pressures.
- **HRG4+ & IR allocation changes** – the risks and pressures created by changes to tariff are now included in the financial plan
- **BI & data quality/timeliness** – risk for planning activity levels with lack of data.
- **QIPP** – the previous performance of the CCG has been lower than the levels in this plan.
- **BCF** – the minimum amount required is in the plan but discussions are still to take place with the local authorities.
- **CHC** - Although growth has been added this remains a volatile area.
- **Running costs** – increasing the capability and capacity of the CCG has resulted in a fully committed running cost allocation.

Our Activity Modelling

We have worked with our provider partners to incorporate the impact of our known financial efficiency, growth and demand management, and recovery plans on the activity we will contract for.

Our approach to activity modelling

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The activity submission is based on an estimation of the planned level of activity for the 2017/18-2018/19 contract, calculated based on the financial plan value for each provider divided by the average activity cost. The methodology applied to calculate the financial plan for each Acute contract (at POD level) is as follows:-

The acute contracts in the financial plan are based on recurrent outturn position at month 6, adjusted for any known full year effects of investments or other changes. Tariff uplift and efficiency is then applied as per national guidance (2.1% uplift, 2% efficiency, plus an additional uplift for HRG specific CNST premium, equivalent to 0.7% of total tariff spend). Demographic growth is applied, based on the national IHAM model and in line with STP plans. The allocation adjustment for HRG4+ and IR rules have been applied based on the Trusts impact assessment. Proposed QIPP schemes have then been applied. The value of these schemes are based on the confirm and challenge numbers aligned with the Financial Plan, these are pending agreement with the Trust. Schemes have therefore been applied to the main contract and point of delivery that they are expected to impact.

The baseline modelling for the York Trust contract is well underway. We have agreed the baseline (should nothing in the system change) and are now finalising and negotiating the contract value to take into consideration the outstanding AQNs, a local assessment of growth requirements and QIPP schemes. The baseline activity is based on the following methodology:-

- 12 months data (July 15 – June 16), adjusted for forecast outturn as at Month 6 (2016/17) at Point of Delivery and Specialty level. The Forecast outturn is pre-populated by NHSE in the activity template for referrals and SUS based on the T&R database and therefore there are likely to be issues associated with using different datasets. The CCG uses referral data directly received from the Trust and adjusts SUS to remove activity which should be excluded for contracting and payment purposes i.e. activity seen in the Ambulatory Care Unit (ACU) which are coded as Day Case or Non-elective but are excluded as they are not admissions funded by PbR and are funded based a partial block and partial fixed local price payment model.
- Growth is included in the baseline based on the STP levels of growth (IHAM) but will be adjusted for based on a local assessment of trends and ONS population change as the CCG has implemented various schemes to manage demand. The IHAM estimated level of growth not take into account the excluded ACU activity (mentioned above) or the impact of the CCG's Referral Support Unit which has historically contained growth.

Our approach to activity modelling

- A further adjustment is applied to reflect the impact of local initiatives and pathway changes not fully reflected in the baseline (such as community diabetes service which reduces acute activity, the implementation of the ACU, coding correction for Palliative Medicine etc.)
- An adjustment for the Trust's coding and counting notification from the 30th September 2016 is applied.
- The impact of the IR rules are included based on the Trusts impact assessment.
- There are three Activity Query Notices currently being investigated being investigated by the Trust which are likely to impact on the baseline once concluded. We aim to resolve these early is the New Year.
- QIPP adjustments will be applied to the baseline and agreed with the Trust to derive the contract financial value.

Our Contracting and Risk position

We have agreed a Heads of Terms document which incorporates all the areas we will work jointly with our providers around in 2017/18 to close the activity and financial gap in the current contract values.

The programmes of work supporting that Heads of Terms will be captured within our ACS programmes to ensure there is a coherent link between the transformation work we do and the impact on our contracts (transactional).

Annex 1: Our Existing Work

We are already working in some areas to drive improvement and transformation with our partners.

These include the **GP Forward View, Urgent & emergency care, cancer** and **mental health**.

Not all our work is captured in coherent strategies or system-wide programmes, however, which means not everyone understands our work in a consistent way.

Our operational plan will take this work and develop it further as part of the system-wide programmes with our ACS and STP.

The following slides provide a high level summary of our work.

Prevention

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We have an agreed Prevention and Better Health Strategy that underpins the work on lifestyle improvement prior to elective surgery and more broadly the ambition to improve health and reduce inequalities which requires changes in the way that CCG resources are currently used.
The ACS and STP will work to identify the opportunities for all partners to deliver prevention 'at scale' across the system in order to have the greatest impact for our population well-being and demand on our services.

AIMS:

The CCG's aim as a partner in the local health and health system is to achieve the best health and well-being for everyone. We work with our local authority partners and our joint health and well-being strategies to enable and encourage people to live the healthiest lives possible within the resources available. This supports the system in getting the best value from the resources and prevent any avoidable use of NHS resources.

The Prevention and Better Health Strategy has been developed to demonstrate how focusing our efforts on prevention, self-care and shared decision-making can support a shift in the way health and care resources are valued, and to empower patients in the Vale of York to become more active participants in shaping their health outcomes.

This strategy is focussed on:

- tackling the common risk factors (especially smoking and obesity) for many of the major diseases affecting the population,
- improving the appropriate use of health care (including through increased 'shared decision making' and raising awareness of Patient Related Outcome Measures - PROMS)
- ensuring patients gain the most benefit from the health care interventions they receive
- supporting people to take responsibility for their own health.

This strategy underpins the specific policy approach for improving the MSK pathway and utilisation of elective surgery through the provision of patient support resources and collaboration with local authority partners in the commissioning of weight management and smoking cessation services.

Future prevention work will develop the collaborative commissioning of further prevention services with partner organisations, including detecting pre-diabetes and high blood pressure, reducing inactivity and alcohol consumption, increasing immunisation and uptake of cancer screening and helping people to understand their options and manage their own health through self-care and shared decision-making.

Primary Care: Delivering the General Practice Forward View

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AIMS:

1. **Investment in Primary Care – estates and workforce**
2. **Build resilience and patient access across practices in and out of hours, through:**

- Supporting, developing and extending the Primary Care workforce
- Transform the way technology is deployed and infrastructure utilised – developing an estates strategy
- Better management of workload and redesign how care is provided
- Addressing variation and benchmarking
- Improving data quality and continuous improvement
- Implementation of risk stratification tools

Primary care also have a pivotal role in:

- Delivering prevention and managing population health
- Managing system demand
- Developing and delivering new models of out of hospital care as part of integrated care teams in an accountable care system (ACS)

The CCG **GP Forward View Action Plan** outlines the proposed workstreams to drive this programme of work forward and align the plans to the emerging ACS. This has been submitted on 23/12/16 alongside this Operational Plan. The CCG Primary Care Committee has refreshed its governance arrangements in order to more effectively deliver this GPFV and support the Operational Plan and ACS.
The CCG Council of Representatives and the Local Medical Committee are working with the CCG Executive Team and the Clinical Executive to provide steer and support to the delivery of the Operational Plan.

Clinical Thresholds

NHS Vale of York Clinical Commissioning Group

Opportunities to standardise and optimise across the HCVSTP	
Improving the musculoskeletal (MSK) pathway	Improving the musculoskeletal pathway, for improving lifestyle risks prior to elective surgery and to manage the utilisation of elective surgery. Working with patients, public and partner organisations to improve health and reduce inequalities whilst making better use of resources and delivering NHS England Directions and the journey together towards a sustainable health and social care system that optimises outcomes for patients and the population you serve. Plans for improving the musculoskeletal (MSK) pathway – taking account of RightCare information, the financial challenges faced by the CCG, and your ambition to improve outcomes from surgery and to improve health across the population. Our plans for managing utilisation of elective surgery - taking account of the opportunity to improve lifestyle risks pre-operatively, improve outcomes from elective surgery and the financial challenges fac by the CCG.
Managing utilisation of elective surgery	This strategy is focused on: tackling the common risk factors (especially smoking and obesity) for many of the major diseases affecting the population, improving the appropriate use of health care (including through increased 'shared decision making' and raising awareness of Patient Related Outcome Measures - PROMS), ensuring patients gain the most benefit from the health care interventions they receive and supporting people to take responsibility for their own health. This strategy underpins the specific policy approach for improving the MSK pathway and utilisation of elective surgery.
	The strategy also aims to be consistent with the Local Authorities' Health and Wellbeing strategies and to promote the 'Wanless Report' recommended 'fully engaged scenario'. The strategy provides an analysis of the effects of smoking and obesity on health in general, the impact of smoking and obesity on outcomes of health care interventions and the benefits of stopping smoking and of losing weight / improving fitness pre-operatively.

Urgent and Emergency Care: Delivery Board Improvement Plan

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Delivery of the 4 hour A&E standard (including the new provider A&E scorecard) including the implementation of 5 elements of the A&E Improvement Plan	
ED Streaming:	Review of the Ambulatory Care Unit at 12 months is ongoing; colleagues are working to assess sustainability in the current format, and if there is the requirement for additional working hours (staffing) at the weekend in addition to the current provision. This work will be completed by the end of December 2016. There is also an acute frailty plan to improve the proportion of comprehensive geriatric assessment at the earliest opportunity which YTHFT are leading for both their sites.
NHS111:	Our partners have shared with us their design for new pathways across all of Yorkshire. We have a representative on the planning group for the Clinical Advisory Hub and have planned to roll out the expanded DOS to include social and voluntary care in this CCG area before the end of January 2017.
Ambulance ARP:	Our partners have shared their plans for this change in ambulance provision across all of Yorkshire before March 2017 and we are supportive of this.
Improved Flow:	YTHFT are leading the rollout of the SAFER standards across all of their acute and community hospital wards, as well as reviewing the use of clinical checklists and 'Red & Green days'. Their medical director is leading these workstreams.
Improved discharge processes:	Review and planning for all 'stranded' patients with stays of 7 days or more – this is a key area of improvement to which we are committed. The A&E delivery board on 7th December has this as a key agenda item as work with ECIP during 2016 has not yet delivered a significant change. Discharge to assess pathways are in operation for a limited number of areas; this is planned to roll out across all wards prior to April 2017. Work on Trusted Assessor proposals in private care homes has been ongoing for a significant period of time; the scheme has been operational in Council run care homes for some time, however the standard model cannot be implemented in this health economy. More scoping is ongoing to review if there is an in-hospital model that private care homes would support. There is no confirmed implementation date for this workstream for this reason.

Urgent and Emergency Care: Seven Day Hospital Services

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Meeting the four priority standards for seven-day hospital services for all urgent network specialist services by November 2017	
Steps and actions to implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 including a clinical hub that supports NHS 111, 999 and out-of-hours calls.	**Time to consultant review:** this standard has improved significantly during 2016, with the time for initial triage falling from over 100 minutes to 33 minutes across 7 days on the introduction of the Primary Care streaming in July 2016. With the additionality of the Comprehensive Geriatric Review planned as part of YTHFTs frailty plans we do not anticipate a difficulty in meeting this standard. **Diagnostic services:** Vale of York CCG are leading a comprehensive review of diagnostic services across 7 days currently. This is working with both primary care to ensure access in and out of hours and refining current pathways within YTHFT, This will deliver against a number of different workstreams over the next 12 months, and anticipate delivery against standards by November 2017. **Consultant directed interventions:** YTHFT are again leading on this workstream; a comprehensive review of consultant job plans to provide 7 day services has been commenced and it is anticipated that this level of service will be delivered by November 2017. **Consultant review:** progress against this standard is ongoing, also being led by YTHFT. It is anticipated that this will be met in all areas, including geriatric and HDU care by November 2017. The Vale of York CCG is a key member of the **STP Urgent and Emergency Care network**; with the Deputy Chief Operating Officer leading a number of workstreams across the region. The Urgent Care lead in the CCG is also a member of the group rolling out the **Clinical Hub (Advisory Service)** and plans are in place to deliver this to the approved trajectory; learning from the lessons in the affiliated West Yorkshire Vanguard/Accelerator site. Reprovision of the OOH GP service during 2015 included integration of NHS111 and out-of-hours and support is being provided to Yorkshire Ambulance Service to further integrate 999 services over the next two years. They hold the detailed plans for this workstream.

Urgent and Emergency Care: networked & Liaison services

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Meeting the four priority standards for seven-day hospital services for all urgent network specialist services by November 2017	The CCG has already commissioned a comprehensive **Urgent Care Practitioner programme** that delivers 'see and treat' across all of Vale of York CCG; with direct access for all Care Homes, Community Services teams and the York Integrated Care Team. This has been instrumental in reducing the proportion of avoidable transportation to A&E already; particularly in the area of falls and minor injuries. An improvement to the software used by NHS111 provided by Yorkshire Ambulance Service at the start of November 2016 is anticipated to increase further the proportion of NHS111 patients that are referred through to this part of the system as there is additional capacity available in the service to do this. This will further reduce the proportion requiring transportation.
Initiating cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis	The CCG has already designed and commissioned an **ED Psychiatric Liaison Service** within the last two years that delivers urgent care for those in a mental health crisis. This has a 1 hour response time within ED at all times, and includes multidisciplinary and multiagency support across Health, Social Care, Police and local Voluntary Sector services supporting those with drug and alcohol issues locally. Our **local** Better Care Funds also support a number of schemes including 'Pathways' for those who are hard to reach or are persistent attendees and provision of street triage and a 136 Suite.

Integrated Out of Hospital Care: an emerging Accountable Care System (ACS)

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VoY CCG plans to work with its commissioner and provider partners over the coming months to develop an accountable care operating framework for the VoY. An Accountable Care System Board would be accountable for delivering outcomes and represent all partners.

Such a framework would support closer integration between all aspects of care (primary, community, mental health and social) through a focus on realigning resources in such a way that maximises outcomes (end results) for residents and patients

Health and social care outcomes for the VoY population are commissioned through place-based integrated strategic commissioning. Local Accountable Providers provide an integrated set of services determined by local priorities and supported by common standards of governance, operations and decision-making. Delivery of services is based around primary-care focused neighbourhood teams, building on the CCG's pioneering work on integrated care hubs.

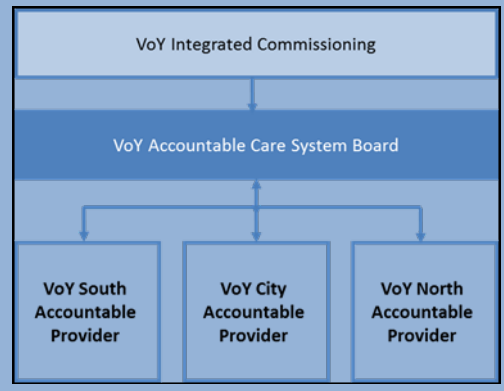
The CCG recognises that development of an accountable care system for the population of the VoY will require much further work.

A high-level five phase approach to the phases of work required is emerging that describe the process from agreeing a strategy to defining the accountable care framework (and the outcomes that it will need to deliver) to being able to negotiate and issue new contracts with providers.

The emerging ACS partners will come together on the 8th December to refine the programme of work and agree the governance required to mobilise this programme of work. . It is anticipated that linking the current pioneer Integrated Care Hubs pilots to the local Accountable Care System will commence in April 2017 and be a continuous programme of work from that point forward.

Principles

1. **Working together our system will:**
2. **Be person-centred, holistic and individual, involving people in their decisions**
3. **Promote independence**
4. **Be underpinned by effective communication and integration software to connect information systems**
5. **Offer value-for money and be cost-effective, rebalancing investment towards prevention and early intervention and removing/disinvesting in duplication**
6. **Support increased multi-disciplinary working and empower the front-line, thereby increasing professional satisfaction**
7. **Give a timely and unambiguous response to need**



Integrated Out of Hospital Care: an emerging Accountable Care System (ACS)

NHS
Vale of York
Clinical Commissioning Group

The Accountable Care System approach proposes new models of care across three place based localities within the Vale of York that allow us to take joint responsibility for improving the care and support of our population. These models will be tailored to the needs of the local population, system partners and geography

Vale of York CCG has been trialling three models of Integrated Care Teams, the forerunner of Multispecialty Community Providers, since June 2014. These include a model supported by General Practice, an outreach/response model supported by York Teaching Hospitals NHS Foundation Trust who provide acute and community services, and a community bed based model supported jointly by community staff and General Practice. Of these models, the first model supported by General Practice is being rolled out wider at present, so that all practices within the City of York boundary area will be participating. Initial results in managing attendances, preventing readmissions and providing proactive care for those with long-term conditions and at end of life have been good. It is planned that the whole of City of York will be incorporated into the existing Integrated Care Team by March 2017. The other models continue to be reviewed for effectiveness.

Additionally, as this team expands, work is ongoing to incorporate a number of other existing and planned schemes into this model. The first of these will be the reablement pathways that were designed with a large amount of patient and staff participation at the start of 2016. This work will be jointly done with City of York Council and joint outcomes are being finalized currently. The next phase will incorporate the Social Prescribing scheme with this; currently this is being run by York CVS. A formal review of effectiveness will be published by York St. John University in January 2017. Planning for current community services to be added and additional services to be transferred from the acute to the community sector is also well underway.

The CCG already support a monthly ‘Partners in Care’ meeting and have tested and implemented a number of schemes to support local care homes. We commission a number of beds in a local care home for rapid reablement with support from the acute sector in providing therapy support, we have provided a direct line for care homes to the Urgent Care Practitioner service and are gradually moving to the single GP/Home model. In addition, there have been a number of projects in both council run and private care homes that have tested new technologies such as dementia alarms, telemedicine support and run initiatives to review medication and improve diet and hydration among residents. We anticipate this will go some way to manage adherence to any future standards.

Mental health: Adult

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Adult mental health		
Strategic Aims	**Specific targets**	**What we intend to do**
That by 2020/21, there will be increased access to psychological therapies for people with common mental health conditions with the majority of new services being integrated with physical healthcare.	19% access in 2019 25% access in 2020/21 (National target of 3000 therapists to be co-located with GPs by 2020/21) 75% accessing therapy in 6 weeks (2020) 95% accessing therapy in 18 weeks (2020)	• Commission IAPT services with mental health therapists being co-located in primary care • Develop joint agency plans with the provider to meet access and timeframe targets • Implement the pilot in Harrogate for Integrated IAPT Early Implementer • Participation in NHS England programme for digitally-enabled IAPT (details to be available autumn 2016)
To provide timely access to evidence-based, person-centred care for people with first episode psychosis, which is focused on recovery and integrated with primary and social care and other sectors.	53% of people experiencing a first episode to begin treatment with a NICE-recommended package with a specialist early intervention in psychosis (EIP) service within 2 weeks of referral (2018/19) 25% of teams rated as good in CCQI assessments (2018/19)	• Develop joint agency plans with the provider to meet quality and timeframe targets following national audit for 2017/18
A reduction in premature mortality of people living with severe mental illness (SMI) and more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year	30% of people with SMI registered with a GP to have physical health screening / interventions (2017/18) 60% of people with SMI registered with a GP to have physical health screening / interventions (2018/19)	• Develop joint agency plans with the provider

Mental health: Adult

NHS
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Clinical Commissioning Group

Adult mental health		
Strategic Aims	Specific targets	What we intend to do
Increase access to Individual Placement Support enabling people with severe mental illness to find and retain employment.	Increase by 25% in 2019 against 2017/18 baseline	• Collect data to create a 2017/18 baseline • Develop joint agency plans with the provider • Implement workplace support workers as part of the IAPT services 2017/18
For all areas to provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice – delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.	To meet recommended best practice guidelines.	• Implement plans that will develop as a result of a review of current provision against core standards during 2016/2017. • Develop joint agency plans with the provider to ensure properly resourced crisis resolution and home treatment teams • Implement the safe haven schemes in York • Plan the safe haven schemes in Harrogate, Hambleton and Richmondshire and Scarborough • Consideration of potential additional crisis care capital investment bids in 2017/18 to improve health-based places of safety.
Eliminate inappropriate out of area treatments (OATs) for acute mental health care	Elimination of out of area placements for non-specialist acute care (2020/21)	• Develop joint agency plans with the provider to ensure robust monitoring of OATs for all bed types • Develop joint agency plans with the provider to ensure demonstrable reduction in acute OATs
Provision of 'core 24' mental health liaison services in emergency departments and inpatient wards in acute hospitals	Liaison mental health teams to be in place in all acute hospitals (2020/21) 'Core 24' services to be in place in 50% of acute hospitals (2020/21)	• Develop joint agency plans with the provider • Work within STPs to achieve buy-in across the organisations which will commission, provide and partner with those services and ensure that savings are identifiable in order to be reinvested. • Consideration of acute hospitals within the STP footprint that can serve as centres of excellence. • Consideration of models of crisis care for children and young people evaluated by NHS England during 2016/17

Mental health: Adult

NHS
Vale of York
Clinical Commissioning Group

Adult mental health		
Strategic Aims	Specific targets	What we intend to do
To provide timely access to diagnosis and evidence-based, person-centred care for people with dementia	By 2019 half of CCGs should have diagnosed 67% of estimated local prevalence. By 2020 the number being diagnosed and starting treatment should be increased by over 5% compared to 2015/16 baseline.	• Review of services against forthcoming NHS implementation guidance focusing on post-diagnostic care and support and development of a plan to address the gaps. • Increase the diagnostic rates in all CCGs
Work with TEWV NY who are a pilot site on an NHS England led programme to put in place new approaches which strengthen care pathways to improve access to community support, prevent avoidable admissions, reduce the length of in-patient stays, and eliminate inappropriate out of area placements.	The pilot will be formally monitored and outcomes evaluated	• Develop a joint agency plan with the provider

Mental health: Adult

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Adult mental health		
Strategic Aims	Specific targets	What we intend to do
Provision of armed forces / veteran mental health services.	By 2020/21, all NHS-commissioned mental health providers will have armed forces champions and a specific named clinician with an expertise in military trauma.	• Develop joint agency plans with the provider 2017/19 • Support co-commissioning work with NHS England for the national procurement of local specialist community services, and investment in research to improve the evidence base on effective interventions for the armed forces community. 2017/18
Expand community-based services for people who require them to prevent avoidable admissions and support 'step down' and ongoing recovery in the community as soon as appropriate for the individual and as close to home as possible.		• Evaluate current pathways in and out of mental health secure care with a focus on expanding community-based services
Reduction in suicide levels	Reduction of 10% against 2016/17 baseline	• Implement local multi-agency suicide prevention plans together with local partners 2017-2020

Parity of Esteem	The CCG is working closely with partner organisations to raise the profile of mental health across the local economy giving it true parity of esteem. Several key strategic objectives for mental health have been included in the local Health and Wellbeing Strategy.
Carers	The local provider has begun to work with mental health carers to ensure that their voices are heard and services are further developed in terms of crisis response services. The local system was also successful in a capital bid to develop a local Safehaven facility.

Mental Health: Crisis and Liaison

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Liaison mental health services (for adults, older adults children and young people)	The CCG and Provider are implementing an agreed and funded service development and improvement plan for a dedicated mental health crisis and liaison response for children and young people presenting to emergency departments, in wards and community settings which includes provision for a response across extended hours. The liaison service commissioned needs to provide a 1 hour response time following an Emergency Department referral and 24 hour response time following a ward referral (adults). The CCG is partially compliant currently.
	The CCG is working closely with the provider TEWV to quantify the number of patients and reasons for OAT and validate action plans to reduce the use of all types of mental health out of area placements. A trajectory for 2017/18 will be confirmed in Q4 of 2016/17. These will inform an Out of area treatment and plans to reduce the usage of out of area placements fo non-specialist acute mental health inpatient care. The CCG is partially compliant currently.
	Crisis resolution home treatment teams (adults) are being commissioned which offer intensive home treatment in line with recommended practice (i.e. by routinely visiting people at least twice a day the first three days of home treatment, providing twice daily visits when required thereafter, and routinely offering visits that allow enough time to prioritise therapeutic relationships and help with social and practical problems) The CCG is fully Compliant currently.
Crisis Concordat including Suicide	Likewise there has been a very strong crisis care concordat which has been very progressive in supporting projects such as Pathways Together which employs support workers to assist people with complex lives reduce their dependence on crisis, emergency and other statutory services. Psychiatric liaison and crisis response services are developing now across the Vale of York and are a key part of the local service offer in-reach into acute hospitals and emergency departments which will continue to grow and develop further. After a recent suicide audit the CCG and partners will develop an action plan to tackle future suicide rates by 10% against the 2016/17 baseline. All partners are committed to making the Vale of York a safer place.

Mental health: Children and Young People

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Children and young people's Mental Health		
Strategic Aims	Specific targets	What we intend to do
Increase access to high-quality evidence based mental health care treatment for children and young people.	Increase access by 7% in 17/18 Increase access to 32% by end 18/19	• Implement actions resulting from Local Transformation Plans for children and young people's mental health to be published on 31 October 2016 • Commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people • Develop joint agency plans with the provider to achieve targets
Increase access to evidence-based community eating disorder services	95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases	• Commission dedicated eating disorder teams in all areas • Join QNCC ED • Baseline current performance against the access and waiting time standard 2016/17 and plan for improvement from 2017/18 • Develop joint agency plans with the provider to achieve targets
For in-patient stays for children and young people to only take place where clinically appropriate, to have the minimum possible length of stay, and to be as close to home as possible to avoid inappropriate out of area placements.	By 2020/21 elimination of in-patient stays where clinically inappropriate. Zero out of area placements for non-specialist acute care. Zero use of beds in paediatric and adult wards	• Implement actions resulting from collaborative commissioning plans with NHS England's specialist commissioning teams to be published by December 2016. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need and where there are reductions releasing resources to be redeployed in community-based services • Move towards all general in-patient units for children and young people to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways • Utilise money released from pump-priming of 24/7 crisis resolution and home treatment services to achieve further improvements in access and waiting times • Develop joint agency plans with the provider to achieve targets

Mental health: Children and Young People

NHS
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Clinical Commissioning Group

Children and young people's Mental Health		
Strategic Aims	Specific targets	What we intend to do
For all areas to be part of CYP IAPT including taking part in workforce capability programme.	National target for at least 1,700 more therapists and supervisors to be employed to meet additional demand.	• Commission CYP IAPT in all areas in 2017/18 • Ensure that all services are working within the CYP IAPT workforce programme. • Implement joint agency plans between CCGs and providers to ensure continuing professional development of staff
To ensure availability of 24/7 urgent and emergency mental health services for children and young people.		• Collect data to create a 2017/18 baseline • Develop joint agency plans with the provider to achieve targets

Perinatal mental health		
Strategic Aims	Specific targets	What we intend to do
Increase access to evidence-based specialist perinatal mental health care	100% access by 2020/21	• outcome of bid to perinatal community fund expected October / November 2016 • If bid unsuccessful plan 2017/18 for service • Include service in mainstream CCG allocations from 2019/20

Mental Health: Children and young people

NHS
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The CCG is working closely with key partners to building sustainable system wide transformation to deliver improvements in children and young people's mental health outcomes	
The CCG is working with partners updated and re published the assured local transformation plan (LTP) from 2015/16 which includes baseline data The CCG has published the refresh of the Local Transformation Plan on its website. Baseline data is being currently being collated, which needs to be incorporated into the published plan to make this action fully compliant..	Partially compliant
The CCG is working closely with the provider TEWV on developing collaborative commissioning Tier 3 and 4 CAMHS plans. In addition TEWV are part of a pilot for Tier 4. It is expected this action will be compliant by end of December 2016.	Partially compliant .
The CCG will publish the joint agency workforce plans detailing how they will build capacity and capability including implementation of Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT) transformation objectives. This action is part of the Local Transformation Plan, to be completed this year (16/17).	Partially compliant
Development of new adult and older people's inpatient, treatment and assessment facility. The CCG has identified the need for fit for purpose mental health estate and facilities supported by significant consultation as a key priority for transformation since 2015.	Partially compliant

Mental health: Quality Targets

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Other areas		
Strategic Aims	Specific targets	What we intend to do
Increased levels of patient satisfaction as recorded by the Friends and Family test	Maintain or increase the number of people recommending services (currently 88-96%)	• Work with providers to ensure feedback improves services
Increase uptake of Personal Health budgets	1-2% of population to have a personal health budget by 2020	• Review and implement action plan developed by Personal Health Budget Steering Group • Work with CCGs to promote the PHB service
Improved access to healthcare	75% of those with LD on a GP register to receive an annual health check	
Support delivery of a 24/7 integrated care service for physical and mental health	An integrated care service for physical and mental health should be implemented by March 2020 in each STP footprint including a clinical hub that supports NHS 111, 999 and out-of-hours calls.	• Work with partners to develop a delivery plan including using a cross-system approach to prepare for a forthcoming waiting time standard for urgent care for those in a mental health crisis.
Use of accountable payment approaches which have a payment component linked to quality and outcomes.		• Implement for adult mental health in 2017/18.

Mental health: Dementia Access Plan

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Item	Action	Lead	Start	Measure/outcome	By when	Progress
1	Monthly review of activity from eMBED	PH/LB	w/c 7/11	October primary care coding result	10/11	Complete
2	Draw up list of practices to contact	PH/LB	w/c 7/11	6 larger practices identified	10/11	Complete
3	Discuss with clinical executive	LB	w/c 7/11	Garner support as agents for change	10/11	Complete
4	Contact 7 key practices	LB	w/c 14/11	Practices booked in diary	21/11	Complete
5	Discuss with Council of Representatives	LB	w/c 14/11	Gain commitment to improve	17/11	Complete LB spoke to PE
6	Update NHS England Quality Team	PH/LB	w/c 14/11	Work through funding agreement	24/11	Complete
7	E-mail to promote increased levels of coding	PH/LB	w/c 21/11	E-mail to “targeted” practice managers	24/11	Complete LB to chase 19/12
8	Raise profile at GP Education Event	LB	w/c 28/11	Gain greater uptake	28/11	Complete
9a 9b	Update Finance & Performance and Governing Body	PH LB	w/c 28/11 w/c 28/11	- Update performance report - Provide verbal update on progress	01/12 01/12	Complete Complete
10	Monthly review of activity from eMBED	PH/LB	w/c 5/12	November primary care coding result	08/12	Complete
11	Update SMT	PH/LB	w/c 12/12	Provide update on progress	13/12	Complete
12	Review practice activity & contact next group of practices below 67%	PH/LB	w/c 12/12	Gain commitment to improve	16/12	Complete
13	Discuss with Clinical Executive	LB	w/c 12/12	Gain support to improve further	16/12	Internal discussion To update January 2017
14	TEWV new Older People Community Team to support initiatives	TEWV	w/c 9/1/2017	Support to practices & care home settings to raise & sustain coding levels	31/3/17	Awaiting further details
15	Draft GP bulletin – mental health	PH/LB	w/c 19/12	Focus on dementia coding feature	20/12	To draft
16	Update Council of Representatives	LB	Feb 2017	Raise coding level beyond 67%	28/2/17	To be completed

Services for People with Learning Disabilities

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Learning Disability		
Strategic Aims	Specific targets	What we intend to do
Implementation of Transforming Care Partnership plans		• Deliver published plans with local government partners enhancing community provision for people with LD and/or autism • Develop alternatives to hospital care, crisis services and community support 2016/17/18
Reduction of LD inpatient bed capacity	By 2019 there is a national target of a reduction of CCG-commissioned beds to 10-15 per million and of NHS-commissioned beds to 20-25 per million.	
Improved access to healthcare	75% of those with LD on a GP register to receive an annual health check	• Work with primary care and providers to develop
Reduction of premature mortality for those with autism and/ or LD		• Work with partners to reduce mortality by improving access to health services, education and training of staff and by making reasonable adjustments

Services for People with Learning Disabilities

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Building The Right Support agenda	With the approval of NHS England the CCG has joined with neighbouring CCGs to developing a shared plan to deliver the Building The Right Support agenda by creating a transforming care partnership across North Yorkshire and York
Reduction in inpatient capacity target	Mindful of the requirement to reduce inpatient capacity to the required levels, the CCG has already worked with its provider and closed one inpatient facility. Plans are progressing to support the provider in creating responsive teams to support people in their own homes rather than admitting people to hospital environments. The CCG is working closely with local authority partners, NHS England and its fellow North Yorkshire and STP CCGs to ensure that the system has the capacity to do this in the safest way possible as service users pass down through forensic and acute services in the national drive to transform the care of people with learning disabilities.
Coding of LD in general practice	Locally and in conjunction with its provider organisation and the local authority partners the CCG is developing resources to improve coding in primary care records as well as promoting the uptake of annual health checks. Although this will be challenging, the provider is willing to support education events for primary care staff.
Building The Right Support agenda	With the approval of NHS England the CCG has joined with neighbouring CCGs to developing a shared plan to deliver the Building The Right Support agenda by creating a transforming care partnership across North Yorkshire and York.

Services for People with Learning Disabilities

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Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.	A **Transforming Care Partnership Board (TCP**) has been established to manage and deliver the 'Building the Right Support' (BTRS) agenda across the York and North Yorkshire geographical footprint; including representatives from Clinical Commissioning Groups (CCGs) supported by the Partnership Commissioning Unit (PCU), Local Authorities and Provider organisations. An 'Enhanced' Community Learning Disability Service; providing Positive Behavioural Support (PBS), the introduction of an out of hours Learning Disability Crisis service covering North Yorkshire and York, and the introduction of specialist early intervention nurses to prevent admission to hospital will be operation from early 2017. Work is also ongoing to enhance the learning disability workforce, develop the provider market and ensure seamless transitions through preparing for adulthood through specialist workstream groups. A programme of co-production is underway.
Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population. Consideration needs to be given over as to how the CCG will prepare for these developments.	The Transforming Care Partnership (TCP) has set a downward trajectory to ensure meeti the required reduction of inpatient beds over the three year length of the programme. The CCG is currently meeting its trajectory to reduce CCG commissioned beds. However, the TCP area as a whole is slightly off trajectory due to increased activity in specialist commissioned beds. Work to progress achievement of the combined bed reduction trajectory is being managed through the TCP with support from NHSE Area team. Work is ongoing (as described above) to ensure the community support is in place to facilitate discharge from hospital settings and ensure re-admission rates are minimal.
Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.	Latest figures the CCG has shown that across Vale of York 51% of people with a Learning Disability have had a health check within Primary Care. Clearly there is further work to be undertaken to achieve 75% and we are working with Primary Care Colleagues to progress this. Increasing the offer of Annual Health Checks and Health Action Plans is a CQUIN in 16/17 for our statutory Learning Disability Provider.
Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism	The CCG is part of a countywide Learning Disability Screening Task Force. This group is working to increase the numbers of people with a Learning Disability who have cancer screening (particularly Breast, Bowel and Cervical Cancers). The CCG is working with Primary Care and providers to ensure accessible information and reasonable adjustments. We are heavily involved in the local Partnership Boards to progress this work.

Complex Healthcare Services: CHC

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Although Vale of York ranks at an average position across CHC and FNC in total, there are potentially areas of savings, if the CCG were to move closer to the lower end of the comparators.

The area for which Vale of York CCG is an outlier, primarily relates to Joint Funded Care. The CCG is both an outlier in terms of activity and unit cost.

For Joint Funded Care, however, VoYCCG has the second highest volume of activity per 50,000 population and the second highest unit cost, with only Scarborough and Ryedale CCG ranking higher. This would suggest that the health contingent of Joint Funded packages is significantly higher than other CCGs or that these joint packages are higher cost in total.

CCG will review potential areas of savings related to CHC and FNC in more detail and through discussion with other commissioning organisations. For example the CCG could consider approaches such as:

• Applying a block contract to a range of providers for blocks of activity, rather than negotiating individual packages of care

• As stated in previous CCG recommendations, the CCG could consider linking with Local Authorities and passing over negotiation of packages to them. Evidence suggests that Local Authorities are more successful in generating lower rates than for health

• Investigating whether the strengthening of community and primary care services may be a more cost-effective approach than necessarily commissioning expensive nursing packages

Personal Health Budgets (PHBs)

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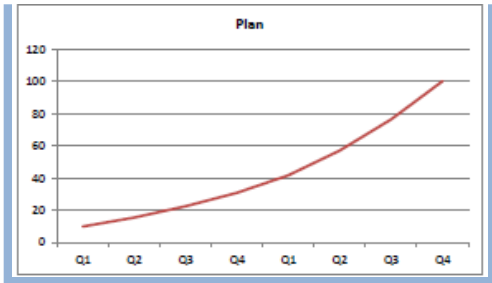
The current trajectory based on identification of 1-2% of the CCG population by March 2019 is outlined below and has been submitted on behalf of the CCG on 24.11.16

		E.N.1	Q1	Q2	Q3	Q4
Personal Health Budgets	2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	20	35	55	80
		2) New personal health budgets that began during the quarter (total number per CCG)	15	20	25	30
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**35**	**55**	**80**	**110**
		4) GP registered population (total number per CCG)	356,701	356,701	356,701	356,701
		Rate of PHBs per 100,000 GP registered population	**9.81**	**15.42**	**22.43**	**30.84**
	2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	110	150	205	275
		2) New personal health budgets that began during the quarter (total number per CCG)	40	55	70	85
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**150**	**205**	**275**	**360**
		4) GP registered population (total number per CCG)	358,917	358,917	358,917	358,917
		Rate of PHBs per 100,000 GP registered population	**41.79**	**57.12**	**76.62**	**100.30**



The CCG has started to develop the delivery programme required to start meeting the challenging trajectory for PHBs identified by NHSE and Local Government.
This will include both the associated programme requirements and costs, and the running costs of delivering the PHB assessment and implementation once clients are identified from the cohorts identified by national mandate as being appropriate for PHBs.
It is likely that this programme of work would be taken forward collaboratively on a HCVSTP level in order to ensure consistency of approach and shared good practice.

In line with the Five Year Forward View, personal health budgets are part of the wider drive to give people more choice and control. They have real potential to improve outcomes, quality of care and reduce people's reliance on unplanned acute care by enabling people living with long term conditions and disabilities to manage their health in ways that work for them. Both the Government's Mandate to NHS England for 2016-17 and NHS Operational Planning and Contracting Guidance for 2017-19 reaffirm the Government and NHS England's commitment to the rollout of personal health budgets.
CCGs should consider making personal health budgets a mainstream way of delivering NHS Continuing Healthcare. The Mandate sets a clear expectation that 0.1% of every local population will have a personal health budget or integrated personal budget by 2020. The Integrated Personal Commissioning (IPC) Programme is shaping the way the health and social care system will work for people with complex needs in future. CCGs need to ensure they are considering equally the access to personal health budgets for mental health.

Personal Health Budgets: National Mandate requirements

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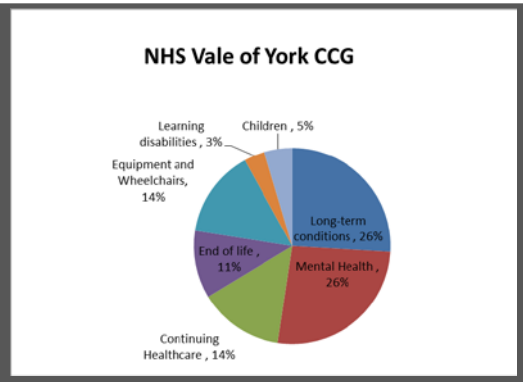
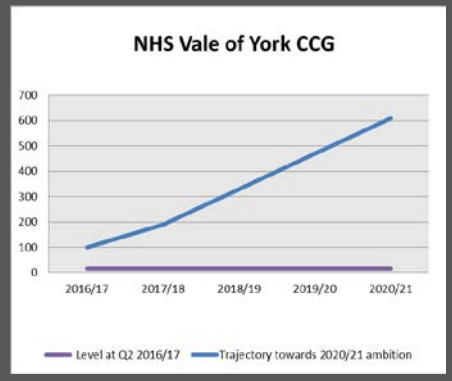
The STP Aide-Memoire on personalisation and choice describes the actions STPs and CCGs need to undertake in relation to PHBs.

- Local areas need to set out what they have done or are doing to identify groups of people who may benefit from having a personal health budget.
- Local areas need to consider the financial aspects of introducing personal health budgets and integrated personal budgets at scale, for example how to avoid double running costs.
- Local areas need to set out how they plan to work with providers to free up funding (or identify sources of funding) for personal health budgets and integrated personal budgets. It is important that personal health budgets and integrated personal budgets are introduced in a sustainable way so areas will want to take a staged approach to avoid destabilising current services.
- Local areas need to set out how they will ensure people have the right level of support and that processes are in place to enable this support to be available.
- It is important that CCGs/STP Footprints work with local people to develop their commissioning intentions and the local offer for personal health budgets.
- Local areas need to set out how they will work across health and social care to ensure integrated personal budgets become a reality and how they plan to keep abreast of the latest learning from IPC Programme.
- As local STP Footprints are cross agency, areas should align their personal health budget systems and process, sharing elements of the process where possible. This will ensure that people can move seamlessly from one system to another, particularly where place-based systems of care are beginning to emerge, for example, for people with learning disabilities or for children with special educational needs and disabilities**.**





The population cohorts outlined for targeting include:
NHS Continuing Care
Joint-funded arrangements
Mental health
Learning Disabilities & Autism
Children and Young People
Long-term conditions
End of Life
Equipment including wheelchairs

Better Care Fund

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Three Better Care Funds with three local authorities covering 100% of our population	The Better Care Fund link between CCG and local authorities will progress and build in 2017/18 through the emerging Accountable Care System and associated Partnership Board and locality delivery groups. Local delivery groups will be developing a shared agenda and priorities/ areas of common concern for their local areas which will deliver measurable benefit and impacts to their local population. The current BCF schemes could be integrated within these emerging transformative partnership programmes. The intention is to maintain or grow current levels of BCF investment through this partnership working.

Elective Care and delivery of our RTT Targets

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The CCG will deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT), returning to a sustainable position in 2018 based on the following improvements:

Reduce unnecessary outpatient appointments	1. Maintaining and continually improving its demand management through its ongoing development of referral guidelines and clinical thresholds; continuation and expansion of its Referral Support Service (referral management centre) and expanding the number of specialties where clinical review of referrals (i.e. peer review of referrals) take place. 2. Looking at innovative ways in which referrals can be confirmed as appropriate e.g. use of dermatascopic images for dermatology referrals reviewed by clinicians before being confirmed as appropriate 3. Collaboratively working with specialist consultants (dermatology, endocrinology, neurology, diabetes)to provide an initial review of referrals 4. Utilising Referral Support Service to review all 2 week waits to ensure that all those needing such appointments are seen in a timely manner. 5. The RSS was introduced in April 2013 and in that financial year reduced overall outpatient demand by 8%. During the intervening years it has helped maintain demand at or below growth levels – see next slide to show that the CCG is still within the top 10 performers for North CCGs for benchmarking of demand. 6. The CCG continues at innovative ways of maintaining services in the community and has introduced a gain/share approach with GP Federations to reduce the number of dermatology referrals going onto secondary care (April-August figures indicated a £45,000 reduction in expenditure for those federations taking part) 7. The CCG is scoping the potential of expanding this scheme to gynaecology, ENT and gastroenterology

Elective Care and delivery of our RTT Targets

NHS
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Clinical Commissioning Group

Delivery of patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018

Note the ERS service is undertaken by the CCG's Referral Support Service on behalf of GP practices
Latest figures from NHS Digital indicates 65% usage of e-referrals (as at July 2016 – an 11% improvement from the previous year).
During 2017/18 CCG will be working with secondary care colleagues to achieve identified target through:
Taking all MSK and onward Orthopaedic referrals through the RSS (currently undertaken by the existing MSK provider)
Work with secondary care colleagues to ensure that they will only accept electronic referrals

Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups

Please note that in 2013 the CCG in collaboration with York Hospital introduced a Conditions Register that identified areas/conditions for follow-up – this successfully reduced the 1st:Follow Up rate to below 1:2. Consideration to be given to utilise this to audit the appropriateness of follow-ups in relation to this during 2017/18. This incorporates improvements in both elective and non-elective pathways

- During 2016/17 the CCG was a first-wave organisation to implement the new RightCare programme and is currently working pathways to improve performance across, all to be in place during 2017/18:
- MSK services (including Orthopaedic activity, particularly looking to reduce hip and knee surgery rates and knee arthroscopies). To support this the CCG in collaboration with all partners in the health system, will implement a new integrated MSK model by April 2017
- Circulation – looking across the whole health system to improve performance in chronic heart disease, stroke and arterial fibrillation
- Gastroenterology

All the above link in to work incorporated into the Hull, Coast & Vale STP work programme and as such the CCG will take the lead for the RightCare approach for MSK (including General MSK/Pain Management/Orthopaedics/Rheumatology/Osteoporosis/Trauma & Injury) & Gastroenterology across the whole footprint.

- The CCG will also instigate a second phase of RightCare that will reflect elective care pathways for Respiratory and Neurology
- Work will also take place with STP partners identifying the potential for developing options for Ophthalmology service provision across the whole footprint. This to be initiated by a meeting in December of all concerned providers and commissioners. A finalised approach to confirmed by April 2017.
- Workstream to review outpatient service provision and scoping out how this can be delivered in a more effective, efficient and viable manner

Cancer Alliance: Workplan (for approval January 2017)

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Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report:	The Cancer Alliance will be acting as the delivery arm of the STP Cancer Plan. The cancer element of the STP plan is aligned to delivery of the cancer taskforce recommendations. An initial piece of work reviewing the STP cancer work plan against the 96 recommendations has been undertaken and is attached for information. • VOY and SR CCGs are represented on the Cancer Alliance Board and will actively work together across organisations to implement the Cancer Task Force Recommendations. • The STP cancer plan also contains potential for simplified arrangements between providers and commissioners. • The Scarborough/York Cancer Locality Group will update its existing work plan to ensure it underpins the STP priorities and delivers at local and COG (VoY and S&R) level
Ensure all elements of the Recovery Package are commissioned, including ensuring that: **• All patients have a holistic needs assessment and care plan at the point of diagnosis** **• A treatment summary is sent to the patient's GP at the end of treatment and** **• A cancer care review is completed by the GP at the end of treatment**	The STP section on digital enablers contains the need for sharing information on holistic need and treatment summaries. The ambition is to make the recovery package available to all people living with and beyond in 2017/18. A baseline assessment of what is in place across the region is being undertaken by the network. There are both CCG and STP level groups in place to support advancement of this agenda. A working group, including providers and commissioners has been formed across York and Scarborough.

Cancer Alliance: Workplan (for approval January 2017)

NHS
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Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity and the other NHS Constitution cancer standards. If this standard is not currently being consistently delivered then please describe the anticipated date of recovery:	The cancer work stream of the STP is working together with the acute and specialist work stream re diagnostics. Initially providers are tasked with undertaking demand and capacity reviews and these are underway. They are also advising of estimated gaps in kit such as CT and MRI for the next 5 to 10 years so that the capital and estate impact can be quantified. As part of this we will also be looking at GP direct access. There is a Yorkshire and Humber intention to procure a PAC system that will initially support shared viewing of images and later potentially, also shared capacity for diagnostics and reporting. The Humber, Coast and Vale providers are linked into this (York/Scarb trust is not part of the procurement as they have just procured new kit but they are hoping to be linked in to the sharing of images and perhaps capacity). A decision will need to be made regarding whether this system is best used Yorkshire and Humber wide or on Humber Coast & Vale footprints. We will be looking to design a new model of sustainable diagnostics and the solution to this will need to fit urgent and emergency care ambitions as well as with any redesign that results from the acute and specialist work stream. We are also linking with the West Yorkshire alliance to determine where we can gain greater benefit from working together on this. We work with our local provider to monitor performance and to understand where and why breaches are occurring. We have an agreed provider IPT policy in place that will support the identification and removal of barriers to achieving 62 days. Additionally, the pathways work (including lung) and the high value pathways work across Yorkshire and the Humber should support streamlining of pathways and adherence to best practice, enabling patients to move more effectively through the system. A piece of work reviewing current achievement against 28 day diagnosis has been undertaken and actions required as a result of this will be identified through the cancer STP work stream and taken forward.

Cancer Alliance: Workplan (for approval January 2017)

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Make progress in improving one-year survival rates by delivery a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission: **In addition to the diagnostic programme of work mentioned above which will increase the capacity within diagnostics to support earlier diagnosis we will also:**	• The work of the lung element of the cancer STP aims to increase the proportion of lung cancers diagnosed at Stage 1 and 2 and to match the current best in England. Similarly, we would hope that further work on the high value pathways across Yorkshire and Humber will drive improvements in early diagnosis, (through reviewing the place of diagnostics in each pathway) quality of care and consequently survival rates. • We will continue to support primary care to refer suspected cancer cases early via the 2 week wait system through the use of site specific 2ww forms (developed by our Cancer Clinical leads & provider colleagues). • Our CRUK facilitator is available to provide GP training in cancer related issues via the GP Educational Development forum. • CRUK are also working with the lead GP to support practices to review their cancer Practice Profiles through 1:1 meetings with practices and will continue to monitor for improvement. • We will work with CRUK to explore the potential for community champions that can increase public awareness of signs and symptoms of cancer and the need to present early.
Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types:	The STP plan contains the intention for implementation of risk stratified pathways for breast, prostate and colorectal patients. The lead nurse is working within the trust to develop plans for this, and the breast team are already looking to develop a pathway. A risk stratified pathway for colorectal is already in place at the York site. The team also has strong links with the HCV wide Living with and Beyond Programme which aims to support developments across the regional footprint.

Cancer: local CCG programmes

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Cancer Alliance	By deploying our Network Support managers the CCG has had regular and sustainable attendance at the developing Cancer Alliance and STP led cancer strategy meeting. The alliance and STP led groups are tasked with working with providers to develop plans and implement the cancer taskforce report.
Constitutional targets – sustained performance	Although the CCG is proud to be one of the top seven CCG's in the country in terms of cancer performance, it is determined to work hard to continue to deliver sustained performance in line with constitutional targets. It has successfully implemented the NICE approved guidance on 2 week wait pathways for the different types of cancer and these are now an integral part of the local Referral Support System.
Chemotherapy	Locally, the York Against Cancer charity has purchased a mobile chemotherapy truck to deliver services closer to home. The same charity has also worked with the CCG to purchase dermatoscopes to facilitate electronic referrals being supported by photographic evidence of suspicious skin lesions.
Screening uptake increases	Our provider and our Macmillan GP clinical lead for cancer are working to develop screening packs to encourage and support the increased uptake of cancer screening.
Survivorship recovery	Macmillan have agreed to fund two local projects bids supported by the CCG. One will look at improving care co-ordination for people on cancer pathways over the next two years whilst the other will work on delivering a complete Recovery Package for the next three years, promoting survivorship.

Maternity: emerging strategy for local and HCVSTP collaborative development

Vale of York Clinical Commissioning Group

Implement the national maternity services review, Better Births

• Develop an STP maternity commissioning strategy to reflect the national maternity review including VoY specific actions. Implement service redesign through service specifications to increase provision of choice of place of birth
• Consideration of options for out of hours appointments
• Monitor the implementation of providers Action Plan, detailing how they will implement the recommendations by 2020
• Development of new service specifications

Reduce stillbirths, neonatal and maternal deaths and brain injuries caused during or soon after birth, (measurable reduction by 2020, 50% by 2030).

• Work with providers to implement all aspects of the 'Saving Babies Lives' care bundle.
• Provider to consistently collect and review data at multidisciplinary forum,=. Include implementation of lessons learnt, on all stillbirths on an annual basis as a minimum.
• Providers to promote external review of cases
• Providers to communicate all the outcomes to the lead commissioner through an agreed governance route with evidence of responding to local trends or themes
• Provision of specialist postnatal bereavement support

Maternity: emerging strategy for local and HCVSTP collaborative development

NHS
Vale of York
Clinical Commissioning Group

Smoking reduction (Latest data from the IAF for VoY CCG (Q 1, 16/17) shows that the % of smokers at the time of delivery is 12.0%, national rate of 10%)

- Providers to continue to receive detailed data as per the service specification
- Obtain assurance that providers are providing brief intervention at booking and every contact where appropriate and have had training
- Work with CYC colleagues to review provision of smoking cessation support
- Work with primary care colleagues to support smoking cessation advice and support

Increase access to evidence-based specialist perinatal mental health care (100% access by 2020/21)

- Plan to bid in 2017/18 for increased service provision
- Include service in mainstream CCG allocations from 2019/20
- Review access to midwives postnatally
- STP review of available services and models of care
- Establishment of a specialist postnatal de-b[illegible] service

Healthy weight promotion during pregnancy

- BMI recorded at booking
- Support extension of healthy eating and weight maintenance programme in pregnancy to patients with raised BMI as well as gestational diabetes
- Work with Public Health to support access to Healthy weight support and exercise information
- Work with PHE/CYC colleagues to develop/implement a local obesity strategy

Maternity Choice and Personalisation Pioneers test i[illegible] the concept of a Personal Maternity Care Budget (PMCB)

Developing a Local Offer programme.

Tools and resources developed for the programme will help STP Footprints and CCGs to think through how to successfully implement personal health budgets and integrated personal budgets in line with the mandate Requirements

Review of Quality Indicators

- Receive and review regional and local maternity dashboards
- Regular meetings to review quality of all aspects of maternity services with providers develop quality indicators across STP footprint through the STP Quality Leads meeting

Specialised Commissioned Services: complex neuro-rehabilitation services

NHS
Vale of York
Clinical Commissioning Group

NHSE Specialised Commissioning (Yorkshire and the Humber) review of Specialised Rehabilitation for patients with complex needs (adults with TBI and ABI)

The CCG awaits the outcome from the NHSE Yorkshire and Humber review of specialised rehabilitation services for complex neurological conditions and will appraise the options for the future commissioning of these services. We will aim to work collaboratively to support the development of the Yorkshire and Humber wide commissioning pathway with standards as set out in the NHS England Specialised Rehabilitation for patients with complex needs service specification.

During 2017/18, Phase one of the delivery plan will address NHSE specialised commissioning and the preferred option will be presented to SCOG on the 2nd December.

Phase two in 2018/19 will address the neuro-rehabilitation services that are commissioned by CCG's.
The aim of the review is to improve and standardise the quality and availability of specialised rehabilitation for patients with complex needs due to acquired brain injury by providers able to meet the requirements as set out by the British Society of Rehabilitation Medicine (BSRM) and the Commissioning Guidance for Rehabilitation (NHS England 2016 https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/improving-rehabilitation/)

There is evidence within 'The Commissioning Guidance for Rehabilitation' that maximising an individual's independence and activity levels will reduce care costs, keep them in work and reduce the risk of their acute admission.
Collaborative commissioning is important, but so is collaborative delivery; complex neuro-rehabilitation lends itself to cross system delivery partnerships.

Improving Quality in Our Organisations

NHS
Vale of York
Clinical Commissioning Group

Our plans to improve quality of care, particularly for organisations in special measures.

Draft Quality
egy VoYCCG Nov

Each commissioned provider is contractually required, to submit information on recognised indicators relating to patient safety, quality and clinical effectiveness of services. These include

- Patient experience information from internal and external surveys, Family and Friends, complaints and PALS information
- Incident and Serious Incident reporting data, compliance with national and local reporting timeframes. Quality of reporting, analysis, including medication errors, never events and completed investigation reports
- Infection prevention and control measures, including clinical practice, environmental audit data and numbers of healthcare –associated infections and outbreaks of infections identified

Where the CCG is not the lead contractor robust systems exist to challenge quality assurance based on the recognised indicators above.

In addition the CCG has developed their Quality Assurance Strategy and Action Plan which describes how the CC

- Routinely measure and monitor all quality indicators and data within the contract in line with NHS England's Qua Monitoring and Escalation Process.
- Continues to plan clinical visits and walk rounds across provider organisations
- Hears and recognises the voice of the person, their carers and families through complaints / compliments / surveys and development of key relationships with Healthwatch and others such as the Maternity Services Liaison Committee and Older Peoples Forum
- Ensures there is on-going scrutiny of Risk Registers
- Collects and scrutinises soft intelligence through the CCG portal 'Yor-Insight' and partnership working
- Maintains dialogue with Quality Leads across Yorkshire and Humber and participation in key pieces of work such as the National Maternity Review Assurance
- Contribution to inspections and monitoring of action plans from CQC and others
- Shares information and intelligence across the system and enacts appropriate escalation via Quality Surveillance Groups (NHSE)
- Rigorously applies safeguarding processes (currently there are no providers in special measures)

Improving Quality in Our Organisations

NHS
Vale of York
Clinical Commissioning Group

National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services

Utilising skills in patient safety improvement, the CCG has mechanisms in place to support providers, relevant to the Carter productivity and efficiency report which makes clear; improving workforce efficiency can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need, and reduced dependency on agency staff.

The development of new service models means building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings. The CCG is an active participant in developing workforce plans that support the Sustainability and Transformation Plans and new models of care.

The National Quality Board's safe staffing improvement resource is integral to the CCG's clinical visits and walk rounds with provider organisations.

Participation in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare

The CCG continues to support providers to develop effective strategies for learning from mortality and reduction of avoidable deaths. Development of assurance based on the robustness of the investigation behind the Standard Hospital Mortality Rate figure is key as part of this process.

The CCG's main provider is participating in the National Mortality Case Record Review Programme. The aim of the 3 year programme is to understand and introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland.

Alongside the work relevant to reduce premature mortality as part of the countywide Learning Disability Screening Task Force the CCG is seeking assurance from all providers about their action to reduce death related problems. In addition, the CCG will continue to seek assurance from our providers in response to the Learning Disability Mortality Review (LeDeR) pilot and work with Primary Care to raise awareness. This includes strengthening Learning Disability Registers and the requirements for annual health checks.

The CCG is also an active participant in reducing mortality for people with serious mental health and ensuring that Mental Health Providers are feeding back progress and developments. In addition the North Yorkshire and York Suicide Task Prevention Group and Early Suicide Surveillance Group review data on a quarterly basis to detect themes and subsequent actions to address this. The plans are to also include all drug and alcohol deaths and apply the same process.

The HCVSTP – Local Programmes for Place Based Care

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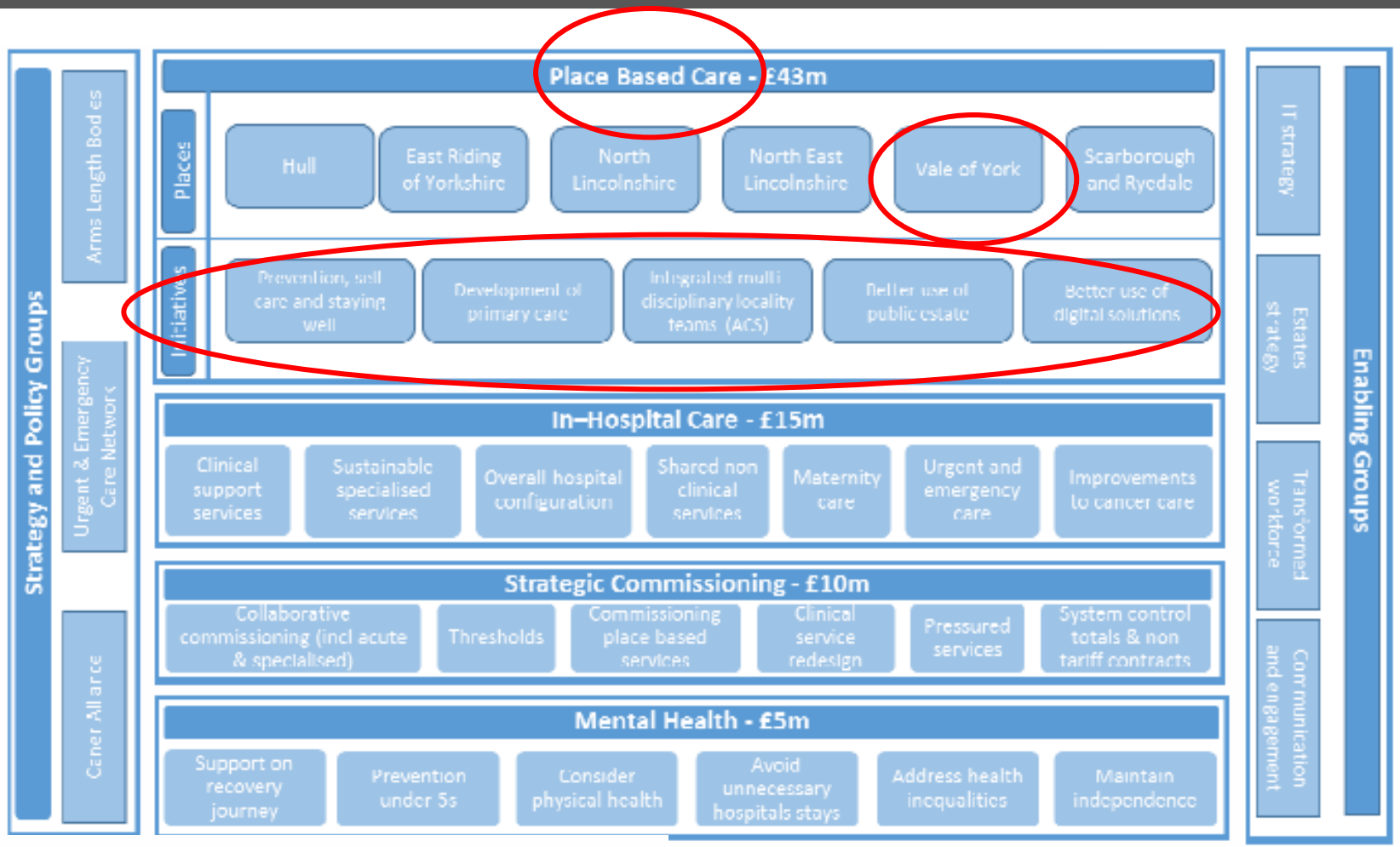
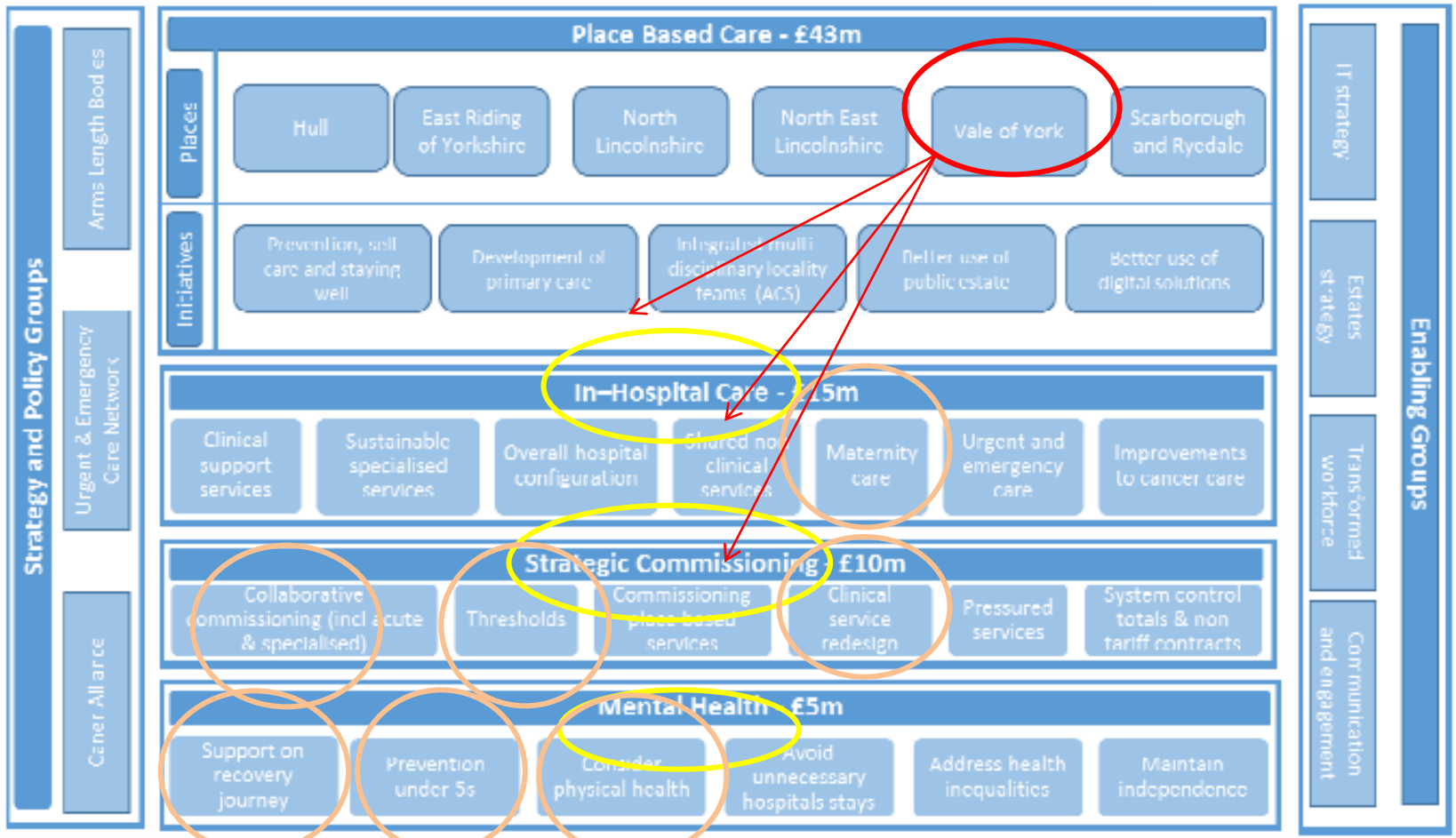
The CCG collaborates across the Humber Coast and Vale STP along with the 5 other local 'places' (CCGs). The HCV STP currently identifies a range of local 'place-based' transformations which all 6 CCGs are delivering. These are captured in our Plan on a Page with our local VoY system partners and define our priority programmes of work.



HCVSTP Collaborative Programmes – Supporting Delivery of Local VoY Priorities

NHS Vale of York Clinical Commissioning Group

The HCV STP is also mobilising a number of collaborative improvement work programmes with all 6 local CCGs and STP partners which will support us in delivering transformation and improvement at scale and pace in a way which we would not be able to do commissioning alone. Our Plan on a Page shows the links through to these collaborative programmes. Standardisation of thresholds, prescribing and single contracts are core to this work to drive out efficiency and provide consistency in outcome improvement at pace.



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Vale of York
Clinical Commissioning Group

Update to Operational Plan 2017-19 Financial Plan information following 27 February final submission

Governing Body Meeting
2 March 2017

ANNEX 3

Summary Financial Plan – Key Metrics – 27 February Submission

	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s
Surplus/Deficit	(28,096)	(44,149)	(53,907)	(54,542)	(38,057)
In year Allocation		449,675	458,826	470,892	487,948
In year Surplus/Deficit	(21,801)	(16,054)	(9,758)	(546)	16,394
Improvement of in-year position		**5,746**	**6,296**	**9,212**	**16,940**
Actual % improvement		**1.3%**	**1.4%**	**2.0%**	**3.5%**
1% of allocation – required Improvement		4,497	4,588	4,709	4,879
Business Rule for 1% of allocation improvement for Deficit CCG met					
QIPP Target		15,900	14,300	13,900	14,400
QIPP % (on recurrent in-year allocation per NHSE model)		3.5%	3.0%	3.0%	3.0%

ANNEX 3

Summary Financial Plan – 4 Year Expenditure - 27 February Submission

	2017/18 Plan £000s	2018/19 Plan £000s	2019/20 Plan £000s	2020/21 Plan £000s
York Teaching Hospital NHS Foundation Trust	185,268	180,584	176,258	173,902
Other Acute Commissioning	45,472	47,438	51,166	52,444
Mental Health Services	44,868	44,927	44,832	45,374
Community Services	29,920	31,370	31,473	31,840
Continuing Care	26,839	26,947	27,123	27,841
Funded Nursing Care	4,998	5,198	5,406	5,622
Other Commissioning	20,936	21,316	21,115	17,084
Primary Care Prescribing	51,459	52,120	54,333	56,639
Primary Care	48,714	51,649	52,699	53,774
Running Costs	7,256	7,033	7,033	7,033
Total Expenditure	465,729	468,583	471,438	471,553
Allocation	**421,580**	**414,677**	**416,985**	**433,496**
Surplus / (Deficit)	**(44,149)**	**(53,907)**	**(54,452)**	**(38,057)**

Financial Opportunity – Updated for Final Financial Plan Submission 27 February

- The CCG identified 6 key areas of financial opportunity based on the population analytics and health benchmarking findings.
- These opportunities have been subject to an NHS England Confirm and Challenge process with the relevant executive director, clinical, operational and finance and contracting leads signing up to schemes that deliver close to the same overall amount, phased differently. Although the overall opportunity still exists, it is the confirm and challenge numbers that have been used in constructing the CCG's financial plan.
- The CCG and partners are now actively mobilising the Vale of York accountable care system (ACS) based around a three locality delivery model. The intention is that joint programmes of transformation will be developed based on the specific local needs and priorities of these locality populations that will best address the current gaps in funding, health and social care in outcomes for the VoY population.

Section reference	Opportunity	Initial Assessment					Confirm and Challenge Assessment				
		Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)
(4.2)	*1) Elective orthopaedics*	4.2	1.3	1.0	1.0	1.0	3.0	0.8	2.3	0.0	0.0
(4.3)	*2) Out of hospital care*	21.3	0.0	9.1	7.2	5.0	15.0	3.6	4.5	4.3	2.5
(4.4)	*3) Contracting for outpatients*	5.0	3.0	2.0	0.0	0.0	2.0	1.0	1.0	0.0	0.0
(4.5)	*4) Continuing healthcare and funded nursing care*	9.3	3.1	2.5	2.5	1.2	9.6	1.8	2.5	2.5	2.8
(4.6)	*5) Prescribing*	6.2	1.7	1.5	1.5	1.5	6.2	1.6	1.6	1.5	1.5
(4.7)	*6) High cost drugs*	2.0	0.2	0.6	0.2	1.0	2.1	0.3	0.6	0.2	1.0
	Other	0.0	0.0	0.0	0.0	0.0	9.8	6.8	1.8	1.0	0.2
	Total	**50.0**	**9.4**	**16.7**	**12.4**	**9.6**	**47.7**	**15.9**	**14.3**	**9.5**	**8.0**

NHS
Vale of York
Clinical Commissioning Group

Vale of York Medium Term Financial Strategy

A new approach to commissioning

FINAL v0.1

Contents

NHS Vale of York Clinical Commissioning Group

NHS Vale of York Clinical Commissioning Group

EXECUTIVE SUMMARY

Executive Summary

Vale of York's current situation

- Vale of York (VoY) CCG commissions health services on behalf of a population of 350,000.
- The CCG has had an underlying financial deficit since its creation in 2013 and reported a deficit position of £6.3m at the end of 2015/16.
- The CCG is one of nine to have recently been put into Special Measures by NHS England and received Legal Directions on 1st September 2016.
- VoY responded with the development of a Financial Recovery Plan ('FRP'), submitted to NHSE on 6th October 2016, and including a plan to achieve an in-year deficit of no more than £7m (£13.3m cumulative)[1].
- A new Accountable Officer has also been appointed (in post from 3rd October) to oversee the rapid organisational change required and inject challenge.

Purpose of financial strategy

- The CCG recognises the need to articulate a strategic plan which addresses the underlying causes of financial deficit and identifies a path to sustainability.
- VoY spends less per head of population than any other CCG within the STP footprint yet receives the lowest allocated spend per head from NHSE (a function of how the allocation formulae recognises the health needs of the population).
- This means that the CCG needs to spend 11% less per person than the STP average in order to live within its means.

- The Medium Term Financial Strategy seeks to:
  - **outline a plan** for how the CCG can reach a balanced and sustainable financial position;
  - **align with existing system plans**, in particular, the Humber, Coast and Vale Sustainability and Transformation Plan (which the CCG is a partner to);
  - **meet key statutory financial targets and business rules;**
  - **be consistent with the CCG's vision** and support the delivery of the CCG objectives;
  - recognise and **meet the scale of the challenge** in the Five Year Forward View;
  - **deliver operational and constitutional targets;**
- VoY has taken a fundamentally different approach to the development of its strategy based on a detailed understanding of its local population needs which has allowed it to pinpoint a number of areas it needs to focus on.

A new approach to commissioning

- The CCG believes that, in order to deliver real change, a radical new approach to system leadership, commissioning and delivery is now required.
- Up until now, the health and social care system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.

1) Improvement Plan in response to NHSE Legal Directions (issued 1 Sept 2016), 6 October 2016

The CCG recognises that, in order to deliver real change, a new system wide approach is required

Vale of York Clinical Commissioning Group

Executive Summary

- This is evidenced by the fact that only 24 to 29% of the CCG's targeted QIPP cost savings have been achieved over the past two years.
- Moving forward, VoY needs to play its part in redesigning and delivering a new health and social care system which is better able to care for patients, whilst also delivering financial sustainability.
- VoY's strategy for doing this is embedded in the work of the STP and includes a vision for new models of accountable care in VoY, strategic commissioning across the system and new approaches to system governance and risk sharing.
- This builds on the ideas put forward in the Five Year Forward View and best-practice national and international examples of whole population management and outcomes-based commissioning.
- VoY has already made progress in a number of areas, for example in articulating a vision for a VoY Accountable Care System.

Financial opportunity

- The CCG has identified 6 areas of immediate financial opportunity to focus on: Elective Orthopaedics, Out of Hospital, Outpatients, Continuing Healthcare, Prescribing and High-cost Drugs.
- Combined, these 6 opportunities have the potential to release savings to the CCG in the order of £50m by 20/21.
- Following a Confirm and Challenge process led by NHS England the CCG has now identified specific interventions and schemes (including the 6 opportunity areas and others) with a total value of £47.7m.
- This would allow the CCG to reach in-year surplus by 20/21 although a cumulative financial deficit of approximately £51m would still remain, or at best, £38m with further QIPP not yet identified.
- The CCG has agreed delivery plans, next steps and work with stakeholders to progress each of the 6 major opportunities.
- Further work to firm up the size and potential for delivery of the additional pipeline opportunities is ongoing.

Next steps

- Moving forward, VoY recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals.
- Development of the financial strategy will require close collaboration with providers and other STP partners, as well as a strong and realistic understanding of the capabilities required to deliver the new vision articulated.

NHS Vale of York Clinical Commissioning Group

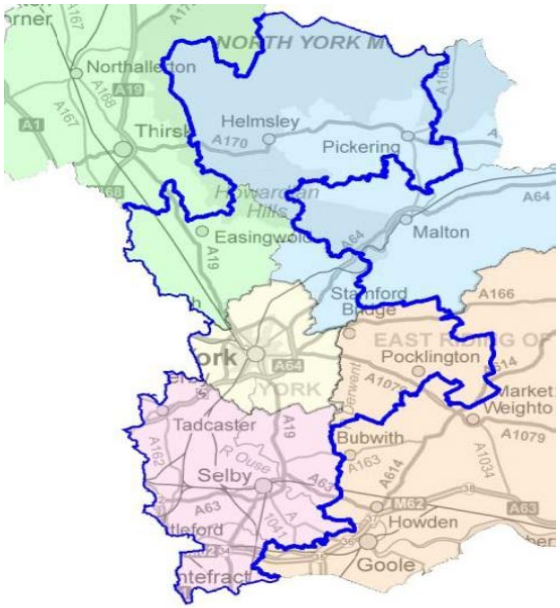
SECTION 1: INTRODUCTION

Vale of York Clinical Commissioning Group

1.1 Introduction

- Vale of York CCG is responsible for commissioning the following healthcare services on behalf of a population of 350,000:
  - Planned hospital care
  - Urgent and emergency care
  - Community health services
  - Mental health and learning disability services
  - Tackling inequality including children's health and wellbeing
- VoY's footprint covers an area of approximately 857 square miles that runs broadly north to south through North Yorkshire. It is mainly rural with a number of small market towns and the main urban centre of York .
- The Vale of York is a comparatively affluent area but with pockets of significant deprivation in the York, Selby and Sherburn-in-Elmet areas.
- Three local authority areas span VoY's commissioning population:
  - City of York Council
  - East Riding of Yorkshire Council
  - North Yorkshire County Council
- The CCG has 27 GP member practices.
- VoY's commissioning budget was £435.3m in 2016/17, with minimum growth from 2015/16 .
- Allocations, albeit indicative for future years, suggest the CCG can expect to receive minimum growth in allocations to 20/21.

- The main providers of VoY's services are:
  - York Teaching Hospital NHS Foundation Trust (acute and community services)
  - The Leeds Teaching Hospitals NHS Trust (acute services)
  - Leeds and York Partnership NHS Foundation Trust (specialist mental health and learning disability services)
  - Tees, Esk and Wear Valleys NHS Foundation Trust (mental health, learning disability and eating disorder services)
  - Hull and East Yorkshire Hospitals NHS Trust (acute services)



The CCG has had an underlying financial deficit since its creation in 2013

Vale of York Clinical Commissioning Group

1.2 Recent financial performance

- The CCG has had an underlying deficit since its creation in 2013.
- Consistent under delivery of QIPP (24% of QIPP achieved in 2014/15 and 29% achieved in 2015/16) means that the organisation has been reliant on non-recurrent mitigations.
- The CCG reported a deficit position of £6.3m at the end of 2015/16. This represented a significant deterioration of £10.25m from the planned 1% surplus of £3.95m. Consequently, the CCG was classed as an organisation in turnaround.
- The CCG has experienced a range of financial and operational challenges in recent years including:
  - Growth in demand, particularly acute services, over and above that which was planned for
  - Stretched workforce and gaps in clinical leadership
  - Historical financial difficulties have strained local partner relationships
  - Limited existing joint commissioning arrangements
  - Rising elderly and frail local population leading to increased pressure on services
  - Shortfalls in the programme management and governance of QIPP schemes leading to under performance

Financial Year	2013/14	2014/15	2015/16	2016/17 Forecast
Planned Surplus/ (Deficit)	£3.7m	£2.1m	£3.9m	(£13.3m)
Actual Surplus/ (Deficit)	£2.1m	£3.9m	(£6.3m)	(£28.1m)
Planned QIPP	£10.9m	£9.4m	£19.5m	£12.2m
Actual QIPP	£4.7m	£2.3m	£5.6m	£1.9m
% delivery	43%	24%	29%	15%
Of which recurrent	£4.7m	£2.3m	£5.6m	£1.7m

The CCG was placed in Special Measures in September 2016 and has subsequently responded with a Financial Recovery Plan

Vale of York Clinical Commissioning Group

1.3 Recent history

Special Measures

- The CCG is one of nine CCGs to have recently been put into Special Measures by NHS England and received Legal Directions from the NHSE Commissioning Board on 1 September 2016.
- The Legal Directions included the requirement for VoY to:
  - Produce an Improvement Plan that sets out how it shall ensure that the capacity, capability and governance of the CCG is made fit for purpose including agreeing with the NHSE Commissioning Board how it will strengthen its financial leadership;
  - Provide for the implementation of the recommendations of the CCG Capability and Capacity Review date 28 January 2016.

VoY response

- The CCG is determined to respond positively and at pace to the Legal Directions it has received.
- The CCG has developed a Financial Recovery Plan ('FRP') with an independent assessment of facts, figures and projections. This was submitted to NHSE on 6th October 2016 and includes a plan to achieve an in-year deficit of no more than £7m (£13.3m cumulative)[1].
- A new Accountable Officer has also been appointed (in post from 3rd October) to oversee the rapid organisational change required and inject challenge.
- The FRP also outlines plans to develop the capacity and capability of the CCG through strengthening of the senior team, a new management structure and revised governance processes. This has included the creation of four new executive posts.
- Development of a new commissioning approach and this Medium Term Financial Strategy, based on evidence, benchmarking and the principles of accountable care.

1) Improvement Plan in response to NHSE Legal Directions (issued 1 Sept 2016), 6 October 2016

Without further change beyond 16/17, the CCG's in-year deficit would reach £39m by 20/21, with a cumulative deficit of £176m

NHS Vale of York Clinical Commissioning Group

1.4

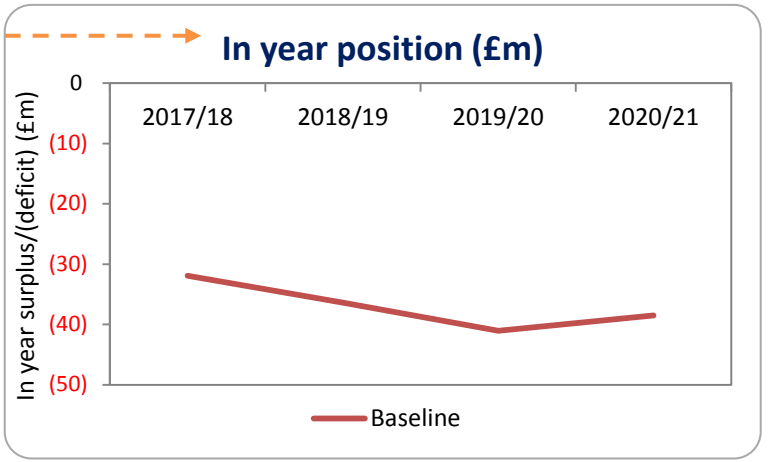
Forecast financial position: baseline

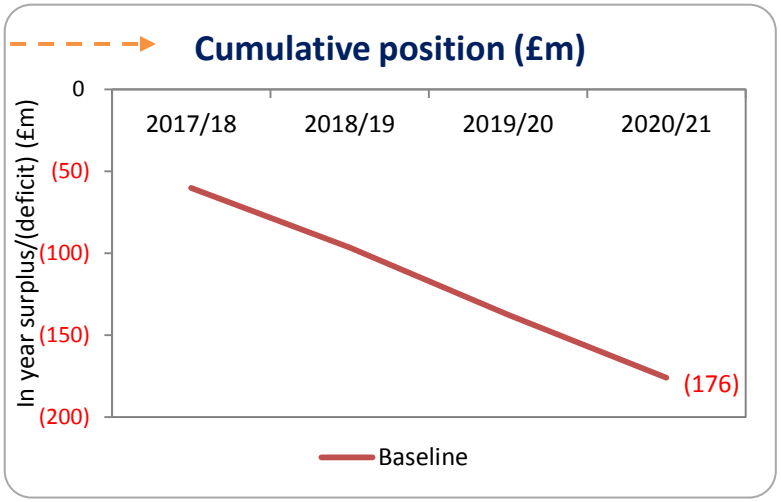
Baseline position

- These graphs illustrate the CCG's financial position to 20/21 based on no further QIPP delivery beyond 2016/17.
- Under this scenario, by 20/21:
  - The CCG's **in-year deficit** would be £39m
  - the **cumulative deficit** would be £176m
- These figures are in line with with modelling from the STP.

Implications for Legal Directions

- In this position the CCG would **fail to meet** the requirements of both its current legal directions and NHS planning guidance:
  - the CCG's legal directions require the CCG to achieve an in-year break even position in 2017/18;
  - the 2017 to 2019 NHS Planning Guidance states that deficit CCGs are *"expected to plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved".*





1.5 Plan for document

- In addition to the development of the FRP, the CCG recognises the need to develop a longer-term strategic plan which addresses the underlying causes of its financial deficit and identifies a path to financial sustainability.
- The Medium-term Financial Strategy seeks to:
  - Outline a plan for how the CCG can reach a position of a recurrent balanced, sustainable financial position;
  - Align with existing system plans, in particular, the Humber, Coast and Vale (HCV) Sustainability and Transformation Plan (STP), which VoY is a key partner to;
  - Meet key statutory financial targets and business rules;
  - Be consistent with the CCG's vision and support the delivery of the CCG objectives;
  - Recognise and meet the scale of the challenge in the Five Year Forward View;
  - Deliver operational and constitutional targets.

- This Medium-term financial Strategy is structured as follows:
  - **Section 2** describes the CCG's overall approach to change including its plan for a radical new approach to commissioning based on a population health management approach and accountable care, grounded in the vision of the STP.
  - **Section 3** presents the findings of population analytics and benchmarking which has been carried out to understand the underlying causes of VoY's financial deficit and pinpoint areas where it needs to focus in the future, given its local population needs.
  - **Section 4** presents a number of immediate cost saving plans which have been identified through the analysis completed in Section 3, including plans for their delivery and the combined financial opportunity they represent.
  - **Section 5** provides a summary of next steps that VoY will take to progress the strategy.
  - **Section 6 Appendices** provide some supporting additional information.

NHS Vale of York Clinical Commissioning Group

SECTION 2: A NEW COMMISSIONING APPROACH

VoY CCG recognises that it will need to take a fundamentally different approach if it is to become financially sustainable

Vale of York Clinical Commissioning Group

2.1 New system approach to change

- The CCG believes that, in order to deliver on the cost saving opportunities that it has identified, a radical new approach to system commissioning and delivery is now required.
- Up until now, the health and social system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.
- This is evidenced by the fact that only 24% to 29% of the CCG's targeted QIPP cost savings have been achieved over the past two years.
- In order for the CCG to reach in-year balance by 20/21 the QIPP that must be delivered year on year equates to 2.4% of allocation. In order to eliminate the cumulative financial deficit by 20/21, a 3.3% year on year QIPP is required. This compares with an actual QIPP delivery of 1.5% in 2015/16 and 0.6% in 2014/15.
- Based on past performance, it is likely to be very challenging for Vale of York CCG to achieve an in-year balance in financial year by 20/21, let alone an elimination of its cumulative deficit by then.
- The implication is that a radically different approach to delivery of cost savings is required.

Financial Year	2014/15	2015/16
Programme and running cost allocation[1] (£m)	375,751	381,161
Planned Surplus/ (Deficit) (£m)	2.1	3.9
Actual Surplus/ (Deficit)	3.9	(6.3)
Planned QIPP	9.4	19.5
Actual QIPP	2.3	5.6
% delivery	24%	29%
Planned QIPP (% of allocation)	2.5%	5.1%
Actual QIPP (% of allocation	0.6%	1.5%

(1) Vale of York CCG 5 year plan 2014-2019
(http://www.valeofyorkccg.nhs.uk/data/uploads/publications/5-year-plan/nhs_vale_of_york_ccg__integrated_operational_plan_2014_to_2019-final-30th-june-with-signatories.pdf)

2.2 Sustainable Transformation Plan (STP) work

- The Humber, Coast and Vale (HCV) STP recognises that ensuring system sustainability must be the focus of all partners to the local health locality going forward.
- The HCV current in-year deficit for FY15/16 is £87m and this is projected to increase to an in-year figure of £420m under a "do nothing" scenario.
- The STP vision aims to tackle a number of challenges across the locality including i) poor acute provider performance; ii) provider sustainability; iii) care market sustainability; iv) the devolution agenda; v) increasing demand; and vi) an ageing primary care workforce.
- The STP identifies 6 key priorities as a route to achieving system sustainability:

1. **Greater focus on prevention -** including a focus on the broader determinants of health to drive wellbeing and prevention at scale through social investment
2. **A single acute provider model across the STP footprint** – including acute services working in a consolidated model, standardised clinical pathways, shared back office and a networked tertiary care model with links to Leeds and Sheffield
4. **Out of hospital accountable care** – including a standardised care model, a new approach to managing demand through population management approaches, transformed primary care, and increase in personal health and care budgets
5. **Mental health –** new care models and market stimulation, including better navigation of pathways, an improved approach to dementia and increased uptake of personal health and care budgets
6. **Strategic commissioning** – including common standards and planning assumptions, a smaller number of contracts, new approach to performance management of acute providers, and outcomes focused contracting approaches
7. **System-led governance** – including new rules of engagement between organisations, new approaches to payment and contracts and new statutory duties and obligations accounted for

- Further detail to the STP is provided in the Appendices.

(1) Humber, Coast and Vale STP Finance Template (submitted October 2016)

2.3 System-led change

- VoY recognises that simply expanding the current model will not deliver financial sustainability.
- Moving forward, VoY needs to play its part in helping to redesign and deliver a new health and social care system which is better able to care for patients, whilst also delivering system financial sustainability.
- VoY's strategy for doing this is now embedded in the work of the emerging accountable care system, it's Local Place Based Plan and collaborative work within the STP – these includes a vision for new models of accountable care in VoY, strategic commissioning across multiple commissioner organisations and new approaches to system governance and risk sharing.
- This builds on the ideas put forward in the Five Year Forward View and best-practice examples taken both nationally and internationally on whole population management.
- Such an approach needs to based on joint working with provider and commissioner partners in the VoY and across three localities to support a whole system change that will reduce cost, manage demand and deliver better results for patients by:
  - Realigning resources within the system through an outcomes-based approach, which focuses on measuring and rewarding outcomes (end results) rather than inputs;
  - Allowing system efficiencies to be realised – duplication and over supply is eliminated while "cost shift" from one service line or organisation to another is avoided
- ;
  - Incentivising and implementing a whole system approach to prevention at individual, community and place levels across VoY and the HCV;
  - Focusing on the priorities for each locality which transform services and models of care and best deliver the improvements in outcomes – finance, health and well-being and care & quality;
  - Enabling the achievement of a scaled reduction in demand, enabled by a new relationship between residents and public services whereby individuals are empowered to take control of their own health and wellbeing;
  - Reducing dependence on oversubscribed and expensive specialist resources such as emergency services, non-elective admissions, general practitioners and care homes;
  - Supporting the right care and the right workforce to be delivered in the most efficient cost settings which deliver best outcomes for patients, including having GPs coordinate more joined-up care closer to home, and improving VoY's community response to help people leave hospital sooner;
  - Employing new contracting models and payment structures, including a phased move away from PbR, to enable an increased alignment of resources to outcomes;
  - Having an effective governance and leadership structure to develop and deliver these plans, which overcome challenges the CCG has faced in the past on collaborating effectively as a health economy;

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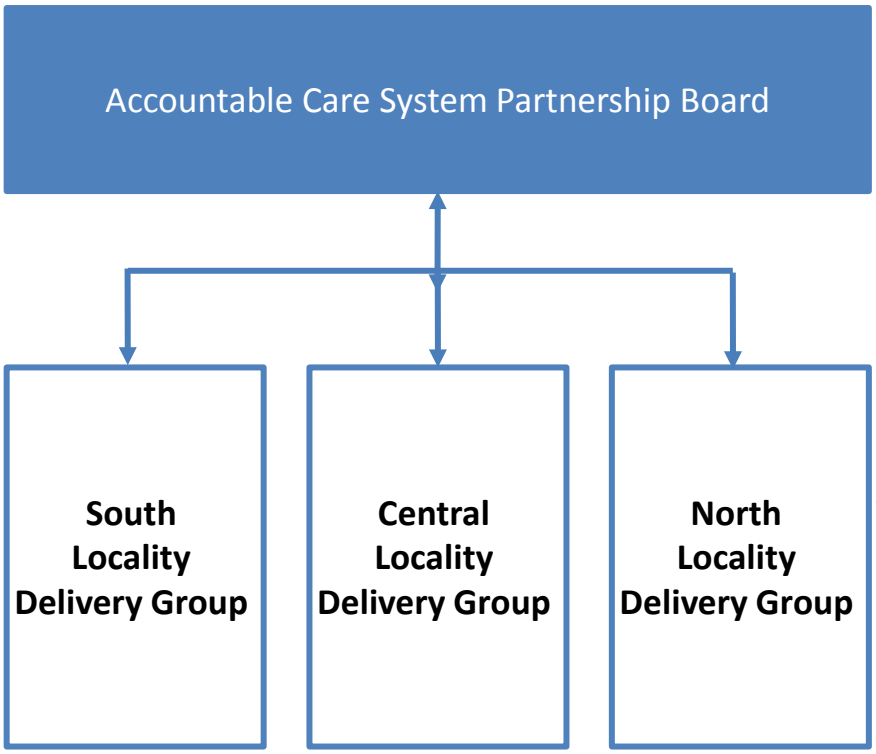
2.4 Accountable care framework for VoY

- The CCG and partners are now actively mobilising the Vale of York accountable care system (ACS) based around a three locality delivery model. The intention is that joint programmes of transformation will be developed based on the specific local needs and priorities of these locality populations that will best address the current gaps in funding, health and social care in outcomes for the VoY population.
- This emerging accountable care system will support closer integration between all aspects of care (primary, community, mental health and social) through a focus on realigning resources in such a way that maximises outcomes (end results) for residents and patients.
- The CCG and partners have come together in an emerging accountable care system, as presented below:



Accountable Care System Partnership Board (with organisational form to be determined) is accountable for delivering agreed outcomes which best address the gaps in outcomes for the VoY locality. The Board includes representatives from providers and commissioners across the health and social care system.

Locality level commissioners and providers offering an integrated set of services determined by local priorities. This will be supported by common standards of governance, a shared asset based approach to delivery and joint decision-making. Delivery of services is based around community focused locality teams, building on existing work delivering integrated care hubs and other examples of local authority and Public Health services and new ways of working which are proving to have a positive outcome on population health improvement.

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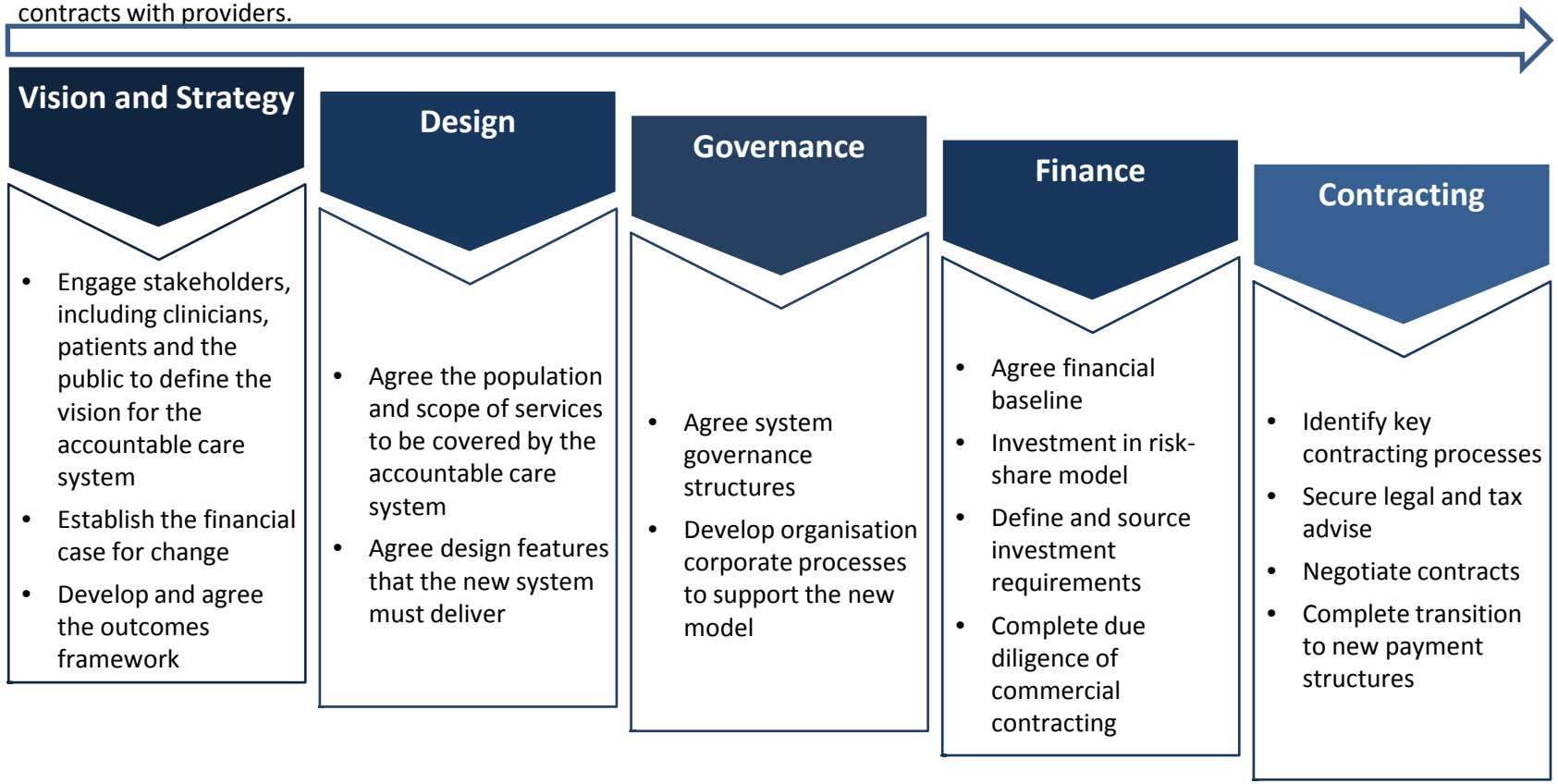
2.5 Steps to deliver an accountable care system

- The CCG recognises that development of an accountable care system for the population of the VoY will require an iterative and phased approach to mobilising alongside all health and care partners. This process has started and the ACS Partnership Board and three Locality Delivery Groups will have all met at least once by March 2017.
- A high-level five phase approach to the phases of work required is provided below. This describes the process from agreeing a strategy to defining the accountable care framework (and the outcomes that it will need to deliver), through to being able to negotiate and issue new contracts with providers.



Successfully implementing an Accountable Care Model will require the VoY system to demonstrate a series of capabilities

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2.6 Characteristics of successful Accountable Care systems

- A review of the experiences of other health and social care systems in delivering accountable care models indicates that successful systems demonstrate a number of common characteristics and capabilities.
- VoY recognises that it will need to work with others within the system do a full self-assessment against these characteristics and then develop a plan for filling any identified capability of resourcing gaps – a review of how ACSs are developing across the STP will support this assessment.

1

- Clearly defined outcomes for the accountable care model which are aligned to the VoY Local Place Based Plan objectives (and STP)
- Focus on priorities for each locality
- Key outcomes and KPIs are shared and agreed with all impacted stakeholders
- The process for monitoring, evaluating and responding to outcomes is established

2

- Clear governance arrangements which reflect appropriate stakeholder representation
- Incentives in place to support the system to continually develop and improve outcomes
- Proposed structures are appropriate and proportionate to effective delivery and shared decision-making

3

- Options for contracting structures have been considered and a preferred approach selected – e.g. outcome based models, capitated budgets
- Proposal incorporates approach to risk management including controls to manage safety, reputational, demand and financial risks
- Clear proposals for managing performance are incorporated

4

- Comprehensive delivery plan in place including resource requirements, detailed timeline, key governance check-points, activities and interim outcomes
- Impacts of accountable care system on workforce, estates, IT and other enablers are clearly demonstrated and built into the delivery plan.
- Investment set-up costs and resource requirements have been allocated.

5

- Key capabilities to implement the plan have been defined and mapped against the current capabilities of the organisations involved e.g. Programme Leadership, PMO, enablers, clinical expertise
- A plan to fill "gaps" identified through the capabilities assessment has been agreed with appropriate resources set-aside

2.7 National policy context

- As VoY develops its thinking, it is determined to take advantage of new national thinking on accountable care models.
- This includes drawing on guidance from NHS England and the findings from the accountable care vanguard programmes.
- NHSE has stated that it expects 50 to 60% of the population will be served by a whole population model by 2020/21. It has made available a number of supporting tools and guidance to support local care economies to move towards new models of care which VoY seeks to draw on – examples include guidance on how to implement Multi-speciality Community Provider (MCP) models.
- The emerging core components of a successful MCP model align closely with VoY's vision for its own accountable care system and include a population health and care model focused on proactive and preventative care; empowerment of patients and local people to support each other and themselves; and multi-disciplinary care professionals working together to deliver health and care services for their population.
- Further clarity on the role of the GP contract within an MCP model is an area that is being looked at by a number of the vanguards and by NHS England directly. Emerging thinking indicates that general practice *must* be at the heart of the MCP model and that no MCP can be commissioned without the inclusion of primary medical services. There may be a number of different transition paths for GPs becoming part of an MCP.
- A further area where guidance is expected is the capabilities that health and social care providers who form an MCP will be expected to demonstrate. Capabilities that MCPs may be asked to demonstrate include:
  - capability to work within existing resources and deliver value for money;
  - be a well-managed and transparent organisation;
  - have full and clearly defined decisions rights;
  - use its budget flexibly in a way which enables it to innovate;
  - work collaboratively with other organisations to deliver integrated care;
  - fully harness the opportunities of digital technology;
  - empower and organise staff to work in different ways;
  - mobilise patients and their families, carers, communities and the voluntary sector;
  - give its patients choice and control and protect NHS values;
  - respect the trust placed in it by VoY's community and the tax payer; and
  - be a good employer for all staff.

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2.8

Summary of VoY's new approach to commissioning

- VoY CCG recognises that it will need to take a new approach if it is to become financially sustainable. Up until now, the health and social system which VoY is part of has failed to produce the correct incentives and behaviours which lead to large scale efficiency savings.

- VoY's strategy for delivering change is grounded in the work of the Humber, Coast and Vale STP and includes a vision for commissioning based around the development of an accountable care system for the population of VoY.

- Characteristics of the new system of care will include:
  - Realigning resources within the system through an outcomes-based approach to commissioning;
  - Supporting the right care and the right workforce to be delivered in the most efficient cost settings ;
  - Incentivising and implementing a whole system approach to prevention;
  - Employing new contracting models and payment structures, including a phased move away from PbR, to deliver the right incentives and behaviours;

- Successfully implementing an Accountable Care Model will require the VoY system to demonstrate a series of capabilities and work closely with its local and STP partners to deliver on this significant programme of change.

- Section 3 will now present the findings of population analytics and benchmarking which has been carried out in order to pinpoint opportunities for VoY to focus on in the future, given its local population needs. Section 4 will then present plans for delivery of a number of immediate cost saving opportunities, including the financial opportunity they represent.

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SECTION 3: POPULATION ANALYTICS AND BENCHMARKING

We have used an innovative approach to understanding how we currently spend our population allocation based on population need

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3.1

VoY's approach

Report sections		Key activities
3	***Population analytics and benchmarking***	• Reviewed weighted population allocation to understand areas where VoY does and does not "live within its means" • Conducted benchmarking with other STP commissioners to understand areas of VoY over- and under-spend • Reviewed VoY population characteristics to identify underlying cause of the deficit • Reviewed Right Care analysis to identify potential areas of saving • Reviewed other literature/best practice to identify additional opportunity ideas
4	***Financial opportunity***	• Identified specific financial opportunities based on population analytics/benchmarking analysis undertaken • Quantified opportunities based on evidence available • Phased savings over four year period to 20/21 • Calculated residual financial "gap" for VoY CCG under different scenarios • Reviewed delivery plans and enablers for each opportunity identified • Agreed approach to working with stakeholders and immediate next steps

VoY CCG's spend per head of population is the lowest in the Humber, Coast and Vale, however VoY also receives the lowest allocated spend per head from NHSE

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3.2

CCG spend per head

In 15/16, Vale of York CCG's **spend per head of population** was the lowest in the Humber, Coast and Vale STP footprint; at the start of 16/17, Vale of York CCG's plans also showed the **lowest forecast spend per head** (as shown in the table below).

However, Vale of York CCG has the **lowest allocation** per head in the STP footprint due to the relatively low calculated health needs of the population.

This means that, although the CCG's forecast spend per head was 9% lower than the STP average, this still leads to the **highest percentage forecast overspend** compared to funding allocation for FY17.

	NHS East Riding of Yorkshire CCG	NHS Hull CCG	NHS North East Lincolnshire CCG	NHS North Lincolnshire CCG	NHS Scarborough and Ryedale CCG	NHS Vale of York CCG	Vale of York % below STP average
Spend per head (£k, FY16)(1)	1.22	1.29	1.29	1.25	1.30	**1.13**	8%
Forecast spend per head (£k, FY17)(1)	1.26	1.31	1.31	1.26	1.34	**1.13**	9%
***Allocation per head (£k, FY17) (2)**	1.24	1.31	1.31	1.26	1.33	**1.11**	10%
FY17 % overspend forecast	1%	0%	0%	0%	1%	**2%**	

*Allocations are calculated based on the weighted population, with future years forecast using ONS population growth estimates. Understanding the basis behind the funding allocation, and comparing this with actual spend, can help to identify areas where spend may need to be reduced for the CCG to live within its means.

(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) NHS England Allocations CCG Core Services

There is reduction of 11% made to the allocation to VoY owing to population need, level of health inequality and remoteness

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3.3 Explaining the population weighted allocation in more detail

- The relative youth, health and affluence of the VoY population means that there is a reduction of **11%** made to the unweighted allocation for VoY:
  1. This is largely driven by acute need **(-10%)** since, compared to the STP average, Vale of York has a lower proportion of population aged 50+
  2. There is also a **1%** reduction for unmet need and health inequalities as the population has a relatively low mortality ratio for under 75s
  3. There is no adjustment for the remoteness criteria
- The CCG is therefore only allocated 89p per person for every £1 per person allocated across the country. In contrast, the other CCGs in the STP footprint are allocated £1.02-£1.07 per person for every £1 per person allocated across the country

NHS Funding Formula

- Further explanation behind the calculation of allocations and the key drivers for the VoY population weighting are discussed in the **Appendix**.
- The funding allocation received by CCGs firstly depends on the number of people registered to GPs within that CCG. The registered population is then weighted based on:
  1. **Healthcare service need due to age, gender and other factors**
  2. **Unmet need and health inequalities, based on standardised mortality ratio for those under 75 years of age**
  3. **Unavoidable costs of remoteness**

Key steps in the population weighting formula (15/16 population)[1]

	Unweighted 2015 registrations	**1. Population weighted for healthcare service need**	**2. Population weighted for unmet need and health inequalities**	**3. Population weighted for cost of remoteness**	Overall % uplift as a result of weighting	"Allocation units" per person
NHS East Riding of Yorkshire CCG	301,429	313,027 (+4%)	306,262 (-2%)	306,122 (-0%)	**2%**	1.02
NHS Hull CCG	291,334	291,741 (+0%)	305,964 (+5%)	305,823 (-0%)	**5%**	1.05
NHS North East Lincolnshire CCG	168,957	174,887 (+4%)	177,690 (+2%)	177,608 (-0%)	**5%**	1.05
NHS North Lincolnshire CCG	171,625	174,057 (+1%)	175,258 (+1%)	175,178 (-0%)	**2%**	1.02
NHS Scarborough and Ryedale CCG	118,999	127,351 (+7%)	125,586 (-1%)	127,734 (+2%)	**7%**	1.07
NHS Vale of York CCG	**352,219**	**317,732 (-10%)**	**313,992 (-1%)**	**313,847 (-0%)**	**-11%**	**0.89**

(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet J)

VoY's target allocation per head for FY17 is below all other commissioners within the STP

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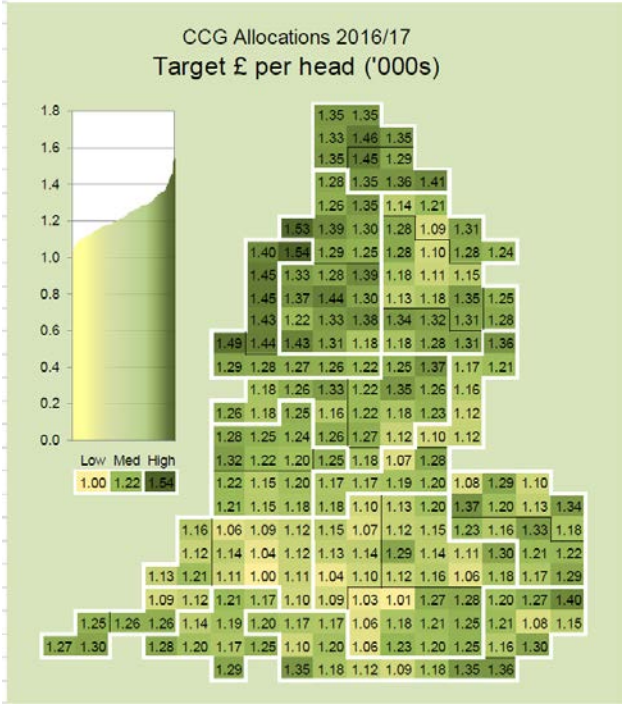
3.4

FY17 target allocations

- Target allocations are calculated based on the weighted population
- Future years are forecast using ONS population growth estimates
- Vale of York CCG has the **lowest target allocation per head in the STP footprint** for FY17, due to relatively low calculated health needs. VoY needs to target spend 11% less per person than the STP average in order to live within its means
- "Actual" allocations are then calculated based on a combination of the target allocation and the previous year allocation
- **All CCGs in the STP footprint have an actual allocation higher than their target**, so allocations will grow more slowly in this STP than the national rate

	Target allocation per head (£k, FY17)(1)	Actual allocation per head (£k, FY17)
NHS East Riding of Yorkshire CCG	1.24	1.24
NHS Hull CCG	1.28	1.31
NHS North East Lincolnshire CCG	1.28	1.31
NHS North Lincolnshire CCG	1.25	1.26
NHS Scarborough and Ryedale CCG	1.31	1.33
NHS Vale of York CCG	**1.09**	**1.11**
Vale of York % below STP average	**11%**	**10%**



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY receives a lower allocation weighting for population age distribution compared to others in the STP

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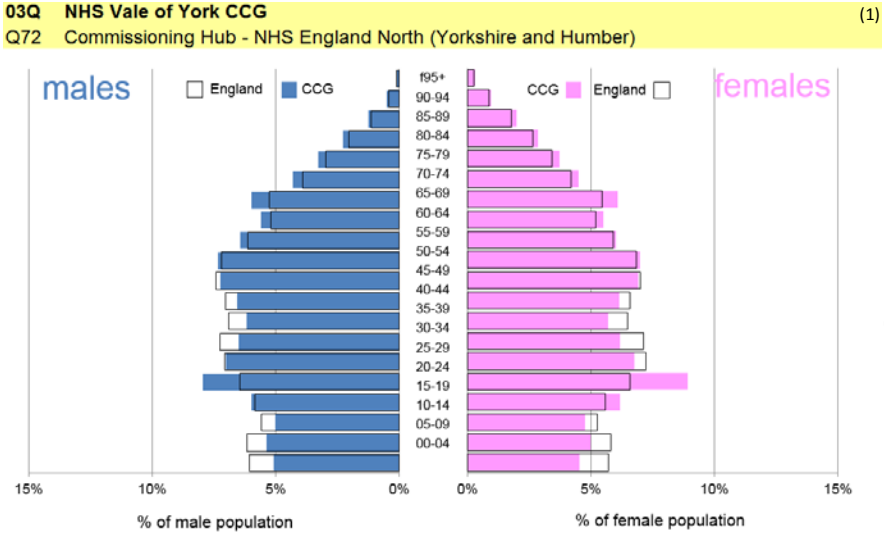
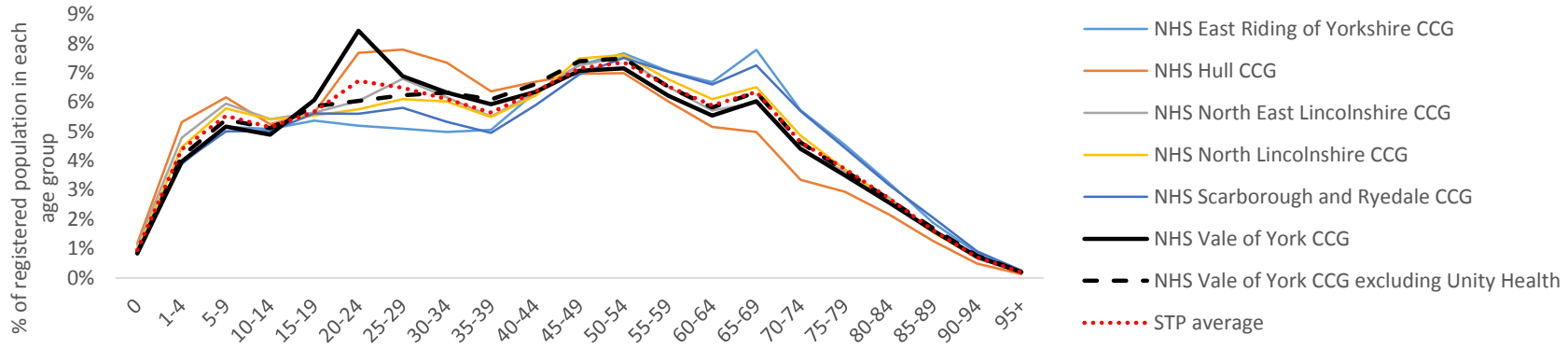
3.5 Population need

- The biggest factor in the population weighting is age distribution, as the elderly tend to have the greatest healthcare needs
- **Compared to the national average** (as shown on the right), Vale of York CCG has a higher proportion of population aged 50+
- However, compared to the STP average (shown below), Vale of York has a lower proportion of population aged 50+, although a higher proportion aged 90+
- This drives a lower weighting for Vale of York CCG **compared to the STP average**, as there are relatively fewer elderly patients. This is discussed further on the following slide
- The higher proportions in the 15-19 and 20-24 age groups is largely due to university students in York (as shown in the age distributions graph below with Unity Health excluded)



Age distributions by CCG(1)



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet A)

VoY has a relatively high acute spend for its level of patient need

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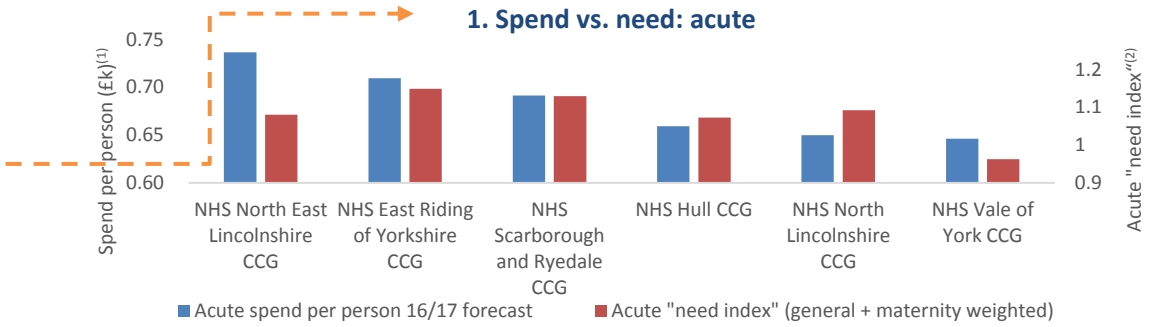
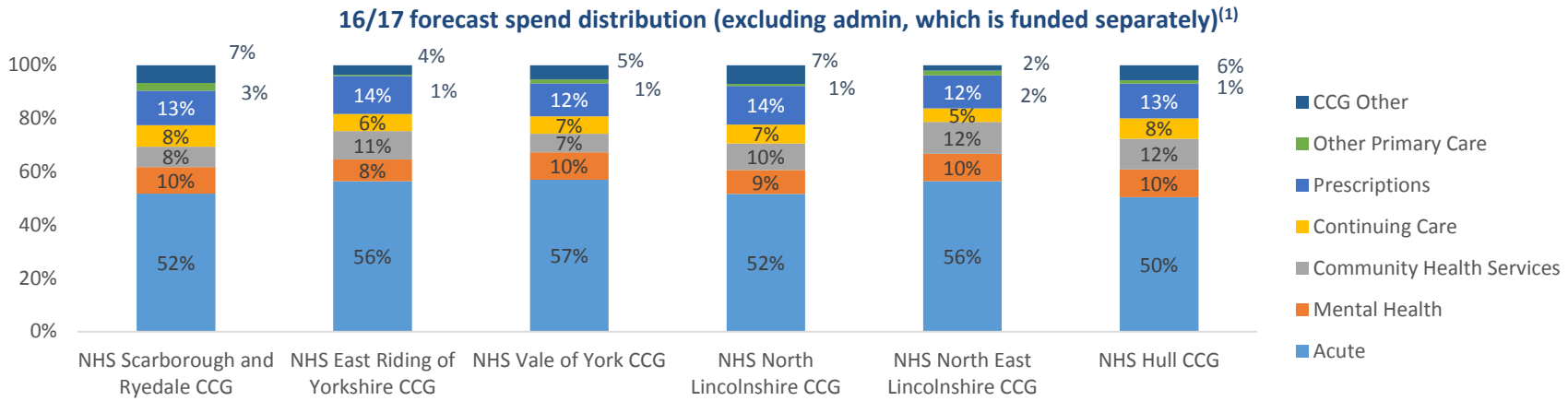
3.6

Acute spend

- A comparison of forecast spend versus need (as calculated through the population weightings) is useful for identifying areas of potential "overspend" within Vale of York
- Within the STP footprint, Vale of York CCG has a **relatively high acute spend** for the level of patient need
- Based on forecasts from the start of 16/17 (shown below), Vale of York CCG also has the **highest proportion of acute spend amongst the STP commissioners**
- Further detail is provided in the **Appendix**





(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets C and E)

Variability in primary care referral behaviour indicates there may be an opportunity to reduce acute spend

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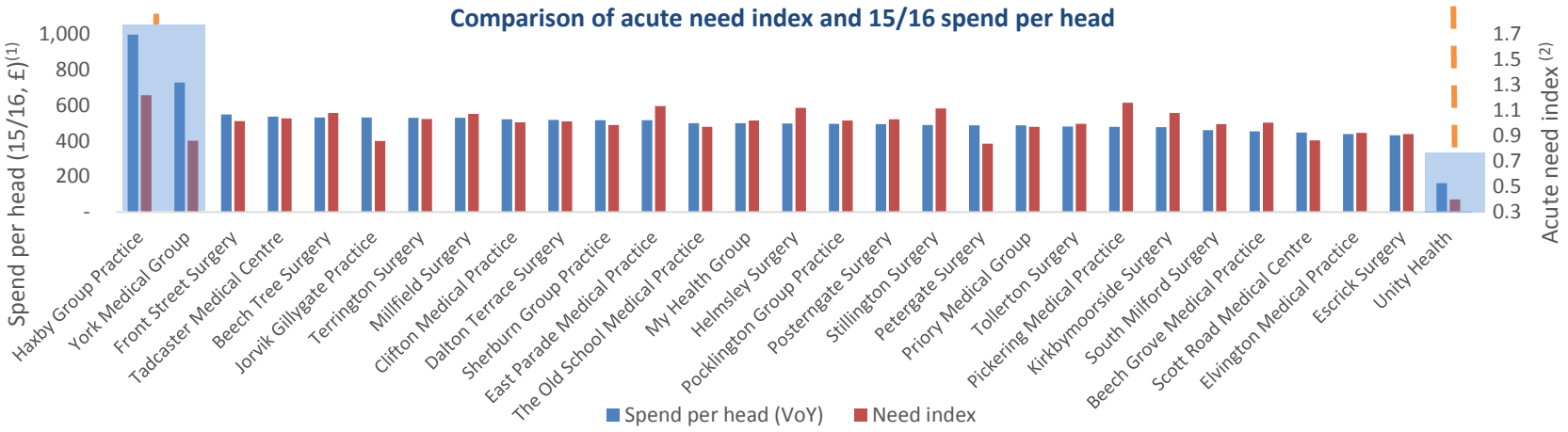
3.7 Primary care referrals

- There is wide variation in the spend per person on acute care by GP practice, indicating a potential opportunity to reduce acute referrals through a stronger primary care offering /behaviour change
- The chart presented compares acute spend per head with patient need, by GP practice:
  - **Haxby Group Practice** and **York Medical Group** are two **outliers**; they also have the highest spend per head relative to patient need, and are two of the three largest GP practices in the CCG (over 65k patients), responsible for a total acute spend of £57m in FY16
  - There may be multiple reasons for the variations however it could indicate an unnecessary level of referral to acute care when enhanced community or primary care might better serve the patients' needs
  - The University campus health centre has a high spend per head compared to need. This may result from a neighbouring elderly population to the campus



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet C)
(2) SUS data 2015/16

VoY spends less on community health services compared to others within the STP

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3.8 Community spend

- The chart on the previous slide also indicates that VoY has the **lowest proportion of community health services** spend in the STP
- The table below illustrates the 16/17 forecast spend per head for each of the STP CCGs, across different areas of spend. VoY CCG spends 36% less per head on community health services than the STP average.
- This indicates that there is **potential for the CCG to increase spend on community services,** which may support patients to receive care closer to home and reduce the need to spend on acute services

16/17 forecast spend per head (£, April 2016 forecasts)(1)

	NHS East Riding of Yorkshire CCG	NHS Hull CCG	NHS North East Lincolnshire CCG	NHS North Lincolnshire CCG	NHS Scarborough and Ryedale CCG	NHS Vale of York CCG	% below STP average
Acute	710	659	737	650	691	646	5%
Mental Health	103	136	135	112	134	118	3%
Community Health Services	133	151	156	126	101	78	36%
Continuing Care	81	100	67	90	109	74	13%
Prescriptions	179	170	161	182	172	141	15%

(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY spends relatively more on older people (75+) than others within the STP, in both planned and unplanned care

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3.9

Inpatient activity and spend profile (FY16)(1)

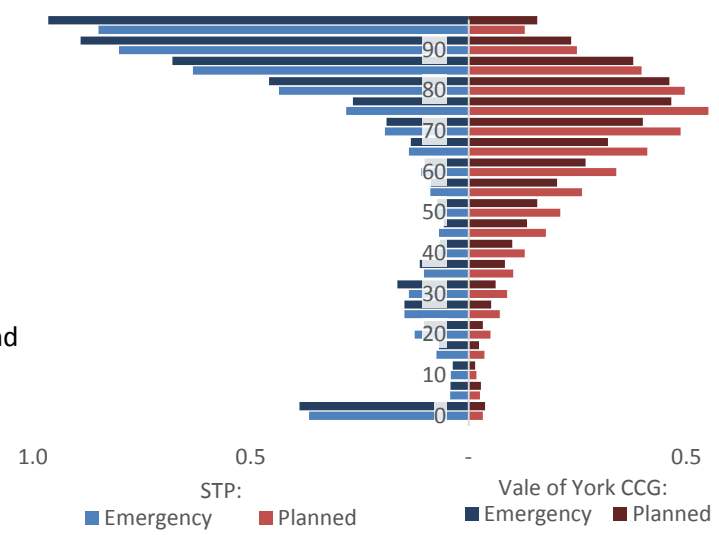
Planned inpatient care (elective and day case)

- Vale of York CCG had fewer spells per person in the population than the STP average across all age bands except 0-9 and 95+
- The spend per person was lower than the STP average for ages 5-69, but higher than the average for ages 70+

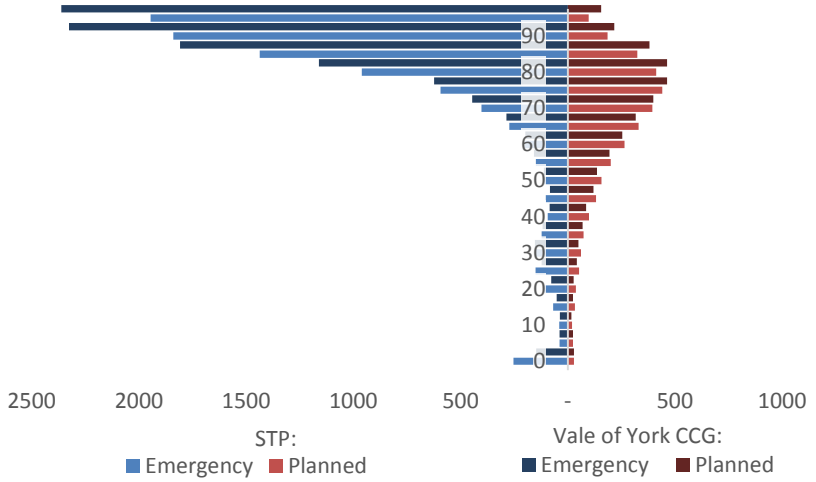
Emergency inpatient care (non-elective)

- The population aged 80+ had 9% more spells per person but 25% higher spend per person in the population
- The population aged 40-79 had fewer spells per person but a higher spend

Spells per person by age band



Spend per person by age band (£)



- On average, the FY16 spend per person on inpatient spells was **2% lower** at Vale of York CCG than across the STP:

	STP average	Vale of York CCG	% difference
Spend per head (planned)	£149	£140	-6%
Spend per head (emergency)	£223	£225	+1%
Spend per head (total)	**£372**	**£365**	**-2%**

(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

In planned care, there are particular opportunities in orthopaedics

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3.10 Elective orthopaedics

- Vale of York CCG's average spend per person in the population on planned care was 15% higher than the STP average for trauma and orthopaedics (T&O). The difference is most marked for older patients
- Findings from the population analytics and benchmarking indicates that VoY spends relatively more on older people (75+) than others within the STP in both planned and unplanned care. It is likely that high spend on T&O is a key driver of this overspend
- RightCare benchmarking shows that the CCG has the **4th highest primary hip replacement rates** in the country and high rates of knee replacement compared to similar CCGs

What is the potential saving?

- By bringing spending in line to the STP average, VoY could save £4.2m on planned T&O. This figure is also backed up by RightCare benchmarking findings

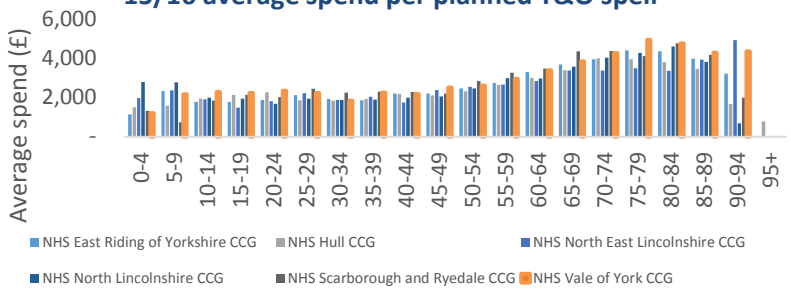
Key assumptions:

- Reduce elective orthopaedics spend to the average of the 10 similar CCGs identified by RightCare benchmarking
- Includes £0.2m savings in 17/18 identified from arthroscopies
- Includes £0.4m savings in 17/18 identified from a review of knee replacement coding & tariff following change in NICE guidance

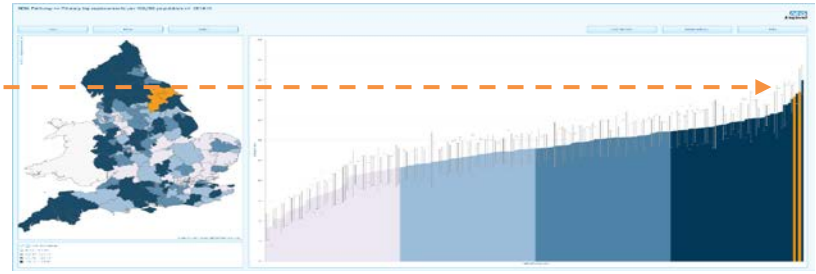
15/16 spend per head across the STP and at Vale of York CCG(1)

	STP average	Vale of York CCG	% difference
Spend per head (planned T&O)	£44	**£51**	**+15%**

15/16 average spend per planned T&O spell(1)



Primary hip replacement rates



(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

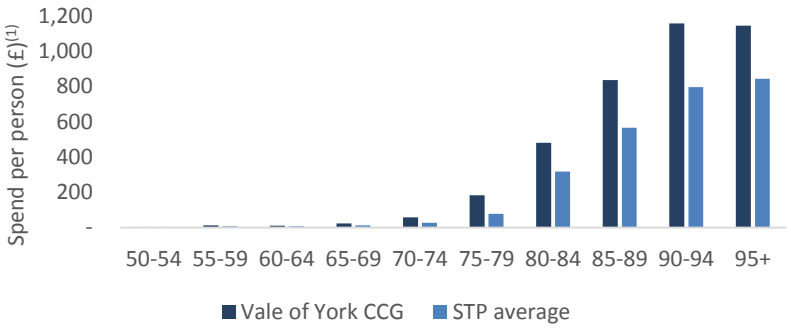
3.11 Geriatric and respiratory medicine

- In 15/16, the CCG's non-elective inpatient spend per person in the population was greater than the STP average in all four of the largest treatment specialties (Geriatric Medicine, Respiratory Medicine, Trauma & Orthopaedics, Cardiology), which account for over half of the CCG's non-elective inpatient spend; this was largely due to spend on patients aged 50+
- There are particular opportunities to reduce in spend Geriatric Medicine and Respiratory Medicine, as shown to the right:
  - In Respiratory Medicine, the Vale of York population aged 50+ had twice as many spells per person than the STP average (weighted for age distribution). The spend in VoY per person was double the STP average overall
  - In Geriatric Medicine, the Vale of York population aged 50+ had both more spells per person and a higher spend per spell (weighted for age distribution). The spend in VoY was 64% higher than the STP average overall

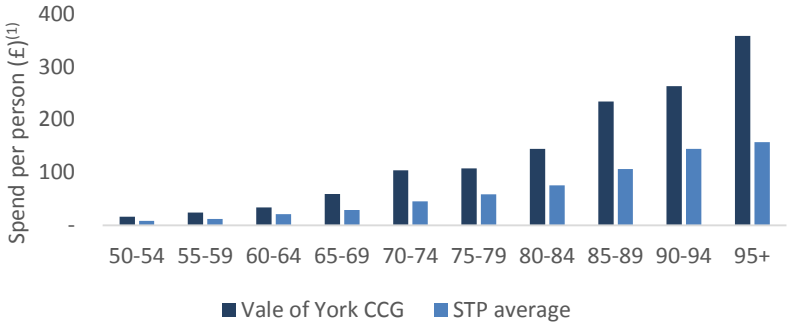
Average non-elective spend per person in the population aged 50+ (£)

	STP average	Vale of York CCG	% difference
Geriatric Medicine	£78	£128	+64%
Respiratory Medicine	£35	£70	**+101%**
Trauma & Orthopaedics	£34	£43	+28%
Cardiology	£29	£43	+49%
Total other	£213	£159	-25%
Total	**£389**	**£443**	**+14%**

Spend per person in the population on non-elective Geriatric Medicine



Spend per person in the population on non-elective Respiratory Medicine



(1) SUS data 2015/16; population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

VoY spends more on Joint Funded Care than most other CCGs within the STP

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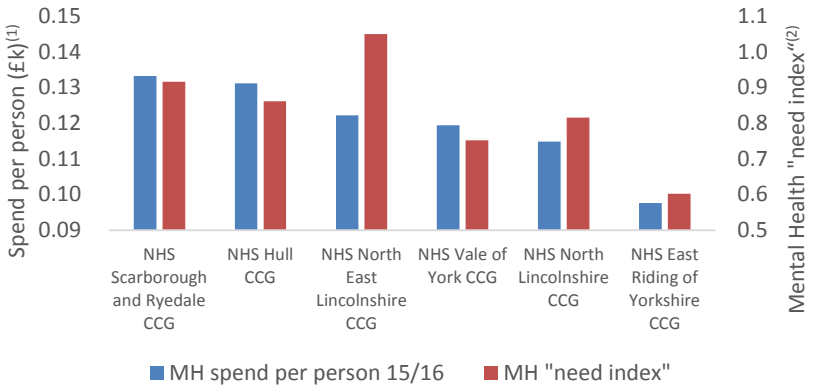
3.12

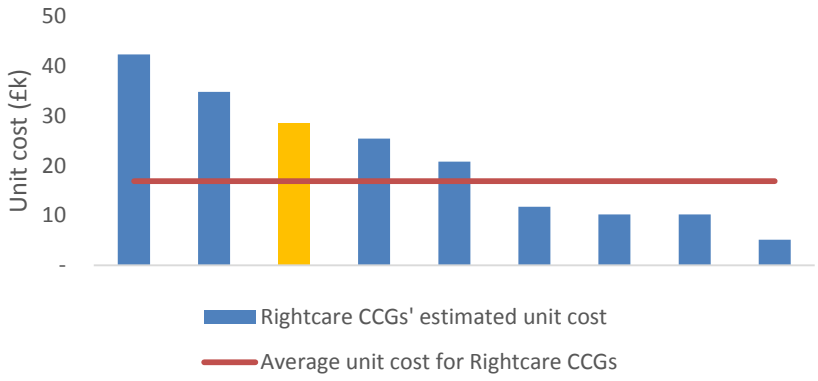
Continuing Healthcare

- STP benchmarking on mental health suggests that the CCG is not an outlier, and in 15/16 the CCG's spend on mental health services was relatively near to the STP average
- However, in May – August 2016, the CCG conducted a review into Continuing Healthcare (CHC) and Funded Nursing Care (FNC) budgets
- This covered low volume, high cost packages of care, specifically those within CHC, FNC and Mental Health
- The review included benchmarking of Vale of York expenditure and activity against available data sources for Yorkshire and the Humber CCGs and RightCare comparator CCGs
- Although Vale of York ranks at an average position across CHC and FNC it total, there are potentially areas of savings, if the CCG were to move closer to the lower end of the comparators
- The area for which Vale of York CCG is an outlier primarily relates to Joint Funded Care. The CCG is both an outlier in terms of activity and unit cost
- Against the RightCare average the CCG spends £800 per patient per annum more on Fully Funded CHC packages and £11,600 more on Jointly Funded packages. The variation to the best performing CCG in the benchmark is significantly greater
- This suggests that spend on fully funded and jointly funded CHC packages should be a key area of focus for the CCG

Spend vs. need: mental health



Joint funded care: unit cost variation(3)



(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet D)
(3) Review of Financial Procedures and Forecasting of Continuing Healthcare and Funded Nursing Care Budgets and Benchmarking (presented to Quality and Finance Committee August 2016)

VoY has traditionally performed well on prescribing although there are pockets of comparatively high spend

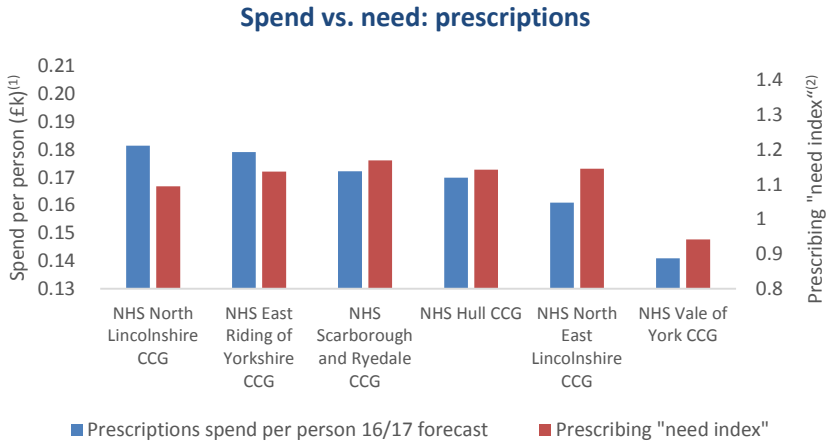
Vale of York Clinical Commissioning Group

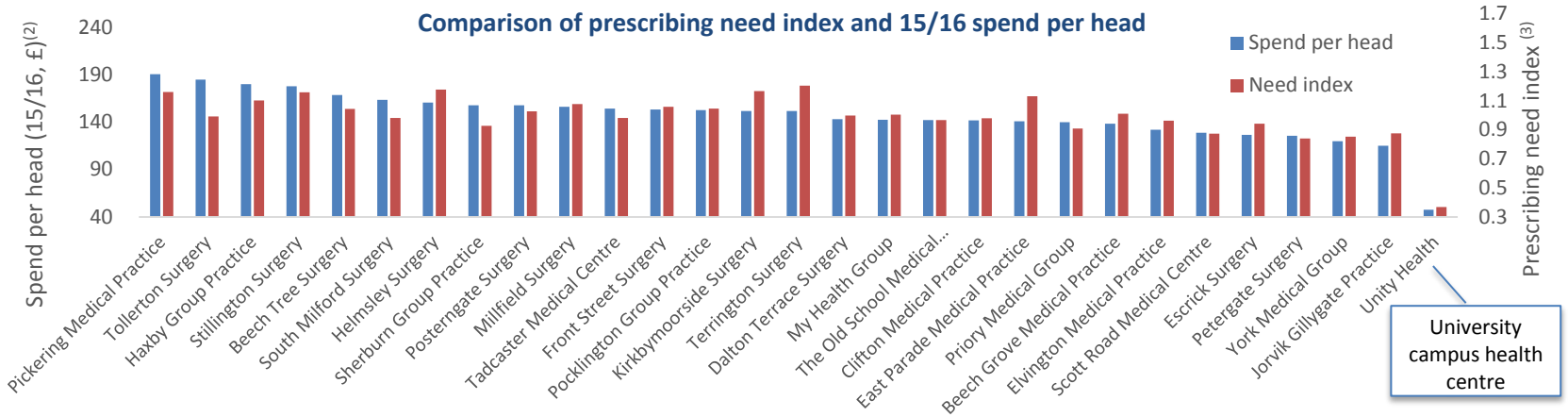
3.13

Prescribing

What is the evidence?

- Within the STP, Vale of York CCG has a relatively low prescribing spend compared to other commissioners and for its level of patient need, as illustrated in the chart opposite.
- However, there are pockets of comparatively high levels of prescribing spend within the CCG (e.g. Tollerton Surgery), where there could be opportunities for further efficiencies
- While there may be a number of reasons for the variation between GP practices (shown below), it could indicate an unnecessary level of prescribing in some instances
- If all practice alliances (Unaligned practices as an alliance) reduced to the CCG average spend per weighted head of population this would save £2.5m; £5.5m potential saving if all reduced to the lowest alliance





(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21
(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet D)
(3) 2015-16 Prescribing Data

By matching the performance of its top 5 performing comparators, the CCG could target additional prescribing savings

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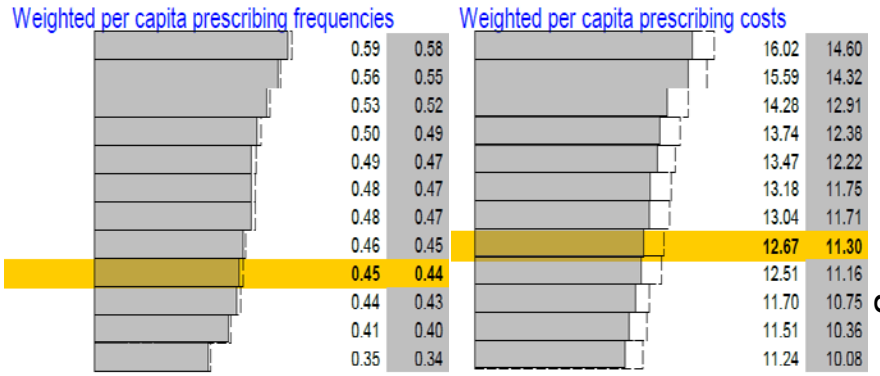
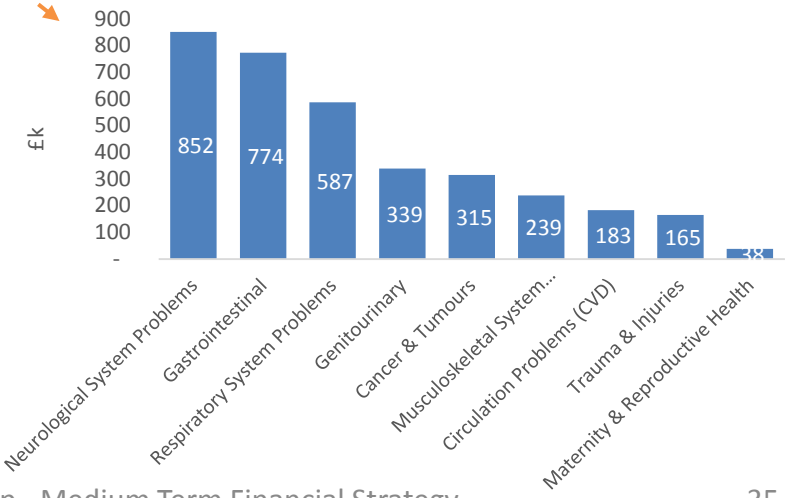
3.14 Prescribing

- Analysis performed by the Regional Drug and Therapeutics Committee on RightCare comparators (completed in July 2016) finds that VoY performs **4th and 5th out of 12 comparators** on weighted per capita prescribing frequencies and costs, respectively
- RightCare analysis also indicates that the CCG could target £3.5m of savings in prescribing costs (i.e. 7% of prescribing spend), compared to the top 5 comparison CCGs. The key disease areas for these opportunities are:
  - Neurological system problems
  - Gastrointestinal
  - Respiratory system problems
- This target opportunity does not take into account the high levels of growth in prescribing costs expected by NHS England (average growth of 4.6% per year for 17/18 to 20/21), which would increase the target savings to £4.2m by 20/21
- The CCG believes this target can be stretched further, given the historically strong achievement of prescribing savings in the past, which makes prescribing a **key area of focus for the CCG** where there is a high level of confidence that savings can be made

Prescribing frequencies and costs, analysed through Regional Drug and Therapeutics Committee, RightCare comparators (July 2016)



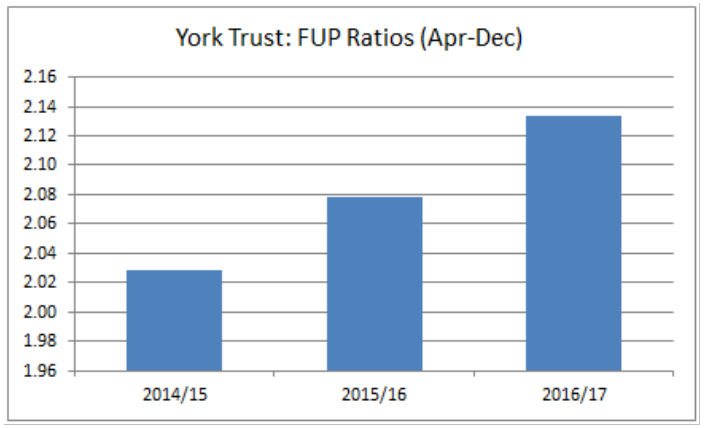
Opportunity based on top 5 comparators (£k)[1]



(1) RightCare 'Where to look' packs – January 2016

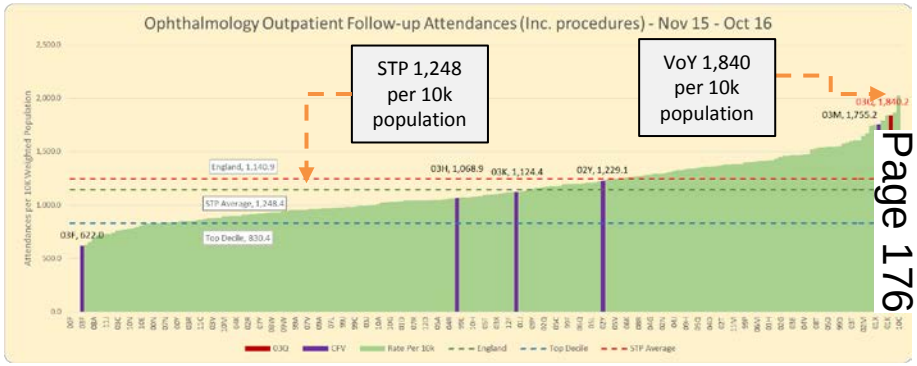
3.15 Outpatient appointments

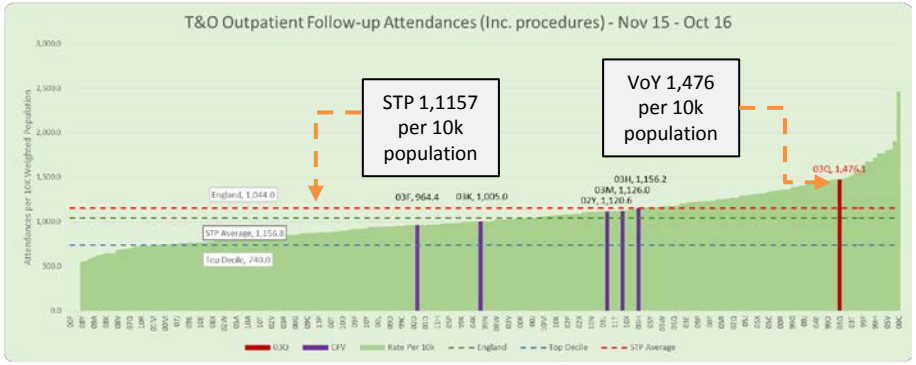
- VoY believes that there may be opportunities to achieve additional cost savings through a reduction in the number of commissioned outpatient appointments, in particular with regards to follow-up appointments.
- This is encouraged in the NHS 17/19 NHS Planning guidance that proposes new payment mechanisms to reduce the number of unnecessary follow-up outpatient appointments. Guidance stipulates that a percentage of follow-up costs will be bundled into first attendances
- In 2014/15 YTHFT developed and implemented the Conditions Registers to ensure only those patients that require an acute based appointment are followed-up bringing the first to follow-up ratio down to 1:2.02. Since then there has been a gradual increase in the ratio.



(1) HES data extract

- The opportunity is reinforced by national benchmarking data (1) around outpatient follow-ups and procedures within the two largest specialty areas for the VoY.





- The use of outpatient procedures may be beneficial in terms of avoiding day cases. However, the CCG is still likely to be an outlier that requires further exploration.

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3.16

Summary of population analytics and benchmarking

- Although the CCG spends less per head on its population than any of the other STP commissioners (8% below the STP average), it is allocated the least. This is largely due to its lower calculated population need resulting from its relative youth, health and affluence
- The CCG needs to spend 11% less per person than the STP average in the future in order to live within its means
- Population analytics and benchmarking indicates that the CCG should target the following areas:
    - A reduction in spend on acute care, where the CCG has a relatively high spend, given its level of patient need
    - Savings in planned orthopaedics care where the CCG spend is 15% higher per head than comparators
    - A re-focus on community care investment, given its comparatively low spend, particularly targeted at reducing non-elective spend on older patients
    - Reductions in spend on joint funded care, where the CCG is a comparatively high spender
    - Further opportunities for efficiency savings in prescribing
    - Reducing the number of follow-up outpatient appointments
- Section 4 will now identify specific plans for the realisation of these opportunities in more detail, including agreed plans for delivery and a quantification of the financial opportunity that the plans represent

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SECTION 4: FINANCIAL OPPORTUNITY

We have identified 6 specific financial opportunities which we are taking forward to delivery immediately

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4.1

6 key opportunities

- The CCG identified 6 key areas of financial opportunity based on the population analytics and health benchmarking findings
- These opportunities have been subject to an NHS England Confirm and Challenge session with the relevant, executive director, clinical, operational and finance and contracting leads signing up to schemes that deliver the same overall amount, phased differently. Although the overall opportunity still exists, it is the confirm and challenge numbers that have been used in constructing the CCG's financial plan

Section reference	Opportunity	Initial Assessment					Confirm and Challenge Assessment				
		Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)	Total potential spend reduction (£m)	17/18 (£m)	18/19 (£m)	19/20 (£m)	20/21 (£m)
(4.2)	***1) Elective orthopaedics***	4.2	1.3	1.0	1.0	1.0	3.0	0.8	2.3	0.0	0.0
(4.3)	***2) Out of hospital care***	21.3	0.0	9.1	7.2	5.0	15.0	3.6	4.5	4.3	2.5
(4.4)	***3) Contracting for outpatients***	5.0	3.0	2.0	0.0	0.0	2.0	1.0	1.0	0.0	0.0
(4.5)	***4) Continuing healthcare and funded nursing care***	9.3	3.1	2.5	2.5	1.2	9.6	1.8	2.5	2.5	2.8
(4.6)	***5) Prescribing***	6.2	1.7	1.5	1.5	1.5	6.2	1.6	1.6	1.5	1.5
(4.7)	***6) High cost drugs***	2.0	0.2	0.6	0.2	1.0	2.1	0.3	0.6	0.2	1.0
	Other	0.0	0.0	0.0	0.0	0.0	9.8	6.8	1.8	1.0	0.2
	Total	**50.0**	**9.4**	**16.7**	**12.4**	**9.6**	**47.7**	**15.9**	**14.3**	**9.5**	**8.0**

- This chapter also includes VoY's agreed approaches to delivering the opportunities identified, driven by the CCG's overarching new approach to commissioning, described in Section 2 based around the following key headings:
  - What is the potential saving?
  - Key assumptions
  - How can this be delivered?
  - What are the agreed next steps?
  - How will the CCG work with stakeholders?

By bringing spending in line to the STP average, VoY could save £4.2m on elective orthopaedics

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4.2 Opportunity 1: Elective orthopaedics

What is the potential saving?

- By bringing spending in line to the STP average, VoY could save £4.2m on planned T&O. This figure is also backed up by RightCare benchmarking findings

Key assumptions:

- Reduce elective orthopaedics spend to the average of the 10 similar CCGs identified by RightCare benchmarking
- Includes £0.2m savings in 17/18 identified from arthroscopies
- Includes £0.4m savings in 17/18 identified from a review of knee replacement coding & tariff following change in NICE guidance

How can this be delivered?

- New approaches to contracting are required including use of outcomes-focused commissioning, new population management based approaches
- Potential consolidation of suppliers including working differently with private providers (65% of planned trauma and orthopaedics in VoY is currently delivered through private providers)
- Greater focus on patient self-management of musculoskeletal conditions
- Enhanced orthopaedic knowledge base in primary care and greater support GPs to better manage patients' expectations
- Use of clinical thresholds where carefully managed and evidence tested

What are the agreed next steps?

- Continued development of the new MSK pathway including patient direction to self-management tools, more referral to lifestyle interventions and evidence-based decision making prior to surgical intervention
- Development of an MSK web hub which will act as a source of information for GPs and patients and provide information on treatment options, sign-posting, and help to manage patient expectations
- Development of commissioning statements relating to BMI and smoking thresholds for hip and knee arthroplasty and hip and knee arthroscopy. Processes to be put in place to monitor implementation of thresholds via CCG's Referral Management Centre
- Implementing the CCG's *"our NHS, let's take care of it campaign"* – first phase will aim to raise awareness of waste medicine and costs to the local economy

4.2 Opportunity 1: Elective orthopaedics

- Provide support to GPs to improve their knowledge and skills through online video demonstration of joint examination, post-graduate training events and support for GPs wishing to gain more expertise in managing MSK conditions. Also ensure closer working with physiotherapists and extended scope practitioners in GP practices
- Further conversations with providers and system stakeholders to develop new approaches for contracting and payment based on whole population management strategies

How will the CCG work with stakeholders?

- Engagement with primary care to support GPs in using new MSK care pathways and engagement with the public to promote usage of the MSK web hub
- Engagement with providers and other partners in the STP to explore new models for commissioning and contracting
- MSK Programme Delivery Board consists of the commissioner, primary care and three local providers

4.3 Opportunity 2: Out of hospital care

What is the potential saving?

- The STP analysis has estimated a potential £21.3m cost saving for Vale of York CCG, over 4 years to 20/21, by reducing need for acute care and avoiding emergency hospital admissions
- This potential saving has subsequently been supported by the further work undertaken by BDO Consulting to determine a more localised, patient level opportunity assessment for the CCG's Out of Hospital programme which estimated £20.5m.

Key assumptions:

- The STP out of hospital intervention consists of a number of targeted programmes. Each programme is assumed to reduce emergency admissions and/or A&E attendances by a percentage agreed across the STP
- Reprovision investment into primary or community services is between 10% and 50% of the cost savings, depending on the programme
- Provider fixed costs need to be recognised in the assessment of the net savings deliverable

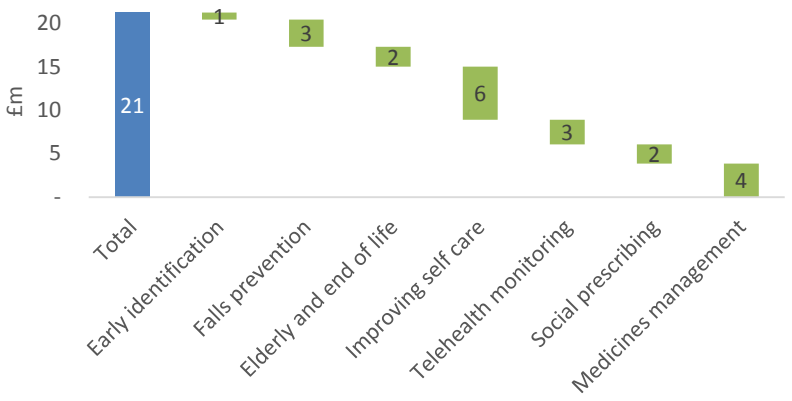
How can this be delivered – The STP vision?

- The STP vision supports integrated care pathways with primary, community and acute services working in coordination to enable patients to be treated closer to home where appropriate

(1) Modelling for the Humber, Coast and Vale STP Finance Template (submitted October 2016)

- Seven of the twelve STP-wide interventions are targeted at reducing emergency admissions and A&E attendances across the whole population, including the elderly, COPD and long term conditions:
  - Early identification
  - Falls prevention
  - Elderly and end of life
  - Improving self care
  - Telehealth monitoring
  - Social prescribing
  - Medicines management
- The total potential saving is divided between the seven STP-wide interventions shown in the graph below

STP estimated potential savings from integrated care(1)



4.4 Opportunity 2: Out of hospital care

- These interventions will prevent or reduce emergency acute activity through new models of care as part of a move towards Accountable Care services
- This will include reconfiguration of community services to deliver care closer to home in line with the CCG's vision

How can this be delivered? – Independent benchmarking and identification of high-cost patient cohorts

- In late 2016, NHS Vale of York CCG commissioned BDO Consulting to complete an independent review of patient level activity which based on a clinical review and the VoY Out of Hospital programme could potentially be deflected away from an acute setting
- Four separate cohorts were identified:
  - Acute conditions that should not usually require hospital admissions = £2m
  - Ambulatory Emergency Care deflections = £7.5m
  - Long term condition as the patients primary diagnosis = £9m
  - Two or more long term conditions (included in the 13 diagnosis codes) = £2m
- This equates to a combined total of 11,854 admissions

What are the agreed next steps?

- Work with the Humber, Coast and Vale STP to make detailed and fully costed plans for these STP-wide interventions
- Production of locality information packs that allow the identification of the opportunity at a practice and disease specific level to inform the development of targeted interventions
- Collaborate with the local community and acute providers on potential early adoption of some of these schemes
- Strong focus on geriatric and respiratory medicine given the comparatively high areas of spend in these specialities for York

How will the CCG work with stakeholders?

- Continued engagement with local authorities and community care providers both in the Vale of York area and the STP footprint
- Engagement with primary care to support GPs in changing behaviours around referral patterns

Reducing unnecessary outpatient appointments represents an potential saving opportunity of £7.1m over 4 years

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4.5 Opportunity 3: Reduced follow-up outpatient appointments

What is the potential saving?

- Potential saving of £7.1m over 4 years to 20/21
- Key assumptions:
  - Target a 1:1 new to follow-up ratio for outpatients through only providing follow-up appointments where there is clinical need
  - Reinvest 30% of savings into primary and community care

How can this be delivered?

- Increased care closer to home and reduced requirements for patients to attend hospital appointments unless it is clinically necessary
- Further streamlining of elective care pathways and outpatient redesign
- Contracting differently for outpatients including a move towards 1:1 first to follow up ratio
- The CCG continually carries out detailed and robust assessments of acute activity as part of its business as usual processes. This will be supplemented by an independent review of contract performance in 2016/17

What are the agreed next steps?

- Improved patient guidance and information
- Consider local variations to NHS planning guidance on payment reform including more far reaching reforms to complement local redesign

How will the CCG work with stakeholders?

- Engagement with primary care to encourage GPs to provide follow-up care
- Closer working with acute clinicians to explain the need for change and demonstrate the benefits
- Collaboration with STP partners on new approaches to contracting/payment

4.6

Opportunity 4: Continuing Healthcare

What is the potential saving?

- £9.6m over 4 years to 20/21
- Key assumptions:
  - £3.1m cost saving if performing at average unit cost in Fully Funded and Joint Funded care
  - £9.3m cost saving if performing at best unit cost in all areas (excluding CCGs with zero spend)
  - The CCG has modelled a move to the average (i.e. £3.1m cost saving) in 17/18 and to the best performing CCG (i.e. £9.3m cost saving) by the end of 20/21

How can this be delivered?

- Review of approaches to commissioning continuing health care including population management approaches and outcomes based contracts
- Stronger reporting and forecasting and increased scrutiny of benchmarks
- New approach to negotiation with providers
- Consider the utilisation of out of area placements in localities where the cost of care is lower than Vale of York
- Ensure adequate and timely case reviews are undertaken and are sufficiently resourced
- Negotiate the relative contribution of Health to Joint Funded Packages of Care

What are the agreed next steps?

- Further internal working between CCG finance and contracting teams to agree strategy and approach to future contracting
- Review and learning from successful joint commissioning approaches applied elsewhere

How will the CCG work with stakeholders?

- Work with community services providers to strengthen services and reduce the need for expensive nursing care packages
- New approaches to agreeing defining value and agreeing outcomes with providers

£6.0m represents the potential cost saving opportunity to VoY for prescribing over 4 years (stretch target)

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4.7

Opportunity 5: Prescribing

What is the potential saving?

- £6.2m cost saving over 4 years to 20/21 (£1.5m per year)
- Key assumptions:
  - Target saving of 3% per year, based on historic prescribing QIPP achievement
  - If the Medicines Management Team resource remains as it is then there is a highly probable risk that the targeted prescribing QIPP for 17/18 will not be delivered. As it stands the team have identified the capacity to deliver c£900k.

How can this be delivered?

- The prescribing QIPP programme has been split into four key areas with multiple individual schemes within each:
  - **De-Prescribing:** Targeted reductions in dose or cessation of medication that may be causing harm, of little benefit or potentially inappropriate. This will include Medication Reviews , specials interventions and Therapeutic Area Reviews.
  - **Rebates:** The CCG will make use of manufacturers' drug rebate schemes in line with the CCG's rebate scheme policy to continue to ensure a high standard or corporate behaviour, clinically appropriate prescribing whilst maximising savings on products supplied.
  - **Reducing Medicines Waste:** Including the reduction of repeat prescribing. This will be achieved through targeted and formal medicines optimisation training to all primary care staff.
  - **Quality Intervention:** Continue to improve high quality prescribing through cost effective medicines choices including the use of Optimise Rx, Specials and the Antibiotic Quality Premium.

What are the agreed next steps?

- A detailed programme of work has already been identified that delivers around £900k of the potential opportunity in 17/18.
- Further review and consideration of the medicines management team and potential approval of additional investment to deliver larger savings.
- Methodology to be agreed to quantify and monitor delivery of savings associated with the Reducing Medicines waste area.

How will the CCG work with stakeholders?

- Continued work with primary care to change behaviours and reduce prescribing frequency
- Work with pharmacists on waste campaigns
- Work with NHSE to ensure, where necessary ,appropriate contract arrangements and levers are used with pharmacists.

High cost drugs represent a potential saving of £2m over 4 years for VoY

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4.8

Opportunity 6: High cost drugs

What is the evidence?

- Reduction in high cost drugs due to increased competition/opening up of biosimilar alternative medicines:
  - Etanercept price reduction
  - Biosimilars for Rituximab (2017), Adalimumab (2018), Ranibizumab and Aflibercept (2020)

What is the potential saving?

- £2.1m potential saving over 4 years to 20/21
- Key assumptions:
  - Assumes 40% initial reduction in prices, 20% in following year with 50-50 gainshare between provider and commissioner

How can this be delivered?

- Commissioners and providers share the cost reduction benefit
- Acute providers take responsibility for managing the transition away from higher cost drugs and risks associated with this – including medicines management and changing consultant prescribing behaviour

What are the agreed next steps?

- Ensure contracts with acute providers in place with 50-50 gainshare agreement included
- Regular discussions with acute provider pharmacy leads to refined saving assumptions as biosimilar products come to market and ensure that patients are switched are the earliest suitable opportunity

Combined, delivery of the 6 opportunities in full imply that the CCG could reach in-year surplus by 19/20, but with a cumulative financial deficit of £51m still at 20/21

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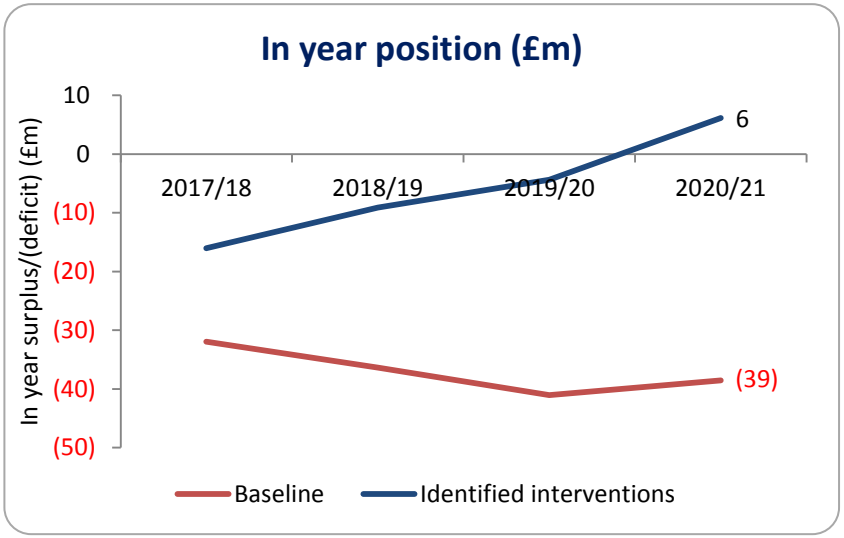
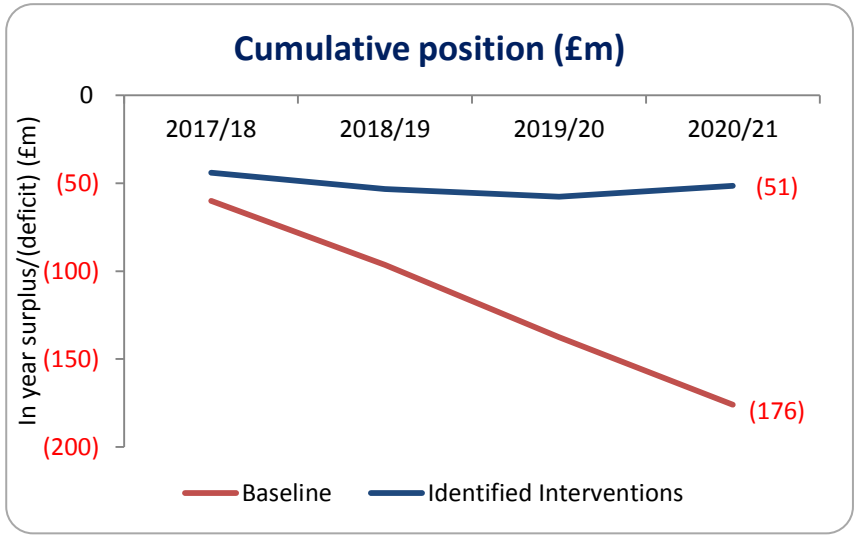
4.9

20/21 financial position with full delivery of 6 key opportunities

- The graphs below the CCG's in year and cumulative position:
  - Without making any QIPP savings, the in-year deficit would be £39m by 20/21, with a cumulative deficit of £176m ("do-nothing" scenario)
  - If the specific interventions and schemes identified through the Confirm and Challenge process were achieved in full, the CCG would reach in-year surplus by 19/20 but would still have a cumulative deficit of £51m at 20/21





We are continuing to identify a number "pipeline savings schemes" but these opportunities are at planning stage only

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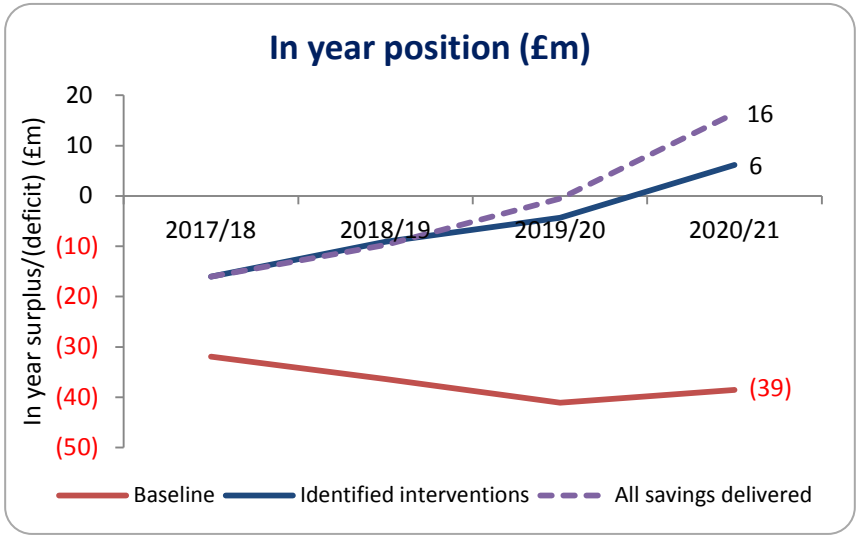
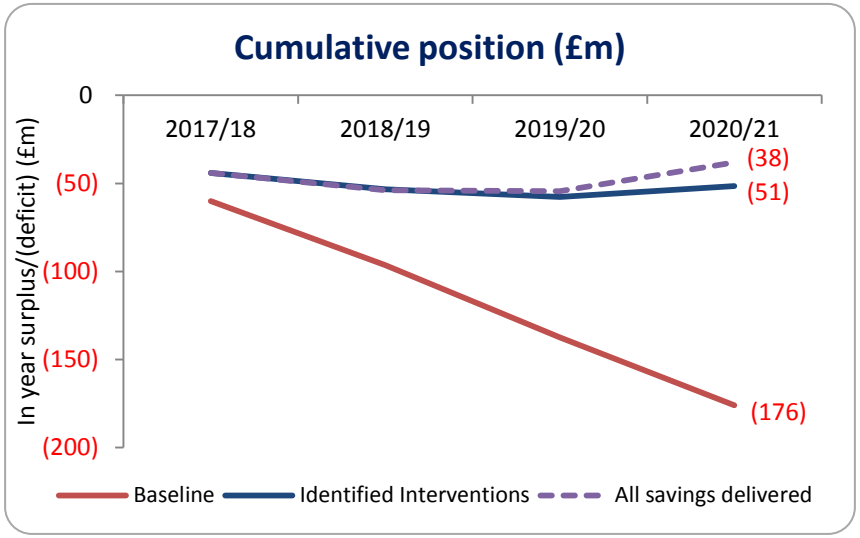
4.10

Additional opportunities

- The CCG is developing a further pipeline of schemes and opportunities which do not yet have savings quantified.
- These pipeline savings schemes are reflected in the plan as unidentified savings in 19/20 and 20/21
- If these unidentified savings were developed into specific interventions and schemes and were delivered in full then the CCG would reach in-year financial balance by 19/20 but would still have a cumulative deficit of £38m at 20/21





If the CCG were to implement the 6 opportunity areas in full, its in-year surplus would be c£45 per head by 20/21 (compared to allocation)

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4.11 3 scenario summary

- The tables below summarise the in-year and cumulative position under the three scenarios discussed:

In year position (£m)

	17/18	18/19	19/20	20/21
"Do nothing"	(32.0)	(36.4)	(41.1)	(38.5)
Identified Interventions	(16.1)	(9.1)	(4.4)	6.2
All interventions (including pipeline savings schemes)	(16.1)	(9.8)	(0.5)	16.4

Cumulative position (£m)

	17/18	18/19	19/20	20/21
"Do nothing"	(60.0)	(96.4)	(137.5)	(176.0)
Identified Interventions	(44.1)	(53.3)	(57.6)	(51.5)
All interventions (including pipeline savings schemes)	(44.1)	(53.9)	(54.5)	(38.1)

- Over 80% of the total savings opportunities have been reviewed through the Confirm and Challenge process and developed into identified interventions and schemes
- Achieving all savings including pipeline schemes would bring the CCG's spend in line with the funding allocation by 20/21, with an in year surplus of c.£45 per head by 20/21

	FY18	FY19	FY20	FY21
Estimated spend per head with identified interventions (£k)	1.31	1.30	1.32	1.33
Estimated spend per head with all interventions (£k)	1.31	1.30	1.31	1.30
Allocation per head (including core, admin and primary medical allocations) (£k)	1.26	1.28	1.30	1.34
% overspend/(underspend) forecast	**4%**	**2%**	**(0)%**	**(3)%**

4.12

Summary of financial opportunity

- VoY has identified 6 potential opportunities for cost reduction based on findings from the health analytics and benchmarking work: elective orthopaedics; out of hospital care; contracting for outpatients; continuing healthcare and funded nursing care; prescribing; and high cost drugs
- The biggest opportunity is out of hospital care, which has the potential to achieve £21.3million cumulative savings by 20/21, if delivered in full
- If the potential savings of all identified interventions were achieved in full, the CCG could reach in-year surplus by 20/21 but would still have a cumulative deficit of £51m at 20/21
- The CCG has identified a number of additional “pipeline savings schemes” but these are at planning stage only and their numbers have not been rigorously benchmarked or tested
- VoY is clear on the next steps for taking forward each of the six major opportunities identified and is carrying out further work to progress plans on the pipeline schemes

NHS Vale of York Clinical Commissioning Group

SECTION 5: NEXT STEPS

Moving forward, VoY recognises the need to progress its financial strategy forwards, whilst also delivering on shorter-term goals

Vale of York Clinical Commissioning Group

5.1 Next steps

- VoY's current situation means that it must now focus on articulating a strategy for reaching long-term financial sustainability whilst also ensuring that it delivers on short-term goals.
- As outlined in the Financial Recovery Plan, short-term priorities for the VoY include:
  - focussing on organisation stabilisation
  - delivering on key financial and operational targets articulated in the plan
  - adhering to constitutional standards
  - delivering on QIPP plans
  - meeting other requirements of the NHSE Directions, including organisational capability building and governance reforms
- In order to drive forward the medium-term financial strategy, VoY will work quickly with system partners to drive STP plans to delivery. This includes:
  - agreeing approaches to strategic commissioning across the STP, including at what spatial level commissioning will take place for different services
  - agreeing a delivery model for the single provider model across the STP footprint
  - agreeing models of system governance which will inform how the STP invests and delivers programmes of work going forward
  - agreeing system wide strategies for tackling named STP priorities including mental health and out of hospital care
- VoY will also focus on its own local population as it further develops plans for the VoY Accountable Care System. As outlined in Section 2, next steps include:
  - engaging providers, clinicians and primary care in the case for change;
  - engaging the public in the reality of the financial decisions that need to be made and how they can help and be a part of that;
  - engaging local authority and social care partners in a system financial solution that integrates services and budgets;
  - confirming the population to be covered by the VoY Accountable Care System and its scope of services;
  - agreeing the financial case for accountable care, including investment requirements;
  - learning more about the application of accountable care models applied elsewhere in the UK and abroad, and considering which aspects of their design are most relevant for the VoY;
  - considering different options of governance and organisational structure to best support the accountable care model;
  - confirming what the other enablers of a move to an accountable care model might be, including specific requirements from stakeholders;

NHS Vale of York Clinical Commissioning Group

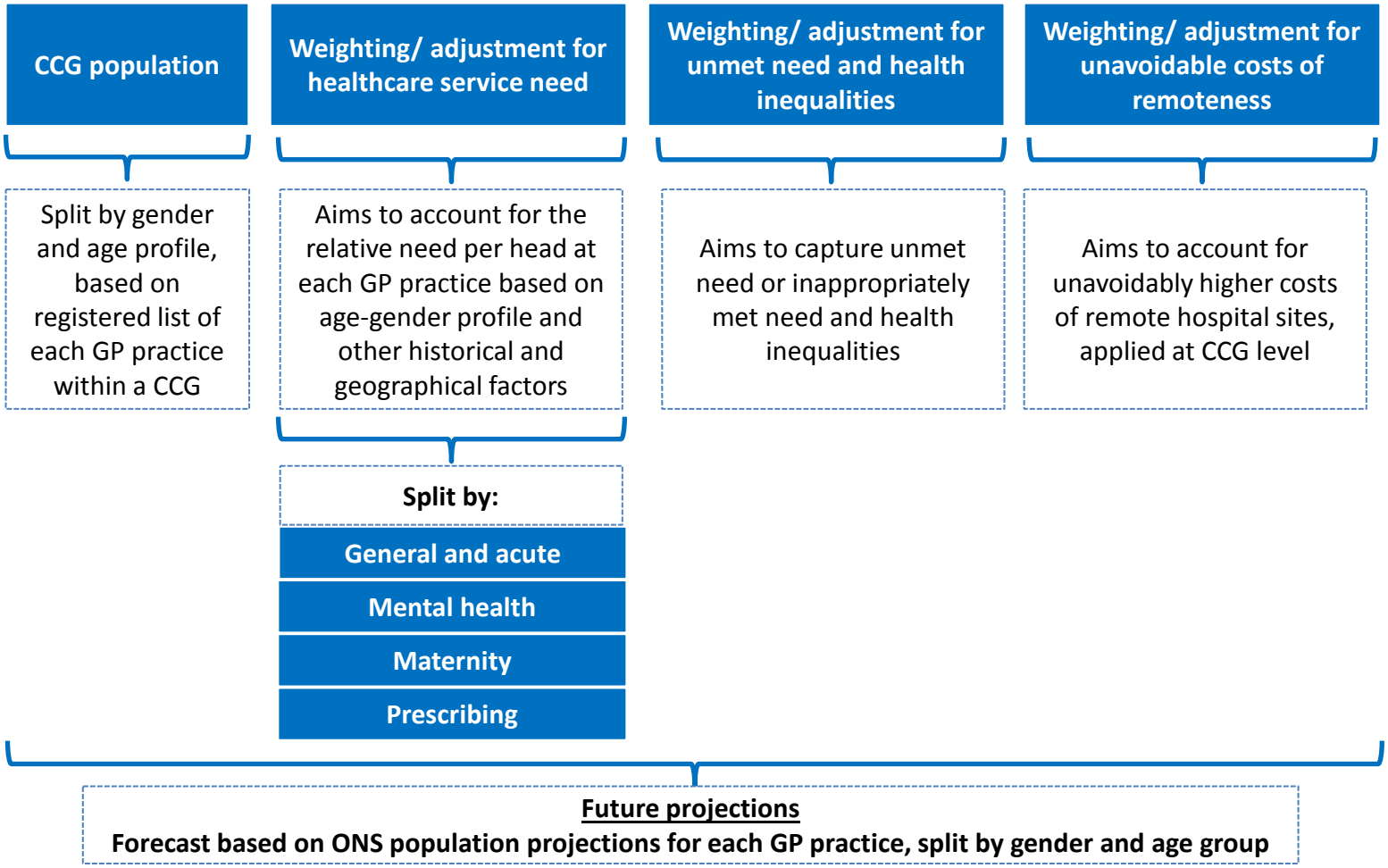
SECTION 6: APPENDICES

Commissioner allocations are calculated based on four key components

NHS Vale of York Clinical Commissioning Group

6.1

Weighted population formula overview(1)

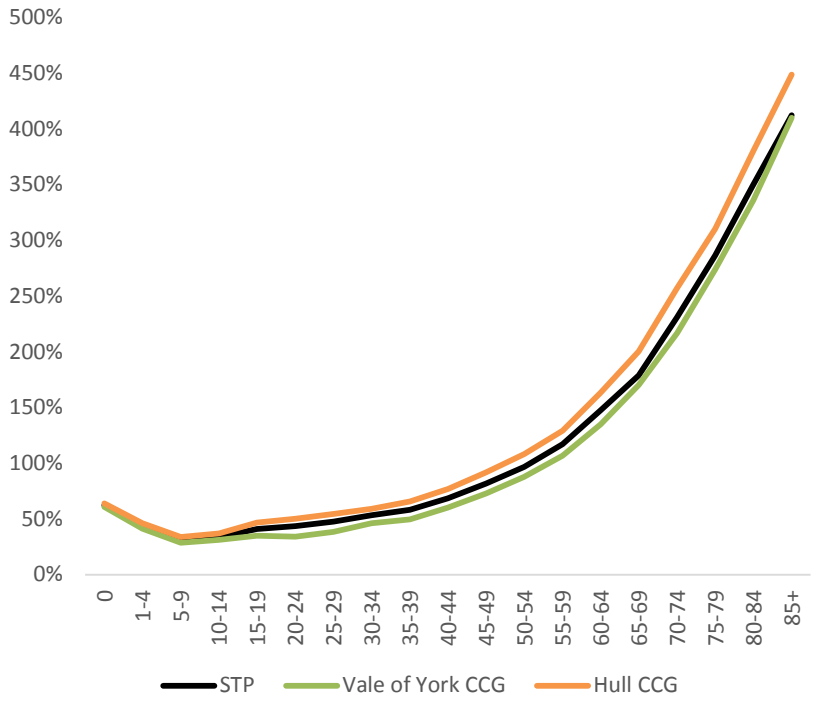


(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

6.2 Acute need weighting

- The graph on the right shows the impact of the acute need weighting by age group across the STP, and specifically for Vale of York CCG and Hull CCG.
- As a result of increased health needs, the more elderly patients have an increased acute need weighting: the weighting means that for every £1 allocated to an "average" person in England, £3 would be allocated to a person with a 300% weighting.
- Weighted populations are normalised to the national total at every stage, so these weightings should be seen as relative rather than absolute.
- Based on the age distributions of registered patients within the STP, the acute need weighting brings the allocation lower for Vale of York CCG compared to the STP average, as the proportion of elderly patients is lower.
- The age distributions also show that Hull CCG has a relatively young population. However, the acute weighting also includes statistical modelling of need estimated from past healthcare use and cost (using FY12-FY14 data).
- The impact of this "past need" factor increases the weighting for Hull CCG but decreases the weighting for Vale of York CCG, which has had a relatively healthier population in the past.
- The highest age group in the weightings is 85+, so they may not fully account for the very elderly (aged 90+) population who have greater health costs than those aged 85-89. As noted in the previous slide, the proportion of Vale of York CCG's population aged 90+ is higher than the STP average.

Acute need weighting impact by age group(1)



- In 15/16, 16% of the CCG's spend on inpatient care was for patients aged 85+; however, the population weightings indicate that only 11% of the CCG's acute care allocation is for patients aged 85.

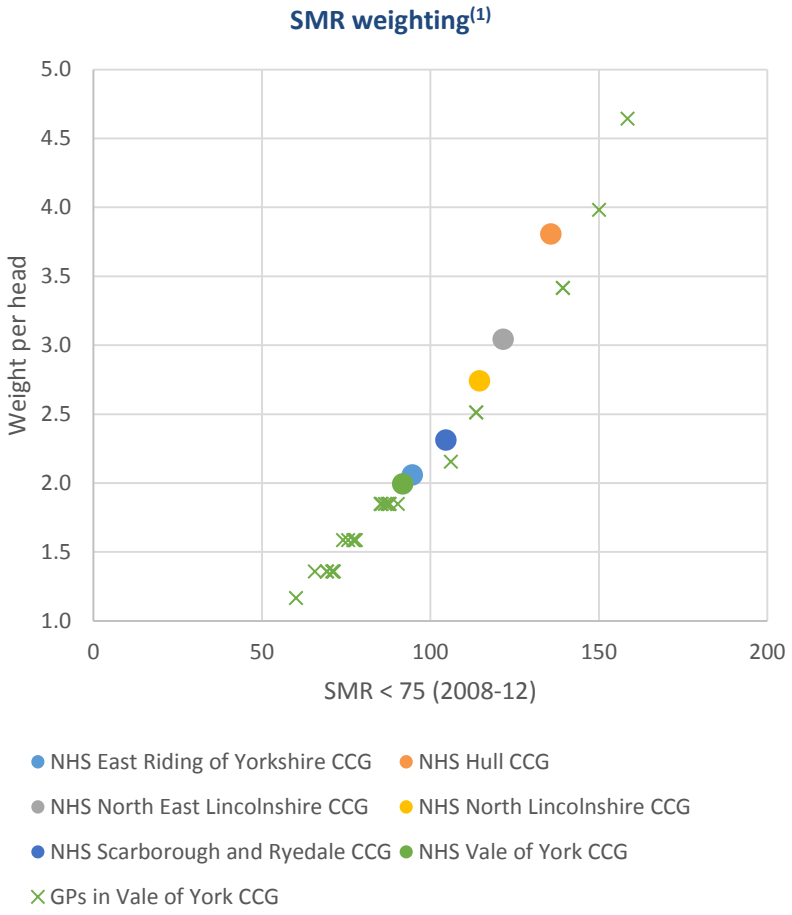
(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets A and C)

VoY receives a lower allocation weighting for inequality compared to others in the STP

Vale of York Clinical Commissioning Group

6.3 Health inequalities

- The weighting for unmet need and health inequalities is based on the Standardised Mortality Ratio (SMR) for those under 75 years of age (SMR<75).
- Vale of York CCG has a lower SMR<75 than the other CCGs in the STP footprint, leading to a lower weighting and a reduced allocation.
- However, 4 of the 29 GP practices within Vale of York CCG have a higher SMR<75 value than the average for any CCG in the STP footprint, indicating pockets of higher deprivation within the Vale of York population.
- These are indicated in the chart on the right:



(1) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheet G)

Vale of York CCG has a relatively high acute spend for the level of patient need

Vale of York Clinical Commissioning Group

6.4

- Within the STP footprint, Vale of York CCG has a **relatively high acute spend** for the level of patient need.
- Spend on mental health services is relatively near to the STP average.
- Vale of York CCG has a **relatively low prescribing spend** for the level of patient need.

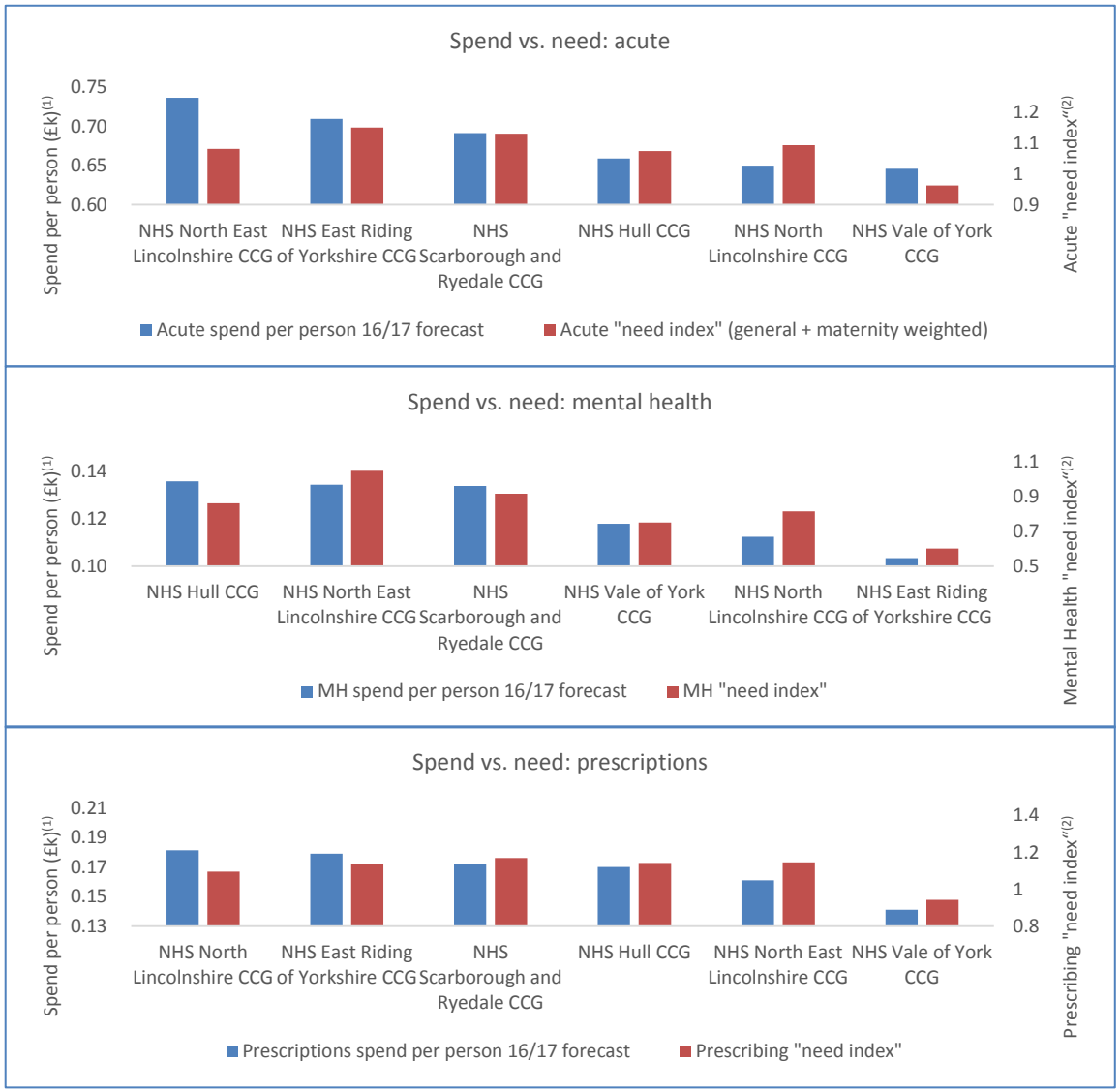
Spend to need ratios (higher numbers indicate a higher spend for the level of patient need):

	STP average	Vale of York CCG	% diff.
Acute (inc. maternity)	633	671	+6%
Mental health	151	157	+3%
Prescribing	152	150	-1%

(1) 2016/17 Finance Plans (submitted to NHS England April 2016); population from Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21

(2) Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 (spreadsheets C-F)

Spend versus need



The VoY non-elective spend per person in the population was greater than the STP average for ages 50+ in the four largest specialities

Vale of York Clinical Commissioning Group

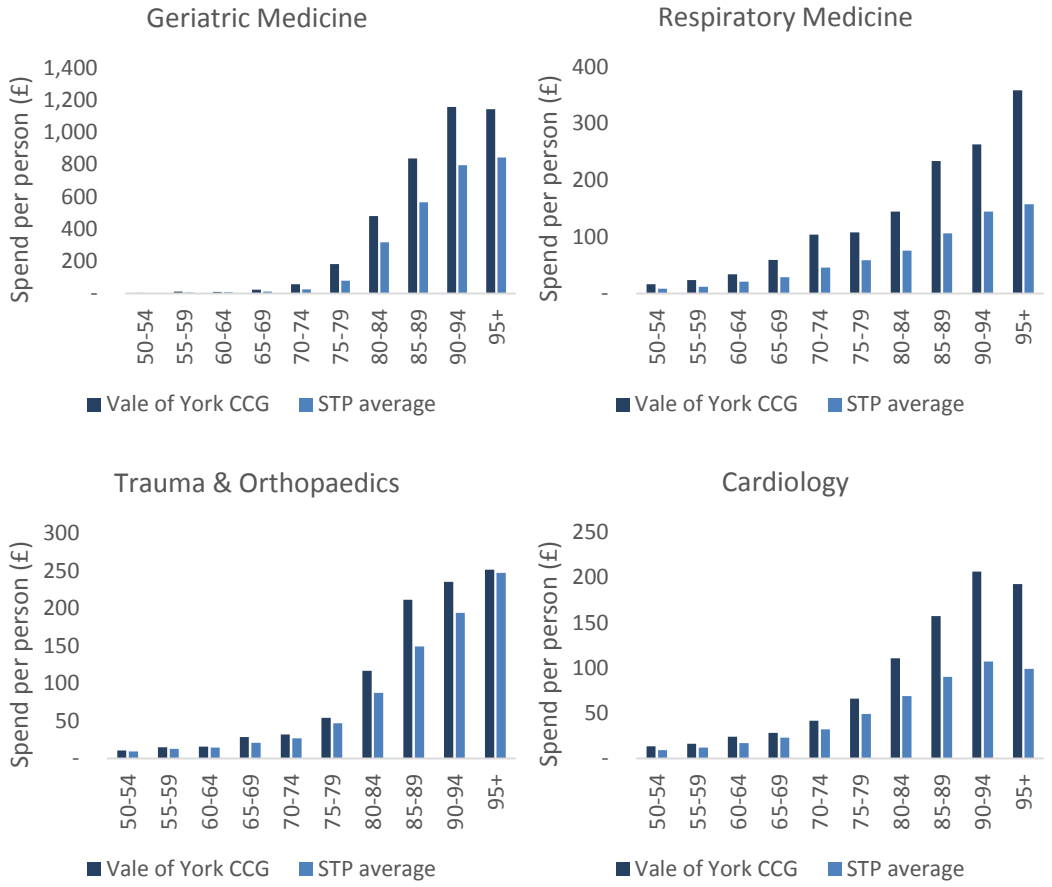
6.5

- Over 50% of Vale of York CCG's non-elective inpatient spend was in the largest 4 specialties: Geriatric Medicine (22%), Respiratory Medicine (14%), Trauma & Orthopaedics (9%), Cardiology (8%).
- The spend per person in the population was **greater than the STP average** for ages 50+ in all four of these specialties.
- The spend in respiratory medicine was **£5m higher than the STP average**, when weighted for age distribution, due to **twice as many spells per person** and a similar average spend per spell.
- The spend in geriatric medicine was **£6m higher than the STP average**, when weighted for age distribution, due to both more spells per person and a higher spend per spell.

Average spend per person in the population aged 50+ (£)

	STP average	Vale of York CCG	% difference
Geriatric Medicine	£78	£128	+64%
Respiratory Medicine	**£35**	**£70**	**+101%**
Trauma & Orthopaedics	£34	£43	+28%
Cardiology	£29	£43	+49%
Total other	£213	£159	-25%
Total	**£389**	**£443**	**+14%**

Non-elective spend profile



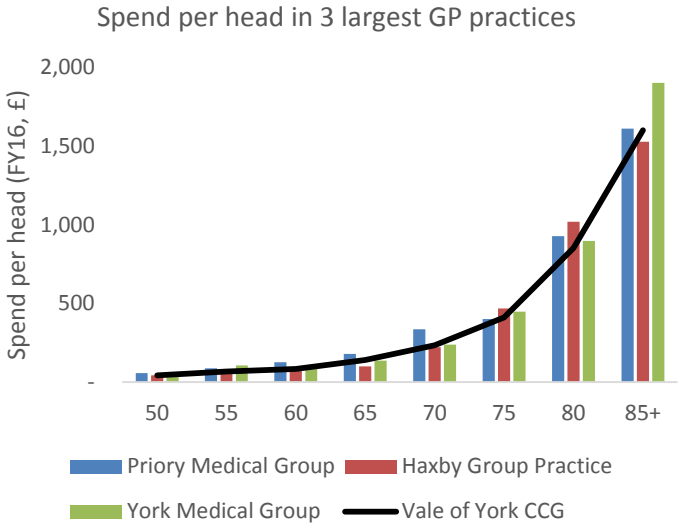
*Reducing the CCG's spend per head to the STP average for Geriatric Medicine and Respiratory Medicine for ages 50+ would bring the CCG's total non-elective spend per head to **13% lower** than the STP average, meeting the requirement of the allocations.*

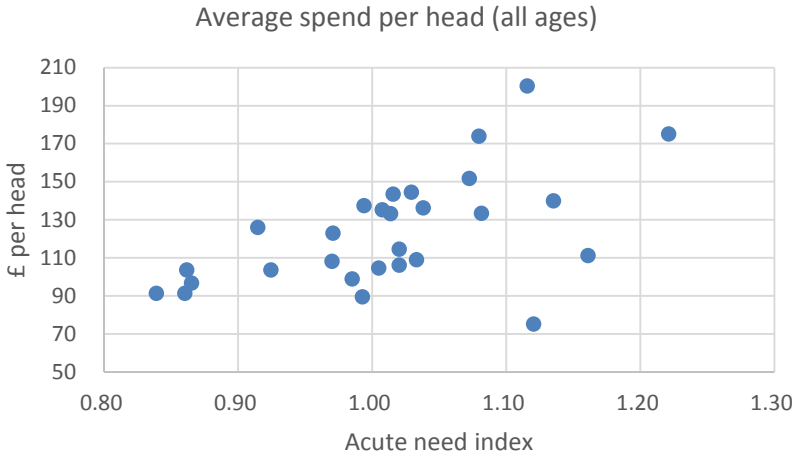
Spend per head compared with need index varies by GP practice

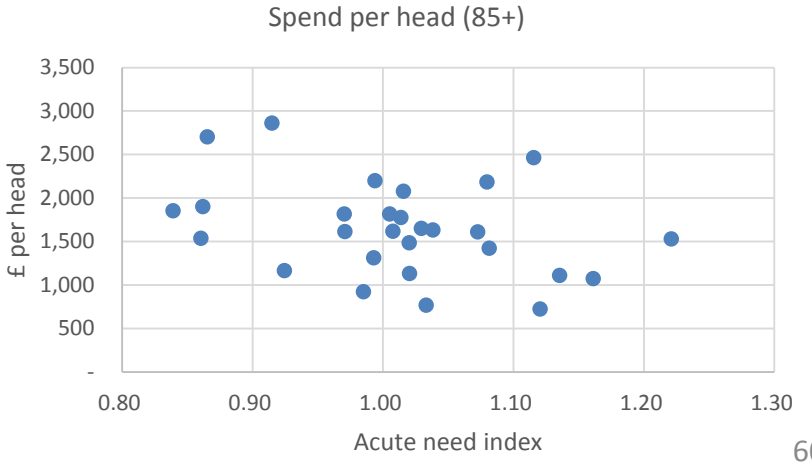
Vale of York Clinical Commissioning Group

6.6 Non-elective spend profile by GP

- The graph on the right shows the non-elective spend for ages 50+ in the largest 4 specialties (Geriatric Medicine, Respiratory Medicine, Trauma & Orthopaedics, Cardiology), for the 3 largest GP practices in the CCG.
- For ages 85+, the average spend per head is highest at York Medical Group, which has the lowest need index, and lowest at Haxby Group Practice, which has the highest need index.
- Average spend per head appears to increase with acute need index (shown below). However, spend per head for ages 85+ appears to **decrease with acute need index**.
- The acute need weighting allocates 4-5 times as much funding to people aged 85+ than to people aged under 50, but the FY16 inpatient spend per head was **10 times larger**. This indicates that the high non-elective spend on elderly patients is not in line with the funding allocations.







Note: Unity Health, with acute need index of 0.4, is not shown on these graphs.

6.7 STP: Locality plan on a page

Locality Objectives

1. Sustainable local services and viable small hospitals services, through the Ambition for Health Programme on the East Coast and an Accountable Care model for the Vale of York
2. Ensure that Scarborough Hospital and other major services are of a high quality, are financially sustainable and that we all have access to the right care, in the right place, at the right time
3. Return to financial balance by reducing demand and an activity shift. Promoting self help and prevention and providing services as close to home as clinically possible to offer a greater range of services outside of acute settings, reduce unplanned attendances and admissions and support a timely return home from acute episodes
4. Effective and appropriate planned care via the referral support service, new approaches to outpatients and clinical advice, and community-based pathways re-design informed by RightCare analysis
5. Mobilise the community resource and assets, enabling the voluntary and community sector to offer flexible support and ensure patients aware of the right place to access the right support for their needs

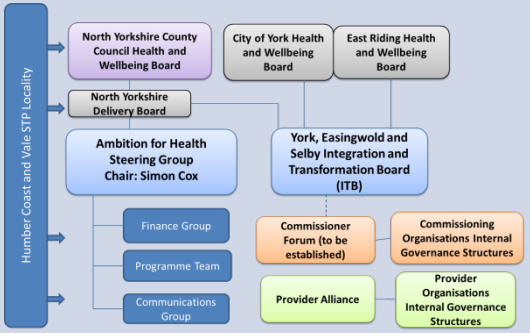
The Case for Change

The local community has an ageing population who are high users of health services, with the over 85's representing approximately 5% of the population, and accounting for approximately 20% of non-elective emergency admissions. The health needs of this cohort of patients have to be supported in a different way to achieve improved outcomes and address rural isolation alongside operational and financial sustainability.

In addition to forecast growth, the health and social care services are experiencing financial and operational pressures, partly as a result of an increase in demand and acuity of patients but also increasing workforce pressures in healthcare and domiciliary care.

Governance Arrangements

Management and clinical leads for the supporting work streams will be confirmed at the locality launch in October 2016.



Key Delivery Risks

- Vale of York Legal directions and supporting Financial Recovery and Improvement Plan
- Scarborough & Ryedale CCG Finance Recovery Plan
- System financial position
- Workforce availability
- Care market stabilisation
- Critical Care

Key Projects

- Ambition for Health programme
- Accountable Care development –
- Out of Hospital Strategy – including mental health
- Small sustainable hospital pioneer and ECIP
- Crisis Care review
- Prevention Strategy and Smoking Cessation
- Digital Roadmap and universal capabilities
- IAPT improvement plan
- Outpatients reform – Expert consultation
- Primary Care Strategy (GP 5YFV)

Targeted Clinical and Care Outcomes

- Constitutional Target delivery
- Improvements in population health measures, including: smoking cessation, reduction in obesity, alcohol related admissions, cancer survival (to address premature mortality from cancer)
- Acute activity maintained at sustainable level

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Health & Adult Social Care Policy & Scrutiny Committee **29 March 2017**

Report of the Director of Public Health

Public Health Services Commissioned by NHS England - Vaccinations, Immunisations and Screening.

Summary

1. This report focuses specifically on the screening, vaccination and immunisation responsibilities of the local authority and will not cover the other elements of Health Protection.

2. A paper was presented to the Health and Wellbeing Board in November 2016 to provide assurance that the health protection arrangements meet the needs of the local population, and this was accepted.

Background.

3. Health protection is the domain of public health which seeks to ensure that the health of the residents of York is protected from major incidents and other threats, while reducing health inequalities. This broad definition includes the following functions in relation to vaccination and immunisation and screening programmes:

   - National programmes for vaccination and immunisation
   - National programmes for screening, including those for antenatal and newborn; cancer (bowel, breast and cervical); diabetic eye screening and abdominal aortic aneurism screening.

4. From 1 April 2013, the reforms arising from the Health and Social Care Act 2012, transferred health protection responsibilities (specifically relating to Vaccinations, immunisations and screening) to the following organisations and requires the provision of assurance from:

- NHS England (NHSE) who are responsible for the commissioning and implementation of the national screening and immunisation programmes across Yorkshire and Humber.

- Local authorities who were given additional responsibilities to ensure that their residents are protected.

- The Director of Public Health, who as part of their statutory duties requires assurance that the population is protected against diseases that are preventable either by vaccination or through early detection as a result of national screening programmes.

- The Health Protection Assurance Group. To gain assurance the Director of Public Health is a member of the Yorkshire and Humber Directors of Public Health, Health Protection Assurance Group. The membership of this group includes Public Health England and NHS England colleagues and provides oversight of the screening and immunisation programmes commissioned by NHSE as well as general assurances across the public health system.

- CYC officers who are members of the local Screening and Immunisation Oversight Group (SIOG), Super Flu (seasonal Flu) meeting, North Yorkshire and York Immunisation Programme Board. These meetings enable CYC to hold to account, work with and gain assurance from the organisations that provide and commission these services.

Main/key issues to be considered.

5. Performance against health protection outcomes, including immunisation and screening, is reported through the Public Health Outcomes Framework (PHOF).

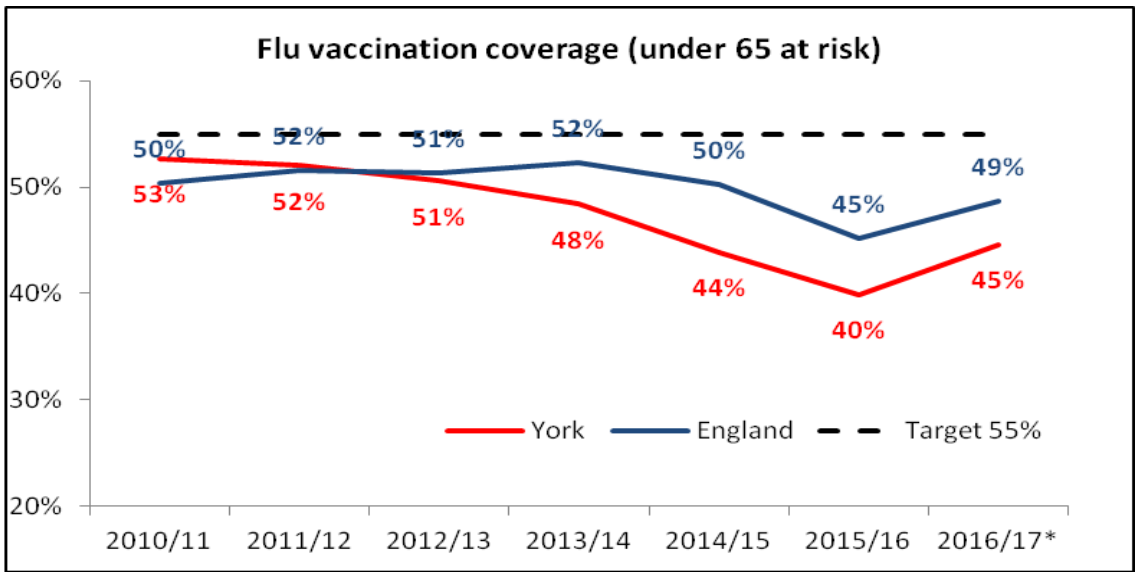
6. Generally York has good uptakes and works closely with key providers to ensure this is maintained, including:

   - Childhood immunisation uptake rates are all similar or better than the England average

   - Uptake of screening for breast and cervical cancer, diabetic eye screening and abdominal Aortic Aneurysm screening (AAA) is better than the England average.

7. Those areas where there is scope for improvement are detailed below.

8. Flu vaccination coverage for under 65's 'at risk' persons. York is in line with the national trend which is below the target of 55% coverage. There has been a declining trend in coverage in recent years but provisional data for 16/17 indicates that, in line with national trends, there has been an increase. This increase may also be due to the implementation of a local flu plan, led by Public Health which included working with the CCG and Adult Social Care to improve vaccination rates.



9. Provisional 2016/17 data for flu vaccination in pregnant women indicates that the vaccine uptake was 52.8% for York compared with 44.8% as an England average. Further breakdown indicates that of these 59.8% are categorised as being part of a clinical risk group. The national target for flu vaccinations is 55% in this group, with an ambitious aim for 100% to be offered the vaccination and a 'high as possible uptake to be achieved'. So whilst York has a higher than England average there is no room for complacency and this has been placed on the Local Improvement Plan for Screening and Immunisations.

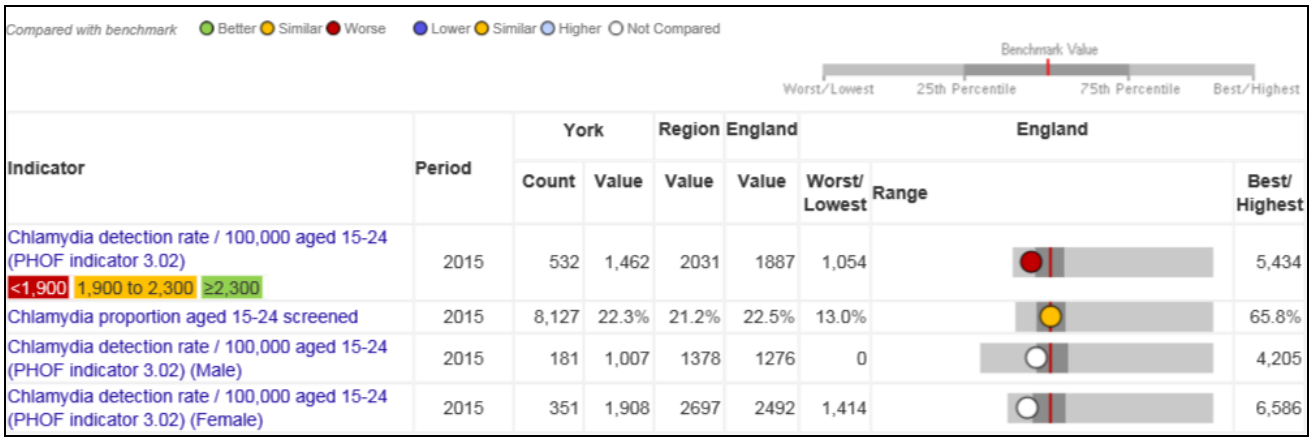
10. In England there are three main cancer screening programmes: Bowel, Cervical and Breast. Across North Yorkshire and York it is acknowledged that there is an inequity in the uptake of cancer screening in those with a learning disability. In order to redress this CYC hosted a Vale of York wide working group to identify how all CCGs and LAs in the area may work alongside Public Health England, to develop a Screening and Immunisation Local Implementation Plan. This plan brings together the key organisations and details an action plan to reduce this. For 2017/18 actions includes: practice nurse

training, provision of 'easy read' materials being available in every GP practice and participation in key awareness campaigns. CYC is also working with the Macmillan GPs to include cancer screening as part of the annual Health Checks. These are offered, through GP practices, to all people with a Learning Disability. The learning disability Health Checks are different to the 'NHS Health Checks' for adults in England aged between 40 – 74.

11. Data taken from the 2014 York Learning Disability Self Assessment Framework indicates that:

- Cervical cancer screening coverage rate is 23% in those with a learning disability compared to 67% for all women aged between 25 and 64
- Breast cancer screening coverage rate is 51%, compared to 72% for all women aged between 50 and 69
- Bowel cancer screening coverage rate is 59%, compared to 57% in the eligible population aged 60 – 69.

12. Chlamydia screening and detection rate. The detection rate for Chlamydia in 15 to 24 year olds is below the national average. It was noted that after further examination of the data that this may be due to a lower incidence of the infection in York.



Indicator	Period	York		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) <1,900 1,900 to 2,300 ≥2,300	2015	532	1,462	2031	1887	1,054		5,434
Chlamydia proportion aged 15-24 screened	2015	8,127	22.3%	21.2%	22.5%	13.0%		65.8%
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) (Male)	2015	181	1,007	1378	1276	0		4,205
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) (Female)	2015	351	1,908	2697	2492	1,414		6,586

13. The data (above) available on the PHE fingertips database is from 2015, which are the most recent full year figures available. Examination of CTAD (Chlamydia Testing Activity Database) shows that for January to September 2016 the England average for Chlamydia detection was 1,872 and for York 1,876. These figures need to be read with caution as they represent only three quarters of the year and further data cleansing is required nationally but it indicates an optimistic forecast

that the detection rate in York has increased. This increase may be as a result of local interventions including the specialist service and working to achieve a higher number of 'partner notifications' per index case than within National BASHH standards.

14. Sexually Transmitted Infections.

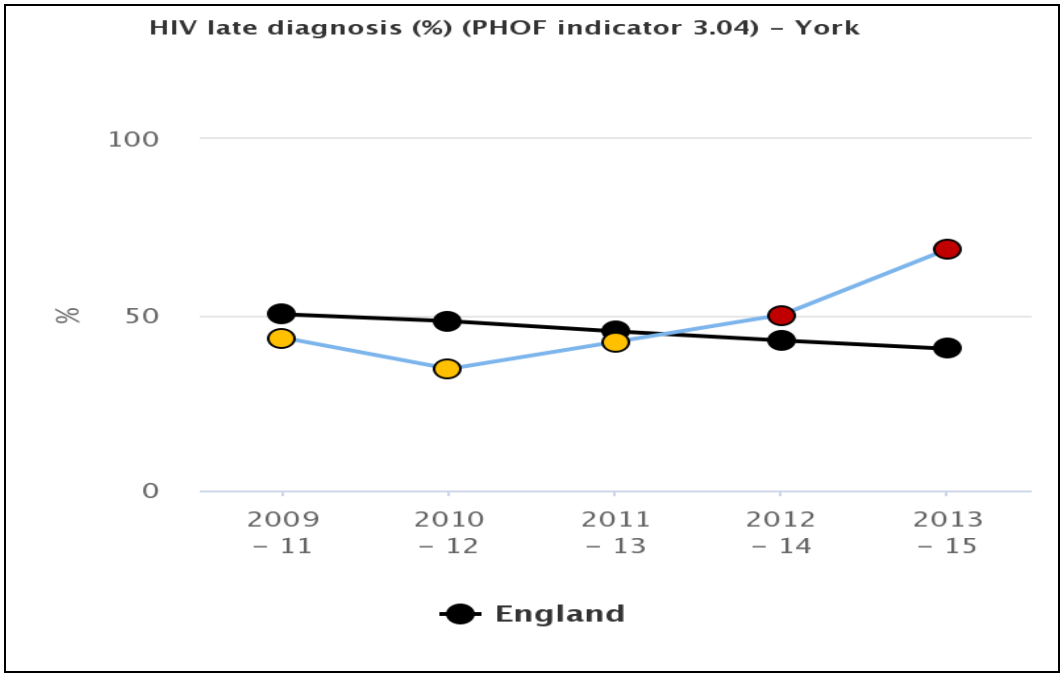
Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher / Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	York		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Genital warts diagnostic rate / 100,000	2015	380	185.9	109.7	118.9	288.2		0.0
Pelvic inflammatory disease (PID) admissions rate / 100,000	2014/15	43	96.7	252.1	236.4	589.2		0.0
Ectopic pregnancy admissions rate / 100,000	2014/15	24	54.0	92.5	89.6	188.1		0.0
Genital herpes diagnosis rate / 100,000	2015	115	56.3	46.2	57.6	198.2		0.0

There has been a significant increase in the rate of diagnosis for genital warts in 2015 against the national and regional downwards trends for this infection. Genital warts remains the most commonly diagnosed viral STI within York followed by genital herpes. There was a decrease in the number of diagnoses of herpes in 2015 although this was not a significant reduction.

15. HIV late diagnosis.



York has a higher percentage (68.8%) of adults newly diagnosed with HIV late dignosis (CD4 count less than 350 cells per mm3) when compared with national figures (40.3%). The small numbers of people diagnosed with HIV result in a large percentage increase in late diagnosis figures. Sixteen (16) people were diagnosed with HIV in the three year period 2013-15 and eleven (11) of them had a late diagnosis.

Data suggests that the number of HIV tests offered has significantly increased from 2009 to 2015 (2,190 to 4,064) but the number of people accepting the test has decreased. Further research would help us understand this trend and why people are refusing the test if they have put themselves at risk; but this could be due to a number of reasons from stigma, to not perceiving that they have engaged in risky behaviour, e.g. heterosexual women. Local research carried out by the specialist sexual health service suggested that those not considered to be in 'high risk' groups are not accepting HIV tests and their symptoms may not be recognized in primary care. A primary care sexual health training event is planned for 2017 to update and encourage local GPs to support patients with 'indicator conditions' to have an HIV test.

16. In regards to the pertussis (Whooping Cough) vaccine in pregnant women, CYC data is not available and the most recent data for the Vale of York CCG area (April 2016 to December 2016) indicates that the CCG has a coverage rate of 93% compared with 76.2% nationally and 83.3% regionally. Uptake has risen locally, regionally and nationally over the last 6 months, however regionally there have been a number of births to women who have not had the pertussis vaccine which has resulted in life changing conditions for their children. Therefore vigilance is required to ensure that we maintain this level of coverage.

Consultation

17. No consultation had taken place, however the content of this report will be taken to the York Health Protection Group meeting.

Options

18. There are no options. Scrutiny is requested to receive and note that assurances and clear arrangements that are in place for the health protection of the residents of York.

Analysis

19. This report forms part of the governance arrangements, and provides scrutiny the assurance that the responsibilities for vaccination, immunisation and screening are being monitored; responsible agencies are being held to account; that good outcomes are maintained and poor performance is being addressed.

Council Plan

20. This report directly relates to the council plan priorities:

- 'A prosperous city for all'
- 'A focus on frontline services'.

Implications

21. There are no specialist implications.

Risk Management

22. There are no risks from this report.

Recommendations

23. Scrutiny are asked to:
    - Receive the report and note the content
    - Act as an advocate for the early detection of cancer though supporting and promotion of the national screening programmes and support the uptake of immunisations and vaccinations where appropriate.

    Reason: To assure the Committee that the health protection arrangements meet the needs of the local population.

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Report Approved ✓ **Date** 13/03/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:

Health Protection Assurance paper, taken to the Health and Wellbeing Board on 23 November 2016.

Annexes: None

Abbreviations

BASHH	The British Association for Sexual Health and HIV. BASHH aims to determine, monitor and maintain standards of quality in provision of sexual health and HIV care and produces resources to assist clinicians in this aim. BASHH standards for the management of STIs and HIV bring together for the key elements of best practice that people seeking help in relation to STIs are entitled to expect, whichever service they choose to attend. They provide a framework for monitoring performance which covers the core principles of STI care, staff training, clinical assessment and management, diagnostics, information governance, links to other services, clinical governance and the engagement of patients and the public

CD4 Count	A CD4 count is a lab test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. In people with HIV, it is the most important laboratory indicator of how well their immune system is working and the strongest predictor of HIV progression.
Chlamydia Index cases.	The first identified case of a particular communicable or heritable disease, in this case Chlamydia.
HIV	Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) is a spectrum of conditions caused by infection with the human immunodeficiency virus (HIV).
Indicator conditions	Clinical indicator diseases are those which can be caused by HIV infection, or are common amongst people with HIV infection.
NHSE	NHS England - Leads the NHS in England, sets priorities and the direction of the NHS and encourages and informs the national debate to improve health and care.
Partner notification	Partner notification is the practice of notifying the sexual partners of a person, known as the "index case", who has been newly diagnosed with a sexually transmitted infection that they may have been exposed to the infection. It is a kind of contact tracing.
PHE	Public Health England - has responsibility for the protection and improvement of the nation's health and wellbeing and aims to reduce health inequalities.
PHOF	Public Health Outcomes Framework - a national set of indicators, set by the Department of Health and used by local authorities, NHS and PHE to measure public health outcomes. This is regularly updated and available at: http://www.phoutcomes.info/public-health-outcomes-framework
STI	Sexually Transmitted Infections.

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Health and Adult Social Care Policy and Scrutiny Committee 29th March 2017

Report of the Director of Public Health

Council Motion – Access to NHS Services

Summary

1. The purpose of the report is to respond to the motion on Access to NHS Services which was passed at the Council meeting on 15 December 2016, and to update the Health and Adult Social Care Policy and Scrutiny Committee on subsequent discussions with the Vale of York Clinical Commissioning Group (CCG).

2. The CCG Governing Body approved the 'Prevention and Better Health Strategy' at its meeting on 1 September 2016. The strategy has been developed to demonstrate how focusing the CCG efforts on prevention, self-care and shared decision making can support a shift in the way health care resources are valued, and to empower patients in the Vale of York to become more active participants in shaping their health outcomes.

3. The strategy is supported by a commissioning statement which outlines the CCG strategy for addressing the lifestyle risk factors of smoking and obesity in pre-operative patients, with the aim of helping them to experience the best possible post-operative outcome. This statement position is that the CCG does not routinely commission an elective (planned) surgical intervention on patients who have a Body Mass Index (BMI) of 30 or above (classified as obese) or patients who are current smokers.

4. On 15 December 2016, elected members debated a council motion on Access to NHS Services proposed by Cllr Stuart Barnes which was unanimously supported. The motion is set out below:

'Council notes:

- *The financial crisis in health facing the NHS and City of York Council, whose public health funding has seen cutbacks in recent years;*

- *The decision of Vale of York Clinical Commissioning Group (CCG) to ration access to NHS services by imposing conditions for surgery on some who smoke or who are obese;*

- *The expert clinical view put forward by the Royal College of Surgeons and comments from its President, Clare Marx, who has labelled Vale of York NHS CCG's policy as "frankly shocking".*

Council agrees with the CCG's aim to reduce levels of obesity and smoking prevalence among York residents, and recognises that individuals must play a part and take responsibility for looking after their own health.

But Council believes the recent CCG policy change regarding the provision of surgery to patients who are obese or who smoke sets a dangerous precedent. A change to restrict and ration health services to specific groups of people is unfair.

Furthermore, Council believes this policy threatens to exacerbate existing health inequalities.

Council resolves:

- *To write to Vale of York Clinical Commissioning Group (CCG), Sir Simon Stephens, Head of NHS England and Jeremy Hunt, Secretary of State for Health objecting to this decision in the strongest possible terms*

- *To request that the Executive commissions the Director of Public Health to assess the impact of this policy, including the impact on health inequalities, reporting back to Health and Adult Social Care Policy and Scrutiny Committee with options recommended to the Executive for what the Council can do to mitigate its impact on health inequalities.'*

5. Copies of the letters sent to Phil Mettam Accountable Officer, Vale of York CCG, Sir Simon Stephens, NHS England and Jeremy Hunt, Secretary of State for Health and the responses received to date are attached as Annexes to this report.

6. This report seeks to brief the Health and Adult Social Care Policy and Scrutiny Committee on the impact of the CCG policy, including the impact on health inequalities, set out the actions across the health and care system that could be undertaken to mitigate against these impacts and proposes a number of recommendations for consideration by Scrutiny Committee members to put forward to the Executive for what the Council can do to mitigate its impact on health inequalities.

Background

Smoking – the case for change for the NHS

7. The cost of smoking in England was estimated in 2014 to be around £2 billion a year to the NHS with an annual cost to the NHS in York for treating smoking-related illness of £3.8 million on average. Smoking remains the leading cause of preventable illness and death in England. Smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smokers under the age of 40 have a 5 times greater risk of a heart attack than non-smokers. Smoking causes around 80% of deaths from lung cancer, around 80% deaths from bronchitis and emphysema, and about 14% of deaths from heart disease. More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, pancreas, stomach, liver and cervix. About a half of all life-long smokers will die prematurely. On average, cigarette smokers die 10 years younger than non-smokers.

8. In addition smoking can cause complications in pregnancy and is also associated with lower survival rates, delayed wound healing, increased infections, prolonged hospital stays and repeated admissions after surgery.

9. The NHS England *Five Year Forward View* makes an increased focus on prevention a priority. Prevention is also a priority in the Sustainability and Transformation Plan for Humber, Coastal and Vale and in the Vale of York CCG Operational Plan for 2017-18. An NHS that is truly committed to improving the health of the population, and not simply to treating patients when they present with specific conditions, must therefore make reducing smoking prevalence a very high priority.

10. NHS England has published Commissioning for Quality and Innovation (CQUIN) supplementary guidance to the NHS standard contract for 2017-19 which focuses on prevention of ill-health from risky behaviours - smoking and alcohol. The CQUIN payment framework enables NHS commissioners to reward excellence by linking a proportion of NHS providers' income to the achievement of local quality improvement goals. This new national CQUIN indicator asks NHS Trusts to identify and record the smoking status of all inpatients and to provide smokers with Very Brief Advice and an offer of medication and referral. The scheme applies to acute trusts in 2018/19 and to community and mental health trusts in both 2017/18 and 2018/19.

11. These CQUINS, which include measures on how many people have been referred for treatment and stopped smoking, offer an important incentive to embed tobacco dependence treatment into care pathways. However the CQUIN payment made to local NHS providers – York Teaching Hospital NHS Trust and Tees, Esk and Wear Valley NHS Trust should be used to provide investment into NHS stop smoking provision. Otherwise increased referrals into the Council Yorwellbeing Service will simply result in long waiting lists for support because the service has such limited capacity.

Smoking – the case for change for local authorities

12. The cost of smoking in England was estimated in 2014 to be £1.1 billion to local authorities in social care costs with around a further £9.8 billion in costs to the wider economy through sickness, loss of productivity etc. The estimated cost to adult social care in York is £3.4 million per annum.

13. Because of the impact of smoking on health in later life, smoking imposes a direct cost to local authorities in the form of additional requirements for social care. The latest estimates of the costs to adult social care (January 2017) are set out in Table 1 below:

Table 1: Social Care Costs of Smoking – January 2017 estimates

Cost to local authorities from increased social care needs	£760m
Cost to self-funders from increased social care needs	£630m
Increased number of people receiving social care support (funded by local authorities)	35,000
Increased number of people receiving social care support (self-funded)	17,000
Increased number of people receiving care from friends and relatives	234,000
Difference in age between when smokers and non-smokers need to access care	4 years

Source: All Party Parliamentary Group on Smoking and Health – Burning Injustice

14. It should be noted that the Care Act 2014 placed a duty on local authorities to enable access to services that reduce the need for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs. Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services. Reducing smoking prevalence reduces social care costs.

Obesity – the case for change

15. Obesity is a global concern. In the UK 23% of adults are obese with a BMI over 30. In 2015 the estimated cost of obesity to the Vale of York CCG was £46 million.

16. Obesity contributes to many illnesses. An obese man is 5 times more likely to develop type 2 diabetes than a man of healthy weight, 3 times more likely to develop cancer of the colon and more than 2 and a half times more likely to develop high blood pressure – a major risk factor for heart disease and stroke.

17. An obese woman is 13 times more likely to develop type 2 diabetes than a woman of healthy weight, more than 4 times more likely to develop high blood pressure and more than 3 times more likely to have a heart attack.

18. Risks of other diseases including angina, gall bladder disease, liver disease, breast and ovarian cancer, osteoarthritis and stroke are also increased.

19. The development of diabetes as a result of obesity is said to be one of the largest ‘time bombs’ for the NHS with potentially 1 in 10 people having Type 2 diabetes by 2034, overtaking smoking as the major cause of premature death.

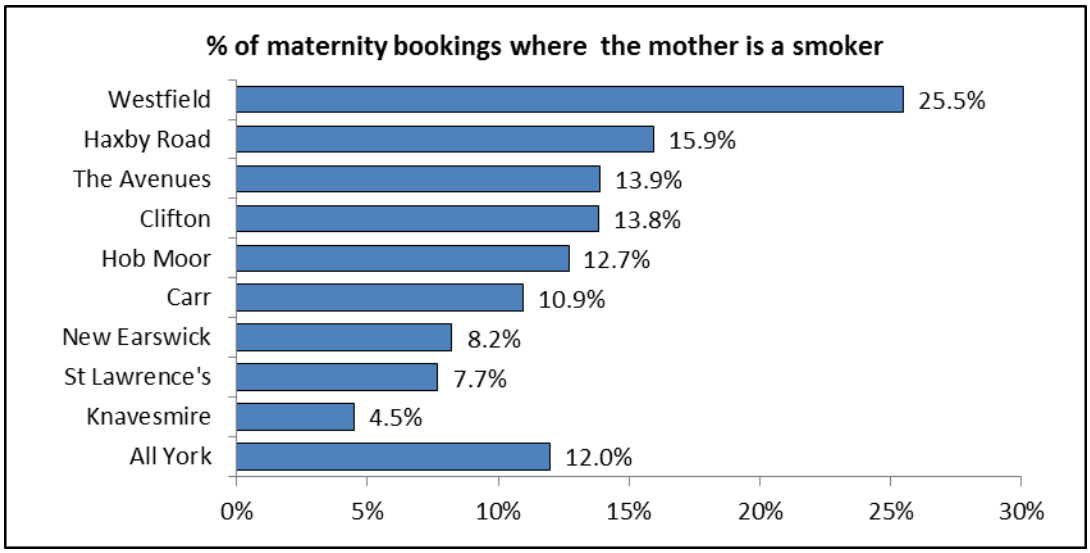
20. Alongside the serious ill-health it can cause, obesity can also reduce people’s prospects in life, affecting individuals’ ability to obtain and hold down work, their self-esteem and their underlying mental and emotional health.

Impact on Health Inequalities in York

21. Although the overall prevalence of smoking and obesity are lower in York than in many other parts of the country we know that there are significant inequalities in smoking and obesity within the local population with a clear link between higher levels of smoking and obesity and deprivation.

22. We do not have good data on the prevalence of smoking in the adult population in York but data is collected by York Teaching Hospital NHS Trust Maternity Services on smoking in pregnancy in women attending Children’s Centres across the City. It is reasonable to assume that smoking in pregnancy is a fairly reliable proxy indicator for smoking levels in the general population in an area. The percentage of women recorded as smoking at the time of their first appointment with the midwife (booking) varies considerably across the City with the rate in Westfield more than five times higher than in Knavesmire. This demonstrates deep rooted cultural attitudes to smoking in some communities in York. Table 2 below shows the % of maternity bookings where the mother is a smoker by Children’s Centre area:

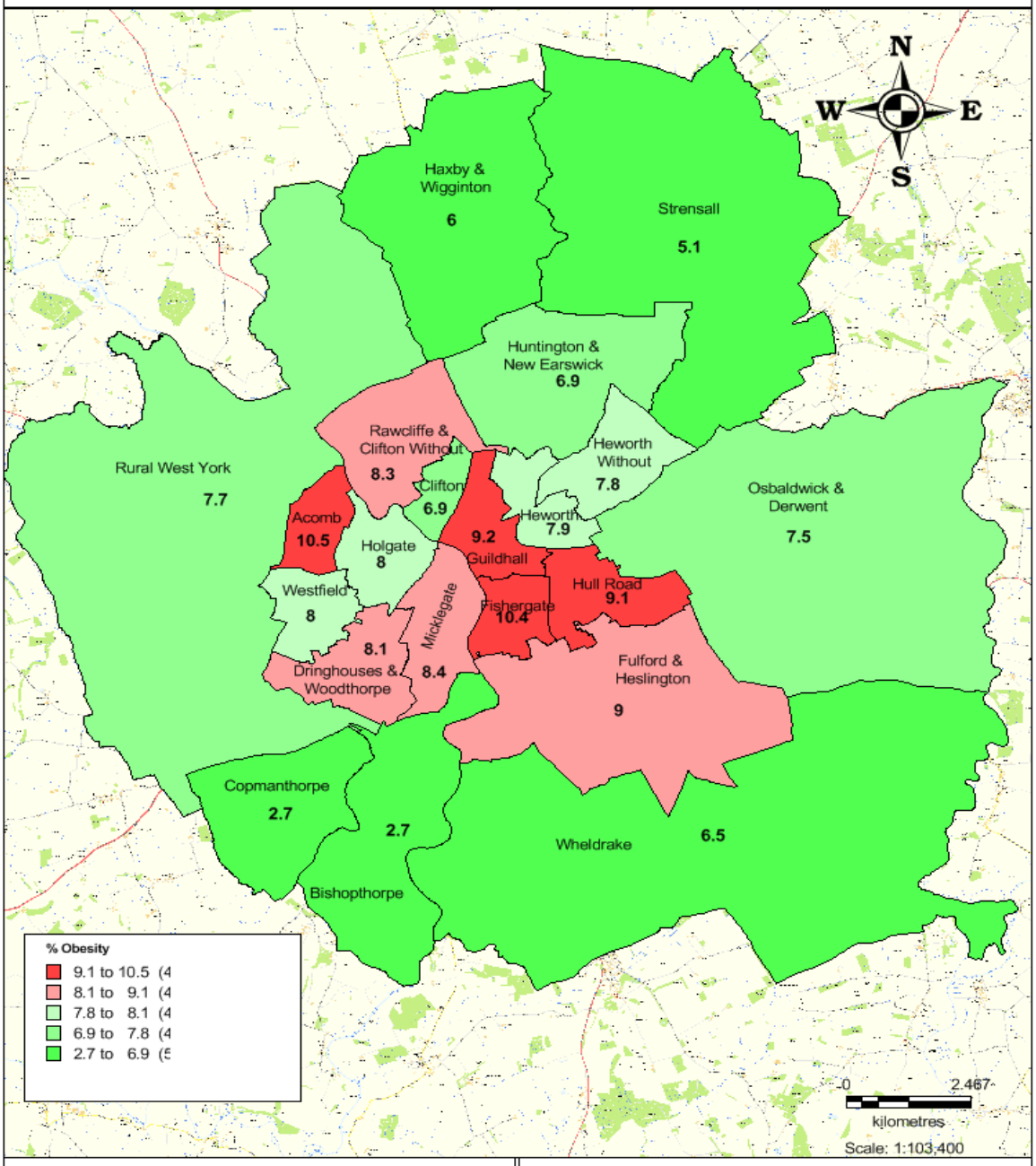
Table 2: Mothers Smoking at Maternity Booking



Source: Business Intelligence Hub

23. Similarly we do not have good data on the prevalence of obesity in the adult population in York. However we have very good data in children collected as part of the National Child Measurement Programme. Children have their height and weight measured in reception class and in year 6. Again this data shows that York has relatively low rates of obesity compared to other areas but there remains a clear gradient with children living in the more deprived areas of the City having a rate of obesity more than twice that in the least deprived areas. The maps below show the variation in obesity levels for children in reception class and year 6 across York:

% of measured children in Reception who were classified as obese, 2012/13-2014/15

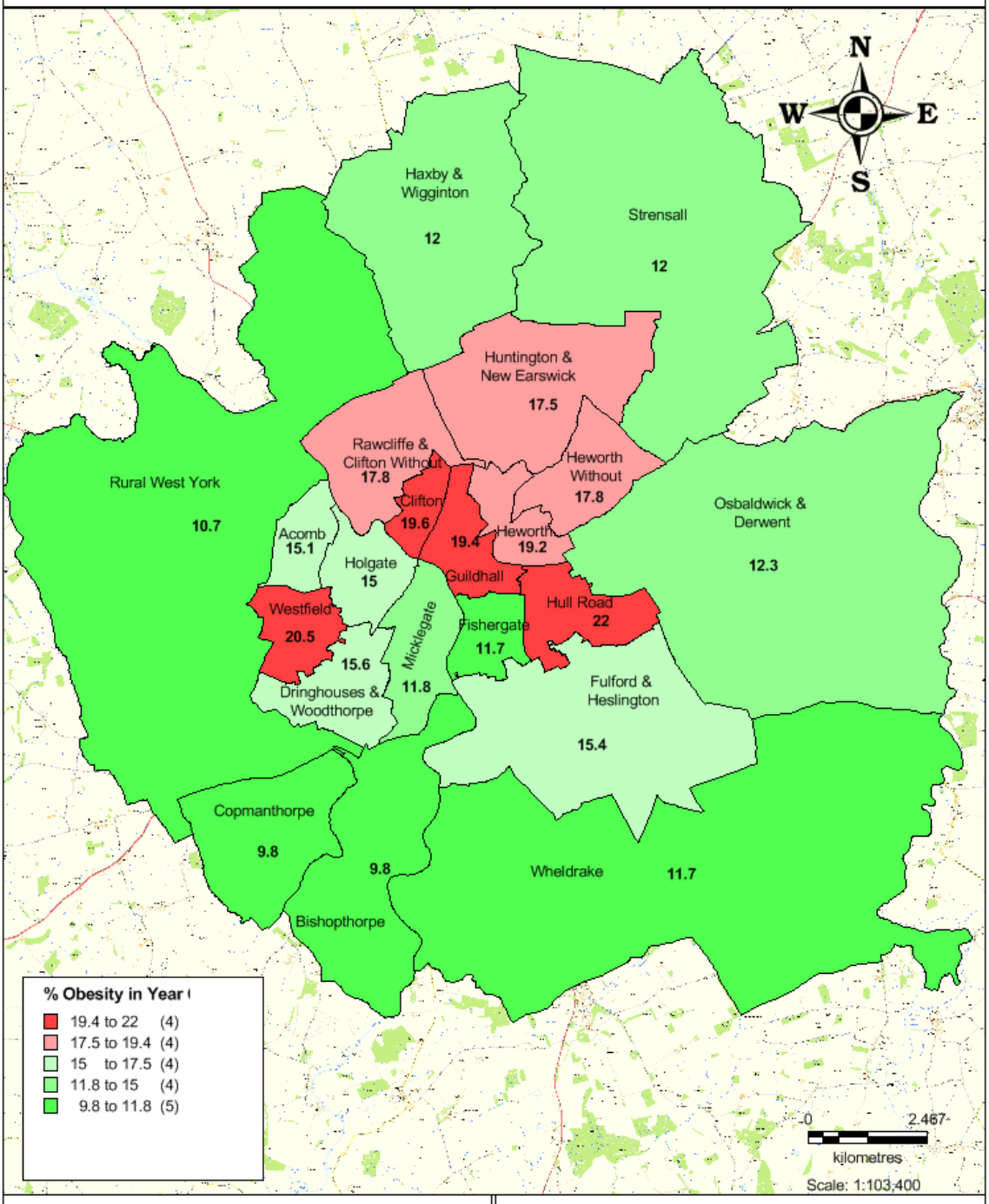


Produced by

Business Intelligence Hub

Created 13/03/2017

% of measured children in Year 6 who were classified as obese, 2012/13-2014/15



Produced by

Business Intelligence Hub

Created 13/03/2017

24. Therefore it is important that any interventions to reduce health inequalities caused by smoking and obesity are targeted in those areas that have the greatest prevalence.

25. The introduction of the CCG policy will improve our understanding of the picture of smoking and obesity across the City since all GPs are now being encouraged to record weight and BMI and smoking status.

26. The CCG has taken steps already to ensure that the most vulnerable patients are not affected by the restrictions applied by the policy. The most up to date list can be found on the CCG website by accessing the link below:

http://www.valeofyorkccg.nhs.uk/rss/index.php?id=optimising-outcomes-1

27. The policy states that exclusions apply to enable access to urgent care, but all patients must be offered access to smoking cessation and/or weight management concurrently regardless of urgency. Exclusions at the time of writing this report include:

    - Patients requiring emergency surgery or with a clinically urgent need where a delay would cause clinical risk:
    - Cholecystectomy
    - Surgery for arterial disease
    - Anal fissure
    - Hernias that are at high risk of obstruction
    - Anal fistula surgery
    - Revision hip surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, recurrent dislocations, impending peri-prosthetic fracture, gross implant loosening or implant migration.
    - Revision knee surgery which is clinically urgent AND where delay could lead to significant deterioration/acute hospital admission. Includes infection, impending peri-prosthetic fracture, gross implant loosening/migration, severe ligamentous instability.
    - Primary hip or knee surgery which is clinically urgent because there is rapidly progressive or severe bone loss that would render reconstruction more complex.
    - Nerve compression where delay will compromise potential functional recovery of nerve.

- Surgery to foot/ankle in patients with diabetes or other neuropathies that will reduce risk of ulceration/infection or severe deformity.
- Orthopaedic procedures for chronic infection.
- Acute knee injuries that may benefit from early surgical intervention (complex ligamentous injuries, repairable bucket handle meniscal tears, ACL tears that are suitable for repair). Other (please specify on the form)
- Lower limb ulceration
- Referrals for interventions of a diagnostic nature:
  - Gastroscopy
  - Colonoscopy
  - Nasopharyngolaryngoscopy
  - Laparoscopy
  - Hysteroscopy
  - Cystoscopy
- Patients with advanced or severe neurological symptoms of Carpal Tunnel Syndrome such as constant pins and needles, numbness, muscle wasting and prominent pain AND that are significantly affecting activities of daily living
- Patients who despite having a BMI >30 have a waist circumference of:
  - Less than 94cm (37 inches) male
  - Less than 80cm (31.5 inches) female
- Children under 18 years of age
- Patients receiving surgery for the treatment of cancer or the suspicion of cancer
- Any surgical interventions that may be required as a result of pregnancy
- Patients with tinnitus
- Patients requiring cataracts surgery
- Vulnerable patients who will need to be clinically assessed to ensure that, where they may be able to benefit from opportunities to improve lifestyle, that these are offered. (Please note that deferring elective interventions may be appropriate for some vulnerable patients based on clinical assessment of their ability to benefit from an opportunity to stop smoking/reduce their BMI/improve pre-operative fitness.) This includes patients with the following:
  - learning disabilities
  - significant cognitive impairment

- severe mental illness[1]

28. City of York Council has reduced the level of investment into stop smoking services as a consequence of Department of Health cuts to its Public Health Grant Allocation. It is no longer practical to fund a comprehensive stop smoking service for all residents who smoke and wish to quit. Smokers are being signposted to resources to help them stop smoking through self-care such as the NHS Smoke Free Service. The website https://www.nhs.uk/smokefree contains a wide array of resources to help people including a free downloadable NHS Smoke Free App, Quit Kit and people can receive free ongoing support including emails and texts.

29. Citizens can also receive advice and support from Community Pharmacists on medications they can buy over the counter to reduce nicotine cravings and improve their chances of quitting e.g. nicotine replacement therapy. For some people a harm reduction approach may be the preferred way forward with a switch to e-cigarettes. Varenicline (Champix) can be purchased privately via an online pharmacy service such as Lloyds Pharmacy On-line.

30. The Council is integrating its stop smoking service into the new Yorwellbeing Service and is prioritising support for pregnant women, pre-operative patients as part of the 'Stop before your op' programme and those patients with respiratory disease or cancer. Free Nicotine Replacement Therapy (NRT) is only available to pregnant women and to those on low incomes. For those on low incomes free NRT is available for a limited period of 2 weeks only after which time they will need to buy their own NRT.

31. City of York has never had a weight management service since the old NHS Primary Care Trust did not invest in weight management services and so funding did not transfer to the Council or CCG respectively to offer this provision. The NHS is responsible for commissioning tier 3 and tier 4 weight management services in line with NICE (National Institute of Health and Care Excellence) guidance. Local authorities are responsible for population

[1] Adults with a serious mental illness are persons who currently or at any time during the past year,have a diagnosable mental, behavioural, or emotional disorder of sufficient duration that has resulted in functional impairment which substantially interferes with or limits one or more major life activities

approaches to promote healthy weight including physical activity. York has one of the highest levels of participation in sport and physical activity in the country but does not currently have any programmes in place to promote healthy eating.

32. The CCG are signposting patients to their website and to other sources of support for weight loss including Slimming World and Weight Watchers.

33. There is some capacity for the Yorwellbeing Service to offer advice and support on healthy weight for those citizens referred to it but this is limited because it is a small service which has focused on providing stop smoking support and developing the NHS Health Checks offer. Capacity will improve in time through the recruitment of volunteer Community Health Champions who will be focusing on providing peer support for healthy lifestyles in communities across the City.

Consultation

34. Consultation has taken place with the Vale of York CCG to better understand the Prevention and Better Care Strategy and plans for implementation and with NHS England.

Options

35. There are no specific options. The Health and Adult Social Care Policy and Scrutiny Committee are asked to consider whether the proposed recommendations are appropriate to be put forward as options to the Executive for what the Council can do to mitigate the impact of the CCG policy on health inequalities.

Analysis

36. Based on the data presented, it has to be recognised that citizens from lower socio-economic groups will undoubtedly be most affected by the CCG Policy. However the Policy is not about rationing access to NHS services but rather that people have support to achieve the best outcomes from their surgery by stopping smoking and losing excess weight first.

37. However concerns remain that without the necessary funding and services in place, this may be difficult to achieve.

38. The impact of decisions that the Council has made in its budget to cut funding to public health services will also impact on access to support for stop smoking and healthy weight and risk exacerbating existing health inequalities. Therefore it is important that available public health resources are targeted to those citizens that are most in need of additional support in order to make the necessary lifestyle change.

Council Plan

39. The report has a focus on improving health and tackling health inequalities linked to smoking and obesity that have an impact on all three of the Council Plan priorities: A prosperous city for all; a focus on frontline services; a council that listens to residents

Implications

40. Consideration has been given to the following:

- **Financial** – the report has no direct financial implications
- **Human Resources (HR)** – the report has no HR implications
- **Equalities** – the report considers the impact of the CCG Prevention and Better Care Strategy on health inequalities. Certain groups in the population are more at risk of health inequalities and so the recommendations, if adopted, will have a positive impact on equalities across the City.
- **Legal** – there are no legal implications

Risk Management

41. There are no specific risks associated with the recommendations in this report.

Recommendations

42. The report proposes a number of options for the Health and Adult Social Care Policy and Scrutiny Committee to consider putting forward as recommendations to the Executive. These are set out below:

- Ask the Executive Member for Adult Social Care and Health to review her decision on the level of support for smokers and in particular the provision of free Nicotine Replacement Therapy for

smokers and funding for Varenicline (Champix) stop smoking medication.

- The Council should set itself an ambition to increase prevention spending and integrate preventive action into all decision making to tackle inequalities utilising a “Health in all Policies” approach.

- The Council, through the Health and Adult Social Care Policy and Scrutiny Committee, and the Health and Wellbeing Board, should hold the leaders across the health and care system to account for looking beyond the interests of their own organisations and driving forward improvement in health and wellbeing outcomes for the citizens of York, leading a cultural change to a health and care system in which different organisations work together to narrow the gap in inequalities across the City.

- Require the Council, together with its partner organisations, to establish innovative ways of tackling inequalities within existing resources, working in partnership with communities using a co-production approach.

Reason: To respond to the Council Motion on Access to NHS Services.

Contact Details

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Sharon.stoltz@york.gov.uk

Dr Shaun O’Connell
Joint Medical Director
Vale of York Clinical Commissioning Group

Chief Officer’s name:

Sharon Stoltz
Director of Public Health

Report Approved	√	**Date** 17/03/17

Specialist Implications Officer(s) - None

Wards Affected: List wards or tick box to indicate all **All** √

For further information please contact Fiona Phillips Assistant Director Public Health
Background Papers

NHS Vale of York Clinical Commissioning Group – Prevention and Better Health Strategy available at: http://www.valeofyorkccg.nhs.uk/data/uploads/governing-body-papers/1-september-2016/item-7.1-prevention-and-better-health-strategy.pdf

Burning Injustice. Reducing the tobacco-driven harm and inequality. All Party Parliamentary Group on Smoking and Health available at: www.ash.org.uk/burninginjustice

NHS England Preventing Ill Health: CQUIN Supplementary Guidance 2017/19 available at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

http://www.valeofyorkccg.nhs.uk/your-health/

https://www.gov.uk/local-wellbeing-local-growth-adopting-health-in-all-policies

Annexes

Annex 1 – Letter to Phil Mettam, Accountable Officer Vale of York CCG
Annex 2 – Letter to Sir Simon Stevens, NHS England
Annex 3 – Letter to Jeremy Hunt, Secretary of State for Health
Annex 4 – Letter to Director of Public Health from Dr David Black, Medical Director NHS England

ANNEX 1

Health, Housing and Adult Social Care Directorate

Public Health
West Offices
Station Rise
York YO1 6GA

Phil Mettam
Accountable Officer
Vale of York Clinical Commissioning Group

Our Ref: KS/SS
Date: 13 January 2017
Email: Sharon.stoltz@york.gov.uk

Via email to: p.mettam@nhs.net

Dear Phil

Access to NHS Services

Further to our recent email correspondence I am now formally writing to you following the Council meeting on the 15 December 2016 where the following Motion was passed:

Access to NHS Services (moved by Cllr S Barnes)

'Council notes:

- *The financial crisis in health facing the NHS and City of York Council, whose public health funding has seen cutbacks in recent years;*
- *The decision of NHS Vale of York Clinical Commissioning Group (CCG) to ration access to NHS services by imposing conditions for surgery on some who smoke or are obese;*
- *The expert clinical view put forward by the Royal College of Surgeons and comments from its President, Clare Marx, who has labelled Vale of York CCG's policy as 'frankly shocking'.*

Council agrees with the CCG's aim to reduce levels of obesity and smoking prevalence among York residents, and recognises that individuals themselves must play a part and take responsibility for looking after their own health. But Council believes the recent CCG policy change regarding the provision of surgery to patients who are obese, or who smoke, sets a dangerous precedent. A change to restrict and ration health services to specific groups of people is unfair.

Furthermore, Council believes this policy threatens to exacerbate existing health inequalities.

Council resolves:

- *To write to the Vale of York Clinical Commissioning Group (CCG), Sir Simon Stevens Head of NHS England and Jeremy Hunt MP, Secretary of State for Health objecting to this decision in the strongest possible terms;*
- *To request that the Executive commissions the Director of Public Health to assess the impact of this policy, including the impact on health inequalities, reporting back to Health and Adult Social Care Policy and Scrutiny Committee, with options recommended to Executive for what the council can do to mitigate its impact on health inequalities.'*

Whilst the Council is supportive of the principles in the Vale of York CCG's Prevention and Better Health Strategy, and welcomes efforts to encourage residents to stop smoking and maintain a healthy weight, there are significant concerns amongst elected Members that the impact of the BMI and smoking thresholds for elective surgery described in the CCG 'Optimising Outcomes from All Elective Surgery Commissioning Statement' will be felt most by those residents living in deprived communities and are, therefore, unfair.

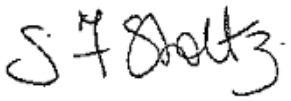
Although the overall prevalence of smoking and obesity are lower in York than in many other parts of the country we know that there are significant inequalities in smoking and obesity within the local population with a clear link to deprivation. Cuts to the Council's public health budget have resulted in a reduction in the services available to support residents with smoking cessation or weight management and there are concerns that support will not be available in a timely way for those patients affected by the CCG policy. Thus there is a real possibility that the policy will have, what I am sure, is an unintended outcome of exacerbating health inequalities across the City of York and therefore the Council has no other option but to object to the policy.

You will note in the last bullet point above that I have been commissioned to assess the impact of the policy, including the impact on health inequalities, and to report back to Health and Adult Social Care Policy and Scrutiny Committee. In order to undertake this health impact assessment I will require the support and co-operation of the CCG in providing the information needed. I would be grateful if you can confirm that the CCG will be supportive of this as an appropriate way forward

and to provide a named lead to actively participate in the health impact assessment on behalf of the CCG.

I look forward to hearing from you.

Yours sincerely



Sharon Stoltz
Director of Public Health

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ANNEX 2

Health, Housing and Adult Social Care Directorate

Public Health
West Offices
Station Rise
York YO1 6GA

Sir Simon Stevens
Chief Executive
NHS England

Via email to:
England.contactus@nhs.net

Our Ref: KS/SS
Date: 13 January 2017
Email: Sharon.stoltz@york.gov.uk

Dear Sir Simon Stevens

Access to NHS Services

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Access to NHS Services (moved by Cllr S Barnes)

'Council notes:

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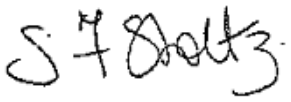
I look forward to hearing from you.

Yours sincerely



Sharon Stoltz
Director of Public Health

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ANNEX 3

Health, Housing and Adult Social Care Directorate

Public Health
West Offices
Station Rise
York YO1 6GA

The Rt. Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

Our Ref: KS/SS
Date: 13 January 2017
Email: Sharon.stoltz@york.gov.uk

Dear Secretary of State for Health

Access to NHS Services

I am writing to you following the Council meeting on the 15 December 2016 where the following Motion was passed:

Access to NHS Services (moved by Cllr S Barnes)

'Council notes:

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I would be grateful if you could note the Council's position and respond accordingly.

Yours sincerely

S Stoltz

Sharon Stoltz
Director of Public Health

ANNEX 4

Our Ref: JW/DB/MH

14 February 2017

Unit 3
Alpha Court
Monks Cross
York
YO32 9WN

Sharon Stoltz
Director of Public Health
Public Health
West Offices
Station Rise
York YO1 6GA

Dear Ms Stoltz

Re: Access to NHS Services

NHS England and the CCG note the motion the Council passed on the 15th December 2016. We appreciate the support that the Council gives in supporting the CCG's aim to reduce levels of obesity and smoking amongst local residents and to reduce inequalities. I also note the recognition the Council gives to the individual's responsibility in looking after their own health. We also appreciate the support that you, as Director of Public Health, have given the CCG including at Governing Body meetings.

I appreciate your concern to understand how the policy will affect existing health inequalities and we will be pleased to support and cooperate with your planned work to assess the impact of the policy. Smoking in particular is heavily concentrated in more deprived populations and is the single biggest driver of health inequalities. This policy is intended to result in people stopping smoking and, therefore, may narrow health inequalities. Certainly, the CCG and NHS England will want to understand the effect of the policy on health inequalities and we welcome your planned review. There have been preliminary discussions at the Clinical Executive Group of the CCG that your colleague, Dr Fiona Phillips, attended evaluating the impact of the policy. The CCG has not finalised its evaluation and would like to discuss integrating your assessment and the CCG's evaluation into one piece of work. This will then inform both the CCG and Council on any further action needed to mitigate any unintended negative effects of the CCG's policy and the Councils Public Health service reductions on local people.

.

We do not agree that the restrictions are unfair. The body mass index (BMI) and smoking thresholds are there so that patients have the opportunity to improve their health and, therefore, to improve the safety of surgery and also to improve the health of the population through the long term benefits of healthier lifestyles. Smoking and obesity cause a huge amount of illness and increase health and NHS costs generally. Patients receiving surgery will not only achieve better outcomes following life style changes, but health care costs will also tend to reduce. This will release resources for the care of other patients. It is for these reasons that the CCG is implementing the threshold at this time. The CCG have taken great care to ensure that their policies are applied fairly and to optimise benefits to patients of lifestyle improvements. In particular:

1. On 30 November 2016 Vale of York CCG emailed local GPs to ensure they are informed of the detail of developments in the CCG's BMI and smoking thresholds and to instruct GPs to await the implementation of the policy.

2. GPs were informed about the start date in January (16th) and provided with the information needed to guide their referrals and to ensure any patients that may need to be exempted from the policy statements can be considered through an individual funding request process. (There are safeguards to ensure that; patients needing urgent interventions are not delayed, patients experiencing a change in their clinical condition can be promptly reviewed, and patients who may have an exceptional clinical need may be referred by their treating clinician into the Individual Funding Request (IFR) process for consideration). The information is available on the CCG's website and is being updated regularly. The CCG lead GP Dr Shaun O'Connell, is available for GPs to contact directly if needed.

3. The CCG is encouraging GPs to record weight and BMI and give brief interventions on every possible occasion because if patients have lost 10% of their weight or stopped smoking for two months by the time they are seen in outpatients they can then be 'listed'. (There is a recent paper in the Lancet demonstrating the effectiveness of these interventions. Recent research has also shown people who strive for greater weight loss achieve more than those with lesser ambitions).

4. Patients not able or wishing to lose weight / stop smoking will still receive the planned intervention after 1 year / 6 months.

5. The CCG has decided not to delay surgery for patients who have been listed for surgery already and who are on a waiting list. The policy will apply to patients who are yet to be listed. The CCG is encouraging GPs and practice nurses to more actively weigh and offer brief interventions for patients as often as possible to support both weight loss and smoking cessation. This will minimise the time patients need to wait whilst they work to improve their lifestyle and reduce their surgical risk. . This helps individuals and the whole population and enables patients who have lost weight or stopped smoking to proceed through to surgery more quickly than if lifestyle interventions are delayed until patients present with symptoms that require surgery.

6. Information for clinicians and patients on locally available support for weight loss and smoking cessation is available on the CCG website. All patients referred into the Referral Support Service who are obese or who smoke will receive a comprehensive letter and leaflet about the impact of lifestyle on their health and how to improve their health. There is also a BMI calculator that patients can use. The Local Medical Committee (LMC) now supports GPs referring patients for assessment for an exercise programme, in the past the LMC did not support these referrals.

We note that the City of York Council is facing financial pressures and it is regrettable that reductions have been made in services available to support residents with smoking cessation and weight management. I hope that your assessment of the impact of the CCG policies will encompass the impact of the Council's decisions on investment in these lifestyle improvement services. Patients may still be successful in stopping smoking and losing weight with advice from their GP practice, but without the support of other public services this opportunity may not be maximised.

In conclusion, the CCG and the Council have challenging financial circumstances and need to work closely together for benefit of patients and the people of the City of York. The CCGs policy aims to improve health and reduce the costs of care and treatment in order to help more patients within the money available. Health inequalities may be reduced through successful smoking quitting and to some extent through weight loss. This will depend upon the uptake of support and success in life style improvement by more disadvantaged groups. I understand your concerns and hope a joint approach can be agreed between you and the CCG to assess and evaluate the CCG's policy and Council's investment in smoking cessation and weight loss services. This will facilitate agreement on any action that may be needed to mitigate any unforeseen disbenefits for the patients / people in the City of York.

Yours sincerely

Moira Dumma
Director of Commissioning Operations

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Health & Adult Social Care Policy & Scrutiny Committee **29 March 2017**

Report of the Public Health Grant Spending Scrutiny Review Task Group

Public Health Grant Spending Draft Final Report

Summary

1. This report provides the Health & Adult Social Care Policy & Scrutiny Committee with all the information gathered in support of the scrutiny review into Public Health Grant Spending, together with the review analysis and draft recommendations.

Background

2. On 1 April 2013 responsibilities for Public Health were transferred from the NHS to local authorities with implementation of the Health and Social Care Act 2012. Local authorities receive an annual ring-fenced public health grant from the Department of Health which has a core condition attached that it should be used only for the purposes of the public health functions of local authorities. The local authority statutory duties for public health services are mainly outlined in the Health and Social Care Act 2012 legislation which include a duty to improve the public's health through mandated and non-mandated functions. There are additional regulations for the use of the grant for delivery of mandated 0-5 child public health services and delivery of services for alcohol and drug treatment.

3. At a meeting in June 2015 the former Acting Director of Public Health suggested Members might wish to examine, as part of a scrutiny review, how the Public Health Grant to Local Government was spent and in July 2015 the Committee received a scoping report on this topic.

4. The Committee agreed to undertake scrutiny review of expenditure on Public Health Grant, with benchmarking against other local authorities, as this would be feasible and would provide useful information to inform resource allocation decisions. The Committee agreed a Task Group

comprising Cllrs Doughty, Cannon, Craghill and Cuthbertson carry out the review on their behalf.

Aim and Objectives

5. The Task Group meet for the first time in October 2015 when the following draft aim and objectives were agreed:

Aim:

To identify a comprehensive understanding of York's public health outcomes and spend and establish a knowledge base for joint use with the Health & Wellbeing Board.

Objectives:

i. To examine and compare York's spends and health and wellbeing outcomes against statistical neighbours

ii. To examine spends and health and wellbeing outcomes of other agencies e.g. NHS England which contribute to the public health of York's residents

iii. Identify underachieving areas of activity and spend in York requiring further focus

Information gathered

6. The review stalled slightly while revised figures from the Department of Health were confirmed, but in early February 2016 Task Group members received a report Public Health Expenditure and Outcomes (Annex A) which looked at how public health expenditure in the City of York is spent in relation to the public health outcomes achieved.

7. The report also gave an overview of spend and outcomes in York benchmarked against other local authorities. It highlighted that the average spend per head of the population on public health in York in 2014/15 was £38.34, which is lower than regional, national and deprivation group averages.

8. A total of £7.76 million was spent on public health in York in 2014/15 with the biggest areas of spend being sexual health (£2.7 million) and substance misuse (£2.5 million).

9. The breakdown of public health spend (in £ thousands) in 2014/15 was:

• Sexual health	£2,729	35%
• Substance misuse	£2,516	32%
• Miscellaneous public health	£916	12%
• Children 5-19	£714	9%
• Smoking	£305	4%
• Physical activity	£259	3%
• NHS health check	£155	2%
• Obesity	£81	1%
• Public health advice	£72	1%
• Health protection	£17	0%
• NCMP	£6	0%
Total	**£7,761**	**100%**

10. Task Group members questioned which services were included in miscellaneous and these include:

- Nutrition initiatives
- Accidents Prevention
- General prevention
- Community safety, violence prevention & social exclusion
- Dental public health
- Fluoridation
- Infectious disease surveillance and control
- Environmental hazards protection
- Seasonal death reduction initiatives
- Birth defect preventions
- Other public health services

11. In York the 12% of public health spend in 2014/15 categorised as miscellaneous is made up of:

- Contribution to adult social care £416,000

- Staffing £392,906
- Dental health contract £43,604
- Soil Association project £41,961
- Share of recharges £20,702

12. The Task Group was disappointed to learn that in early February 2016 the Department of Health confirmed York needed to make further savings in its Public Health budget for 2016/17 of around £70,000. This is in addition to the £508,000 (6.2%) reduction in the city's public health grant allocation in 2015/16.

13. The £508,000 reduction was part of wider Government action on deficit reduction which saw the 2015/16 public health grant to local authorities reduced by £200 million.

14. In 2015/16 the total grant awarded to local authorities amounted originally to £2.8 billion, supplemented by a further £430 million when responsibility for services for children aged 0 – 5 transferred to local authorities from NHS England on 1 October 2015.

15. The further reduction followed the Chancellor's 2015 Autumn Statement which confirmed that Local Authority funding for public health would be reduced by an average of 3.9% per annum in real terms until 2020. This equates to a reduction in cash terms of 9.6% over the same period[1].

16. From a 2015/16 baseline of £3.461 billion (which includes the full year equivalent of the budget for children aged 0-5 and the effect of the in-year saving of £200 million) there was a reduction in the total grant of 2.2 per cent in 2016/17 and a further reduction of *2*.5% in 2017/18.

17. While the figures in paragraphs 7-9 and paragraph 11 have been compiled using 2014/15 actual expenditure the Public Health budget is undergoing considerable change. Some key changes in York for 2015/16 were:

    - There was a part year increase in grant funding due to the transfer of the commissioning of 0-5 years children's public health services from NHS England to local authorities from 1st October 2015 (£916k).

    - There was an in-year grant cut of 509k

[1] Department of Health Local Authority circular 11 February 2016 which set out allocations of the local government public health grant for 2016/17.

- The net impact of the two changes was that the public health grant increased by £407k made up of Children's 0-5 funding (£916k) less the in-year grant cut (£509k).
- There were new items of expenditure: children's 0-5 services (901k); air quality contribution (50k); health protection (12k); housing officer (10k) and suicide prevention (9k).
- There were some reductions in expenditure: tender of sexual health contract saved £549k; end of pharmacy contraception service saved £28k and end of funding for Soil Association project saved £42k (this was a one off project in 2014/15).
- There were some items where existing expenditure increased including staffing (£27k - due to restructure, net figure reduced by vacancies) and Sky Ride (£27k – increased contribution in 2015/16).

18. At a Task Group meeting in March 2016 Members noted that the in-year budget cut of 6.2% in the 3rd quarter of 2015/16 – a total of £509.000 – was largely absorbed by staff vacancies; lower than expected levels of activity in some services and halting planned developments in substance misuse. Budget cuts for 2016/17 of 6.2% and a further 2.2% amounted to £708,000 meaning CYC has lost more than £1.2million of its Public Health budget.

Overview of Public Health budget 2016/17

Public Health Service Area	Budget Allocated (rounded up)
Sexual health and contraception	£1,707.500
Drug & alcohol treatment and recovery services	£2,542,657
Healthy child service (health visiting and school nursing)	£2,400,000
Integrated wellness service	£665,640
Dental health	£10,000
Infection prevention and control / health protection	£50,000

Internal grants to other CYC teams	£466,000 (Adult Social Care & Public Protection)
Core CYC public health (pay and non-pay)	£830,000 (including staff training and some software in CYC services)
Total	**£8,697,097**
Income	Public Health grant – £8,400,000 CYC sports and active leisure – £293,000 East Riding Council health visitors – £44,000 Police & Crime Commission (PCC) – £76,421 Youth Offending Team (YOT) – £28,000
Total deducting income	**£8,255,675 (leaving £144,325 unallocated as a contingency for one-off costs associated with TUPE transfer of Healthy Child Service)**

19. In order to deliver a balanced public health budget it has been necessary to make changes to commissioned public health services. These changes are detailed in the following paragraphs.

20. **Sexual Health & Contraception**

Background

- Sexual health and contraception services were re-commissioned via competitive tender in 2015 – City of York now has an integrated sexual health and contraception service
- But still had old PCT primary care contracts and expensive out-of-area treatment costs.

Changes for 2016

- Budget saving of £400,000 made

- Ended primary care contracts and renegotiating joint commissioning with CCG to only pay CYC costs
- Agreed on regional basis CYC will only pay national tariff for out of area genitourinary medicine (GUM) and not pay for contraception

Risks

- Out of area costs cannot be accurately predicted at start of year
- Prescribing cost in primary care.

21. **Drug & Alcohol Services**

Background

- Contracts date back four years. Originally commissioned for three years and contracts extended for two years to 31st March 2017
- Included primary care contracts of varying quality
- High prescribing costs

Changes for 2016

- £15,000 budget savings to come out of 2016 – working with providers to reduce costs
- Council agreed transitional funding of £26,000 for carers
- Commissioning intention is to go out to competitive tender with the award of a new contract to start in July 2017 with reduced budget.

Risks

- Unable to predict levels of activity at start of year e.g. inpatient detox, prescribing
- We may be unable to award a new contract if value is set too low. Might fail to attract suitable bidder
- Partner expectations of what CYC will fund e.g. Probation, North Yorkshire Police, CCG

22. **Healthy Child Service**

Background

- Responsibility for 5-19 Healthy Child Programme (school nurse and National Child Measurement Programme) transferred to local authorities in April 2013
- Responsibility for 0-5 Healthy Child Programme transferred to local authorities in October 2015

- In August 2015 CYC Executive made a decision to develop in-house integrated Healthy Child Service 0-19 and TUPE staff.

Changes for 2016

- More than 90 NHS staff transferred from York Teaching Hospital to CYC on 1 April 2016
- Consultation planned on new integrated service in partnership with work on developing a new operating model for early intervention and prevention services
- Model for new integrated Health Child Service to be agreed for implementation from June 2017 and this is on schedule.

Risks

- Anticipate a budget overspend non-recurrently for 2016/17 due to one-off transition costs
- No budget savings proposals for 2016/17 but there are anticipated efficiencies that need to be made

23. **Integrated Wellness Service**

Background

- Stop smoking service and NHS Health Checks commissioned as separate services until 31 March 2016
- No public health funded activity taking place on mental and emotional wellbeing, weight management prior to 1 April 2016
- Sport and active leisure a separate arms length service sat within public health team

Changes for 2016

- New service to include smoking, NHS Health Checks, physical activity, healthy eating, mental wellbeing, alcohol prevention
- Life course approach (starting well, living well, aging well) working with communities
- Developing tier 3 prevention services in partnership with CCG
- Changes to universal service offer to residents for stop smoking and NHS Health Checks – new focus will be on residents taking more responsibility for own health with interventions targeted to a risk group to reduce health inequalities
- Changes to funding of Nicotine replacement Therapy to deliver savings of £50,000

- Changes to NHS Health Checks to deliver savings of £45,000

Risks

- New service will not be fully operational until early 2017 so there will be a service gap, except for stop smoking which will continue
- Transition from old service to the new and expectations of partners
- Risk of complaints until new service is fully established

24. **Dental Health**

Background

- CYC inherited a joint York and North Yorkshire contract from the NHS in April 2013
- Health needs assessment and service review undertaken in 2015
- Current service not delivering desired health outcomes or value for money
- Contract ended on 31 March 2016

Changes for 2016

- New service commissioned jointly by NYCC and CYC to reduce budget
- Focused on mandatory dental surgery
- Health promotion on good dental hygiene to be incorporated into new Healthy Child Service
- Delivering savings of £20,000

Risks

- Embedding health promotion into Healthy Child Service during a period of change
- Failure to reduce hospital admissions for tooth extractions under general anaesthetic in children

25. **Infection Prevention & Control / Health Protection**

Background

- Responsibilities of local authorities for IPC and health protection unclear during and after the transfer of public health to local authorities on April 2013

- CYC has worked with NYCC, North Yorkshire CCGs, NHS England and Public Health England to undertake a review of current service provision and agree roles and responsibilities
- Review completed in February 2016

Changes for 2016

- New IPC service commissioned on a North Yorkshire and York footprint
- CYC is an associate commissioner in this contract
- Investment made into the contract and a small contingency budget set aside for responding to disease outbreaks
- Developing additional health protections expertise in the CYC public health team to ensure all risks are managed and CYC is prepared to respond to disease outbreaks

Risks

- Disease outbreaks cannot be predicted. Therefore CYC needs sufficient capacity for planning and response. Capacity will be limited even with the changes being introduced.

26. **Health Promotion Campaigns**

Background

- CYC Public Health has not had a planned or co-ordinated to health promotion campaign to date
- Campaigns have been ad hoc and based on national, rather than local, priorities
- There has been no dedicated public health resource for campaigns

Changes for 2016

- Budget has been allocated with the aim of developing a 12-month rolling programme of campaigns linked to local priorities
- Aim is to involve elected members in supporting campaigns in the wards

Risks

- Engaging people in delivery of the campaigns
- Evaluating the impact

27. **Internal Grants to other CYC teams**

Background

- CYC Public Health has historically made a contribution to adult social care and public protection teams in the council
- It is not clear what impact this contribution is having on health and wellbeing outcomes

Changes for 2016

- Work is to be carried out with adult social care and public protection to understand the services being provided with public health grant monies and evaluate the impact
- A decision can then be made on future funding

Risks

- Engaging other CYC colleagues
- Understanding the impact if public health grant funding were to be withdrawn

28. Since the beginning of the review a number of issues related to public health spending have been considered by the full Health & Adult Social Care Policy & Scrutiny Committee.

Healthy Child Services

- In January 2016 the Committee received a report informing them that as of 1 April the Council would take on responsibility from the School Health Team from York Teaching Hospital NHS Foundation Trust.

- In July 2016 the Committee received an Update Report on the transfer of health visiting, school nursing and the National Child Measurement Programme from York Teaching Hospital NHS Foundation Trust to City of York Council and progress with the development of a new Healthy Child Service.

- In January 2017 the Committee received a further Update Report which noted that a number of efficiencies were being realised.

Substance Misuse

- In July 2016 The Committee considered a pre-decision report on the re-procurement of Substance Misuse and Treatment and Recovery Services prior to an Executive Decision being made. The

Committee asked Officers to review the savings proposals for the new contract. The original proposal was to make the bulk of the savings in years 1 and 2 of the new contract. In discussion, the Committee agreed to recommend that the savings be spread more evenly over the length of the contract to minimise the impact of budget cuts through the transition to the new service and reduce the risk to existing customers through the change. As a consequence it was agreed by Executive that the reduction will be phased in over a 5 year period.

29. The Task Group met again in mid November 2016 when members were given updated information of public health spend. The Task Group noted that:

    - Substance Misuse accounts for 29% of all Public Health spend in York against the 22% England average.

    - In 2014/15 Sexual Health accounted for 35% of the Public Health spend in York (which at the time did not include 0-5 children's services). The comparable percentage in 2016/17 is 25% (sexual health spend out of the public health budget excluding 0-5 children's services) so the sexual health budget had been reduced considerably.

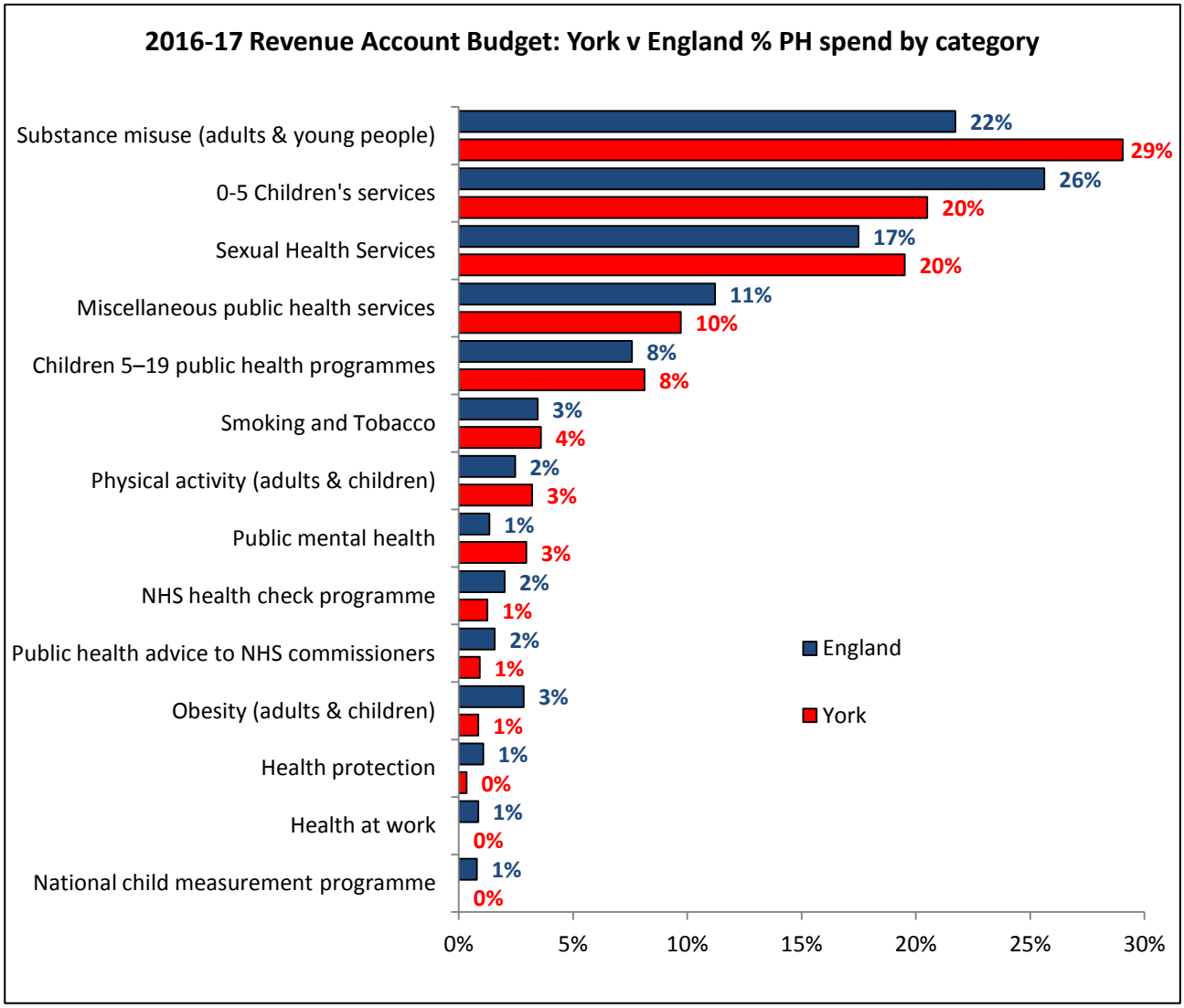
    - Sexual Health accounts for 20% of all Public health spend in York against the 17% England average

    - 0-5 children's services account for 20% of all Public health spend in York against the 26% England average.

30. The Task Group noted that the phased reduction in the new Substance Misuse contract will bring York into line with the national average. Going forward the recommended assessment of the impact of changes on residents' lives will evaluate the appropriateness of the national average spend in York.

31. It also accepted that as York has two major universities it has a higher proportion of residents in the 18-24 age bracket so a higher percentage spend on sexual health is entirely appropriate compared to other local authorities. It was also noted that since 2013 CYC had been funding Clinical Commissioning Group (CCG) services, but that extensive negotiations with CCG had resulted in an agreement that they took responsibility for some of these costs.

Percentage breakdown of public Health Spending by Category: York v England using 2016-17 Revenue Account Budget



32. The Task Group accepted that CYC has a savings profile and most of the savings are already planned. This was a case of effectively pruning budgets and looking at ways to deploy resources effectively.

33. And they noted the importance of partnership working. If the Council can adopt a leadership and partnership approach it can lever in additional activity.

34. Members were informed that Public Health England had published a toolkit around Health in All Policies which focuses on specific public health issues such as obesity or mental wellbeing. It was agreed that public health is not just about health care and that work around prevention is increasingly important. Increasing rates of physical activity,

stopping smoking, reducing alcohol consumption, reducing the effects of environmental pollution, improving housing conditions and raising the importance of a healthy, balanced diet have important parts to play in improving physical and mental heath.

35. It was suggested that partnership working to achieve some of these goals could be linked to the aspirations of One Planet York. One of the 10 principles of One Planet York is to encourage active, sociable and meaningful lives to promote good health and wellbeing.

36. One Planet York notes that: *"where people live and their lifestyle can have significant impacts on their health and wellbeing. Overall health across the city is good, but disparities in outcomes do exist: there is a gap of over six years in male life expectancy between the most and least deprived areas of York.*

37. *Ongoing budget pressures alongside growing demands require a significant change in the way services are planned and delivered. Strong partnerships, effective prevention and early intervention will be vital.*

38. *A sustainable city is one that works to narrow health inequalities, enabling people to achieve and maintain healthy lives. It is important we give people the tools to enable them to be resilient, have good physical and mental wellbeing and feel well connected as part of their local community."*

39. The Task Group agreed that because of the financial challenges, demand on services and the size of public health budgets there was a need to strengthen joined-up working across different parts of the system and develop a whole council approach to help make best use of resources and formulate policies with the key aim of improving the quality of life for the local population.

40. The finance and performance monitor report considered by the Health & Adult Social Care Policy & Scrutiny Committee in February 2017 noted that within Public Health there are net projected overspends on sexual health contracts (+£41k), substance misuse contracts (+£36k) and the healthy child programme (+£31k) due to one-off transition costs relating to the transfer of the school nurse and health visitor staff from York Hospital.

41. These are offset by a projected underspend on staffing of £108k due to vacancies which were held prior to the implementation of the public health restructure.

Options

42. Having considered the information presented in this report Members can:

    - Agree any further work that needs to be undertaken to complete this review;
    - Agree the draft review recommendations in paragraph 53 or;
    - Amend the draft review recommendations in paragraph 53 and agree any additional recommendations.

Analysis

43. York has a higher percentage of the population who are aged 20-24 compared with the national average (11.1% v 6.6%) and this may be one of the factors accounting for a greater share of the public health budget being spent on sexual health services.

44. The overall public health spend per head of population is lower in York compared with the national average. If the spend per head of population on individual public health programmes for York is compared with the national average there is only one area where York has a higher than average spend and that is on contraception (£4.93 per head v £3.91 per head nationally). City of York Council public health team have been funding some activity for contraception for medical reasons which should have been funded by the CCG and actions have been taken in 2016/17 to address this anomaly and reduce council spending in this area.

45. For some public health programmes in York where clear service user activity data is available, it is possible to calculate the cost per service user of providing the programme. For example, the cost per service user in structured substance misuse treatment services in 2014/15 was £1,858.20 and the cost per service user for smoking cessation services was £623.26. (This figure should not be confused with the 'cost per quitter' figures provided in previous scrutiny reports. For smoking cessation programmes this is the number of people setting a quit date. When looking at outcomes we would look at the number of people actually quitting smoking. The 'cost per quitter' in York is £887 which is double the national and regional averages.) Actions have already been put in place or are being developed to address any anomalies.

46. The continued pressure of the public health budget means it will be important to improve the performance monitoring of public health

contracts to achieve quality of provision and the best possible outcomes in relation to expenditure.

47. A positive rating for physical health expenditure against the 'active adults' outcome is a good example of public health working with other departments and agencies to achieve good outcomes despite lower direct public health spend.

48. Changes to the public health budget in 2015/16 include new areas of expenditure on children's 0-5 services, air quality, health protection, housing and suicide prevention, whilst there were some savings due to the re-tender of the sexual health contract and ending the pharmacy contraception service.

49. Many of the issued perceived as difficulties when the review was first agreed, such as sexual health contracts, substance misuse contracts and the healthy child programme, have since been resolved.

50. The challenges for the Council in relation to Public Health Grant continue and the Department of Health has announced further cuts to local authority Public Health Grant allocations:

Local Authority Public Health Grant Allocations – cumulative cuts		
Year	**% Allocation**	**Comment**
2015/16	6.2% reduction	
2016/17	2.2% reduction	
2017/18	2.5% reduction	
2018/19	2.6% reduction	Ringfence removed
2019/20	2.6% reduction	
2020/21	0%	Government will consult on PH services being funded exclusively by business rates

51. Based on these announcements CYC will have lost £1.6 million from its Public Health Grant allocation by 2020.

Consultation

52. The Task Group has consulted fully with the Director of Public Health during the course of this review and has considered information gathered via the Public health England Spend and Outcomes Tool (SPOT), which

was able to provide an overview of spend and outcomes for York, benchmarked against other local authorities in England.

Draft Review Recommendations

53. Members of the Health and Adult Social Care Policy and Scrutiny Committee are asked to note the continued challenges on effective delivery of public health services against a background of cuts to the Public Health Grant and:

    i. Request the Director of Public Health undertake a detailed Health Impact Assessment of the anticipated impact on residents with a further report to Scrutiny to help inform the budget setting process for 2018/19 onwards.

       Reason: So that the Council can make informed decisions about how best to spend the public health grant to deliver improved public health outcomes for residents when the ringfence is removed in 2018/19.

    ii. Ask the Executive to support the recommendation that the Director of Public Health develop a Public Health Strategy for the City that utilises a “Health in All Policies” approach.

       Reason: In recognition of the fact that the Council can only deliver its statutory responsibilities for public health by making the task of improving the public’s health everyone’s business, at the core of the practice of the wider Council workforce whilst also working pro-actively with city partners such as education and voluntary sectors and empowering citizens as partners in improving health and wellbeing at the level of the individual, family and community.

    iii. The CYC Public Health Team are asked to strengthen their management of contracts and oversight of delivery of public health services against clearly defined performance and financial targets.

       Reason: So that the Council can be assured of value for money in the delivery of public health services and that the statutory responsibilities for public health are met.

    iv. That the Director Public Health is asked to show the impact of contract management on residents’ lives. It would be useful for a simple summary to show the breakdown of where funding is allocated this year which could be a template for future years, along with specific outcome indicators.

Reason: To ensure that members are assured about the level of contract management, that contracts are delivered against specific outcome indicators and that remedial actions are available of they are not.

Council Plan

54. This report is linked to A Focus on Frontline Services and A Council That Listens to Residents elements of the Council Plan and supports the key strategic goals that all residents enjoy healthy and independent lives and achieve their full potential.

Implications

55. **Financial**: This report is scrutinising financial information.

- **Human Resources (HR):** There are no HR implications
- **Equalities:** Reducing health inequalities to enabled people to achieve and maintain healthy lives is a consideration of this report.
- **Legal**: There are no legal implications
- **Crime and Disorder:** Spend on crime and disorder is one of the considerations in this report
- **Information Technology (IT):** There are no IT implications
- **Property** There are no property implications
- **Other**

Risk Management

56. The failure to be able to respond to a reduction in public health budgets while also delivering mandated public health responsibilities is included on the public health risk register rated as a red critical risk. With mitigating actions in place this risk is reduced to an amber medium risk.

Recommendations

57. Having considered the information contained in this report and its annex, member are asked agree:

i. Any changes required to this draft final report;

ii. The draft recommendations listed in paragraph 53 above.

Reason: To conclude the work on this review in line with scrutiny procedures and protocols thereby enabling this report to be presented to a future meeting of the Executive.

Contact Details

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Report Approved ✓ **Date** 20/03/2017

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers: None

Annexes

Annex A – Public Health Spending and Outcomes

Abbreviations

CCG – Clinical Commissioning Group
CYC – City of York Council
GUM – Genitourinary medicine
IPC – Infection Prevention Control
NHS – National Health Service
NYCC – North Yorkshire County Council
PCC – Police and Crime Commission
PCT – Primary Care Trust
TUPE – Transfer of Undertakings (Protection of Employment)
YOT – Youth Offending Team

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ANNEX A

Report for Health and Adult Social Care Policy and Scrutiny Committee Task Group

Public Health Expenditure and Outcomes

February 2016

Contents

Introduction

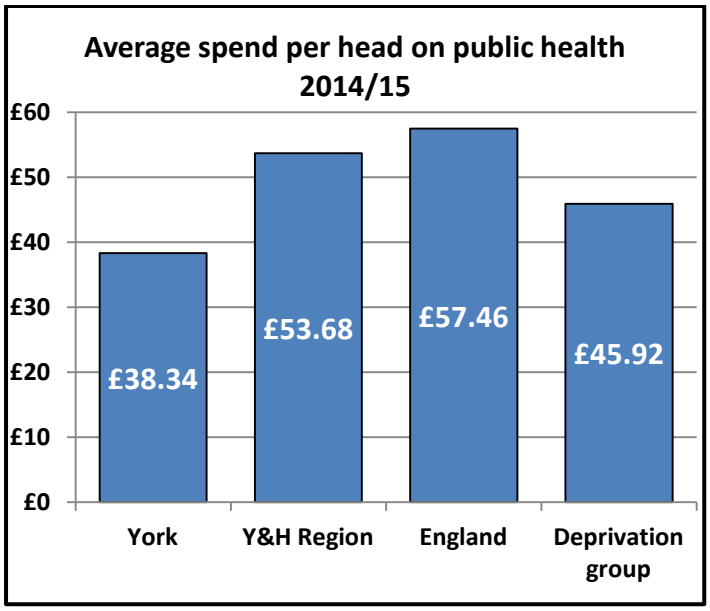
The purpose of this report is to look at the public health expenditure in the City of York Council is spent in relation to the public health outcomes achieved. The report uses the Public Health England (PHE) Spend and Outcomes Tool (SPOT). This gives an overview of spend and outcomes for York, benchmarked against all other local authorities in England. It uses 2014/15 actual spend against the latest public health outcome data. The SPOT tool itself can be found here.

Public Health Spend in York

Average spend per head of population

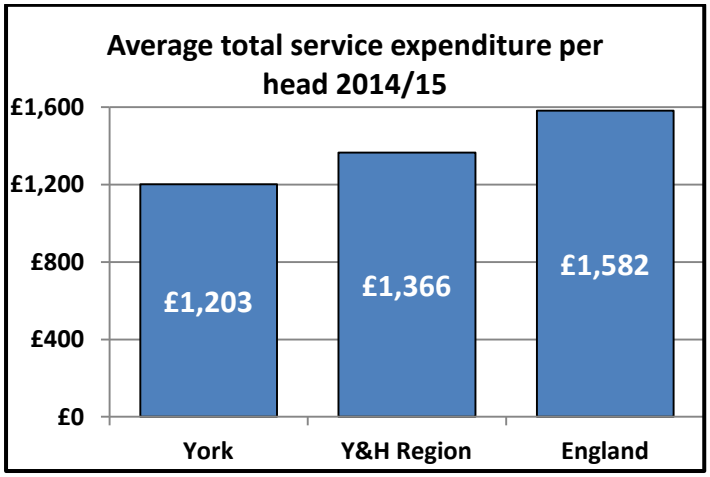
The average spend per head of population on public health in York in 2014/15 was £38.34, which is lower than regional, national and deprivation group averages.

Figure 1: 2014/15 Public Health spend per head.



The expenditure per head of population on all local authority services in York in 2014/15 was £1,203, which is lower than regional and national averages.

Figure 2: 2014/15 Total council spend per head 2014/15



Breakdown of public health expenditure

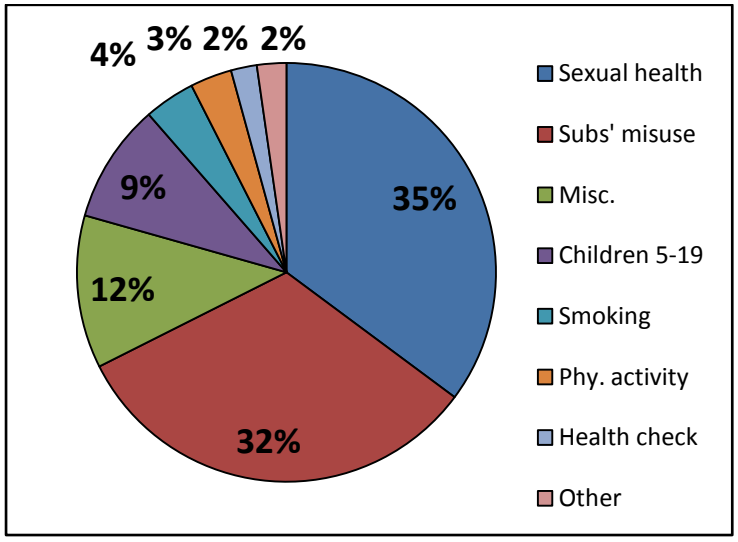
A total of £7.76 M was spent in 2014/15 in York. The biggest areas of spend were sexual health (£2.7M) and substance misuse (£2.5M).

Figure 3: Breakdown of York public health spend 2014/15

Public Health Area	York Total Spend 2014/15	
	£ (thousand)	%
Sexual health	£2,729	35%
Substance misuse	£2,516	32%
Misc. pub health	£916	12%
Children 5-19	£714	9%
Smoking	£305	4%
Physical activity	£250	3%
NHS health check	£155	2%
Obesity	£81	1%
Public health advice	£72	1%
Health protection	£17	0%
NCMP	£6	0%
Total	**£7,761**	**100%**

It can be seen that about 2/3 of the Public Health Budget was spent on sexual health and substance misuse services.

Figure 4: Percentage breakdown of the public health spend in York in 2014/15



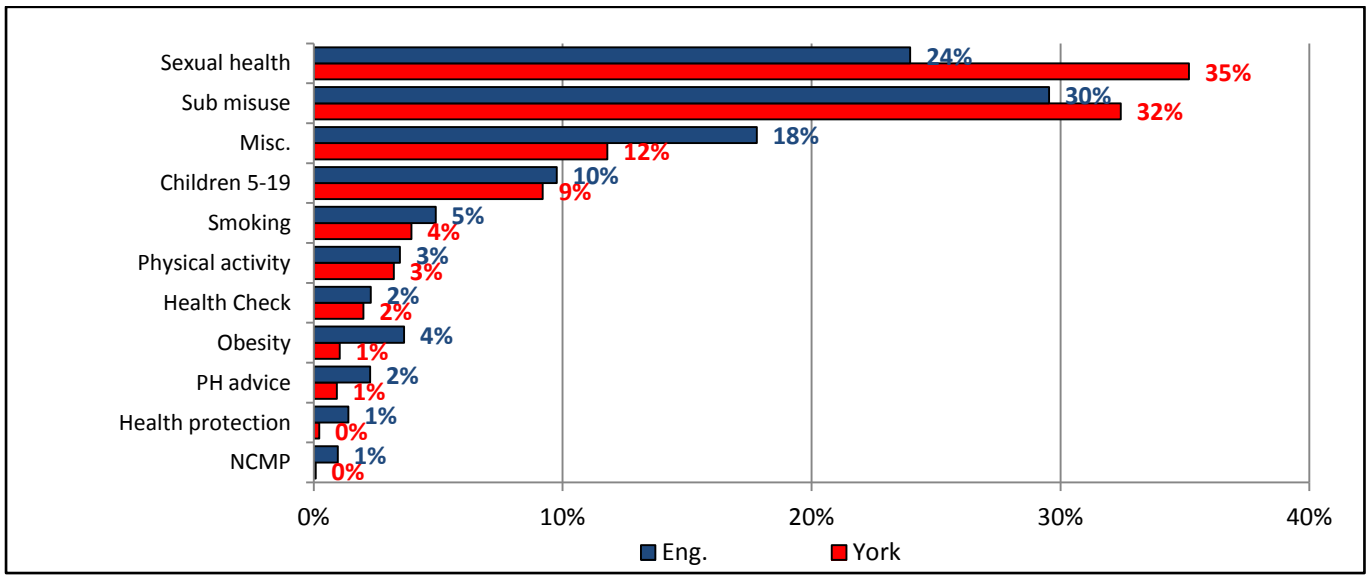
12% of the public health spend (£915,173) was categorised as miscellaneous. This is made up as follows:

- Contribution to Adult Social Care: £416,000
- Staffing: £392,906
- Dental Health Contract: £43,604
- Spend on Soil Association Project: £41,961
- Share of Recharges: £20,702.

Figure 5 shows the proportion of the public health budget spent on each broad area of expenditure for York compared with the national average. Key differences are:

- York spends a higher proportion on sexual health (35% v 24%)
- York spends a slightly higher proportion on substance misuse (32% v 30%)
- York spends a lower proportion on obesity programmes (1% v 4%)
- York spends a lower proportion on miscellaneous programmes (12% v 18%)

Figure 5: Proportion of Public Health Budget spent on each area. 2014-15. York v England.



York has a higher percentage of the population who are aged 20-24 compared with the national average (11.1% v 6.6%) and this may be one of the factors accounting for a greater share of the public health budget being spent on sexual health services.

It has already been noted that the overall public health spend per head of population is lower in York compared with the national average. If the spend per head of population on individual public health programmes for York is compared with the national average there is only one area where York has a higher than average spend and that is on contraception (£4.93 per head v £3.91 per head nationally). It transpires that the City of York Council public health team have been funding some activity for contraception for medical reasons which should have been funded by the CCG and there are plans in place to address this anomaly and reduce council spending in this area.

Public Health expenditure per service user.

For some public health programmes in York where clear service user activity data is available, it is possible to calculate the cost per service user of providing the programme. For example, the cost per service user in structured substance misuse treatment services in 2014/15 was £1,858,20 and the cost per service user for

smoking cessation services was £623,26[1]. Monitoring these figures over time will enable us to identify whether the efficiency of particular programmes is improving.

Figure 6: Cost per service user for selected public health programmes 2014/15

Programme	Spend 2014/15	Total clients in treatment 14/15	Spend per client in treatment
Substance Misuse	£2,516,000	1,354	£1,858.20
Smoking	£268,000	430	£623.26
Sexual Health (all patients seen)	£2,729,000	8,549	£319.22
Sexual Health (York residents only)	£2,729,000	5,829	£468.18

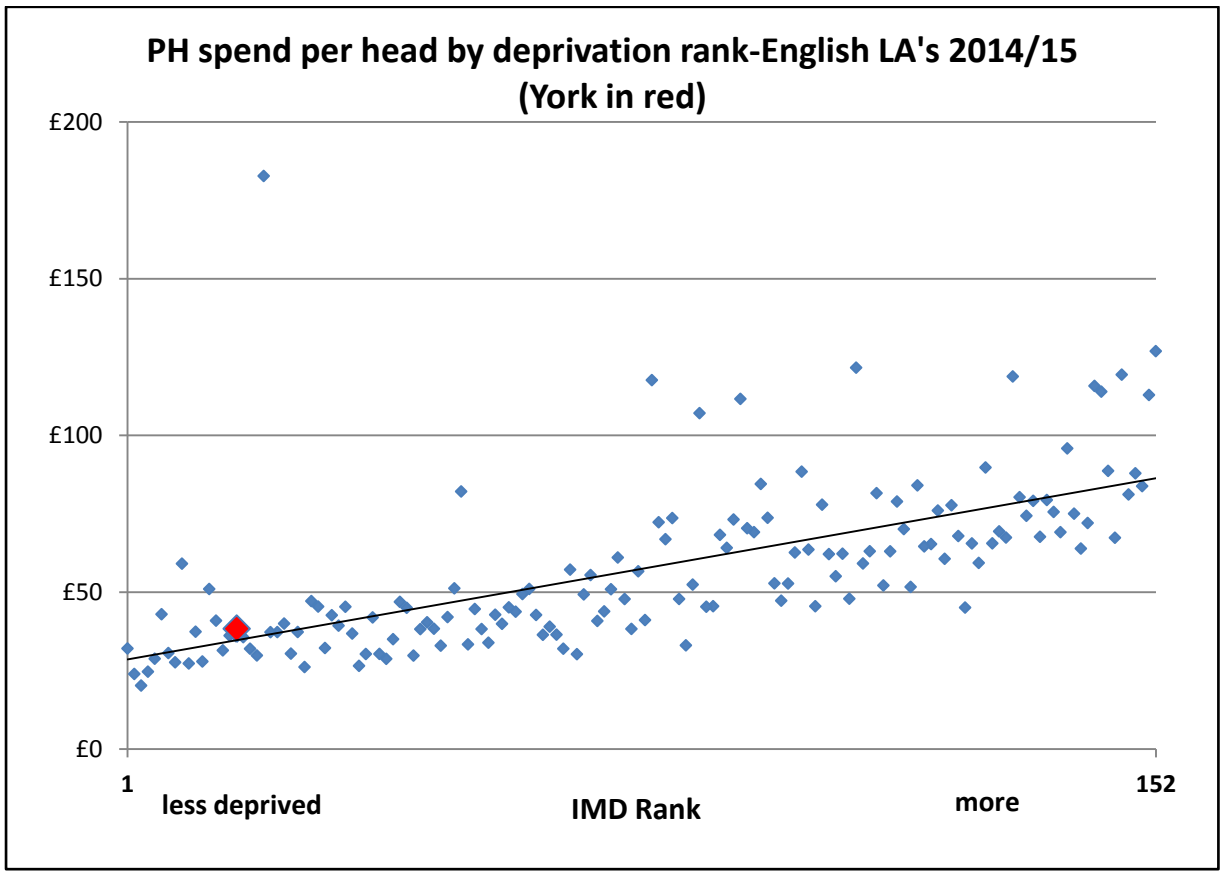
Public health expenditure in relation to deprivation.

If public health expenditure per head for each local authority in England is plotted against the deprivation score for the local authority we can see a pattern whereby spend tends to increase as deprivation increases.

York's position is marked in red on the chart. York is at the 'lower spend-lower deprivation' end of the scale. York has the 40th lowest spend per head and is the 17th least deprived local authority (out of 152).

[1] This figure should not be confused with the 'cost per quitter' figures provided in previous scrutiny reports. For the purposes of this section we are looking at how many service users engage with each programme. For smoking cessation programmes this is the number of people setting a quit date. When looking at outcomes we would look at the number of people actually quitting smoking. The 'cost per quitter' in York is £887 which is double the national and regional averages.

Figure 7: Public Health spend per head by deprivation rank-English LA's 2014/15



It can be seen that there are some local authorities who are 'outliers' in the sense that their spending is disproportionately high compared with their level of deprivation. For example the City of London is the 21st least deprived local authority, only 4 places away from York in the rankings, but around £182 per head is spent on public health compared with the £38 per head spent in York. Many of the outliers are in the London area.

In the SPOT tool York is grouped with 14 other local authorities who have similar levels of deprivation. The average spend is shown below. It can be seen that York's spend is lower than the average however, if the major outlier (City of London) is excluded, York's spend is slightly higher than average.

Figure 8: Public Health expenditure per head of population: York v deprivation decile.

Spend on public health per head of population 2014/15	Value
York	£38.34
Average in deprivation group	£45.92
Average in deprivation group (excl. City of London)	£36.15

Spends v Outcomes

Construction of SPOT charts

The charts below illustrate the way SPOT charts are constructed

- Spend information is plotted on the horizontal axis and outcome information on the vertical axis.
- The red vertical line indicates the average outcomes for England the blue horizontal line indicates the average spend for England. The point of intersection is average spend and average outcome for England
- The quadrants of the chart indicate how well a local authority is doing for an individual area of expenditure and a related set of outcomes. For example if a local authority falls in the bottom right quadrant this indicates a higher spend and worse outcomes.

Figure 9: Construction of a SPOT chart

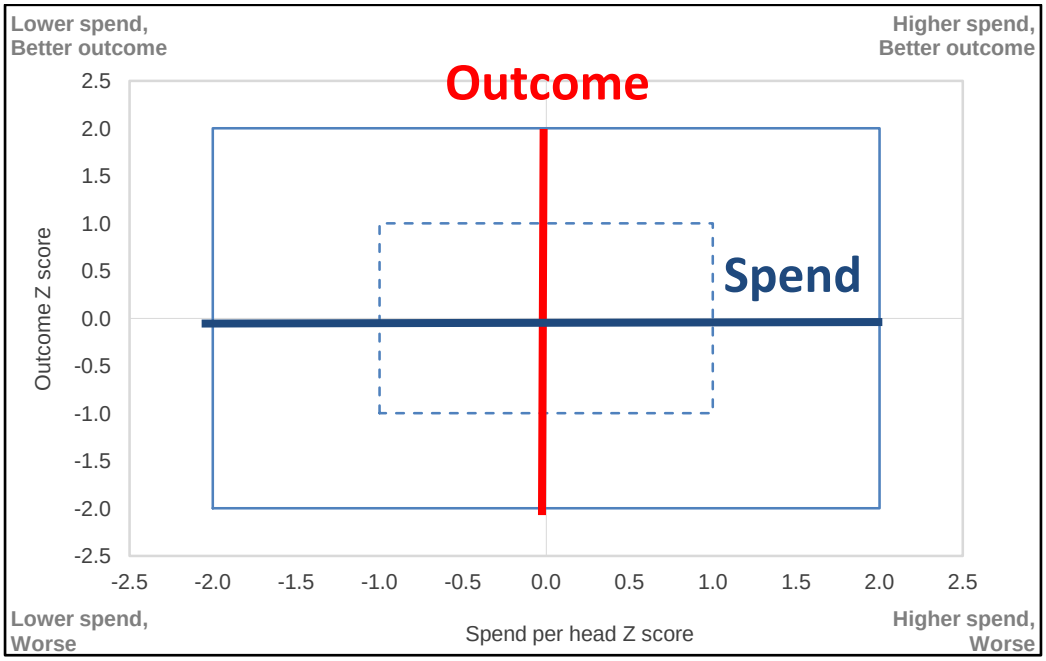
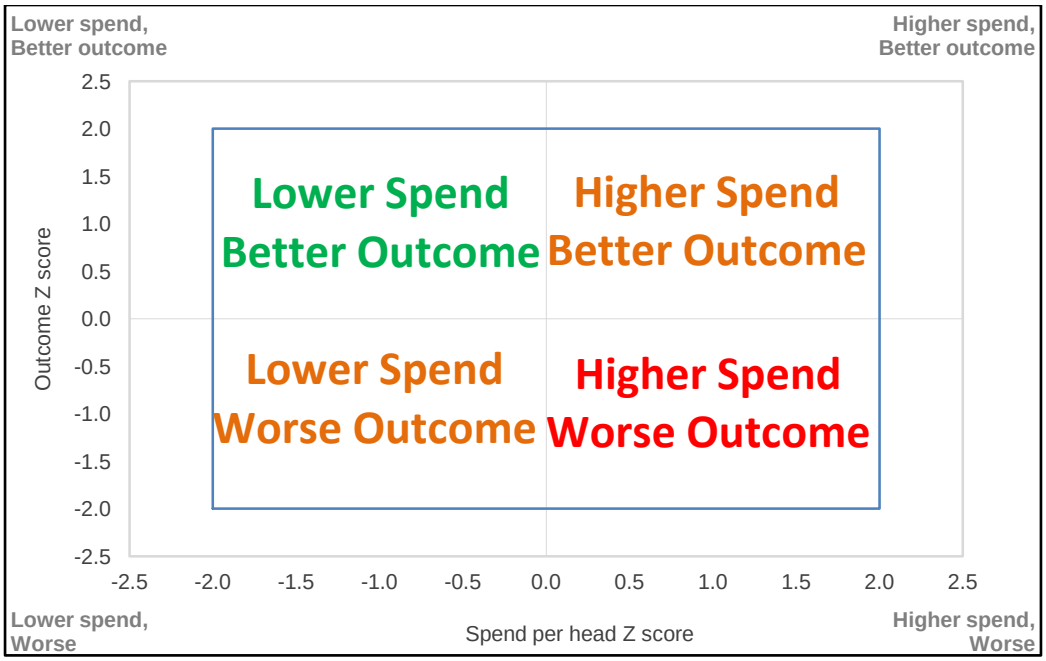


Figure 10: Quadrants of a SPOT Chart

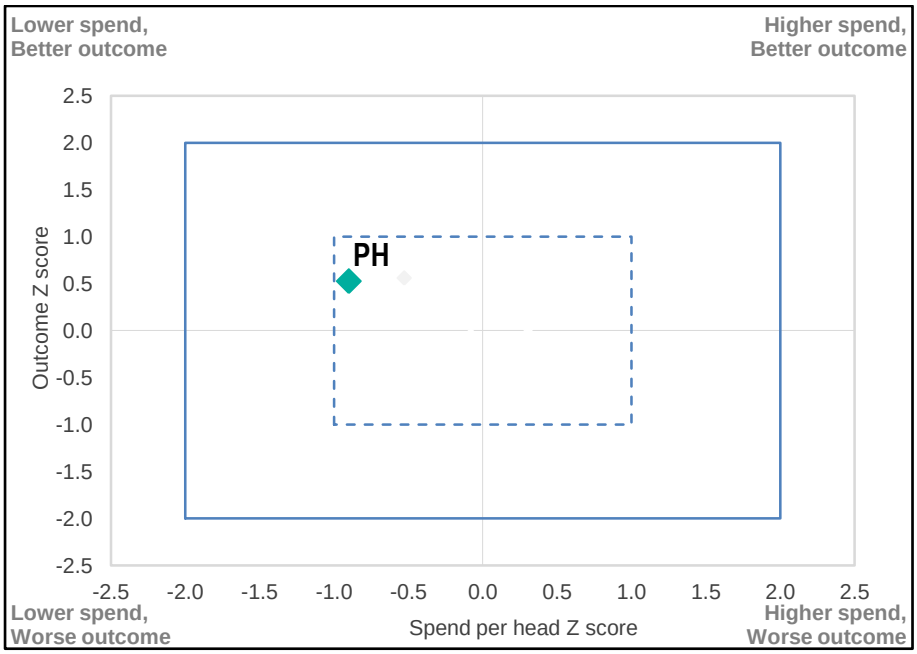


As York has low relative public health expenditure it is likely that we will be on the left hand side of the chart for most spend-outcome combinations.

Public health expenditure v overarching public health indicators

For overall Public Health expenditure and outcomes for 2014/15, York is in the 'lower spend better outcome' quadrant. This was also the case in 2013/14.

Figure 11: Public Health Spend v Outcomes 2014/15

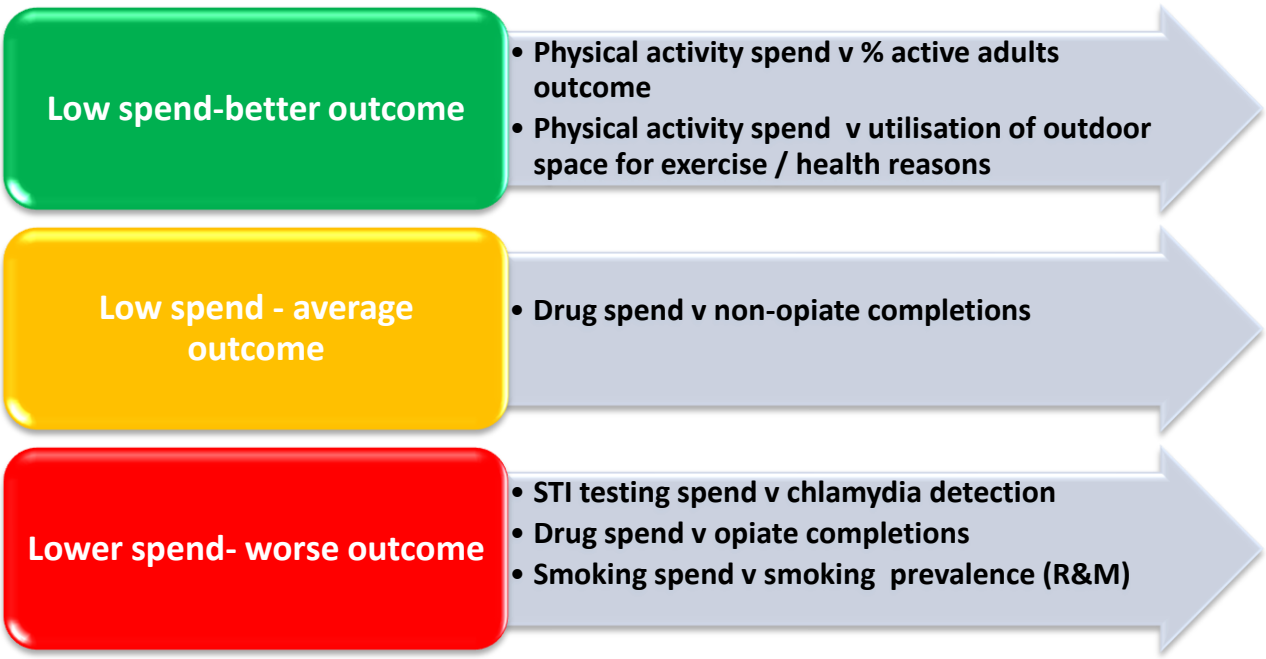


The outcome measures used for this category are life expectancy and healthy life expectancy – the 'overarching' Public health outcomes. Whilst it is a positive finding that York lies in the 'lower spend better outcome' quadrant we know that many things impact on the life expectancy measures as well as spending on public health e.g. the wider determinants of health. It is perhaps more useful to look at specific public health expenditure in relation to specific public health outcomes.

Specific expenditure v specific outcomes

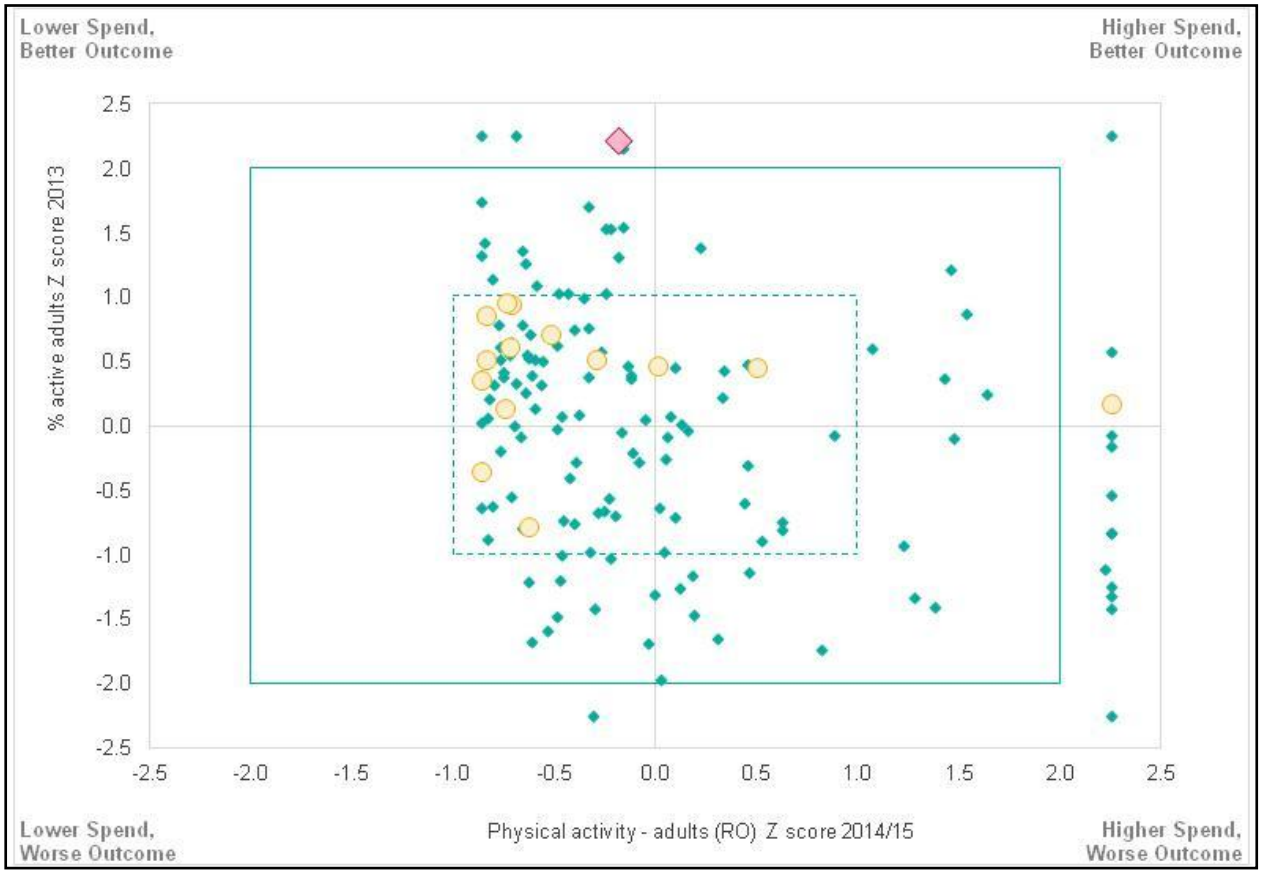
The graphic below shows some examples of public health programmes in York (all of which are classed as lower spend) and whether they have better outcomes, average outcomes or worse outcomes.

Figure 12: Examples of low spend- better outcomes and low spend-worse outcomes programmes in York



As an example, the SPOT chart for expenditure on physical activity in York against the outcome of the percentage of adults in York who are physically active is shown below. The key to the chart is as follows: the large pink diamond shape represents York, the yellow circles show York's deprivation neighbours and the small green diamonds show all the other local authorities in England (the local authorities can all be identified individually on the SPOT tool itself).

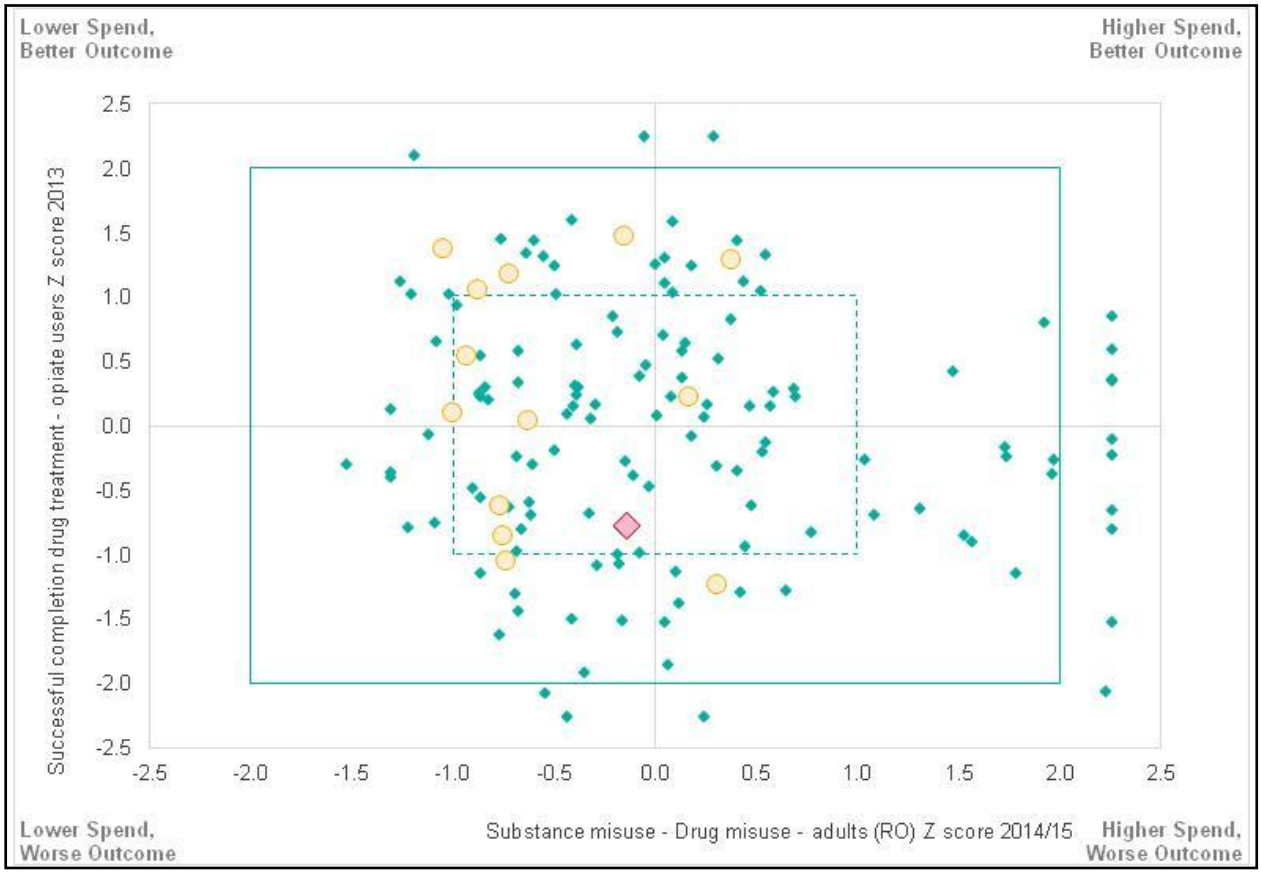
Figure 13: SPOT chart for physical activity expenditure v percentage active adults



The chart shows that York has a slightly lower public expenditure on physical activity but York has one of the best outcomes in the country in terms of adults engaging in physical activity. This is a good example of a 'public health council' in operation as although the direct spend is relatively low, a considerable amount of partnership working and support is provided to other CYC departments and other organisations (e.g. leisure centres, sport clubs, voluntary agencies and universities) to achieve positive outcomes across the city.

Another example is the expenditure on drug treatment against the percentage of opiate users who have a successful completion from drug treatment. York is rated as lower spend, worse outcome.

Figure 14: Adult drug treatment spend v outcomes for opiate users



A practical use of the chart is to identify local authorities with a better rating, for example Calderdale had better outcomes for a lower level of expenditure and it may be useful to contact them regarding their commissioning model as substance misuse service are due to be re-commissioned in York in 2016/17.

Further examples of SPOT charts are shown as appendices.

- Physical activity spend v % Utilisation of outdoor space for health / exercise reasons.
- STI testing spend v chlamydia detection rate
- Smoking cessation spend v smoking prevalence (R&M)
- Overall public health spend v healthy life expectancy for men
- Overall public health spend v healthy life expectancy for women

The SPOT charts can also provide a quick visual representation of York's performance in relation to our deprivation neighbours. For example looking at overall public health expenditure against healthy male life expectancy we do well nationally but less well in relation to our deprivation comparators. For public health expenditure against healthy female life expectancy, however, we do well nationally and also well

in relation to our deprivation comparators (see relevant SPOT charts in the appendices).

With pressures on public health budgets, particularly those programmes which account for the largest share of expenditure such as substance misuse and sexual health it can be seen that there are some risks and challenges. For some areas of these programmes (e.g. chlamydia detection and successful completion of treatment for opiate users) York is already in a lower spend-worse outcome situation so any further reductions in funding could impact negatively on outcomes unless improvements in service design and delivery can be made.

Uses of the SPOT tool

The tool can be used in a number of ways:

- Identifying local authorities who are achieving better outcomes for a similar level of expenditure (or achieving the same outcomes for less money) for specific programmes
- Providing a baseline against which future spend and outcome combinations can be measured
- Identifying risks and challenges i.e. programmes where spends and outcomes are already low and future cuts are planned or necessary.

Caveats about using SPOT tool

- The tool uses current spend against latest indicators. In some cases outcomes may be related more to cumulative expenditure in previous years rather than current expenditure.
- Expenditure on the wider determinants of health e.g. education, housing, leisure, environment etc. also have bearing on health outcomes.
- Some programmes may look less efficient in York due to a smaller population; York can't benefit from economies of scale in programme delivery.
- Local authorities may differ in exactly how they code expenditure so comparison of specific programmes may be flawed. Also the existence of large block contracts for certain programmes may mean that detailed breakdowns

into specific sub-areas of expenditure have to be estimated.

The expenditure data for local authorities used for the SPOT tool is the publically available DCLG General Fund Revenue Account Outturn. To ensure that the public health expenditure is coded in a consistent manner each year it is a recommendation of this report that the Director of Public Health should sign off the public health section of this return.

Changes to public health expenditure: 2015/16

The analysis to date has been done using 2014/15 actual expenditure, however the Public Health budget is undergoing considerable change at present. Some of the key changes in York for 2015/16 are summarised below:

- There was a part year increase in grant funding due to the transfer of the commissioning of 0-5 years children's public health services from NHS England to local authorities from 1st October 2015 (£916k).
- There was an in year grant cut of 509k
- The net impact of the two changes was that the public health grant increased by £407k made up of Children's 0-5 funding (£916k) less the in year grant cut (£509k).
- There were new items of expenditure: children's 0-5 services (901k); air quality contribution (50k); health protection (12k); housing officer (10k) and suicide prevention (9k).
- There were some reductions in expenditure: tender of sexual health contract saved £549k; end of pharmacy contraception service saved £28k and end of funding for soil association project saved £42k (this was a one off project in 2014/15).
- There were some items where existing expenditure increased including staffing (£27k - due to restructure, net figure reduced by vacancies) and Sky Ride (£27k – increased contribution in 2015/16).

Details of the public health grant allocation for 2016/17 are awaited at the time of the report (January 2016).

The key points in relation to future public health spending from the Autumn Statement in November 2015 were as follows:

- The government will make savings in local authority public health spending.
- The government will also consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention.
- The ringfence on public health spending will be maintained in 2016-17 and 2017-18.

The continued pressure on the public health budget means it will be important to improve the performance monitoring of public health contracts to achieve quality of provision and the best possible outcomes in relation to expenditure.

Summary and Recommendations

Summary of Key Points

- In 2014/15 York had a lower spend per head of population on public health compared with regional and national averages.
- The expenditure per head of population on all local authority services in York was also lower than regional and national averages.
- A total of £7.76 M was spent directly on public health in York. The biggest areas of spend were sexual health (£2.7M) and substance misuse (£2.5M).
- 2/3 of the budget was spent on sexual health and substance misuse programmes.
- A higher % of the York budget was spent on sexual health compared with the national average, however York has a relatively high 20-24 year old population.
- York had a higher than average spend per head on contraceptive services, but the reasons for this have been identified
- Public health expenditure was broadly linked to deprivation (except for some London councils).
- The SPOT tool looks at the 2014/15 expenditure in relation to the latest public health outcomes and allocates each local authority to a spend outcome 'quadrant' e.g. low spend-worse outcome or low spend-better outcome.

- York is a 'lower spend higher outcome' authority for overall public health expenditure against overarching life expectancy indicators.
- For expenditure on specific public health programme against specific outcomes there are mixed results.
- A positive rating for physical health expenditure against the 'active adults' outcome is a good example of public health working with other departments and agencies to achieve good outcomes despite lower direct public health spend.
- The tool provides an opportunity to identify local authorities who are achieving better outcomes than York for a similar expenditure e.g. Calderdale for drug expenditure against opiate outcomes.
- There are some positive uses of the SPOT tool (e.g. providing a benchmark and identifying risks and challenges) and some caveats with regards to interpreting the outcomes (e.g. budget coding issues and the lag between expenditures and outcomes).
- Changes to the public health budget in 2015/16 include new areas of expenditure on children's 0-5 services, air quality, health protection, housing and suicide prevention, whilst there were some savings due to the re- tender of the sexual health contract and ending the pharmacy contraception service.
- The government announced that there would be further reductions in local authority public health spending in the Autumn statement in 2015.

Recommendations

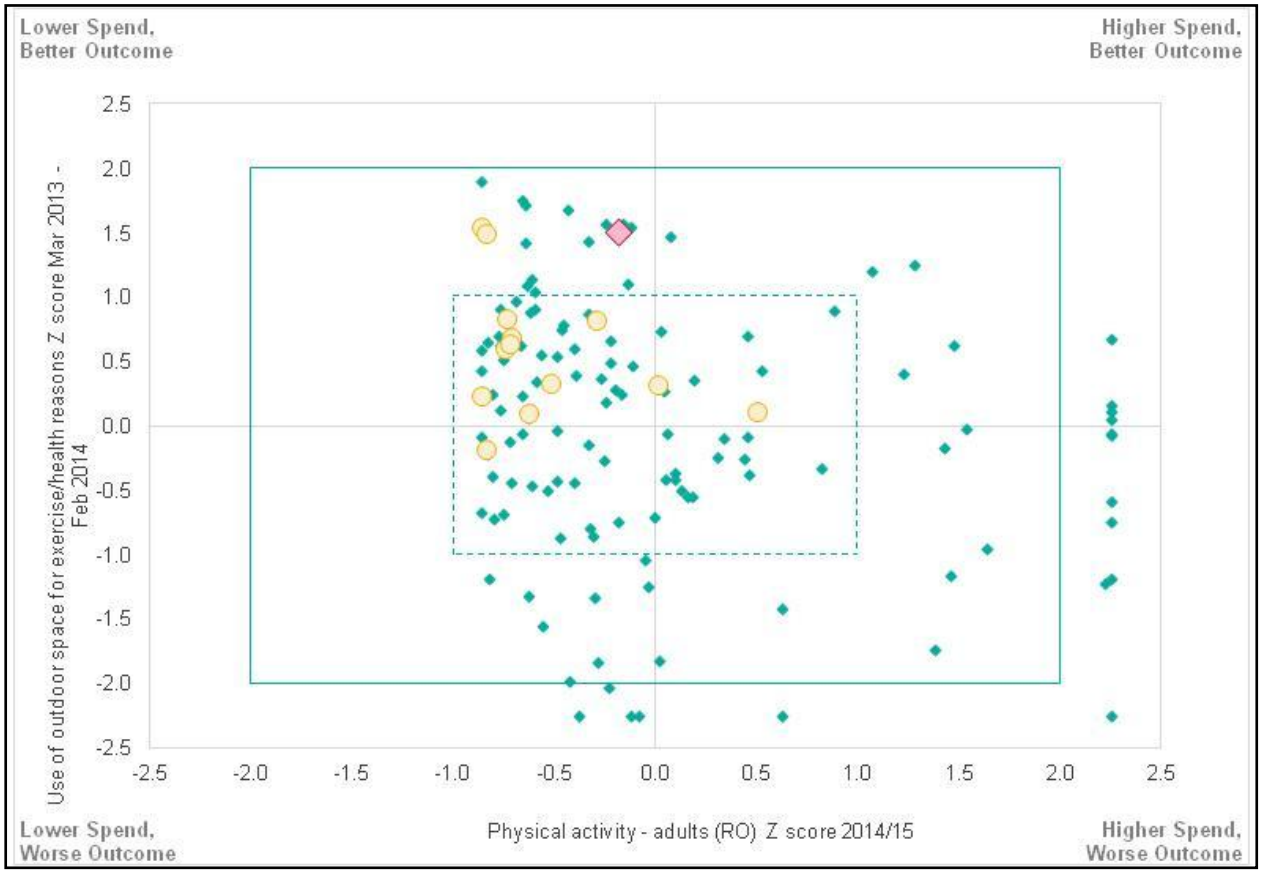
- To use the current SPOT tool ratings as a baseline for monitoring expenditure in relation to outcomes in the future.
- To identify the local authorities who are achieving better spend outcome combinations for specific programmes and to contact them where appropriate.
- Director of Public Health to sign off the public health section of the General Fund Revenue Account Outturn to ensure public health expenditure is coded in a consistent manner each year.
- To improve consistency in the performance monitoring of public health contracts in order to achieve quality of provision and the best possible outcomes in relation to expenditure.

- To be aware of the programme areas currently rated as ‘low spend worse outcomes’ and to be mindful of the potential implications should further reductions in expenditure on these programmes be required.
- To use the NICE value for money tools and guidance when commissioning public health programmes to ensure that services have a robust evidence base in relation to delivering outcomes against expenditure.

Appendices

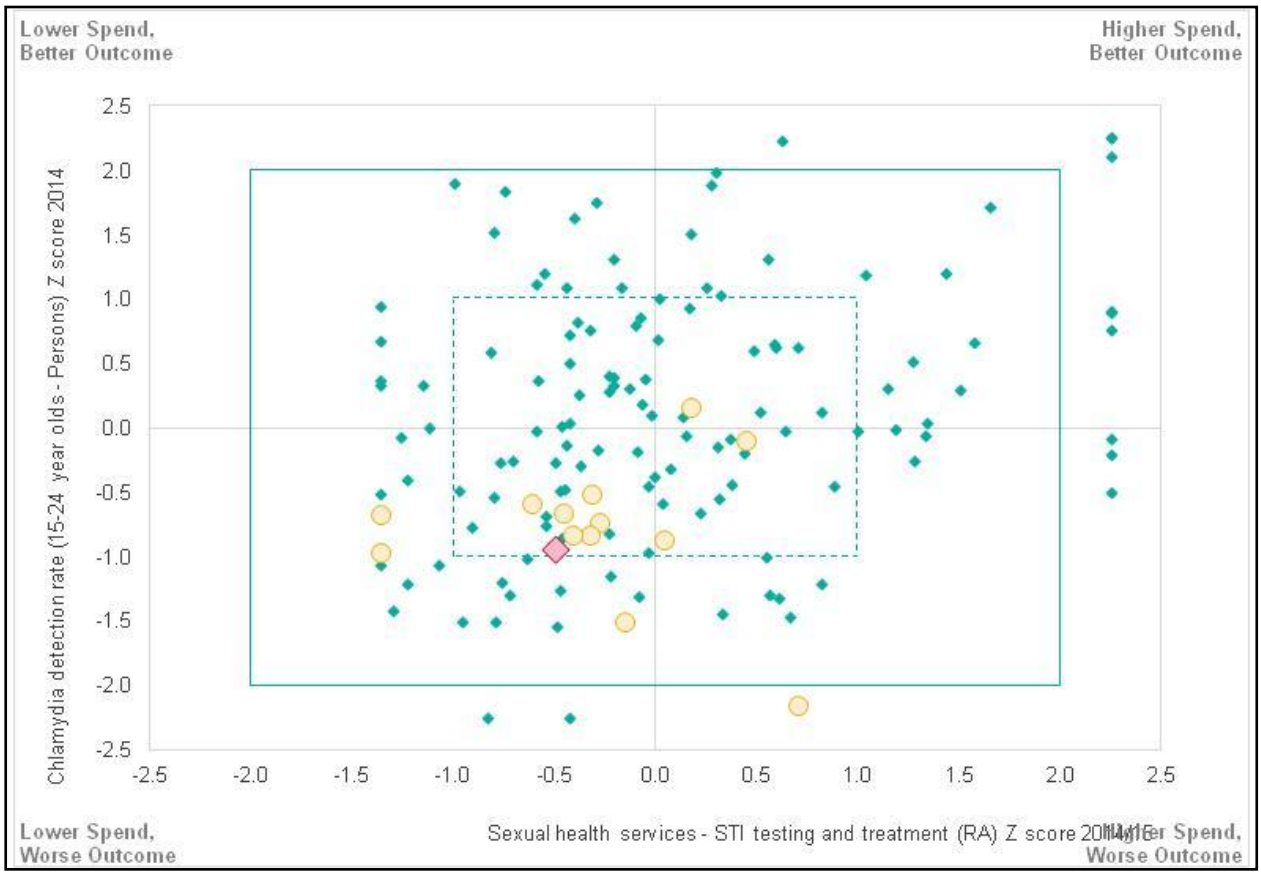
Index of Tables and Charts

SPOT chart for Physical Activity spend v % Utilisation of outdoor space for health / exercise reasons.



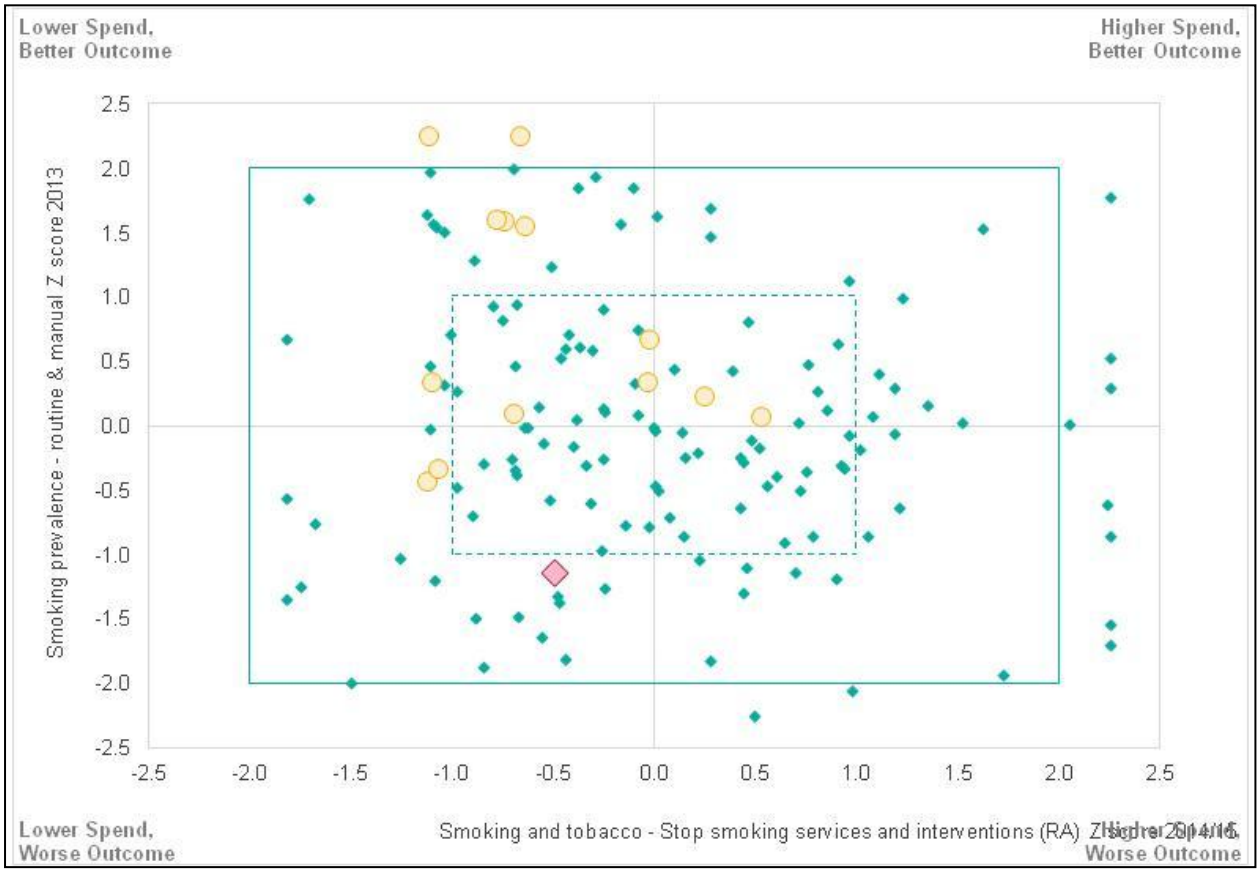
York is rated as 'lower spend, better outcome'.

SPOT chart for STI testing spend v chlamydia detection rate



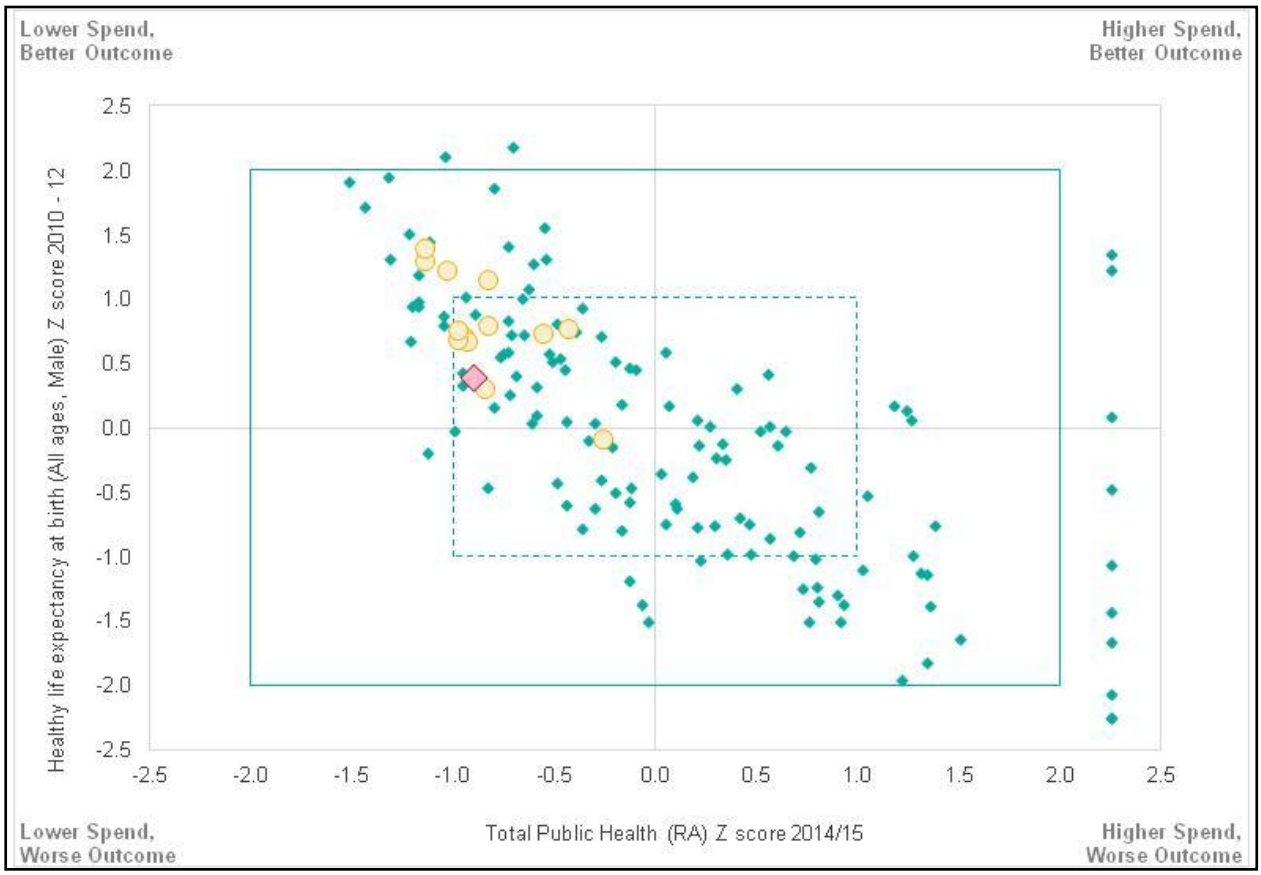
York is rated as 'lower spend, worse outcome'.

SPOT chart for smoking cessation spend v smoking prevalence (R&M)



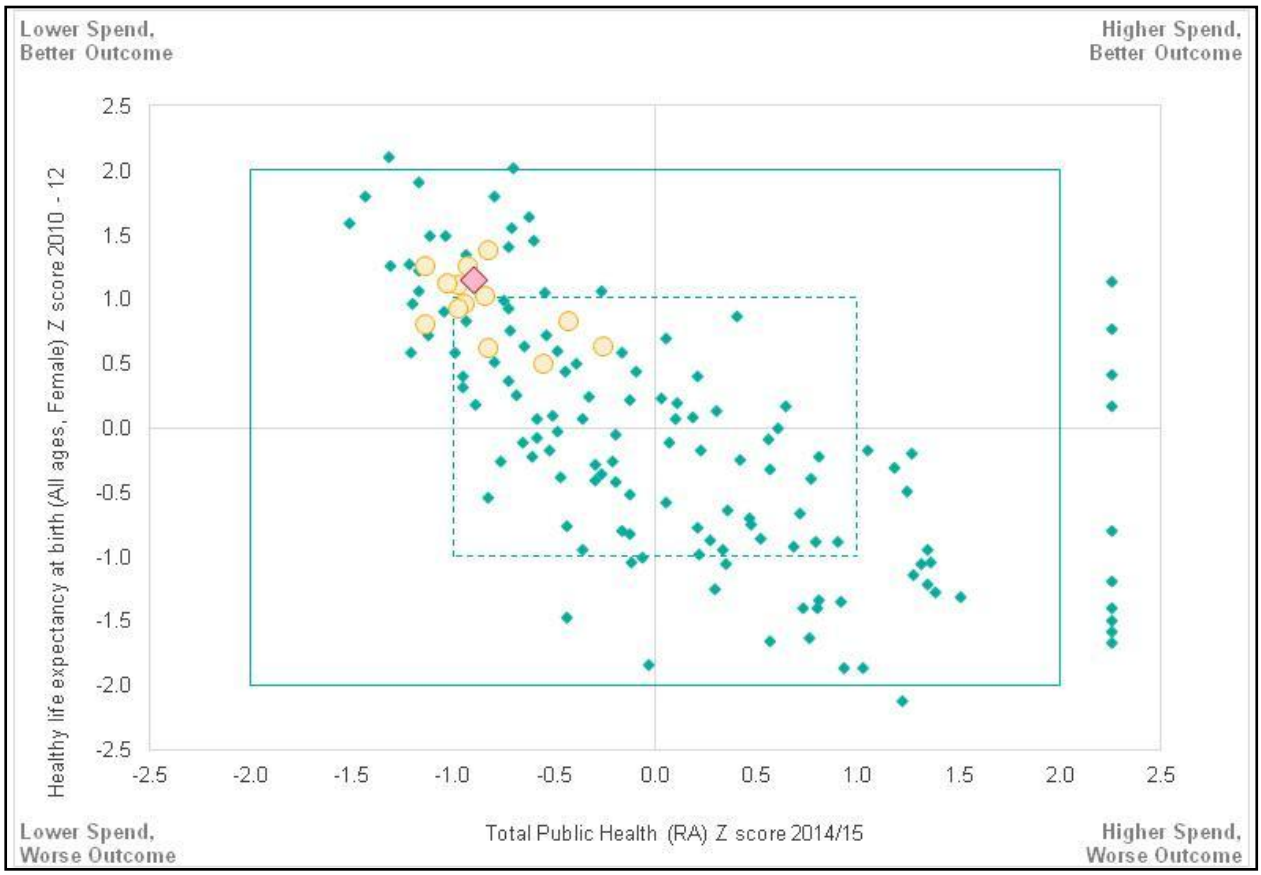
York is rated as 'lower spend, worse outcome'. NB East Riding have better outcomes for similar spend

SPOT chart for overall public health spend v healthy life expectancy for men



York is rated as 'lower spend, better outcome' nationally. But note how deprivation neighbours have better outcomes still.

SPOT chart for overall public health spend v healthy life expectancy for women



York is rated as 'lower spend, better outcome' nationally. York also has good outcomes v deprivation neighbours as well.

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Health & Adult Social Care Policy & Scrutiny Committee Work Plan 2016-17

Meeting Date	Work Programme
Wednesday 22 June 2016 @ 5.30pm	1. Attendance of Executive Member for Health and Adult Social Care to explain her challenges and priorities for the municipal year 2. Be Independent End of Year Position 3. Verbal update on Bootham Park Hospital Scrutiny Review 4. Work Plan 2016/17
Tues 19 July @ 4pm	1. End of Year Finance & Performance Monitoring Report 2. TEWV report on consultation for proposed new mental health hospital for York. 3. Safeguarding Vulnerable Adults Annual Assurance report 4. Position report on Healthy Child Service Board 5. Pre-decision Report on Re-procurement of Substance Misuse Treatment and Recovery Services 6. Work Plan 2016/17
Wed 28 Sept @ 5.30pm	1. Health & Wellbeing Board six-monthly update report 2. 1st Quarter Finance & Performance Monitoring Report 3. Report on change of services at Archways Intermediate Care Unit 4. Update report on CCG turnaround and recovery plans 5. Bootham Park Hospital Draft Final Report. 6. Work Plan 2016/17

Tues 18 Oct @ 5.30pm	1. Annual Report of the Chief Executive of York Teaching Hospitals NHS Foundation Trust. 2. Further update on actions against York Hospital Action Plan. 3. Tees, Esk and Wear NHS Foundation Trust – One Year On in York 4. Work Plan 2016/17 **Circulated Reports** 5. Front Street / Beech Grove GP Practice Mergers 6. Re-procurement of community services and wheelchair services.
Wed 30 Nov @ 5.30pm	1. Healthwatch six-monthly Performance Update report 2. 2nd Quarter Finance & Performance Monitoring Report 3. Briefing Report on Ambulance Cover in York. 4. Update Report on STP 5. Further Update report on CCG turnaround and recovery plans. 6. Work Plan 2016/17 **Circulated Reports** 7. Update Report on Archways and Home-Based Care 8. Update Report on Winter Pressures
Tues 20 Dec @ 5.30pm	1. Update Report on Elderly Persons' Homes 2. Six-monthly Quality Monitoring Report – Residential, Nursing and Homecare Services.

	3. Be Independent six-monthly update report 4. Draft report on new Joint Health & Wellbeing Strategy 5. Healthwatch York six-monthly Performance Update Report (deferred from November) 6. Work Plan
Mon 30 Jan 2017 @ 5.30pm	1. Safeguarding Vulnerable Adults Six-Monthly Assurance Report 2. Update Report on Healthy Child Service 3. Update Report on CCG Improvement Plan including: • Delayed Transfer Of Care • Continuing Health Care • Partnership Commissioning Unit 4. Work Plan 2016/17
Mon 27 Feb 2017 @ 5.30pm	1. 3rd Quarter Finance & Performance Monitoring Report 2. Yorkshire Ambulance Service CQC Inspection report 3. TEWV / CCG report on outcome of consultation for new mental health hospital 4. Update on implementation of recommendations from Bootham Park Hospital Scrutiny Review 5. Work Plan 2016/17
Wed 29 March 2017 @ 5.30pm	1. Bootham Park Hospital – Update Report on NHS England Transfer of Services Action Plans 2. Further Update Report on CCG finance and recovery plan 3. Update Report Public Health Services commissioned by NHS England – vaccinations, immunisations and screening 4. Council Motion – Access to NHS Services 5. Public Health Spending Scrutiny Review Draft Final Report 6. Work Plan 2016/17

Wed 19 April 2017 @ 5.30pm	1. Annual Report of Health & Wellbeing Board. (Deferred from March) 2. Hospital updates on: • Winter experience • Development of community services in light of Archways closure 3. Safeguarding Adults Board Peer review Action Plan (deferred from March) 4. Work Plan 2016/17
Wed 31 May 2017 @ 5.30pm	1. Healthwatch six-monthly Performance Update report. 2. Work Plan 2016/17

June: Six-monthly Quality Monitoring Report – Residential, Nursing and Homecare Services