

**GOVERNING BODY MEETING**

**7 October 2021 9.30am to 11.30am**

**‘Virtual’ Meeting**

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

The agenda and associated papers will be available at:  
[www.valeofyorkccg.nhs.uk](http://www.valeofyorkccg.nhs.uk)

**AGENDA**

<b>STANDING ITEMS – 9.50am</b>				
1.	Verbal	Apologies for absence	To Note	All
2.	Verbal	Declaration of Members’ Interests in the Business of the Meeting	To Note	All
3.		Patient Story <a href="http://www.valeofyorkccg.nhs.uk">NHS Vale of York Clinical Commissioning Group - GP practices in Selby are changing patients' lives with a new approach to their health (valeofyorkccg.nhs.uk)</a> <a href="https://www.youtube.com/watch?v=IsI93C9DxXg">https://www.youtube.com/watch?v=IsI93C9DxXg</a> <a href="https://ockham.healthcare/podcast-selby-town-pcn-classy-care-coordinators/">https://ockham.healthcare/podcast-selby-town-pcn-classy-care-coordinators/</a>	To Receive	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
4.	Pages 4 to 16	Minutes of the meeting held on 1 July 2021	To Approve	Dr Nigel Wells CCG Clinical Chair
5.	Pages 17	Matters arising from the minutes		All

6.	Pages 18 to 37	Accountable Officer Update	To Receive	Phil Mettam Accountable Officer
7.	Pages 38 to 65	Quality and Patient Experience Report	For Decision	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
8.	Verbal	Coronavirus COVID-19 Update	To Note	Michelle Carrington Executive Director of Quality and Nursing / Chief Nurse
9.	To Follow	Board Assurance Framewo	To Receive	Abigail Combes Head of Legal and Governance
<b>ASSURANCE – 10.40am</b>				
10.	Pages 66 to 104	Learning Disability Mortality Review Programme Annual Report 2020/21	To Receive	Michelle Carrington Executive Director of Quality and Nursing/ Chief Nurse
11.	Pages 105 to 114	North Yorkshire and York CCGs Safeguarding Children and Children in Care Annual Report 2020/21	To Receive	Michelle Carrington Executive Director of Quality and Nursing/ Chief Nurse
12.	Pages 115 to 165	City of York Safeguarding Children Partnership Annual Report 2020/21	To Receive	Michelle Carrington Executive Director of Quality and Nursing/ Chief Nurse
<b>FINANCE – 11.10am</b>				
13.	Pages 166 to 176	Financial Performance Report 2021/22 Month 5	To Receive	Simon Bell Chief Finance Officer
14.	Pages 177 to 194	Update to Detailed Scheme of Delegation	To Approve	Simon Bell Chief Finance Officer

**RECEIVED ITEMS – 11.25am****Committee minutes are published as separate documents**

15.	Pages 195 to 196	Chair's Report Audit Committee: 15 July 2021
16.	Page 197	Chair's Report Executive Committee: 23, 30 June, 7, 20, 28 July, 4, 25 August, 1, 8, 15 and 22 September
17.	Pages 198 to 199	Chair's Report Finance and Performance Committee: 24 June, 22 July and 26 August 2021
18.	Page 200 to 201	Chair's Report Primary Care Commissioning Committee: 22 July 2021
19.	Pages 202 to 204	Chair's Report Quality and Patient Experience Committee: 10 June, 8 July and 9 September 2021
20.	Pages 205 to 210  211 to 246	1. Medicines Commissioning Committee Recommendations: June 2021  2. North Yorkshire and York Area Prescribing Committee: July and August 2021 Recommendations, Terms of Reference, Guidelines on defining red, amber, green drug status and New product request form

**NEXT MEETING**

21.	Verbal	9.30am, 2 December 2021	To Note	All
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**CLOSE – 11.30am****EXCLUSION OF PRESS AND PUBLIC**

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

**Minutes of the 'Virtual' Meeting of the NHS Vale of York Clinical Commissioning Group Governing Body on 1 July 2021**

**Present**

Dr Nigel Wells (NW) (Chair)	Clinical Chair
Simon Bell (SB)	Chief Finance Officer
David Booker (DB)	Lay Member and Chair of Finance and Performance Committee
Michelle Carrington (MC)	Executive Director of Quality and Nursing / Chief Nurse
Dr Helena Ebbs (HE)	North Locality GP Representative
Phil Goatley (PG)	Lay Member, Chair of Audit Committee and Remuneration Committee
Julie Hastings (JH)	Lay Member, Chair of Primary Care Commissioning Committee and Quality and Patient Experience Committee
Phil Mettam (PM)	Accountable Officer
Denise Nightingale (DN)	Executive Director of Transformation, Complex Care and Mental Health
Dr Chris Stanley (CS)	Central Locality GP Representative

**In Attendance (Non Voting)**

Abigail Combes (AC) – item 8	Head of Legal and Governance
Dr Andrew Moriarty (AM)	YOR Local Medical Committee Locality Officer for Vale of York
Michèle Saidman (MS)	Executive Assistant

**Apologies**

Stephanie Porter (SP)	Interim Executive Director of Primary Care and Population Health
Sharon Stoltz (SS)	Director of Public Health, City of York Council
Dr Ruth Walker (RW)	South Locality GP Representative

Eleven members of the public watched the “live stream”.

In welcoming everyone to the meeting NW explained that, although the CCG's constitution stated six meetings a year would be held in public, there was an agreement this number may be reduced in view of the transition. Future dates would therefore be confirmed in due course. NW additionally advised that the CCG's AGM would be on the afternoon of Thursday 16 September 2021; the format would be confirmed.



## **STANDING ITEMS**

### **1. Apologies**

As noted above.

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

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

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

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

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

### **4. Minutes of the Meeting held on 6 May 2021**

The minutes of the 6 May meeting were agreed.

#### **The Governing Body:**

Approved the minutes of the meeting held on 6 May 2021.

### **5. Matters Arising from the Minutes**

Matters arising were either ongoing or would be included in discussion of agenda items.

### **6. Accountable Officer's Report**

PM referred to the report which provided updates on the local and system financial position; recovery and transformation; primary care protected learning time; and emergency preparedness, resilience and response.

PM highlighted that a number of financial risks were emerging in respect of the financial position for the first half of 2021/22. Clarity was awaited regarding national resources for the second half of the year. PM emphasised that the robust monitoring via the Finance and Performance Committee continued.

In respect of recovery and transformation PM advised that work was taking place to transform service delivery to meet the increased demand. He referred to the

unprecedented demand in many service areas which was in excess of national, regional and local forecasts. In the acute sector demand was particularly high in urgent and emergency care, notably for children and young people with respiratory concerns. For primary care the significant pressures continued to increase with such as social distancing and infection prevention control measures impacting on ability to accommodate demand.

PM noted the national transition to Integrated Care Systems and explained that Humber, Coast and Vale Integrated Care System intended to have shadow governance arrangements in place from November 2021 in preparation for April 2022. In this context PM referred to NW's introductory remarks about reducing the number of Governing Body meetings in public for the remainder of the year emphasising that the committee structure would continue to ensure governance relating to financial controls, monitoring quality and safety of services and the CCG's statutory duties.

With regard to the transition PM highlighted that the Talent Framework to manage HR processes was still awaited. He assured members that the CCG was working to provide reassurance to staff in the meantime and that reporting in this regard would continue through the committee structure.

NW referred to the protected learning time on 6 July advising that the focus would be on Practice and personal resilience for practitioners and use of IT solutions for patient access. This was a welcome opportunity to share best practice.

With regard to the reduction in the number of Governing Body meetings, PG sought clarification about how committees would escalate concerns. PM responded that as part of the new operating model a protocol would be agreed to ensure appropriate escalation and, if required, an exceptional Governing Body meeting would be arranged.

In response to DB referring to the External and Internal Audit arrangements through the transition PG noted the expectation that the former would focus on the CCG's statutory accounts perspective and the latter would continue to provide assurance, though may adopt a more flexible approach, and would also have a separate role both within the transition and the Integrated Care System. SB additionally noted, although he was not a member of the Audit Committee, he would expect a balanced approach to risk reporting. He also noted that from the national Integrated Care System Operating Framework, which would be transcribed to local guidance, and emerging information, financial arrangements were not expected to be in place before 1 April 2022 and there would be a further year of transition for finance.

In response to the Lay Members enquiring further about availability of information relating to staff, MC advised that employment commitment guidance for below Board level had been issued the previous week, including clarification that roles and job descriptions were not likely to change in the short term, and, a letter from Stephen Eames, Chief Executive and System Lead, Humber, Coast and Vale Health and Care Partnership, had been circulated to staff the previous day. MC confirmed that staff would TUPE to the Integrated Care System with the associated protection rights.

## The Governing Body:

Received the Accountable Officer report.

### 6. Quality and Patient Experience Report

In presenting this report MC highlighted that the June Quality and Patient Experience Committee had been a focused meeting on quality in primary care and medicines management. The presentations, appended to the Governing Body report, had comprised Primary Care Engagement and Feedback, Primary Care Networks End of Year Report and Medicines Management Team Workstreams.

MC explained that the CCG did not have the same contractual arrangements for assurance with primary care as with other commissioned services but was reliant on relationships, voluntary sharing of information, regulatory reports and patient feedback. She expressed appreciation to primary care colleagues for progress within the areas of quality and safety assurance.

In respect of the focused Quality and Patient Experience Committee MC noted Healthwatch representation had welcomed the positive patient feedback discussion following their recent report on access to primary care. She highlighted the achievements of the Primary Care Networks, commending such as the exceeding of targets for health checks for people with a learning disability, the new roles to meet patient needs in different ways and the response to COVID-19. MC also noted that the Medicines Management Team was now giving consideration to quality and safety assurance and associated risk following the presentation of their projects. As with all services, discussion was taking place as to where Medicines Management should sit to ensure best value for this specialist area.

MC referred to the risks monitored by the Quality and Patient Experience Committee which were currently stable. She noted for example that, following the Statement of Action, progress was being made with QN 09 *SEND Inspection and failure to comply with National Regulations*.

MC provided updates on the risks managed by the Governing Body:

- QN 13 *Hepatitis B vaccine in renal patients*: Patients were still being looked after safely in primary care pending a date for the transfer of this service from primary to secondary care, as previously reported. The CCG had agreed to cover the increased cost.
- QN 18 *Potential Changes to North Yorkshire County Council commissioned Healthy Child Programme*: Publication of the outcome of the consultation was awaited. This had been delayed due to both the pandemic and to respond to feedback. The CCG had mitigated part of this risk by employing someone to represent primary care at Child Protection Conferences.
- QN 23 *Care Quality Commission Regulatory Notice in place for Tees, Esk and Wear Valleys NHS Foundation Trust*: The Care Quality Commission had identified areas of concern around risk assessment and were undertaking

further assessments including community and forensic units in advance of a Well Led inspection later in the month. The CCG continued to support the Trust and had identified no further concerns.

MC explained from the Humber, Coast and Vale Health and Care Partnership perspective that the national Quality Board had provided an interim statement; quality metrics and toolkits were now expected to support the system. The Quality Surveillance Group, the top tier forum for raising concerns, was being replaced by system quality groups which would be led by the Integrated Care System instead of NHS England and NHS Improvement. As these new groups would also be responsible for quality improvement their membership would be required to include provider collaborative and improvement resource representation. MC noted that locally the Quality Surveillance Group had held a number of workshops in preparation for this change.

With regard to transition arrangements MC explained that NHS England and NHS Improvement was establishing programmes of work on the developing Integrated Care Systems. She and NW were respectively members of the Quality and the Clinical Leadership programmes but were ensuring close collaboration in the context of "quality is everybody's business" being the golden thread. MC also referred to publication of the Design Framework which described the roles required in the Integrated Care System: statutory roles of Chair and Chief Executive and required roles of Director of Nursing, Medical Director and Director of Finance. Any further appointments would be locally determined.

Detailed discussion ensued in response to DB expressing concern about the negative receptionist feedback on the engagement presentation and emphasising the need to support frontline staff. Whilst recognising the negative impact on patients from the current significant pressure on appointments, HE stressed that rudeness and verbal abuse was unacceptable under any circumstances emphasising that GPs understand the patient perspective and were working tirelessly to meet demand as safely as possible. She also noted the context of media and social media rhetoric, highlighted the perspective of health professionals feeling compromised at not being able to provide the service they would wish to and recognition that safety may also become compromised as a result of pressure across the system. However primary care was trying to manage as well as possible in the present challenging circumstances.

AM concurred with HE's description additionally emphasising capacity as the issue and the public perception that this was limitless. He regretted that it was not possible to meet patient expectations at this time, also emphasising that the Local Medical Committee understood the patient perspective. With regard to the issue of abuse AM commended the CCG's support to Practices and the public messaging campaigns.

NW additionally noted that demand was outstripping capacity in many sectors of the NHS. From the long term perspective consideration was required about such as self care, IT literacy, linked in health education and schooling.

JH reiterated that abuse of staff was unacceptable. She highlighted the need for

messaging to the public emphasising that care was being delivered but in a number of different ways, including face to face when it was considered to be required.

Discussion from the perspective of the CCG legacy and the transition to the Integrated Care System included: the need to refocus on population health and address inequalities; the importance of digital literacy including in terms of management of long term conditions; clear communication with the public; the context of working at 'place'; and emphasis on the continuing importance of and integral role of organisations across the voluntary sector and social enterprise whose support to such as the Primary Care Networks' vaccination programme had been invaluable.

### **The Governing Body:**

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

In relation to the risk register:

- Confirmed assurance that risks to quality and safety for the CCG were identified with appropriate mitigations in place.

## **7. Coronavirus COVID-19 Update**

In view of SP's apologies to the meeting an update, Appendix A, is attached to the minutes.

MC additionally reported a local increase in case numbers, higher than the national average and mainly the Delta variant. Although not necessarily converting to serious illness, this was contributing to the increase in A&E attendance.

MC additionally reported a local increase in case numbers, twice the national average and mainly the Delta variant. Although not necessarily converting to serious illness, this was contributing to the increase in A&E attendance.

With regard to the vaccination programme MC highlighted: the vaccine was now being offered to anyone over 18, the national 'Grab a Jab' opportunity, and the commitment that all over 18s will be offered at least one dose by 19 July. She referred to the end of year Primary Care Network reports that illustrated the work undertaken in this regard but also emphasised that, dependent on vaccine supply, work was continuing with Council colleagues in terms of ensuring everyone, including harder to reach groups, was offered the vaccination.

MC reported that there had been an outbreak of COVID-19 in a care home where, despite having had both their vaccinations, two members of staff, who were not specifically connected, had been identified through routine testing.

MC noted a rise in respiratory illness, not COVID-19, in children and advised that national surge plans were required for the expected surge at different times of the

year than usual. MC noted that work was taking place locally in this regard, including opportunities to work with primary care to look after particularly the under fives. NW additionally noted that regional and local discussions were taking place regarding paediatric attendances at A&E and the potential surge in RSVs (Respiratory Syncytial Virus)

In response to areas of clarification sought by AM, MC confirmed that the CCG was working with Public Health on clearer local messaging about the need for PCR tests for anyone with symptoms, also noting the recently added symptoms. With regard to evidence that personal protective equipment, namely masks, was not as effective against the Delta variant MC advised there had been no further information. In respect of the apparent perception by some members of the public that the pandemic was over MC emphasised that the CCG would maintain a cautious approach to the lifting of restrictions and continue to be guided by advice from Public Health and infection and vaccination rates.

### **The Governing Body:**

Noted the update

*AC joined the meeting*

## **8. Board Assurance Framework**

In referring to the Board Assurance Framework AC highlighted that the risk relating to the Care Quality Commission regulatory notice in place for Tees, Esk and Wear Valleys NHS Foundation Trust was included in DN's slide as it was specific to mental health but could equally have been reported under MC's quality slide. AC noted that new information was colour coded and there were significantly fewer risks than historically.

AC advised that NECS (North of England Commissioning Support) had provided a new risk relating to cyber security which had just been added to the Finance and Performance Committee Risk Register as directed by Internal Audit for the CCG's Information Governance Toolkit. This risk had scored eight which was regarded as tolerable risk for NECS and had only been added for purposes of passing the Data Protection Toolkit.

### **The Governing Body:**

Received the Board Assurance Framework.

*AC left the meeting*

## **ASSURANCE**

## **9. 2020/21 Annual Report and Accounts**

SB referred to the Annual Report and Accounts which had been approved by the Audit Committee on 28 May 2021 noting these had been prepared in line with all

relevant guidance and timetables. All audit findings were unqualified with no matters to report or concerns to highlight.

PG advised that the Audit Committee had commended SB, the Finance Team and colleagues involved in producing the documents, particularly in the context of the current remote working. He also noted the consistently positive commentary from both External and Internal Audit throughout the year highlighting the latter had awarded the two highest levels of assurance for all audits. PG additionally highlighted that he, DB and JH had written a letter of appreciation to all staff congratulating them on their unprecedented efforts.

PM wished to record thanks to the Audit Committee and Finance Team for the clean bill of health, and to everyone who contributed to the Annual Report.

### **The Governing Body:**

Ratified the 2020/21 Annual Report and Accounts.

## **FINANCE**

### **10. Financial Performance Report 2021/22 Month 2**

In presenting this report SB emphasised that the CCG's realistic and transparent approach to managing the financial position would continue. He advised that, although there was a small year to date overspend, a break-even position was forecast in line with the H1, i.e. April to September 2021, plan. SB explained that an increase in continuing healthcare costs was a particular concern with a potential c£2m overspend in the first six months. This was due in the main to increased numbers of fast track and fully funded packages of care as a result of support to maintain acute sector capacity both in response to COVID-19 and to help manage the backlog of people waiting.

SB advised that, except for Funded Nursing Care which was underspent, other budgets were forecast to be largely in line with plan. He emphasised there was no plan to change the CCG's approach to forecast, control and management of the spend. An operational action plan was being implemented in respect of the continuing healthcare overspend with due regard to the overall system position not only in terms of elective activity and emergency capacity but also the overall financial position.

SB reported that given this forecast position, and after including a review of balance sheet, there remained a risk to the break-even plan and forecast of c£1.5m. He noted the advantage of awareness early in the year but also referred to the context of the funding allocation and the expectation that this would be further reduced in the second half of the year. SB highlighted the risk share agreement in place across the Humber, Coast and Vale Integrated Care System to manage the overall system position.

In respect of significant areas outwith the CCG's allocation SB referred to two areas that were subject to reimbursement. He advised that the Hospital Discharge

Programme, managed across Health and Wellbeing Board areas, was expected to be manageable within budget, but the national Elective Recovery Fund of £1bn was currently thought to be oversubscribed by 2:1. Work was taking place in respect of the latter in terms of impact on local financial plans and flexibility.

SB noted that, due to guidance being issued late and developmentally, there was no certainty yet about material elements including the Hospital Discharge Programme and the Elective Recovery Fund. He emphasised that the position would become more challenging in the second half of the financial year with a requirement for increased levels of efficiency and spending control.

### **The Governing Body:**

Received the month 2 Financial Performance Report.

### **RECEIVED ITEMS**

The Governing Body noted the following items as received:

11. Audit Committee chair's report and minutes of 22 April and 28 May 2021.
12. Executive Committee chair's report and minutes of 28 April, 5, 12, 19, 26 May, and 2, 9 and 16 June 2021.
13. Finance and Performance Committee chair's report and minutes of 22 April and 27 May 2021.
14. Primary Care Commissioning Committee chair's report and minutes of 27 May 2021.
15. Quality and Patient Experience Committee chair's report and minutes of 13 May 2021.
16. Medicines Commissioning Committee Recommendations of March, April and May 2021.
17. **Next Meeting**

Date to be confirmed.

PM reiterated appreciation to everyone who had contributed to the CCG's 2020/21 end of year position. NW both added his appreciation and also thanked all health and social care staff for their work.

### **Close of Meeting and Exclusion of Press and Public**

In accordance with Paragraph 8 of Schedule 2 of the Health and Social Care Act 2012 it was considered that it would not be in the public interest to permit press and public to attend this part of the meeting due to the nature of the business to be



transacted as it contains commercially sensitive information which, if disclosed, may prejudice the commercial sustainability of a body.

A glossary of commonly used terms is available at:

<https://www.valeofyorkccg.nhs.uk/about-us/governing-body-meetings/>

## Covid-19 vaccination programme update

The vaccination programme continues to work well in York and North Yorkshire. With all citizens over the age of 18 now eligible. Colleagues will be aware that nationally the availability of vaccines is being managed to move resources to support areas with greatest needs and this changes frequently based on transmission and infection rates.

As of 01 July, at the time of writing this report the vaccination rates for the Vale of York CCG were as follows:

CCG population	Total Population covered	Eligible population	First doses undertaken	Second Doses undertaken	% First Doses delivered	% Second Doses delivered
Vale of York	366,268	303,354	244,925	178,162	80.7%	74.2%
City of York	213,885	179,926	137,968	95,965	76.7%	53.3%

## COVID vaccination programme – work on inclusivity

Together with system partners, most notably Primary Care Networks/Public Health/CYC Contract Tracers/Nimbuscare we have been working to identify any barriers which impact on the uptake of the vaccine and members of the Governing Body have heard already about initiatives such as:

- Myth busting comms via social media
- Multi language and accessible information
- Face book live events
- Print media campaigns, nationally and locally.

We have been working in line with the JVCI priorities to ensure that those most vulnerable to serious harm and/or inpatient admission with Covid 19, have achieved the highest levels of uptake of first and second doses.

As part of specific work looking at areas of inequality, we have addressed queries and implemented changes for example:

- Accessibility to our primary sites, creating transport hardship funds, voluntary transport drivers and public transport information. Increasing the utilisation of bus companies, Age UK and York Wheels drivers to assist patients in getting to Local Vaccination Service

- Engagement with local leaders of different groups, including faith leaders
- Bespoke offers for groups to reflect different needs ie campaign to support vaccinations during Ramadan; specialist learning disability clinics; homeless and asylums seeker service and campaigns to highlight the offer to carers
- In our highest outbreak areas, we've also been working with key employers to ensure increased workforce vaccination rates
- Our contract tracers at both CYC and Nimbuscare have called 1500 individuals not yet vaccinated and eligible to understand reasons for non-take up and this data is influencing changes in our approach to vaccination service delivery.

### **Data on differential take up in York Ward areas**

Recently we have been working with public health colleagues at local and regional level to analyse the take up data to understand where we might want to flex our approaches to allow taking up a vaccine to be as easy and straight forward as possible.

A key element to understand is the way in which the NHS has been rolling out eligibility to be vaccinated and the release of vaccines to support the roll out has impacted those wards which have been identified as low uptake. For example:

Those citizens aged 30-31 were eligible for a covid vaccination on 26 May 21.

Those citizens aged 25-29 were eligible for a covid vaccination on 7 June 21.

Those citizens aged 21-22 were eligible for a covid vaccination on 16 June 21.

Those citizens aged over 18 were eligible for a covid vaccination on 18 June 21.

This means that those wards with higher numbers of young people, identified here as 18-30 years of age have only become eligible relatively recently. That's not the case in every ward, and we know we have more to do, but it has impacted on the reported take up figures by ward.

It remains the case that the supply of vaccines influences our volume of service delivery, and under 40s are predominantly offered Pfizer or Moderna, so when we have a surplus of Astra Zeneca in the system there are some restrictions on the offer but supplies for all approved vaccines are now in line with the government initiative of the 'Big Weekend' and beyond as we approach the next key milestone of 19 July in the government roadmap to release restrictions.

### **Vaccination Services over the weekend of Friday 25 June to Monday 28 June**

Nationally, vaccination teams and supplies have been planned for a 'super

weekend' of vaccinations with more pop-up clinics and walk in services for first and second doses and this was to align with a communications campaign to encourage citizens to come and take up the offer. The 'Grab a Jab' campaign aimed to make it easier and more convenient than ever for eligible people who haven't had their vaccine yet to come forward – crucially boosting the numbers of people receiving their first and second dose jabs. In the city of York there were a series of walk-in, pop-up Covid vaccination clinics at venues across the city for the 'Grab a Jab' weekend but the model of walk-in services is now continuing and is seeing good take up.

### York City Centre vaccination services to support wards with low take up

Partners have been adapting approaches to encourage and increase the vaccination take up in wards where to date there has been lower take up, and we are now seeing increased percentage take up, particularly in wards with more younger people increase now all over 18s are eligible. Its improving, but there is still more to do. We've been monitoring vaccination rates in any ward with less than an 80% take up over the last 2 weeks specifically and can show the following progress:

Ward	Eligible population	% 1 <sup>st</sup> dose vaccinated as at 23 June	% 1 <sup>st</sup> dose vaccinated as at 1 July	% 2 <sup>nd</sup> dose vaccinated as at 23 June	% 2 <sup>nd</sup> dose vaccinated as at 1 July
Fishergate	9,033	54.54%	59.58%	34.68%	36.39%
Fulford & Heslington	3,390	76.90%	79.76%	55.99%	58.29%
Guildhall	14,564	52.86%	58.47%	31.63%	32.76%
Heworth	11,219	70.41%	74.72%	47.84%	49.52%
Holgate	10,505	76.81%	79.77%	49.78%	52.01%
Hull Road	15,142	39.66%	48.80%	39.66%	23.91%
Micklegate	11,616	71.97%	75.22%	46.38%	48.87%
Westfield	11,805	74.81%	77.09%	51.42%	52.76%


We are aware that Fishergate; Guildhall and Hull Road in particular remain at lower levels of vaccination rates but are showing increases week on week in line with eligibility and accessibility of the services.

We remain focused on increasing uptake rates across all cohorts.

## NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

## ACTION FROM THE GOVERNING BODY MEETING ON 1 JULY 2021 AND CARRIED FORWARD FROM PREVIOUS MEETING

Meeting Date	Item	Description	Director/Person Responsible	Action completed due to be completed (as applicable)
2 January 2020	Patient Story	<ul style="list-style-type: none"> <li>Update on establishing a local system approach for pertussis vaccination in pregnancy</li> <li>Ongoing in context of the Coronavirus COVID-19 pandemic</li> </ul>	MC	5 March 2020
2 April 2020				Ongoing
2 April 2020	COVID-19 update	<ul style="list-style-type: none"> <li>Review learning on the part of both teams and organisations</li> </ul>	All	Ongoing
7 January 2021	Quality and Patient Experience Report	<ul style="list-style-type: none"> <li>Feedback session to be arranged for clinical leads for care homes</li> </ul>	MC	

<b>Item Number: 6</b>	
<b>Name of Presenter: Phil Mettam</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – Accountable Officer’s Report</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b>	
<b>Reason for Report</b>  To provide an update on a number of projects, initiatives and meetings that have taken place since the last Governing Body meeting along with an overview of relevant national issues.	
<b>Strategic Priority Links</b>  <input checked="" type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b>  <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	
<b>Impact Assessments</b>  Please confirm below that the impact assessments have been approved and outline any risks/issues identified.  <input type="checkbox"/> Quality Impact Assessment <input type="checkbox"/> Data Protection Impact Assessment <input type="checkbox"/> Equality Impact Assessment <input type="checkbox"/> Sustainability Impact Assessment	

<b>Risks/Issues identified from impact assessments:</b> N/A
<b>Recommendations</b> To receive the report.
<b>Decision Requested (for Decision Log)</b>
<b>Annexes</b> Protected Learning Time Update – report to the Quality and Patient Experience Committee

<b>Responsible Executive Director and Title</b>  Phil Mettam Accountable Officer	<b>Report Author and Title</b>  Sharron Hegarty Head of Communications and Media Relations
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## GOVERNING BODY MEETING: 7 OCTOBER 2021

### Accountable Officer's Report

#### 1. Local and system financial position

- 1.1 At the end of August the CCG has continued its strong financial management performance and is reporting a small underspend and continues to forecast a breakeven position for the first half of the year (H1), in line with plan. I am pleased to be able to report that the overall North Yorkshire and York sub-system financial position remains positive despite overspends in the CCG Prescribing and Continuing Health Care budgets. We will continue to work to mitigate these, however through the system wide approach to financial management, an additional allocation of £2.0m , sourced from the partnership's share of the national Covid-19 funding, will be transacted in September 2021. The North Yorkshire and York agreement represents a joint approach to ensuring that all organisations and the partnership as a whole are able to deliver a balanced financial position for H1.
- 1.2 There are the two key components outside of our core funding in H1, firstly, the Hospital Discharge Programme, for which the Integrated Care System (ICS) has an overall fixed budget. The ICS forecast is now close to balance with a small overspend of £61k. Locally we are £765k over our indicative share and whilst this should not cause a pressure locally in H1, due to the overall ICS position, consistency across CCGs and Local Authorities will need to be managed carefully moving into H2. Secondly, the Elective Recovery Fund, where ICS organisations are reimbursed for elective activity over and above 2019-20 levels is currently forecast to be £130k over budget as our local over performance on the independent sector may not be reimbursed in full due to the ICS position. The CCG is currently expecting to manage this as part of the £2.0m allocation.
- 1.3 In terms of planning, at the time of writing this report, detailed planning guidance and associated allocations for the second half of the year (H2) is still to be published. However, it has been confirmed that the Hospital Discharge Programme arrangements will continue until the end of the financial year.

#### 2. Recovery and transformation

- 2.1 The shock of COVID-19 continues to impact the return to business-as-usual within all sectors of the health service. 'Normal' activity within primary care has largely returned to pre-pandemic levels in terms of appointment numbers while the acute secondary care is yet to recover. Both primary care and all of secondary care are subject to very high demand. The slower recovery in the acute sector is driven by high demand, the complexities of infection prevention



and control, reduced bed numbers and staffing issues. York Hospital has more than 100 beds closed to normal activity, some dedicated to the COVID-19 wards, some closed due to social distancing and some due to staffing shortages. All sectors are suffering from staffing issues. These include high sickness rates, high absence rates as staff take time off to recover, and sheer exhaustion. The combined impact of these staffing issues is that it is increasingly difficult to expand capacity by means of staff working additional hours – the usual approach to addressing peaks in demand and long waiting lists.

- 2.2 Urgent and emergency care continues to present challenges. Demand is high. This is exacerbated by staffing issues at Urgent Treatment Centres reducing available capacity, leading to increased patient flows into the Emergency Department. It is noteworthy that 12-hour trolley waits in the Emergency Department were practically unheard of prior to the pandemic. In August there were some 43 such 12-hour trolley waits in York Hospital, and this figure is expected to increase significantly during September.
- 2.3 The increase in 12-hour trolley waits within the Emergency Department is driven, in part, by increasing difficulties in discharging patients from the hospital. It is noteworthy that care homes are also facing staffing difficulties and one care home was forced to reduce its service from care home to residential home because of a lack of nursing cover. This reduces the options for discharging patients from York Hospital ultimately leading to delays in the Emergency Department.
- 2.4 Health inequalities, exacerbated by COVID-19, continue to be assessed and the output of the assessment will drive and focus work to reduce inequalities
- 2.5 The direct impact of COVID-19 on our local population health continues to be addressed. As at the end of August 2021, two wards were dedicated to COVID-19 within York Hospital and some 37 confirmed COVID-19 positive patients were reported. Long covid is being addressed, at the commencement of the pathway, in accordance with national guidelines, by means of a multi-disciplinary assessment service. This has been in place since March 2021. The service runs out of York Hospital and the assessment identifies the ongoing needs of these patients and puts the service in touch with patients. The multi-disciplinary team includes a consultant respiratory physician, a respiratory specialist nurse, a physiotherapist, a psychologist and an occupational therapist, with cardiology and neurology expertise available if and when needed.
- 2.6 The CCG is working with partner organisations to complete and implement winter plans. The guidance for formal planning for the second half of the financial year, H2 guidance, is not yet available and neither are details of the financial settlement. This guidance will contain mandated planning assumptions. H2 plans for use of the independent sector are relatively

advanced and this sector remains an important part of the recovery drive. The work on the nationally funded Community Diagnostic Hubs continues.

- 2.7 Key recovery and transformation work also continues. The 'Waiting Well' programme continues to develop traction and its importance grows as waiting lists and waiting times lengthen. The national Eye Care Programme is being pushed locally to address issues of concern within secondary care. This programme is in its very early stages and is expected to develop traction over the next months. Work has started to re-energise the Pulmonary Rehabilitation Programme with the aim of increasing the capacity and effectiveness of the rehabilitation services to help those with breathing difficulties to exercise and develop their self-care skills.

### **3. Primary Care Protected Learning Time**

- 3.1 In anticipation of the next Protected Learning Time session that takes place on as another virtual session on the afternoon of the 5 October 2021, the Quality and Patient Experience Committee received a report that celebrated the work that has created, to date, more than two thousand opportunities for professional learning and development. We are looking forward to another useful, positive event on the 5<sup>th</sup> that will once again offer our general practice colleagues and partners the time to share and learn.

### **4. Emergency Preparedness, Resilience and Response**

- 4.1 We continue to try to make the best use of resource across North Yorkshire and York whilst developing systems that will transfer into the ICS. North Yorkshire CCG is attending Emergency Preparedness, Resilience and Response calls on behalf of Vale of York CCG and feeding back. We are working on how we might develop system business continuity plans moving forward, but this work is very much in its infancy at this time.
- 4.2 In terms of governance, the CCG has commenced work on the close down procedure and is heavily involved in the stand-up procedure of the new ICS and Place areas. This is largely lead by national guidance at this stage but will progress at pace in the next 3-4 months.

### **5. Annual General Meeting**

- 5.1 Our 2020-21 AGM took place on the 16 September 2021 via Zoom. We decided once again this year to hold the meeting virtually due to the need to respect social distancing guidelines. The AGM provided members of the local community with an overview of the local health and care system's operational and financial performance.

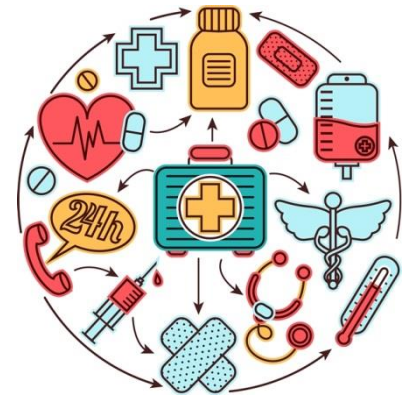
### **6. Recommendation**

- 6.1 The Governing Body is asked to note the report.

## Two years of Protected Learning Time: 2019-21

Protected Learning Time (PLT) events are peer-led sessions for GPs, Registered Nurses, Health Care Assistants, Allied Health Professionals and Physician Associates from across the Vale of York. They are run in partnership with Hull York Medical School (HYMS).

PLT provides an opportunity for healthcare professionals to learn about new clinical developments, updates to national guidance, and best practice whilst also sharing their own experience and knowledge with their peers.



Fundamentally PLT is about improving patient care by providing a dedicated learning time for healthcare professionals away from their busy day-to-day primary care work. These events take place four times a year and are tailored to the needs of clinicians. They are delivered in partnership with NHS Vale of York Clinical Commissioning Group and the Academy of Primary Care, part of the Hull York Medical School. During the pandemic, we moved the sessions online and were able to hold three successful events in this way.

### When do the Protected Learning Time (PLT) sessions take place?

The PLTs take place once a quarter in January, April, July and October. During the pandemic we managed to keep the sessions going via an online event. We were only unable able to hold the April 2020 and January 2021 events.

### What topics have we covered?

The first PLT session was held in January 2019, and since then the events have hosted 8 keynote speakers and 57 different workshops, led by clinicians covering various areas of work in primary care.

In recognition of the difficult winter delivering vaccinations and coping with covid, in April 2021



the PLT was devolved to the Primary Care Networks (PCNs) to focus on staff wellbeing and resilience.

### Keynote speakers:

- **Sepsis – looking into the seeds of time to say which fevers will grow and which will not**, Dr Donald Richardson, Consultant Renal Physician and Associate Medical Director.
- **Addressing Childhood Adversity (ACEs) in Professional Practice**, Dr Warren Larkin, Consultant Clinical Psychologist.
- **Palliative and end-of-life care**, Dr Dan Cottingham.
- **Arts and health for wellbeing: community resilience**, Dr Nicola Gill.
- **Back to Better**, Professor Rebecca Malby.
- **Living with dementia**, Damian Murphy and the Mind and Voices group
- **What Dementia can teach us about love**, Nicci Gerrard - Novelist
- **Myron Rogers**, Leadership of Living Systems: Changing the Way We Change.

### Workshop content:

Adverse Childhood Experiences	Faecal Immunochemical Test	Perinatal mental health
Antibiotic prescribing	Fertility problems and IVF	Planetary health
Arts for health and wellbeing	Healthy Child Programme	Polypharmacy
Avoiding burnout	IAPT and health anxieties	Prescribing safety
Back pain management	Liver function tests	Primary care workforce
Breast cancer	Lower GI 2 week wait	Reducing opiate usage
Cancer screening	Managing weight-loss	Resilient practice
Cancer waits and recovery	Maternal mental health	Safeguarding
CAMHs	Memory assessment services	Self-care: OTC meds
Colorectal pathway and anaemia	Menopause	Sexual health
Creative arts for health	Mindfulness	Smoking cessation
Dementia pathway	New roles in primary care	Suicide prevention
Dementia diagnosis and support	Nimbuscare – GP providers	Surviving and thriving
Deprescribing	Nursing innovation	Tips from the coroner
Diabetes	Nursing recruitment	Urinary Tract Infections
Digital engagement	Online consultations	Wound care
End-of-life care	Paediatrics	

In January 2020, we held our first themed PLT event about the ‘bigger picture’. The session focused on understanding more about patients’ needs and how community-based resources might help to meet them and improve their care outcomes. The event opened with a plenary session followed by three workshops about chronic illness, young adults and avoiding burnout. Over 30 community facilitators representing organisations such as the local authority health and wellbeing teams, link workers and social prescribers, York Explore Library, local singing and dance groups and arts-based community therapies helped run table-top discussions about connecting patients with their community and non-medical resources. [Find out more here.](#)



### How many people have attended?

A total of **2,262 learning opportunities** have taken place. This includes GPs, nurses, health care assistants, pharmacists, allied health professionals and mental health workers.

Event	Number of delegates	Number of presentations
January 2019	356	1 keynote and 7 workshops
April 2019	263	2 keynote and 11 workshops
July 2019	239	1 keynote and 11 workshops
October 2019	261	2 keynote and 11 workshops
January 2020	261	1 keynote and 3 workshops
July 2020	341	1 keynote and 6 workshops
October 2020	289	2 keynotes and 5 workshops
April 2021	Took place in PCNs	Took place in PCNs
July 2021	252	1 keynote and 8 workshops

### What our clinical colleagues have said about the sessions:



**Energetic and very helpful.**

**Great opportunity for collaboration and shift in practices.**

**Adventurous afternoon boy did it pay off. Who would have thought dancing GPs would benefit us!? Broke down barriers between York GPs, challenged the status quo and mindset.**

**I liked the wide range of options for workshops - this allowed different members of our practice to attend each one and feedback.**

**Inspiring presentations and great networking opportunities**

**A great day – thank you!**

**Very engaging and gave lots of areas for thought and improvement in care.**

**Successfully demonstrated the power of creativity and benefits to health and well-being.**

**I learnt something new. A lot of really inspiring and practical tips for helping the planet. Useful tips for managing stress at work which are easy to do between patients. Exactly what I wanted from the sessions.**

**Resilience workshop very practical for a busy GP day**

**Made me think differently about the way I consult patients with dementia, and what I can do to help the patient understand and remember our discussions. I feel I am now more aware of the impact of a dementia**

**Thank you for putting this together it was a very informative afternoon, and a good starting point for my new role as a Care Coordinator.**

**Thank you for delivering the event on a subject (dementia) that needs a light shining on it.**

**Thank you to everyone for their work in pulling this successful event together**

**I felt the new ways of working was helpful, inspiring and positive - giving cases to look at**



**It was a really good afternoon. I enjoyed it, learnt things that will improve my care and feel motivated to try to make some changes.**

**Having some time out of practice to reflect and think about how covid is impacting on general practice and how to take our practice forward positively.**

**An invaluable, inspirational afternoon, thank you**

### **Benefits of the PLT sections:**

As part of the feedback we asked delegates to tell us about the about what they enjoyed about the PLT events.

- Opportunity to network and meet people.
- Breakout sessions – really informative.
- Protected time away from the practice.
- Opportunity to be with colleagues.
- Specific tools and practical examples relating to practice and guidelines.
- Brainstorming, listening to other GPs.
- Learning directly from specialties and the chance to ask questions.
- Chance for all health professionals to come together as a team; for example, HCAs coming together to learn and share with GPs and pharmacists.
- Online sessions have helped to reduce travel and increased access for part-time staff.



### **Learning points:**

At each session we ask clinical colleagues what learning they have taken away from the day that will impact upon the care they give to patients.

- Perinatal mental health session excellent - good practical advice on managing mental health presentations in primary care and role of secondary care.
- Understanding what happens during IVF and fertility prescribing pre-referral testing.
- To try and challenge Adverse Childhood Experience and impact in my consultations.
- Reminder to re-focus practice work on trying to diagnose the condition and maximise use of dementia support workers to ensure patients are connected to community support.
- Checking vitamin D level in women as part of the fertility work-up and document it on referral system.
- Acute use of opioids, it is safe to increase doses. Will review fortnightly.
- More access to investigations website to improve my understanding of which tests to do and what to do about them, which will improve diagnosis and reduce unnecessary tests for patients.
- Being aware of a paediatric consultant on the end of a phone.
- It's good to know that there is a biochemist available to discuss matters.
- Very useful information on antidepressants in pregnancy.
- Asking about ACEs. Rapidly up titrating neuropath analgesia in acute back pain.
- Taking no-dip UTI back to the practice.
- Discussions about pregnant patients regarding medication. Providing improved autonomy. Also discussing the risks of medication in females of child-bearing age.
- Change the way I speak to patients- asking them what matters to them - will give it a try :). Also, consider more social therapy for them, know where to direct them.
- Everything I have learnt in wound care will help me in my HCA role.
- Updated knowledge of diabetes treatment and use of LIBRE device. Better placed to advise patients on these.
- Resilience workshop very practical for a busy GP day.
- Encourage the concept of Social Prescribing, to relevant patients.
- Less Medicine. More well-being.





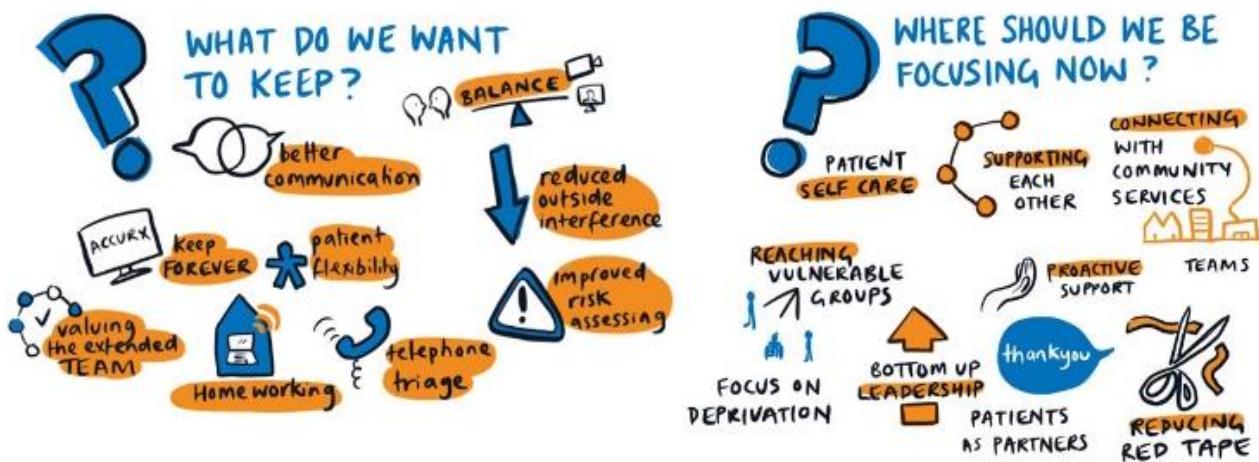
- It was a slow-burner. I realised afterwards that I felt good and it gave me a strong insight into the link between health and creativity.
- Directing patients to and using our social prescriber. Looking at the bigger picture for patients 'What matters to you?'
- Think about my own ways of winding down, and avoiding burnouts in order to make work less stressful!!
- Use of diadem tool for dementia.
- Encourage student nurses to come into general practice.
- Emphasise the importance of sending off a FIT test to patients needing GI referral and send the FIT at the same time as the referral rather than sometimes waiting for the result.
- Empathy bubbles - visualise before I start the day.
- Waste and recycling - lots to do in the place I work in.
- Importance of peer groups to promote change - 'if people are not involved, change does not happen.'
- How to communicate better with patients regarding potential dementia diagnosis
- Becoming a greener practice.
- To become more self-aware and more self-conscious practitioner that will look after himself as well as after my patients.
- Resilience exercises - have signed up to [resiliencepractice.co.uk](http://resiliencepractice.co.uk)
- Encourage more self-care for patients and taking some time for myself
- Being reminded of the voices of those patients with dementia and their carers
- Smoking cessation workshop described greater impact on NHS services that I don't think is so widely known.
- Build up the relationship between the practice and patients with the role of the Care Coordinators to ensure the patients feel listened to, included in their care plan and reassured that we are there to help them, not simply place them in a nursing home if that is not their wish.
- Focus on ensuring equal access to care
- Building relationships with our care homes and PCN Reviewing polypharmacy - taking a more structured approach.
- Staff care and self-care the team is the asset; greater than the sum of the parts.



### Learning from the pandemic

During the July 2020 session we invited Professor Becky Malby, a professor in Health Systems Innovation at London South Bank University, to lead the keynote session.

The purpose of this session was to develop a collective understanding of and enthusiasm for sustaining and improving innovation achieved in the pandemic; and ensure we meet population health needs into the future. The attendees worked together in groups to look at the positive changes that had developed from the pandemic, and where to focus as a system.



### What changes in practice have been made as a result of the PLT events?

We are keen to evidence the impact of PLT on primary care. Here are just a few examples of how the PLT sessions are making a difference in primary care. Here are some quotes from colleagues.

- We have adopted the antibacterial guardianship program and are looking at antibiotic guardian posters.
- Our last workshops helped me change the way I asked questions to children and parents (for prevent and child protection).
- I think more about what the person in front of me wants/needs.
- We will be making some "green" changes to our work practice.
- We are looking at implementing cancer champion training.
- UTI dip will change our practice greatly.
- Looking at dementia diagnosis and tools.
- I'm going to try using the Diadem tool in the care home where I work.
- Helped me with writing a report for the coroner, which I hope has helped the family.

- I offer more support (by way of information) to smokers when discussing smoking cessation.
- I am trying to increase our pick-up rate of dementia so that patients and carers are able to obtain support earlier.
- Safeguarding sessions have helped me be aware of more issues so that I have been more involved with the safeguarding team with patients.
- Updated knowledge of diabetes treatment and use of LIBRE device. Better placed to advise patients on these.
- We have changed the management of abnormal Liver Function Tests.
- We have started FIT testing - have been waiting for it.
- Started mindfulness myself and also recommend to patients.

### Online sessions

Although we appreciate that people enjoy the face-to-face sessions, there have also been some benefits of moving the PLT online.

- Considering it was online it was very well organised and just as informative as being there in person.
- Being able to access from home and so less time-consuming having to commute to racecourse, so less stressful.
- Online meant I didn't have to organise / pay for childcare in order to participate.
- I liked the breakout sessions in the keynote session as we were able to virtually network with other professionals and share their ideas.

### How we have responded to feedback:

It is important to us that these are peer-led events, shaped by health colleagues. As a result, at each session we ask for feedback about how we can improve the sessions. We have responded to suggestions based on what our delegates told us:

You said	We did
We really enjoy the workshops and want more variety to choose from.	At the first session in January 2019, we ran only one set of seven workshops. We increased the number to 11 workshops which we run twice.
As a nurse, I want more sessions relevant to me.	We now have a dedicated HCA and nurse workshop at each session.
The workshops had too many people.	At the first PLT the workshops had up to 70 delegates. Since then we have limited

	the sessions to a maximum of 35 people so that the presenters can facilitate more of a discussion.
We like the networking opportunity.	We changed the layout of the refreshment room to enable easier networking, and kept two refreshment breaks so that colleagues could catch up.
Some of the workshops were fully booked.	We are repeated some of the popular sessions such as liver function test.
We would like to make some suggestions of topics and to run some workshops.	We have built the agenda around health professionals' suggestions on topics such as women's health, polypharmacy, interpreting lab results, paediatrics. We have also had colleagues come forward to deliver workshops about online consultations, planetary health, dementia.
It would be good to get hand-outs, links to presentations and videos.	After each session we place all of the presentations, videos and supporting documents on our website.

### Capturing the day...

During the online sessions we invited a graphic artist to capture the output from the day. These eye-catching drawings are a reminder of the power of collective learning and allowing protected time for health professionals to focus on their own development.

We will also leave you with a few videos which reflect the power of the protected learning time sessions. Please click on the video images to view the short films.

All of the information about the PLT can be found on our website here: <https://www.valeofyorkccg.nhs.uk/about-us/protected-learning-time/> and links to the individual sessions can be accessed here: <https://www.valeofyorkccg.nhs.uk/about-us/protected-learning-time/plt-events/>



**INTRODUCED by DR NIGEL WELLS**  
 This session is a chance for us to review what came from our COVID response + consider how we retain the GOOD...

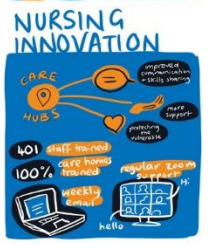
**BACK TO BETTER**



A more collaborative less transactional world



**WORKSHOPS**



PROTECTED LEARNING TIME 7<sup>th</sup> JULY 2020



drawn by Graphic Change

drawn by Cara at GraphicChange.com











2019 - 2021

# PROTECTED LEARNING TIME

JAN APRIL JULY OCTOBER

2262

learning opportunities

57 WORKSHOPS



- KEYNOTES**
- MYRON ROGERS
  - NICCI GERARD
  - DR WARREN LARKIN
  - DEMENTIA MINDS & VOICES
  - DR NICOLA GILL
  - PROF. BECKY MALBY
  - DR DAN COTTINGHAM
  - DR DONALD RICHARDSON



# CREATING OPPORTUNITIES for PROFESSIONAL LEARNING and DEVELOPMENT

I changed the questions I ask patients

great peer-led learning event

interesting and useful

Motivates me to make changes

It had a very positive effect on practice strategy

It's important to have the time to develop your skills

Inspiring speakers


it gives you new ideas

valuable to network

good to learn things to improve my care

We can take the information back and implement it

GPs Nurses Healthcare Assistants Urgent Care Practitioners Physios Allied Health Professionals Students Social Prescribers Community Pharmacists Care Co-ordinations

<b>Item Number: 7</b>	
<b>Name of Presenter: Michelle Carrington</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – Quality and Patient Experience Report</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Decision</b>	
<b>Reason for Report</b> <p>The purpose of this report is to provide the Governing Body with an update on an exception basis on risks and mitigations associated with quality, safety and patient experience across our commissioned services. It summarises by exception, progress and updates on quality, safety and patient experience that is not related to existing risks and provides an update on actions to mitigate the risks aligned to the committee.</p> <p>This detail of this report has been discussed at the Quality &amp; Patient Experience Committee (QPEC) on the 6<sup>th</sup> September 2021.</p>	
<b>Strategic Priority Links</b> <input checked="" type="checkbox"/> Strengthening Primary Care <input checked="" type="checkbox"/> Reducing Demand on System <input checked="" type="checkbox"/> Fully Integrated OOH Care <input checked="" type="checkbox"/> Sustainable acute hospital/ single acute contract <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input checked="" type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b> <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council	<input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council
<b>Impacts/ Key Risks</b> <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Equalities	<b>Risk Rating</b>

**Emerging Risks**

- Risk to safety and provision of mental health services following the outcome of the CQC inspection
- Risk associated with anticipated surge in children's respiratory and mental health problems resulting in increased Emergency Department attendances
- Risk to patient safety and experience due to an increase in system wide pressures ahead of the normal winter cycle

**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

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

**Risks/Issues identified from impact assessments:** N/A

**Recommendations**

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

**Decision Requested (for Decision Log)**

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

<p><b>Responsible Executive Director and Title</b> Michelle Carrington, Executive Director of Quality &amp; Nursing</p>	<p><b>Report Author and Title</b> Michelle Carrington, Executive Director of Quality &amp; Nursing Paula Middlebrook, Deputy Chief Nurse Sarah Fiori, Head of Quality Improvement &amp; Research</p>
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## **1. PURPOSE OF THE REPORT**

The purpose of this report is to provide the Vale of York CCG Governing Body with an exception report on the quality and safety of our commissioned services and a full update regarding risks aligned to the committee.

The exception report will focus upon:

- Support to Independent Care Providers
- System Pressures
- Covid and Flu Vaccination progress
- CQC Involvement with TEWV and mental health services update for adults and children
- Children services – increase in emergency attendances with respiratory illness and mental health problems and anticipated further surge
- Lymphoedema services – closure of Saint Leonards Hospice provision and development of services at YSFT
- Serious Incidents
- Patient Experience
- Communications and Engagement
- Risks to Quality and Safety

## **2. SUPPORT TO INDEPENDENT CARE PROVIDERS**

Significant focus continues to support Independent Care Providers both proactively and in quick response to those reporting Covid 19 outbreaks and other challenges.

August and September continued to observe an overall low incidence of positive covid cases across care providers and at the time of writing this paper there are limited numbers of Covid outbreaks within care settings and domiciliary providers in the Vale of York geographical area (although case numbers are rising within the population) Where outbreaks have been identified these are largely staff members and not residents who are affected. This is encouraging and highlights the continued attention staff are giving to robust Infection Prevention and Control (IPC) practice.

There has however, been an increase in Norovirus within care home settings which is causing concern. The Quality & Nursing Team continue to reiterate advice in relation to managing transmission of these viruses in collaboration with IPC Teams and local authority colleagues. It remains crucial that staff are vigilant towards all IPC risks and not just Covid measures.

As relaxations in general restrictions including the need to isolate, whole system support for care providers continues to be important. Support is extended by the team to any care providers who request it such as private Hospitals, Hospice, Domiciliary Care, Personal Assistants, Independent Living and Assisted Living settings.

Significant emphasis has been placed on collaborating with system stakeholders in supporting the social care workforce following introduction of the grace period on September 16<sup>th</sup> 2021 before vaccination becomes mandatory on November 11<sup>th</sup> 2021. Covid Vaccination will be mandated for anyone who works within a care home, without proof of vaccination individuals who require to enter the building for work purposes will be unable.

Business continuity is a concern and work to understand how vaccine uptake can be maximised and support HR related issues is a priority. Ability to recruit staff into the sector is very challenged and in direct competition with more attractive employment conditions in other sectors.

Capacity in care homes and domiciliary care provision is challenging with colleagues finding it difficult to source placements and care packages. Mutual support across the system is being considered by system leaders.

These challenges are significant as we approach winter and where system pressures are being experienced at an earlier stage in the season. Approaches to consider alternative staffing models are being discussed at senior system leadership level and escalated to the DHSC for support.

The nursing team in collaboration with North Yorkshire County Council (NYCC) have worked to prevent service disruption and minimise the impact of recent provider closures. This has included training offers and observation/ assessment of competency. The team are also working with a number of identified providers to support them in providing safe care to residents and ensure sustainability of the system.

Daily calls have resumed with Local Authority colleagues and Public Health at the Care Home Resilience Gold Call for strategic overview and decision making and with CYC and Public Health on the Testing Priorities Meeting. There is also a biweekly call with CYC. This enables the Quality & Nursing Team to provide contribution/ support where required across the area. Weekly quality & market support calls are held with NYCC colleagues and NY CCG which ensures oversight of issues across the NY system and directs appropriate early response and system collaboration.

As new priorities emerge the team continue to work hard supporting implementation such as the continuing need for support with safe discharge and training including

falls, deteriorating resident across all settings including LD. New priorities aim to work towards a reduction in E Coli bacteraemia, improving hydration, and reducing medication errors in line with local and national priorities. These are all significant programmes of work which the NHS VOY CCG is working closely with colleagues across the system to ensure successful delivery. The Nursing Team are offering training and support to Saint Leonards Hospice in terms of supporting Quality Improvement with a plan to extend the offer to existing staff groups both in York and Scarborough.

Work across the system continues to support flow and utilisation of the Capacity Tracker. This tool is providing increased oversight and provides vital information relating to capacity, business continuity, vaccine uptake for staff and residents which helps to inform the local and national coordination of response to Covid in care settings.

➤ **Community Equipment**

Supporting the return of equipment from care settings and community is a targeted piece of work for the team. Supply issues and greater use for early discharge packages has resulted in shortages and delays which is requiring a concerted effort to maximise stock.

### **3. SYSTEM PRESSURES**

As anticipated there are a range of continuing system pressures which are multifactorial; incidence of covid infections, covid recovery plans, increase in patient needs, vacancies and absence amongst staff. A fully detailed assessment is not provided in this report however pressures are being experienced across primary care, secondary care with an increase in the number of 12 hr trolley waits which were largely absent during the peak of the pandemic, a reduction in St Leonards in patient hospice beds due to staffing challenges and delays in ambulance response times.

The Humber Coast and Vale clinical and operational leaders held an urgent operational pressures meeting in September which resulted in a number of additional actions including risk tolerance and risk thresholds and potential different models of care which is being worked up with system partners.

## 4. VACCINATION

### ➤ COVID-19 Vaccination

The national Covid-19 vaccination program continues with the expansion of the program to 16 – 18 year olds. School vaccination teams have plans in place to vaccinate 12-15 years olds.

The booster program is underway. Booster vaccines are required to be administered no less than six months following the second dose.

### ➤ Seasonal Flu Vaccination

Delivery of the seasonal flu vaccination are underway. National guidance supports the ability to co-administer where it is appropriate to maximise uptake and to support workforce delivery. It is likely that co-administration will support delivery to care homes and housebound patients, however where the covid booster is not yet due, the national steer is to avoid delay of flu vaccine administration to prevent early season flu outbreaks.

Community Nursing teams have previously supported the flu administration program with delivery of vaccines to housebound patients. Due to the increase in community nursing demand, the teams are unable to support the program this year posing additional challenges to primary care teams.

The CCG is monitoring the delivery of the vaccination program and providing assurance to the ICS Vaccination Delivery Board.

The full Flu Immunisation program may be accessed via the following link:

<https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2021-to-2022-letter>

## 5. MENTAL HEALTH

### Care Quality Commission – TEWV

#### ➤ Focussed Re-inspection of 'Acute wards for adults of working age and psychiatric intensive care units'

A focused re-inspection has taken place to 'Acute wards for adults of working age and psychiatric intensive care units'. This included visits to two wards in Foss Park. The outcome of the re-inspection was published on 28th August. The services have been re-rated as 'Requires Improvement' (an improvement from the 'Inadequate' rating in May 2021) The full report can be viewed via the following link:

<https://www.cqc.org.uk/provider/RX3/inspection-summary#mhpsychintensive>

The CCG has agreed to fund additional staffing on a non-recurrent basis for the in-patient services to improve quality and safety.

➤ **Section 29a Warning Notice for Forensic Services and CAMHS**

The CQC have issued a new warning notice following visits to Forensic inpatient areas and CAMHS. Detail of the resulting action plan and timescales will be discussed at the Quality Board in October.

➤ **Well Led Review**

The Focussed inspections have concluded with a Well Led Review. Following an invite by the CQC, the CCG has provided composite response incorporating feedback from both clinical and commissioning leads with responsibility for mental health and Governing Body members. Outcome of the Well Led review is awaited.

**Workforce Pressures**

Workforce pressures are being experienced across a range of mental health services, across acute in-patient, specialty services with adults and children and community. This is impacted due to vacancies, staff sickness, staff isolation, increases in service demand and a lack of available trained staff for backfill.

The risks associated with these, mitigations in place / planned are currently being fully explored with TEWV through the Quality and Performance sub contract meeting.

**Adult Mental Health Services**

**The primary care dementia diagnosis pathway** is currently being reviewed by consultants pending assessment of the first patients who have now been identified and given consent.

**Dementia diagnosis rates** continue to increase gradually since the beginning of the year.

**Improvements to the adult eating disorder** community pathway are in development with support from the ICS and discussions ongoing with the Schoen clinic.



## **Children and Young People's Mental Health Services**

- **Children's Eating Disorders**

The level of referrals into eating disorder team remains very high, and staff continue to struggle to see and assess urgent referrals within the stated 5 day period: TEWV has proceeded with recruitment of additional staff, pending the finalisation of additional MHIS investment this financial year, but this will take some time to work through the system to impact. An ICS wide group has been established to undertake the strategic work required to meet the demand for CAMHs Tier 4 beds.

- **School Mental Health Support Team**

Implementation of school mental health support teams continues well: the Selby team trainees have passed their academic stage and are working fully in schools from September 2021. The new York team has recruited all trainees and senior clinical staff are in place and starting to work with schools.

- **Autism Pathway – Selby**

The CCG successfully bid with North Yorkshire CCG for pilot funds to develop the autism pathway in Selby: a psychology student will work with schools to prepare referrals for autism assessments with the twin aims of reducing waiting times for initial assessment and identify those children who are most likely to be assessed as having autism: this will enable earlier support for them in school.

## **6. CHILDREN'S SERVICES**

### **Respiratory Viral Disease surge in young children**

Public Health England (PHE) alerted health partners in May/ June that there was an anticipated surge in young children aged 0-5 who will develop respiratory viral disease, predominantly Respiratory Syncytial Virus (RSV), one of the main causes of the disease bronchiolitis, an infection in the lower airways. This highly contagious disease is a yearly anticipated occurrence across winter months, however due to the pandemic lock down this did not occur in 20/21. Data from the southern hemisphere evidenced an early emergence in August 2021. PHE modelling predicts that the UK will follow this trajectory.

The concern arises due to unseasonal demand on access to primary and secondary care complicated by other demands health services are currently facing, the consequences of which mean there is a risk of services being overwhelmed.

The disease is especially common in children under 2 years, with the most vulnerable being the very young (0 – 12 months) and those with underlying health needs. There is a spectrum of severity, the worst being life threatening. In the main most children recover well at home, and some require admission into hospital for closer monitoring and intervention.

Nationally, regionally, and locally there are already increasing numbers of young children presenting at emergency departments with respiratory viral disease. Anecdotal intelligence across the UK suggests that the reasons for this are:

- New parents are unfamiliar with their infant being unwell and are particularly worried where they have concerns about their child's breathing
- Accessing primary care can be difficult due the current demands on the service
- 111 thresholds are low and are signposting to ED departments

Locally whilst there are high numbers of children attending ED, there is low acuity with the RSV children that attend and the majority of children are discharged home within hours of attending or the next day.

Primary care, York hospital and VOY CCG are working together and have developed an intermediate care service within a static clinic location in the city as a pilot. Primary care staffing resources are been provided by Nimbuscare and children's expertise from YSHFT. The service is due to commence early October. Impact data will be collected to evaluate the service and consider whether there is a need to continue and any opportunities for expansion across a wider geography.

### **Children & Young people Transformation Programme – HCV ICS Children and Young People's Alliance**

ICS meetings continue monthly and currently focus on the developing of structure, priority setting, workstreams and assurance processes. These elements are gradually taking shape however with respect to the two distinct sub footprints there are clear differences in the organisational delivery of 'place based ' work. Hull, East Riding, North East Lincolnshire and North Lincolnshire have formed an alliance and created a Humber Children's Partnership Board that will collectively take ownership of ICS responsibilities in relation to children and young people. York and North Yorkshire currently do not have this arrangement although initial scoping work is underway. There are differences between York and North Yorkshire and the way services are commissioned despite arrangements with the same health providers.

There are interdependencies with the mental health and learning disability programmes presenting a complex landscape which will require considerable organisation to avoid duplicity and ensure assurance around the priorities to be

delivered. NHSE regional delivery requires assurance from the ICS on a Quarterly basis regarding all aspects of the transformation program. The Vale of York as 'place' will need to ensure it can meet these requirements and deliver the reforms required.

### **Transformation and improvement plan of Community Children's and Special School Nursing**

Special school nursing transformation is underway and following consultation with health and education staff and parents, Nurses will now focus on health prevention and managing complex health needs. Routine health interventions will be undertaken by education staff, following robust training and competency assessment by nurses who will formally delegate this care. Other aspects of community nursing are also being developed and include ambulatory care.

The new transition nurse co-ordinator (funded by the CCG) is now in post and will be contributing to a number of workstreams but predominantly SEND. This is particularly important as the number of young people with SEND and those with life limiting conditions living into adulthood is increasing and the need to coordinate services is vital and ensure improvements in the lived experience for these young people.

### **Children's Therapies Waiting Times**

Children's therapy waiting list times continue to be of concern (with the exception of physiotherapy). Occupational therapy and speech and language therapy length of wait can be up to 50 weeks for patients with a low clinical priority. During the peak of the pandemic, therapy staff were redeployed to other areas of the acute hospital, staff sickness and staff recruitment and retention have all contributed to this situation. The CCG have met with the care group manager and the head of therapies in August to review the actions to address this.

All children on existing caseload should receive the therapies prescribed and statutory timeframes for returning health advice for SEND is met. For those on a waiting list, the associate Designated Clinical Officer for the CCG is supporting therapies with offering interim advice for the EHCP processes.

### **Children & Young People's End of Life & Palliative Care**

Across the Yorkshire and Humber region there are estimated to be in excess of 9224 children living with life-limiting or life-threatening conditions (Fraser et al 2020) and of

these approximately 280 die each year (Hartley et al 2018, unpublished<sup>1</sup>). As children live longer with more complex health needs it is anticipated that this number will continue to increase as it clearly has done over the last decade. Care for these children in the community is limited by the lack of specialist paediatric palliative medicine expertise out with the Children's Hospices and at end of life by the gaps in 24/7 community nursing availability. As a result, children with life-limiting conditions (LLC) often require numerous hospital admissions especially towards end of life. This may not be what children and their families want and it has a significant financial cost to the NHS which could be better utilised.

Currently there are geographical gaps in the provision of funded 24/7 out of hours and end of life (EOL) community nursing care across the region. There is variation in provision dependant on diagnosis with good specialist nursing cover for children with cancer but with no such service for children with other diagnoses. The vision is to develop equitable palliative care for children across the region when, where and how they need it and this vision is underpinned by the principles set out in "Ambitions For Palliative and End of Life Care – a National Framework for Local Action 2015-2020" (2015)<sup>2</sup>, NICE Guidance 2016 (NG61) and the NHSE&I Service Specification for Children's Palliative Care 2020.

This a priority workstream for HCV ICS Children and Young People's Alliance.

Work has begun across York and North Yorkshire with VOY CCG hosting a stakeholder event in early July and the ambitions self-assessment in September 2021. This identifies gaps across the locality, however it is anticipated that services across this sub footprint will not be able to meet the requirements in the specification. Vale of York CCG has committed recurrent funding to Martin House Children's Hospice to work in greater partnership with community children's nursing services. Support from the Yorkshire and Humber Children's Palliative Care Network has been vital to support this work and has pledged support if funding is made available from the collaborative of ICSs across the region. This will include:

- Identifying gaps in service provision and developing strategies to fill these gaps
- Enabling sharing of clinical guidelines and good practice throughout the network
- Supporting the development of strategic priorities with partners across the region
- Facilitation of training and workforce development
- Alignment to the NHSE&I Service Specification & NICE guidance

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<sup>1</sup> Hartley D (2018) Unpublished: Where children die, regional analysis of Child Death Overview Panel (CDOP) Data. YHCPC-MCN.

<sup>2</sup> Ambitions For Palliative and End of Life Care (2015) – a National Framework for Local Action 2015-2020"

## SEND

A Self Evaluation Assessment against the SEND Written Statement of Action was undertaken jointly with CYC in August. Whilst recognising there has been significant progress, the key areas of focus are to ensure there is evidence of 'impact' for children, young people and their families, improve effective collection and provision of health data and maintain the program of work regarding EHCP quality assurance and training schedule.

A shared memorandum of understanding is in development between CYC, NHS VOY CCG and the Parent Carer Forum to describe the operating model and outcomes of working together.

A pre inspection monitoring visit by the DfE and NHSE was undertaken on the 22<sup>nd</sup> September ahead of reaching the reinspection time frame between October 2021 and April 2022. A Joint portfolio of evidence is being collated in preparation.

The new outcomes framework for SEND is operational. This was a significant piece of co-production work between parents, the CCG and CYC and an overview is illustrated as follows:



## **7. LYMPHOEDEMA SERVICES**

The CCG is working with the YSHFT to determine options to consolidate provision of lymphoedema services to ensure a sustainable model. The closure of services at St Leonards has increased waiting times within the trust.

Leads for both the Breast and Dermatology lymphoedema services are undertaking a joint mapping exercise in September to outline current referral / clinical pathways and develop a proposed 'new state' pathway to create a single point of referral and service incorporating the expertise and resource currently available within both services. This will inform next stages of the project plan and potential timescales for implementation.

Links with the complex wound care pathway are required due to the nature of many lower limb wounds having a degree of lymphoedema, therefore early recognition and management opportunities are required including self-care for prevention.

It is therefore likely that the work to create a sustainable Lymphoedema service will incorporate the following components

- Specialist Lymphoedema (all causes) Lead
- Multi-disciplinary team approach – for either direct referral or advice
- Education – community and primary care teams for early recognition and management
- Opportunities for self-care and prevention

## **8. SERIOUS INCIDENTS (SIs)**

The reporting of SIs has continued in line with the SI Framework by all CCG providers, with an overall increase in reporting noted during Q1 in comparison with the previous year's quarterly numbers.

The CCGs main providers continue to engage with and attend the monthly Collaborative SI Panel meeting where there is an open and honest discussion of the cases for review. This is welcomed and viewed as positive and beneficial by both the providers and CCG leads.

### **York and Scarborough NHSFT**

All providers have been challenged by COVID-19 and during a period of exceptional pressure on services they have responded to these challenges.

Workforce issues including redeployment of staff and skill mix alongside training limitations, staff absence and the increased acuity of patients are factors highlighted from SI investigations and recognised as considerable organisational pressures affecting quality and safety.

York and Scarborough Teaching Hospitals NHS Foundation Trust have reported a significant increase in the number of SIs. There has been a notable increase in Falls resulting in harm reported at York and Scarborough Teaching Hospitals Trust. Recurrent themes are discussed and reviewed by CCG leads who routinely attend the Trust internal Pressure Ulcer and Falls panels, and report that these review meetings are stronger and deliver scrutiny on scale with system wide actions in place.

The CCG SI Panel maintains oversight of the types of SIs to determine if any repeated issues or themes are emerging and where necessary discuss with the provider to ascertain the reasons as to why there has been a recurrence.

The Trust is undertaking an extensive review and redesign of the internal SI processes. A rapid improvement programme is being completed, with a representative from the CCG participating in several 'task and finish' groups and attending the Trusts internal SI panel meetings on behalf of the North Yorkshire CCGs. This welcome involvement provides additional assurance and scrutiny of process and the opportunity to influence future processes and policies

### **Tees Esk and Wear Valleys NHS FT**

TEWV report pressures within the service due to a significant increase in referrals since the COVID-19 pandemic, in conjunction with staff vacancies and sickness. Delays are still being experienced in completing the RCAs due to this impact on clinical services. Work is ongoing within the trust with support from NHS England & Improvement as well as CCG leads to support the ongoing quality improvement work along with review of investigations and processes.

### **Annual Patient Safety Congress**

The annual Patient Safety Congress took place in Manchester during September. The Quality and Nursing Team are proud to have three posters accepted for display, one demonstrating the success of falls prevention training in care homes, one the use of virtual support forums during the pandemic in collaboration with Project ECHO and the other for the use of Softer Signs tool in Domiciliary Care which was facilitated by a successful Health Foundation bid. The team have also been invited to present by the National Outreach Forum at conference in relation to the work around the use of a softer signs tool and to receive 'Best of the Abstract for Oral Presentation' Certificate.

### **Patient Safety Specialist Role**

The role of Patient Safety Specialist continues to evolve nationally. More detail concerning how this role fits in commissioning will be reported on following discussion with the national team. Locally work has commenced with key stakeholders to start to understand traction against key deliverables.

## 9. PATIENT EXPERIENCE UPDATE

### Vale of York CCG Complaints

9 complaints were registered in the CCG between April and June 2021.

100% of the complaints were acknowledged within 3 days (in accordance with the NHS complaint procedure). 2 complaint timescales were extended to allow more time to complete the investigations, but all were responded to within the agreed timescale.

1 complaint (Continuing Healthcare) was reopened as new issues were submitted after receiving the CCGs first response. A further response was provided and the case closed.

Specialty/Area	No. of complaints	Outcome after investigation
Continuing Healthcare (CHC)	8	1 upheld 4 partially upheld 3 not upheld
Commissioning of vaccination centres	1	Not upheld

### Learning from feedback

The CCG values all types of feedback about its business and where possible will use it to good effect.

A monthly meeting takes place between CHC managers and the Patient Experience Lead where we review current cases, identify where learning is required and that actions have been implemented and evidence sought where possible. We also review any cases with the potential to escalate to complaints and consider whether steps can be taken to try and resolve any issues early.

### Parliamentary & Health Service Ombudsman (PHSO)

The PHSO is the second and final stage of the NHS complaints procedure for complainants who remain unhappy with the NHS organisation's attempts to resolve their complaint.

One of the CCGs complaints has been referred to the PHSO (relating to the CHC service). A copy of the documentation has been provided to the PHSO and we await their decision.

### Vale of York CCG Compliments

Three people provided positive feedback relating to the conduct and manner of staff whilst carrying out their roles, one for the Patient Relations Team and two compliments for the CHC team.



## **Vale of York CCG Concerns**

105 concerns/enquiries were managed by the Patient Experience Lead during the three month period. These cover a wide-ranging variety of topics, including queries regarding the Covid-19 vaccination programme. Some contacts were complex cases requiring investigation. This figure does not include the daily contacts where straightforward information and advice was given as these are not recorded.

## **10. COMMUNICATIONS AND ENGAGEMENT**

### **Maternity Voices Partnership**

On 4 August 2021 our new MVP Chair, Stacie Jackson-Ross, held the first meeting which had attendance from home-birthing groups, pregnant women, LMS, York and Scarborough Hospital, the University and CCG.

She has made great links with the new Head of Midwifery at YSHFT and has fed back lots of concerns from mothers and families. The hot topics of the moment are: restrictions of partners pre and post birth – causing anxiety around bonding/needling help, keeping staff safe from covid, anxiety of first time mothers.

There was a focus on:

- Birthing choices survey (HCV)
- Maternity services during the pandemic
- How to hear the voice of the seldom heard – those who may live areas of higher deprivation and from a BAME background

### **Actions:**

- Planning focus groups with migrant voices, and working with the community midwives at the children's centres
- More information about what to expect when you are on a ward to help alleviate anxieties – create a number of bite-size videos
- Coproduction of web content with MVP and the digital midwife

### **Smoking during pregnancy**

In 2018 we carried out some engagement work asking mothers about what would help them to give up smoking during pregnancy. Women said they would like more information about the effects of smoking on the baby and having an incentive to stop smoking would help them to remain smoke free. This fed into the research group and public health team to look at a new model for smoking cessation service.

Over the last year the public health team and YSTH have had success in reducing the number of people who smoke at point of delivery, through an incentive scheme and smoking cessation service. Rates decreased from 15% to under 8%.

### **Selby Population Health Management**

A collaborative population health approach is taking place in Selby to look at supporting people with their health and wellbeing. The conversations highlighted the need for more support and activities to help reduce loneliness and isolation. Patients were enthusiastic about being approached directly by their local primary care team, and some are now working together with Care Coordinators and Wellbeing Link Workers in a series of focus groups to help improve the services on offer in the Selby community.

Four focus groups took place in June, and another two in July with the cohort of the population 50-64 with hypertension. Their feedback is helping to form local solutions to supporting the Selby population. In August the leisure centre will be working with the groups to look at services they can commission to respond to the needs of these service users – such as more accessible classes.

The diversity of partners involved meant the focus could be on finding wide-ranging solutions to support people's health and wellbeing, rather than purely medical interventions.

[NHS Vale of York Clinical Commissioning Group - GP practices in Selby are changing patients' lives with a new approach to their health \(valeofyorkcccg.nhs.uk\)](http://valeofyorkcccg.nhs.uk)

### **Quotes from people on the pilot:**

"I had the first telephone call with one of the team and it was really, really good. I think we must have been on the telephone for two hours. It was a really good conversation – she went through all of my issues. It really inspired me to know there was something I could get involved with. Since having that telephone conversation I've been coming to the meetings and trying to improve my health."

"If I hadn't had that letter I'd be dead in two years. It was going that way. I'd spend most of my days sitting around with my feet up. I had no energy. It really inspired me to know there was something I could go and do."

### **Feedback about access to GP services**

We have been working with the Carers Centre as carers have been experiencing difficulty with getting accesses to services.

Common themes: Through conversations with carers, there is feeling of being overwhelmed at the thought of getting an appointment. This is mainly around constant changes to system causing confusion; being told to ring on the day; not being able to book ahead; lack of flexibility around work/ caring roles; a lack of available appointments; trying to obtain an appointment becomes such a task and 'can go on for days'.

#### **Actions:**

- Carer is now on the York Health and Care Collaborative (YHCC) to represent the voice of carers
- Gary Young the CCG Lead Officer Primary Care York is linked in with Craig Waugh (carer's commissioning lead at CYC) and is working on the feedback from carers
- The carers centre and the carers commissioning lead from CYC has been invited to the YHCC to have a set agenda item about carers

#### **National GP survey summary:**

The national GP survey takes place every February by IPSOS MORI and is sent to a sample population.

This year's survey has seen an improvement in patient experience across the Vale of York and quality remains high. However, there are still large differences in experience between areas of the population. To see the results – choose Vale of York from the dropdown box on this page: [Survey and Reports \(gp-patient.co.uk\)](https://www.gp-patient.co.uk/survey-and-reports)

- **Overall experience of using GP services** is up from 79% (in 2020) to 83% in 2021, Compared to other CCG areas we still remain good within the NE&Y region. However, there is a large difference of the patient experience between practices (lowest rating is 67% and highest 99%).
- **Ease of getting through to practice on the phone** has improved since last year 64% easy (60% in 2020). However – large differences between practices. 44% is the lowest, 100% is the highest.
- **Helpfulness of receptionists** – 90% said receptionist were helpful (up 1% on last year)
- **Ease of use of online services:** 74% (down 1% on last year)
- **Satisfaction with appointment offered:** 81% were happy and took the appointment, 17% not happy but took the appointment
- **Overall experience of making an appointment:** 68% were happy with the experience across the Vale of York (up from 57% in 2020). However, patient experience greatly differs across the patch.
- **When asked what type of appointment they last had:** 34% said phone, 59% saw someone in the practice.

- **Respondents were asked if they were given a specific time for an appointment:** 76% were offered a set time, 17% offered a call between certain times.
- **Satisfaction with appointment times:** 59% satisfied (up from 55% in 2020).

### **Quality of GP services:**

We are still performing well in terms of quality

- When asked at the last appointment, did the Health Care Practitioner (HCP) give you enough time, listen to you and treat you with care? Only 2% rated it poor.
- When asked if they felt involved in decisions, had trust in the HCP, felt your needs were met only 4-5% said not at all.
- When asked if the HCP understood their MH needs? 87% said yes, up from 84% in 2020.
- Support with managing Long Term illnesses and disabilities. When asked if in the last 12 months have they had enough support from local services and organisations to manage their conditions? 77% yes (down from 80% in 2020)

### **Actions/recommendations**

- We are conducting a survey to ask patients about access to GP practices during the pandemic. This survey will ask for qualitative and quantitative feedback to unpick some of the narrative.
- To work with the Primary Care Team and Leads to look at the lower performing practices.

### **Northern Quarter Project**

The Northern Quarter Project is a sub group of the Mental Health Partnership and aims to develop a community approach to mental health and wellbeing within the City of York. It began in the north of the city due to the wealth of community assets and established community link worker roles that could be built upon. The ambition of the project is to roll this approach out citywide and therefore the project has been renamed Connecting our City. It has the following key messages:

- All-ages, whole life course approach
- A holistic approach – e.g. housing, environment, employment, relationships, hobbies/interests
- Mental health and wellbeing is everybody's business
- Moving from a medical model to a social model - a focus on promoting wellbeing rather than diagnosing and treating illnesses
- Strengths-based approach - building on individuals' & communities' strengths...

- **It's all about building connections** – connecting people, groups, organisations, generations, projects & initiatives, etc.

There have been a series of workshops and events held over the last two years culminating in a workshop on the 8 July 2021. Throughout the above workshops and events, consistent themes have been identified as priorities for the City of York and have formed part of the proposals for the transformation funding.

1. Development of a Hub
2. Workforce/Culture
3. Investment in the VCSE
4. More social prescriber/LAC/Link worker roles
5. Whole system, whole person, whole life
6. Prevention

### **Learning Disability Red Flag event**

During the week commencing 13 September there will be six events across York and North Yorkshire to raise awareness for people with learning disabilities (and their families and carers) around the signs of symptoms of cancer. They have been co-produced with and will be run by people with learning disabilities. On Friday 17 September there will be a morning session in York and an afternoon session in Selby. We are working with agencies, advocates and LD coordinators to increase attendance.

## **11. RISKS TO QUALITY AND SAFETY**

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

### **Update upon risks being managed by QPEC**

<b>Risk No</b>	<b>Risk Description</b>
<b>QN03</b>	<b>Quality of commissioned specialist nursing services (children)</b>
	Service transformation has now been implemented and needs to progress now to implementation of Quality Assurance. There has been a delay in progressing the QA model during July and August due to the need to respond to the RSV anticipated surge. QPEC approved in September to archive this risk as the initial risk descriptor is now being managed through business as usual.
<b>QN07</b>	<b>Referral for initial health checks – timeliness of CYC referrals</b>
	The description of risk was amended in March 21 to incorporate the additional impact upon timeliness associated with increased numbers of children being identified in need as covid restrictions eased. Timeliness of IHA's were improving throughout 2020 as work to identify blockages in the system and address them was undertaken across the

	<p>safeguarding partnership. Up to date an increase of children coming into care has not been seen although referrals to Children's Social Care where there are concerns about the welfare of children have seen an increase since lockdown eased and schools returned. As of August 21 the position has deteriorated back to pre-improvement levels of 20% for Q1.</p> <p>Numbers impacted are small but still very important and poses a risk because the numbers should not adversely impact on the system : April 2/ May 5/ June 4 / July 4 15 in total . 18 children needed an IHA in Q 1</p> <p>The risk is that there is a delay in their health needs being assessed / identified and therefore a delay in these being managed . The delays are definitely less than previous which is a positive .</p> <p>Designated Nurse for Safeguarding Children and Children in Care continues to work with the LA and the Trust on this issue and reports to the LA improvement board on this so they are also well sighted</p>
<b>QN08</b>	<b>Risks associated with Growing waiting lists</b>
	<p>In February 2021 there were over 2.5k people waiting more than 52 weeks for routine surgery. All patients waiting have been clinically reviewed, validated and prioritised in line with Royal College of Surgeons surgical prioritisation guidelines. Further work to scope the feasibility of sharing elective capacity across acute providers (hubs) continues. Governance arrangements are in place to ensure lines of responsibility for individual patients when they are referred to the Trust, and not yet accepted onto a waiting list. This requires additional monitoring and safety netting by primary care. A key national priority is ensuring focus upon cancer recovery across all aspects - screening through to treatment with safety netting in place at all stages. A process for clinical harm reviews is in place jointly between the CCG, Clinical Network and Trust. Work is also being developed to provide a structure to support patients who are on a waiting list. This is termed as 'waiting well'. This is in recognition that patients will have increasing psychological concern regarding their length of wait and potential deterioration and subsequent increase in urgency associated with their condition. The aim is to ensure patients have access to support / guidance and maximising their personal ability to self care throughout this period and as an indirect consequence reduce the impact upon primary / secondary care specialty services from patients 'chasing' updates.</p>
<b>QN09</b>	<b>SEND Inspection and failure to comply with National Regulations</b>
	<p>A Self Evaluation Assessment against the SEND Written Statement of Action was undertaken jointly with CYC in August. Whilst recognising there has been significant progress, the key areas of focus are to ensure there is evidence of 'impact' for children, young people and their families,</p>

	<p>improve effective collection and provision of health data and maintain the program of work regarding EHCP quality assurance and training schedule.</p> <p>A shared memorandum of understanding is in development between CYC, NHS VOY CCG and the Parent Carer Forum to describe the operating model and outcomes of working together.</p> <p>A pre inspection monitoring visit by the DfE and NHSE was undertaken on the 22<sup>nd</sup> September ahead of reaching the reinspection time frame between October 2021 and April 2022. A Joint portfolio of evidence is being collated in preparation.</p> <p>The new outcomes framework for SEND is operational.</p>
<b>QN 12</b>	<b>Missed pertussis jab for expectant mothers posing a risk to unborn babies</b>
	<p>The CCG continues to monitor vaccination rates. CCG vaccination rates throughout 20/21 have been consistent with the previous year at 86/87% (This is against a national varying rate of 60-90%)</p> <p>Whilst there has been exploration of the ability to provide vaccinations at the 20 weeks scan, the capacity within maternity services at YSHFT to consider this alongside the wider maternity transformation work associated with the Long Term Plan is currently prohibitive. Concern therefore remains regarding slow progress in reducing this risk in the longer term and an increased risk of infection as we move out of the pandemic with increased socialisation of mums and babies.</p>
<b>QN 20</b>	<b>Risk to patient safety due to increased rates of nosocomial infections</b>
	<p>There is an increase in D&amp;V across the locality and we have noted that YSHFT is an outlier nationally in terms of EColi bacteraemia. This has been escalated to the HCAI meeting and actions to understand the data better and identify appropriate interventions are underway. Further Covid nosocomial transmission has been noted within YSHFT and the Trust are investigating.</p>
<b>QN 21</b>	<b>Children and Young people's therapy waiting times at York and Scarborough Teaching Hospitals NHS FT</b>
	<p>Waiting times have increased. A further meeting with the Head of therapies and the care group manager took place in August 2021. Waiting lists for SLT and Occupational Therapy remain high with some 'low priority' cases waiting up to 50 weeks. Issue has been raised with Trust Executive Board.</p>
<b>QN 22</b>	<b>Quality and safety of acute hospital discharges following the introduction of new discharge standards during the pandemic.</b>
	<p>A new NY&amp;Y forum has been established led by VoY CCG Chief Nurse. This brings together system partners who are crucial to understanding and contributing to discharge pathways, processes and standards - ensuring that each partner's needs are considered i.e. Local Authority, Primary care, Acute Trust, Independent care providers and the patient / family voice. The aim initially is to establish and agree a set of 'Quality and Safety' metrics which the group are currently progressing.</p> <p>There are a range of established groups in place which contribute to / or have a focus upon discharge - therefore consideration is being given as</p>



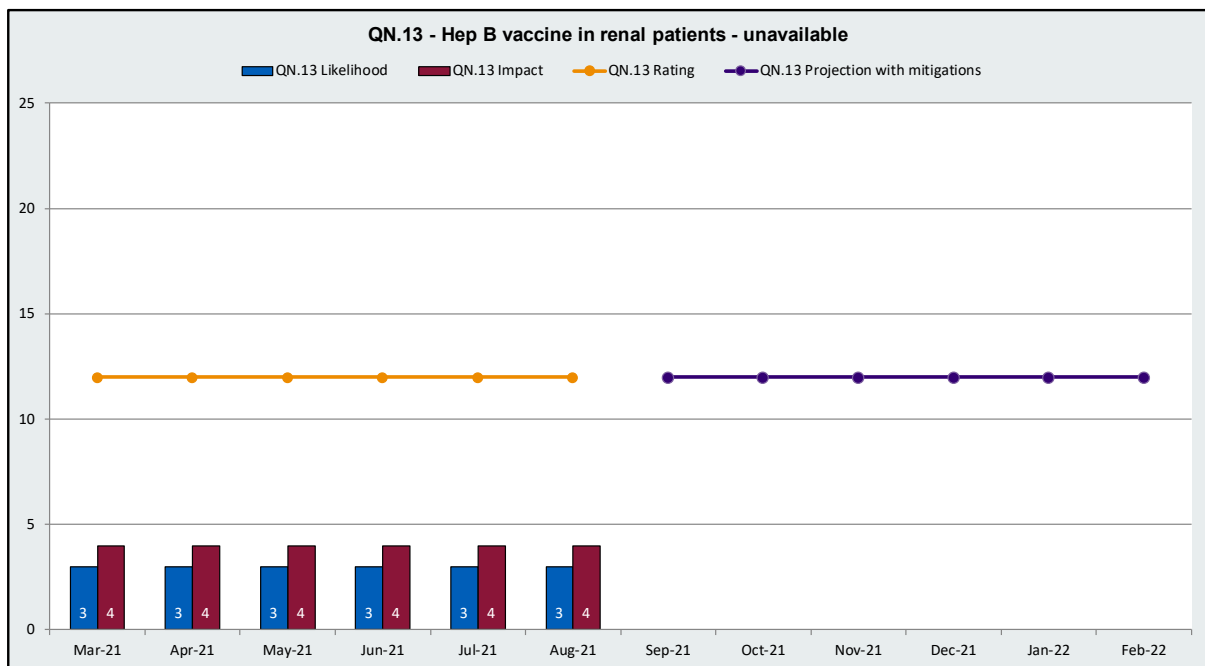
	<p>to whether the improvement work required can be embedded and sustained through existing forum.</p> <p>Draft standards have now been developed and are being sent out for consultation. These standards have been taken from the plethora of guidance and standards produced nationally and locally. After consultation, next steps will be to agree a program of implementation across the system and to test if Humber would also take the same approach in order to have one ICS standard.</p>
<b>QN 24</b>	<p><b>Respiratory viral disease surge in children 0-4 years causing unprecedented unseasonal attendance at York Hospital ED with increased pressure on primary care</b></p> <p>New Risk agreed at QPEC September 21</p>
	<p>A pilot clinic is due to commence on the 4<sup>th</sup> October to provide a community ambulatory clinic for children with 'amber symptoms'. This is to be located at Askham Bar and provided as a collaboration between Nimbuscare and YSHFT specialist children's services. The pilot evaluation will inform options for future expansion.</p>
<b>QN25</b>	<p><b>Maternity Services at York Hospital</b></p> <p>New Risk agreed at QPEC September 21</p>
	<p>Following assessment against core standards, LTP transformation targets and CNST, the Trust has identified a lack of assurance in some core areas. A core factor is that midwifery levels fall below the number identified as being required when the nationally approved maternity workforce capacity/acuity tool is applied (Birthrate plus) For the York site. Maternity services have been required to undertake a large program of transformation - all aspects designed to 'save babies lives' and improve the physical and mental wellbeing of mum / parents. Over the last 18 months there has been a significant focus upon keeping services safe during the pandemic with no reduction in activity within maternity services. The impact of the resource specifically means the Trust is unable to roll out 'continuity of carer' for the York population.</p> <p>There is a slight uptick in the number of incidents and Serious Incidents being reported by the Trust, however other benchmarking data on the Maternity Dashboard does not indicate the Trust to be an outlier in other safety indicators.</p> <p>The risk however is that further challenges to staffing levels could impact sustainability and safety.</p> <p>Mitigations in place include: Trust undertaken a staffing review and recruitment of additional midwives including consideration of overseas recruitment. Trust Patient Safety Team working closely with Risk Management Midwife to ensure robust clinical governance arrangements in place. Clinical Lead undertaking a thematic review of all SIs over the last year to determine whether there are any as yet unidentified themes or actions. Close working with LMS for quality and safety oversight in addition to monthly meetings between new Head of Midwifery and CCG Lead for maternity and updates requested at monthly CCG / Trust Quality meeting. NHSE/I undertaking further assessment of evidence submitted</p>

	to demonstrate compliance with Ockenden recommendations. Additional Obstetricians appointed for support across York and Scarborough. Regional Assurance visit to review Continuity of Carer progress scheduled for 30 <sup>th</sup> September.
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## RISKS MANAGED BY GOVERNING BODY

### QN 13 Hep B vaccine in renal patients:

<b>Title</b>	Hep B vaccine in renal patients - unavailable
<b>Operational Lead</b>	Paula Middlebrook
<b>Lead Director</b>	Michelle Carrington
<b>Description and Impact on Care</b>	There is not an adequately commissioned Hepatitis B vaccination service for renal patients leading to a risk that patients may not receive it.



#### Mitigating Actions and Comments

##### Date: Sept 2021

Patients with chronic renal failure potentially remain at increased risk of hepatitis B virus (- HBV) infection because of their need for long term haemodialysis. Due to impaired immune responses, HBV infection in haemodialysis patients may be subclinical, and such patients may become carriers of the virus.

NHSE wrote to both Primary Care and Secondary Care Trusts informing them that the responsibility for provision of Hepatitis B vaccinations was transferring from Primary care to Secondary care renal services from July 2019. Prior to this there was an effective process in place for Primary care to deliver the vaccinations.

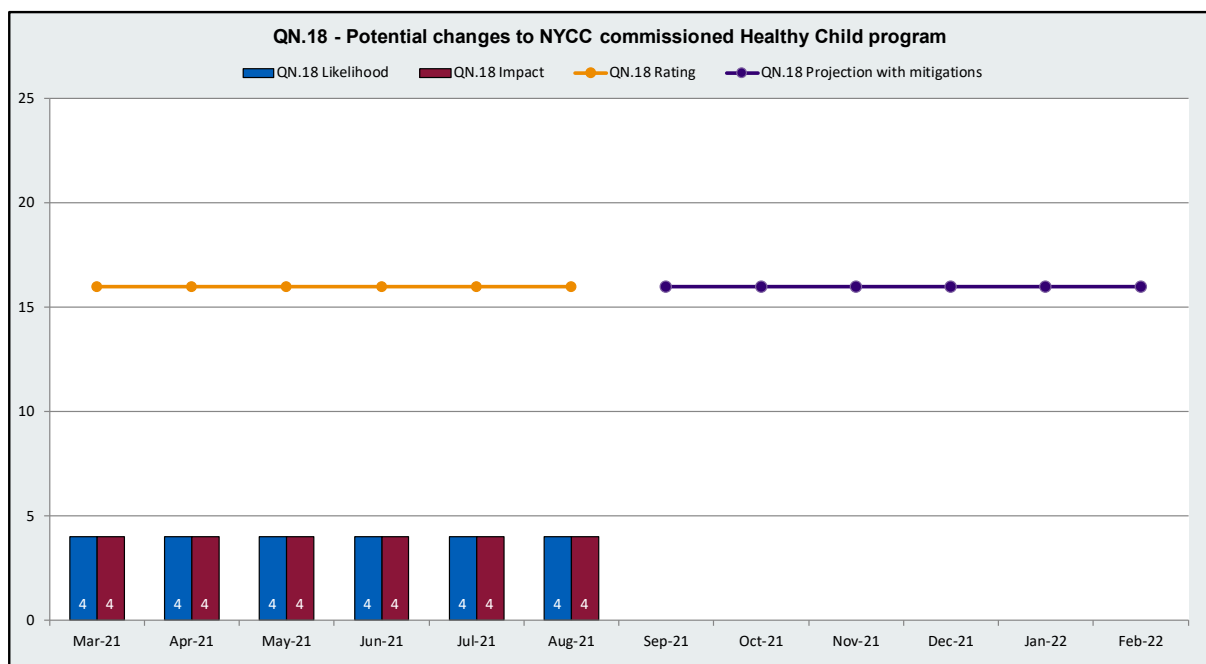
Local GPs have continued to provide vaccination at the request of YSHFT with an initial formal agreement in place until the end of March 21 which has been extended until October 2021.

The increase of primary care demand generally is noted and may increase the risk as primary care is unable to meet the gap in provision. Further discussions have taken place with the Contracting team at YSHFT requesting a timed implementation plan and revised costing model.

YSHFT has confirmed that a community delivered model is in the advanced stages of development with a further internal meeting scheduled on the 6th October to progress. It is anticipated that the new model would initially focus upon new patients as a transitional model. A further verbal update will be provided to Governing Body.

## QN 18 Potential changes to NYCC commissioned Healthy Child program:

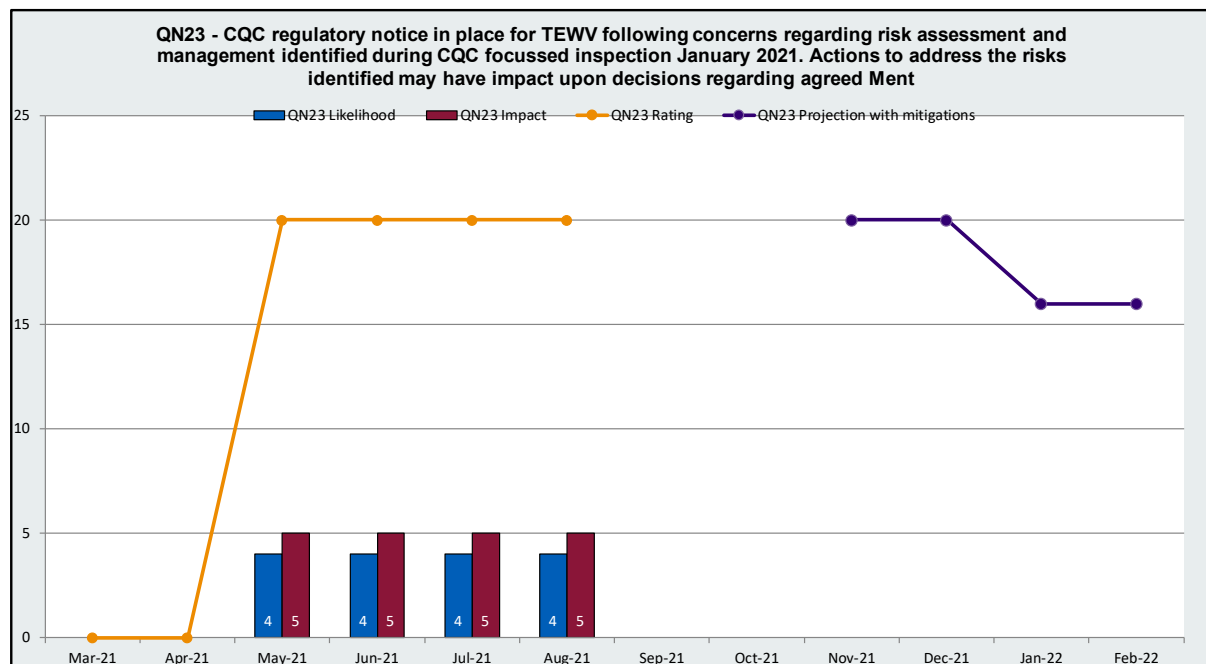
<b>Risk Ref</b>	<b>QN.18</b>
<b>Title</b>	<b>Potential changes to NYCC commissioned Healthy Child program</b>
<b>Operational Lead</b>	Karen McNicholas
<b>Lead Director</b>	Michelle Carrington
<b>Description and Impact on Care</b>	The new HCP model will create gaps in service delivery within the system, particularly for 5 – 19year olds which will impact upon health services.



<b>Mitigating Actions and Comments</b>
<b>Date: 23rd August 2021</b>
<p>The Designated Professionals have successfully recruited to a post to ensure that there is a health contribution at all Initial Child Protection Conferences (ICPC's). Work has continued to take forward approaches to Level 1 bladder and bowel advice - signposting families to first level of advice which would mitigate the loss of Level 1 provision.</p> <p>An update regarding the overall service transformation following completion of the consultation is awaited.</p>

## Risk associated with the outcome of the CQC inspection to TEWV and regulatory notice.

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




<b>Mitigating Actions and Comments</b>
<b>01-Sep-21</b>
NHSE/I led Quality Board established which is meeting monthly. NYCCG Chief Nurse representing both NYCCG and VoY CCG. Trust Action plan regarding the section 29a improvement notice returned to CQC on 21st May. Progress and assurance of delivery is being monitored by the Quality Board. The immediate actions from the section 29A warning notice have now been completed. Focus is upon sustainability. Desk top review underway by NHSE/I EQIA undertaken for the proposed in patient workforce investment, with further work required to understand full mitigations and QIA assessment upon any risks to agreed MHIS priorities. CQC follow up inspection undertaken which has concluded with a CQC Well Led review in August, The CCG has provided feedback to the CQC regarding the Well Led Review as requested. The Focussed re-inspection of Acute wards for 'Adults of working age and psychiatric intensive care units' outcome was published on 27th August. CQC had visited 12 wards across TEWV, 2 of which were at Foss Park and 2 Intensive Care Units. The revised outcome rating has improved from 'Inadequate' to 'Requires Improvement' - improvements in overall risk assessments and governance had been seen. Full report available via webiste. Both NYCCG and VoY CCG are providing focussed support to the Trust Patient Safety team. A further Section 29a Warning Notice has been issued to the Trust in August for Forensic services and CAMHS. The detail of which is yet to be shared with the CCG alongside details of the resulting action plan and timescales

## **12. RECOMMENDATIONS**

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

In relation to the risk register Governing Body is requested :

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

<b>Item Number: 10</b>									
<b>Name of Presenter: Michelle Carrington</b>									
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>								
<b>Report Title – North Yorkshire and Vale of York CCGs Annual Learning Disability Mortality Review</b>									
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b>									
<b>Reason for Report</b>  <p>The Learning Disabilities Mortality Review (LeDeR) Programme is a programme aimed at making improvements to the lives of people with learning disabilities, through a national review into their deaths, to improve the standard and quality of care for this group of people. The Programme was established as a result of one of the key recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). CIPOLD reported that many people with learning disabilities were dying earlier of preventable health conditions younger than they should, and up to 30 years earlier than the rest of the population. Some of the reasons related to the standard of health and social care that they received, but also related to other wider social determinants of ill health, such as poverty and social exclusion.</p> <p>The overall aim of the LeDeR programme is to help reduce premature mortality and health inequalities in this population, through driving improvement in their lives and in the care that they receive.</p> <p>This report, which was also presented at the July Quality and Performance Committee, presents information about the deaths of people with learning disabilities who were reported into the LeDeR programme from across the North Yorkshire and York system. It evaluates and summarises the key themes trends and recommendations arising from the reviews.</p>									
<b>Strategic Priority Links</b>  <table border="0"> <tr> <td><input type="checkbox"/> Strengthening Primary Care</td> <td><input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care</td> </tr> <tr> <td><input type="checkbox"/> Reducing Demand on System</td> <td><input type="checkbox"/> System transformations</td> </tr> <tr> <td><input type="checkbox"/> Fully Integrated OOH Care</td> <td><input type="checkbox"/> Financial Sustainability</td> </tr> <tr> <td><input type="checkbox"/> Sustainable acute hospital/ single acute contract</td> <td></td> </tr> </table>		<input type="checkbox"/> Strengthening Primary Care	<input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care	<input type="checkbox"/> Reducing Demand on System	<input type="checkbox"/> System transformations	<input type="checkbox"/> Fully Integrated OOH Care	<input type="checkbox"/> Financial Sustainability	<input type="checkbox"/> Sustainable acute hospital/ single acute contract	
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<input type="checkbox"/> Sustainable acute hospital/ single acute contract									
<b>Local Authority Area</b>  <table border="0"> <tr> <td><input checked="" type="checkbox"/> CCG Footprint</td> <td><input type="checkbox"/> East Riding of Yorkshire Council</td> </tr> <tr> <td><input type="checkbox"/> City of York Council</td> <td><input type="checkbox"/> North Yorkshire County Council</td> </tr> </table>		<input checked="" type="checkbox"/> CCG Footprint	<input type="checkbox"/> East Riding of Yorkshire Council	<input type="checkbox"/> City of York Council	<input type="checkbox"/> North Yorkshire County Council				
<input checked="" type="checkbox"/> CCG Footprint	<input type="checkbox"/> East Riding of Yorkshire Council								
<input type="checkbox"/> City of York Council	<input type="checkbox"/> North Yorkshire County Council								

<b>Impacts/ Key Risks</b> <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
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**Emerging Risks**

<p><b>Impact Assessments</b></p> <p>Please confirm below that the impact assessments have been approved and outline any risks/issues identified.</p> <p> <input type="checkbox"/> Quality Impact Assessment                      <input type="checkbox"/> Equality Impact Assessment  <input type="checkbox"/> Data Protection Impact Assessment                      <input type="checkbox"/> Sustainability Impact Assessment </p> <p><b>Risks/Issues identified from impact assessments:</b></p> <p>N/A</p>
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**Recommendations**

Governing Body is asked to receive the report.

**Decision Requested (for Decision Log)**

Report received.

<p><b>Responsible Executive Director and Title</b></p> <p>Michelle Carrington: Executive Director of Quality and Safety / Chief Nurse</p>	<p><b>Report Author and Title</b></p> <p>Allison Brown: Specialist Practitioner – LeDeR; NHS North Yorkshire CCG</p> <p>Julie McGregor: Program Director Transformation; NHS North Yorkshire CCG</p> <p>Samantha Rigg: Project Administrator, Adult Safeguarding; NHS North Yorkshire CCG</p>
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## **North Yorkshire and Vale of York CCG Annual Learning Disability Mortality Review (LeDeR)**

**1<sup>st</sup> April 2020 – 31<sup>st</sup> March 2021**

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### **Authors and Contributors**

**Allison Brown:** Specialist Practitioner – LeDeR; NHS North Yorkshire CCG

**Julie McGregor:** Program Director Transformation; NHS North Yorkshire CCG

**Samantha Rigg:** Project Administrator, Adult Safeguarding; NHS North Yorkshire CCG

## Executive Summary

This is North Yorkshire and Vale of York CCGs CCG's Annual Report of the Learning Disabilities Mortality Review (LeDeR) programme. It presents information about the deaths of people with learning disabilities who were reported into the programme. The purpose of the 2020/21 Annual Report is to evaluate and summarise the key themes and trends from the LeDeR reviews reported between 1st April 2020 and 31st March 2021 and will focus on factors including:

- 50% of cases were males – this is lower than nationally at 58%.
- 100% of adults with learning disabilities whose deaths were reviewed were White British – this is higher than nationally at 90%.
- 76% of deaths occurred in hospital which is an increase from last year's figures and reflects the number of Covid 19 deaths which occurred in hospitals.
- The most common confirmed cause of death was Covid 19 (38.1%).
- 50% of completed Reviews concluded that individuals received care that met or exceeded good practice (Grade 1 or 2) – compared to 56% nationally.
- The average age of death for females was 65.7 years and 66.7 for males. The latest national figure was 59 years for females and 61 for males.

Themes and trends linked to best practice, learning and recommendations are also summarised. Some of the themes from the local data have been compared to the national 2019 LeDeR Annual Report data for comparison. This report is available to read at <http://www.bristol.ac.uk/sps/LeDeR/resources/annual-reports/>

The North Yorkshire and Vale of York CCG Annual LeDeR Report (this document) will be shared with key local stakeholders.

## Section 1: National and Local Context

### 1.1 Introduction

The Learning Disabilities Mortality Review (LeDeR) Programme is a world-first programme of its kind aimed at making improvements to the lives of people with learning disabilities, through a national review into their deaths, to improve the standard and quality of care for this group of people.

The programme, implemented across England, is aimed at identifying learning and was delivered by the University of Bristol and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Nationally, work on the LeDeR programme commenced in June 2015 for an initial three-year period. In North Yorkshire and Vale of York CCG, implementation commenced in November 2016, and by the end of 2017, the LeDeR programme was fully rolled out across England.

People with learning disabilities, their families and carers have been central to developing and delivering the programme nationally.

Under the LeDeR programme all Clinical Commissioning Groups (CCGs) areas must deliver a local procedure for reviewing deaths of people with a Learning Disability as part of this national review.

The Programme was established as a result of one of the key recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). CIPOLD reported that many people with learning disabilities were dying earlier of preventable health conditions younger than they should, and up to 30 years earlier than the rest of the population. Some of the reasons related to the standard of health and social care that they received, but also related to other wider social determinants of ill health, such as poverty and social exclusion.

The overall aim of the LeDeR programme is to help reduce premature mortality and health inequalities in this population, through driving improvement in their lives and in the care that they receive.

The LeDeR programme collates and shares anonymised information about the deaths of people with learning disabilities nationally, so that common themes, learning points and recommendations can be identified and taken forward into Policy and practice improvements.

## **Values and Principles**

The core principles and values of the programme are:

- valuing the contribution of people with learning disabilities and their families to all aspects of our work
- taking a holistic perspective, looking at the circumstances leading to deaths of people with learning disabilities, and not prioritising one source of information over another
- aiming to ensure that reviews of deaths lead to reflective learning, which will result in improved health and social care service delivery
- to embed reviews of deaths of people with learning disabilities into local structures to ensure the continuation of the learning taken from the reviews.

The issues and causes of death identified within the national LeDeR Annual Report (published 16 July 2020), alongside the findings from locally completed reviews reflect the many challenges that people with a learning disability face in living their lives.

Whilst there is much work already underway nationally and locally to improve access to healthcare to address inequality, there is more work to be done. Through the development of new tools to support Practitioners and Providers and new resources to develop skills and awareness, we aim to improve access to the right care and support, through developing a culture of improved information, knowledge, vigilance, and interventions for people with a learning disability.

### **1.2. National Context**

People with a learning disability experience significant health inequality when compared to the rest of the general population. To put this into context the life expectancy for people with learning disabilities in 2020 can be equated to what the rest of the general population could have expected in the 1940's.

The 2018 Learning Disabilities Mortality Review (LeDeR) found the median age at death was 60 for men and 59 for women, for those (aged 4 and over) who died April 2017 to December 2018. This is significantly less than the median age of death of 83 for men and 86 for women in the general population. This means the difference in median age of death between people with a learning disability (aged 4 and over) and the general population is 23 years for men and 27 years for women.

However, these health inequalities should not be inevitable and can be mitigated by improved education, prevention, early intervention, and timely access to healthcare throughout their lives.

### **1.2.1 LeDeR Policy and Implications**

On 23rd March 2021, NHSE/I published their first LeDeR Policy setting out for the first time for the NHS, the core aims and values of the LeDeR programme and the expectations of different parts of the health and social care system in delivering the programme from June 2021. From 1st June, the LeDeR programme will transfer to a new web-based IT system from the University of Bristol web-based platform. The Policy also introduces the inclusion of Autism into the programme from the Autumn of 2021.

In response to the change and following stakeholder engagement, the new name for the LeDeR programme is 'Learning from Life and Death Reviews – people with a learning disability and autistic people'. However, it will continue to be called LeDeR.

The changes include a new IT system run within the NHS, a two-stage review process and later in the year, we will begin reviewing the deaths of people with a diagnosis of Autism.

The fundamental push of the Policy is to drive change and service improvement further, by focusing in on deaths where there is concern about the care of the person and/or significant learning to be gathered.

As part of the Policy, ICSs will have a central role going forward and be responsible for ensuring all aspects of LeDeR continue to be carried out, including new governance arrangements and a strategy to reduce Health Inequalities and premature deaths at a local level and very importantly, that actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality. This enables the ICS to identify good practice and what has worked well, as well as where improvements in the provision of care could be made. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.

CCGs will initially take this work forward until ICS come fully online. It is likely the workforce model will not be fully agreed or in place until next April, this is due to the significant changes ahead regarding CCGs and ICSs across England, which impacts on these decisions.

By 1st April 2022, all changes within the Policy must be implemented by ICSs, subject to legislative changes relating to ICSs being passed in coming months. Changes to the LeDeR reporting system.

Guidance has been circulated to CCGs detailing the changes ahead and key dates which will impact on completion of reviews. This will indicate key actions and decisions needed by Local Area Contacts (LACs), to minimise disruption and delay in completing reviews and guard against any loss or replication of information and data.

As of the 31<sup>st</sup> of April, all current allocated local reviews have been completed and approved. The new local LeDeR Quality Assurance Panel, managed by the CCG, had continued to meet weekly ensuring that all cases were approved in an efficient and timely manner.

This marks a significant achievement and is testimony to the hard work and commitment by reviewers, the local LeDeR team and the CCGs internal mechanisms that have resulted in swifter allocation, as well as robust quality and assurances processes that are now embedded.

## LeDeR Bristol Annual Report 2021

Bristol will produce one final Annual Report analysing the death that occurred from the 1<sup>st</sup> of April 2020 to the 31<sup>st</sup> of March 2021. Date for publication is to be confirmed.

### LeDeR Policy CCG key actions for 2021/22

- Must have a robust plan to ensure that reviews are allocated within 3 months and completed within 6 months of the notification of death.
- Ensure that local governance for LeDeR is robust to demonstrate that action is being taken from local review findings to improve services, reduce health inequalities and address premature mortality.
- Ensure that the issues found in local reviews are raised with Senior ICS Care System leaders, including local authority partners, supporting joined-up action to improve services, reduce health inequalities and reduce premature mortality.
- Every CCG is a member of a 'Learning from LeDeR' Steering Group and have a named person with lead responsibility including a BAME lead.
- Produce an Annual Report. Annual Reports will be expected to be published by 30th June every year going forward a following its presentation at a public meeting of the CCG Board.
- Analysis of all regional learning and actions taken from last year's CCG reports will be shared, along with several good practice examples of CCG templates by the end of February 21.
- Very few CCG reports were published with an easy read version. CCG are asked to consider this in planning of this year's reports, given one of their key stakeholders are people with a learning disability. The Accessible Information Standard would provide the basis of good practice around this area.
- LeDeR to be included in the 3-year strategy (Phase 4 planning) demonstrating action taken in response to the issues identified in LeDeR reviews and national findings, including how the local system will reduce the health inequalities faced by people including those from BAME communities who have a learning disability.

It is expected this will be at ICS level.

### 1.2.2 Definition of Learning Disabilities

The LeDeR programme follows the definition outlined in 2001 by the white paper 'Valuing People'.

Learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- a reduced ability to cope independently (impaired social functioning) which started before adulthood, with a lasting effect on development.

### 1.2.3 Scope of the LeDeR Programme

Initial reviews are undertaken of **all** deaths notified to the LeDeR programme of people with learning disabilities aged 4 years and older in England.

The following reviews will take precedence over local reviews:

- Serious Case Reviews (SCRs)
- Safeguarding Adult Reviews (SARs)
- Safeguarding Adults Enquiries (Section 42 Care Act)
- Domestic Homicide Reviews (DHRs)
- Serious Incident Reviews
- Coroners' investigations
- Child Death Overview Panel (CDOP)
- Mothers and Babies Reducing Risk through Adults and Confidential Enquiries (MBRRACE).

#### **1.2.4 Notification of a Death**

The person reporting the death is asked to provide as much of the core information required to notify a death as possible. The information provided is checked by the National LeDeR team to ensure that the death meets the inclusion criteria for the LeDeR programme. Once confirmed, the death is transferred to the LeDeR LAC who in turn will carry out their own local eligibility checks prior to allocation to a reviewer.

#### **1.2.5 Confidentiality and Data Sharing**

The National LeDeR programme applied to the national Confidential Advisory Group (CAG) for Section 251 (of the NHS Act 2006) approval for the use of patient identifiable information, in order that reviews can be undertaken of the deaths of people with learning disabilities.

The programme has been given full approval to process patient identifiable information without consent. Specifically, this provides assurance for health and social care staff that the work of the LeDeR programme has been scrutinised by the national CAG. The CAG is appointed by the Health Research Authority to provide expert advice on uses of data as set out in the legislation and advises the Secretary of State for Health whether applications to process confidential patient information without consent should or should not be approved.

The key purpose of the CAG is to protect and promote the interests of patients and the public whilst at the same time facilitating appropriate use of confidential patient information for purposes beyond direct patient care. More information about Section 251 approval is available at: [www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/](http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/)

### **1.3 Local Context**

This Report is the published report on the learning from deaths of those people with learning disabilities within North Yorkshire and Vale of York CCG. The report covers the period of **1st April 2020 until 31st March 2021**.

The aim of this report is to bring information together to understand and to reflect on themes that can inform and improve practice across the health and social care community in North Yorkshire and Vale of York CCG.

It's important to remember that the people whose deaths are reported were known and loved by many and their loss will have had a profound impact on those around them.



### 1.3.1 Covid-19 Impact

Covid-19 has presented a new set of challenges that are expected to emerge over a period of time. Rapid learning from Covid-19 related deaths is a National priority which will also be supported in the local region. The Covid-19 pandemic has demonstrated nationally and locally that there is a disproportionate impact on people with learning disabilities. People with learning disabilities were seen to be more likely to have other physical health problems such as obesity and diabetes and certain kinds of learning disability, such as Down's syndrome, can make people more vulnerable to respiratory infections, which can increase their risk of dying from Covid-19.

A rapid learning review (see reference 1) of the deaths of people identified as having learning disabilities with Covid-19 across England (1) found 451 per 100,000 people registered as having a learning disability, died with Covid 19 between 21<sup>st</sup> March 2020 and 5<sup>th</sup> June 2020, a death rate 4.1 times higher than the general population after adjusting for other factors such as age and sex.

The report also states among people with learning disabilities, the rate of Covid-19 deaths for adults in residential care was higher than the rates of Covid-19 deaths of adults with learning disabilities generally. This difference is likely in part to reflect the greater age and disability in people in residential care. It was found that people with learning disabilities are likely to have had difficulty recognising symptoms of Covid-19, or following government advice about getting tested, self-isolation, social distancing and infection prevention and control, the report says. It may also be more difficult for people caring for them to recognise the onset of symptoms if these cannot be communicated.

On the 12<sup>th</sup> of November 2020, the University of Bristol published its report into the deaths of 206 people with a learning disability at the start of the Covid-19 pandemic. Two of the CCGs reviews were included in the report.

#### Local Covid-19 deaths

	Death notifications/Covid 19 cases
Deaths notified in Q1	9 Covid-19 related deaths
Deaths notified in Q2	1 Covid-19 related deaths
Deaths notified in Q3	4 Covid-19 related deaths
Deaths notified in Q4	4 Covid-19 related deaths (1 case cause of death unknown at present)

Locally deaths in Quarter 1 showed an increase in the average notifications of over 60%, 24 deaths were reported and of these 9 deaths were attributed to Covid-19. The previous year the average number of deaths per quarter was 10. Quarter 1 figures show a reflection of the sharp increase in Covid-19 deaths during the first wave of the Pandemic. In quarters 2, 3 and 4 deaths reverted back to previous average figures however, in Quarter 3 and Quarter 4, 40% of deaths were attributed to Covid-19 mirroring the second wave of the Pandemic.

## Section 2 - LeDeR Process in North Yorkshire and Vale of York CCG

### 2.1 Purpose of the LeDeR Review

The purpose of the LeDeR Review is to:

- Identify any potentially avoidable factors that may have contributed to the person's death.
- Develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.
- Identify good practice

## 2.2 Initial Review

Drawing on the wider learning from work on reviewing deaths in NHS Trusts, the LeDeR methodology places the person with learning disabilities at the centre of the review. The 'pen portrait', is a strength based focused recording of the person's likes, abilities, character and communication and is at the heart of the review.

Sadly, for some individuals it is not possible to complete more than a basic pen portrait due to a lack of family involvement and with so little of their life having been documented. Some care settings are better at being able to describe who the person was, their likes and dislikes, whilst others are not.

A chronology is completed detailing at least the last year of the person's life. From the information collated reviewers are required to analyse information and formulate recommendations based on issues and learning identified. These smart, measurable, achievable, realistic and timely (SMART) recommendations identify where quality can be improved and good practice shared, through the identification of recurrent themes

## 2.3 Multi-agency Review as part of the LeDeR Process

The purpose of the Multi-agency Review is to include the views of a broader range of people and agencies who have been involved in supporting the person who has died, where it is felt that further learning could be obtained from a more in-depth analysis of the circumstances leading up to the person's death.

There are several circumstances that would indicate that a Multi-agency Review is required. These may be identified very early on in the initial review process or may emerge as the review progresses. A Multi-agency Review is always required:

- Where the assessment of the care received by the person is graded high at a score of 5 or 6 within the 1-6 rating scale.
- When any red flag alerts are indicated in the Initial Review.
- If there have been any concerns raised about the care of the person who has died.

The table below details the number of Multi-agency Reviews held in North Yorkshire and Vale of York CCG.

No of Multi-Agency Review Meetings	Relating to No of Deaths
1	1

## **Section 3 - Accountability & Governance**

### **3.1 Accountability**

Whilst the programme is managed by Bristol University on behalf of NHS England, NHSE/I have aligned LeDeR to the national Transforming Care Programme (TCP). The on-going development and progress of LeDeR locally is therefore monitored through North Yorkshire and Yorkshire Transforming Care Partnership Board and the North Yorkshire Mental Health and Learning Disability Partnership Board.

### **3.2 LeDeR Steering Group**

The North Yorkshire and York LeDeR Steering Group has continued to strengthen its membership from across the North Yorkshire TCP footprint. The group provides oversight, support and governance for the local delivery of the programme, operating within the CCG

Constitution and aligning with relevant CCG policies and procedures. The group is an established pathway for exchange of information with the North Yorkshire and Yorkshire Transforming Care Partnership Board and the North Yorkshire Mental Health and Learning Disability Partnership Board.

The group met quarterly. Members include: -

- Director of Quality and Governance North Yorkshire CCG (or representative).
- Commissioning Lead for Mental Health and Learning Disability NY CCG.
- CCG Designated Professional's for Safeguarding Adults representative.
- NHS Provider organisations representatives.
- Director for Public Health, North Yorkshire County Council (or appropriate representative).
- Director for Public Health, City of York Council (or appropriate representative).
- CCG Designated Doctor for the Child Death Overview Panel (corresponding member).
- Child Death Overview Panel representative (corresponding member).
- North Yorkshire Safeguarding Adult Board representative.
- City of York Safeguarding Adult Board representative.
- North Yorkshire Safeguarding Children Partnership representative.
- City of York Safeguarding Children Partnership representative.
- North Yorkshire County Council Assistant Director, Care and Support.
- Service user representative (to be confirmed).
- GP Lead for Learning Disabilities (corresponding member).
- NHS England and Improvement, Health Inequalities Senior Manager -North East Yorkshire and LeDeR Regional Coordinator.
- LeDeR Reviewers may attend with the agreement of the Chair.
- Specialist Practitioner/Local Area Contact.

Terms of reference are agreed and a local information sharing agreement is also in place. (Appendix 1).

- The group continues to review the Government guidance and national directives in relation to Covid-19 and people with a learning disability basis and share out relevant information through already established networks.
- The first local LeDeR Bulletin was presented to the local Steering Group in December 2020 and a further LeDeR Bulletin, published in easy read format, was circulated in

February 2021. This is disseminated via the LeDeR Communication Network which includes the Adult Partnership Boards, local Health Providers and the North Yorkshire Health Action Group.

- Data collection captures more information from reviews, steered by the themes and learning found both locally, regionally and nationally. Learning into action continues to be monitored by the local LeDeR Steering Group.
- A quarterly Position Statement setting out the local delivery of the LeDeR program is produced and presented at the LeDeR Steering Group and subsequently submitted to the North Yorkshire and Vale of York's CCGs Quality Assurance Committee, provided to the Learning Disability Integrated Care System (ICS) Transforming Care Partnership Group and Board and the local Safeguarding Boards.

### **Local Updates**

- The Local LeDeR Team still sit in the CCGs Quality structure, however, is now led by the Programme Director of Transformation which has been devolved by the CCGs Chief Nurse.
- Due to an increase in funding from NHS England the post of Specialist Advisor/Local Area Contact continued for a further 2 years which commenced at the beginning of November 2020.

### **3.3 Quality Assurance (QA) Panel**

The system of quality assurance for completed reviews by the weekly CCG LeDeR Quality Assurance Panel has proven to be successful. The process ensures appropriate scrutiny of reviews by the LeDeR Local Area Contact and Director for Transformation. Specialists, including the LeDeR Regional Coordinator are co-opted onto the Panel, as necessary. This enables learning and actions to be agreed and formally recorded. The lessons and actions are then presented to the LeDeR Steering Group.

### **3.4 Local Reviewers/Conducting Reviews**

The Local Area Contact is informed of a new death by the National LeDeR review system. They identify a suitable reviewer(s) to allocate the person for a LeDeR review (Appendix 2).

Recruitment and retention of reviewers has continued to be a challenge and Covid-19 capacity issues has compounded the challenge. As the programme has evolved over the last three years, funding opportunities have arisen through NHSE/I and the Transforming Care Programme and North Yorkshire and Vale of York CCG have been successful in securing funds to employ Reviewers in 2020/21.

The funding has also made it possible for 36 LeDeR reviews to be outsourced. These reviews have been completed to a high standard with quality assurance being provided from both NHSE/I regionally and latterly the Local LeDeR Quality Assurance Panel. This has enabled the targets for reviews to be completed within the NHSE/I timeframe (i.e., allocated within three months of notification and completed within six months of being notified).

## Section 4 – Findings from Deaths in North Yorkshire and Vale of York CCG

### 4.1 Deaths Notified to the LeDeR Programme

For the purposes of comparison, any national figures referenced relate to the national LeDeR Annual Report 2019/2020, published in 2020.

In total 55 death notifications were received and 100% of the allocated reviews were completed.

The improvement has been made possible in part due to additional funding awarded by NHSE/I, which has allowed the CCG's to contract with a third party to complete reviews. There has also been a concerted effort by NHS reviewers and the wider team to achieve these targets, this has been an exceptional accomplishment given the existing volume of outstanding reviews coupled with the increased volume of referrals due to the impact of Covid-19.

### 4.2 Deaths Notified

	Death notifications
Deaths notified in Q1	24 deaths.
Deaths notified in Q2	10 deaths
Deaths notified in Q3	10 deaths
Deaths notified in Q4	11 deaths (1 case cause of death unknown at present)

Of the current active and completed cases, 5 were child deaths (aged 18 or below).

### 4.3 People's death by Age Group

Information regarding the age of death is of significance to the LeDeR Programme, given that this is a key marker of health inequality. The age range of deaths reported was 4 years – 92 years.

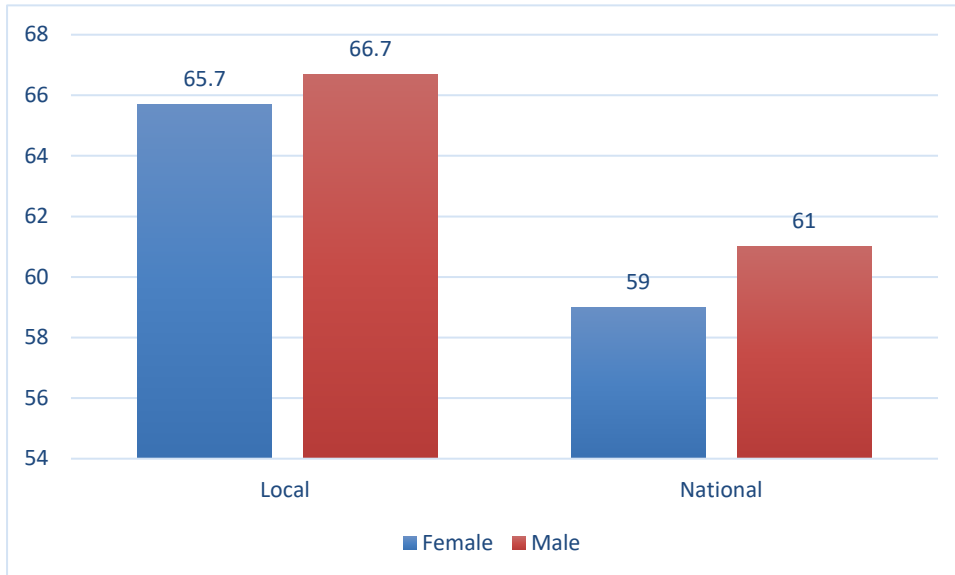
Age at death	2019/2020	2020/2021
4 - 40	16%	6.5%
41 - 60	22%	37%
61 - 95	62%	56.5%

The increase of deaths in the 41- 60 age group was a direct impact of Covid-19.

#### 4.4 People's death by Gender

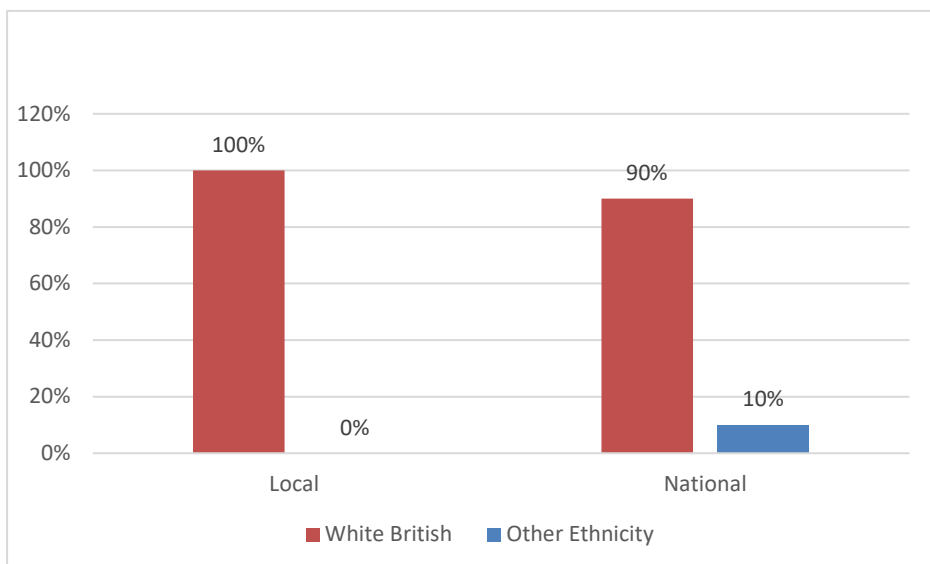
Of the completed reviews, the numbers of male and female deaths were equal. This was a change from last year's figures where male deaths outnumbered female deaths. Nationally, 58% were males.

#### 4.5 People's death by Age



Locally the average age of death for females was 65.7 years and 66.7 for males. The latest national figure was 59 years for females and 61 for males.

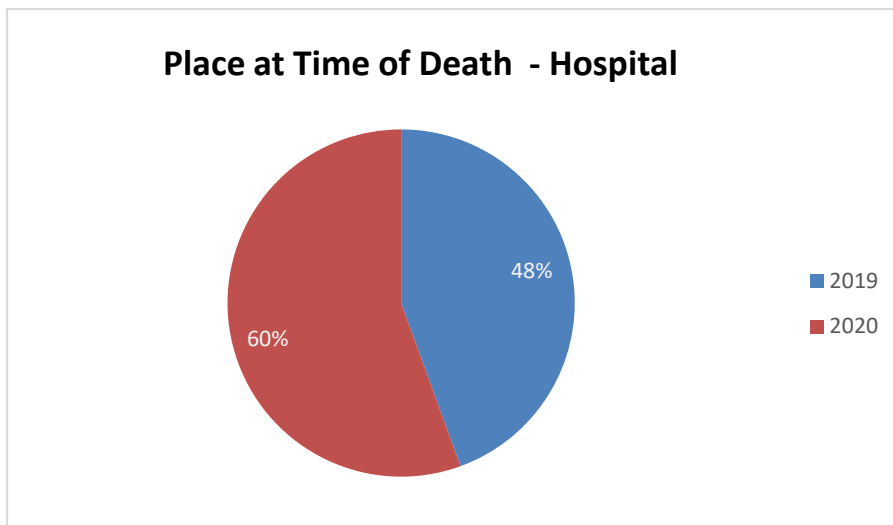
#### 4.6 People's deaths by Ethnicity



The 2019/2020 National Annual LeDeR Report reported that the majority of people who died, 90%, were of White British ethnicity, 10% were from other ethnic groups.

Locally 100% of people were reported as being White British ethnicity.

#### 4.7 Place at Time of Death



In 60% of cases locally, the place of death was in a hospital which compares exactly with the findings from the 2019 National LeDeR Annual Report. Locally this demonstrates an increase of 12% from last year's figure of 48%. Most of the Covid-19 deaths occurred within a hospital setting.

**Note: From this point onwards graphs data relates to completed cases only (adults)**

#### 4.8 Cause of Death

The cause of death is reported using a completed Medical Certificate of Cause of Death (MCCD).

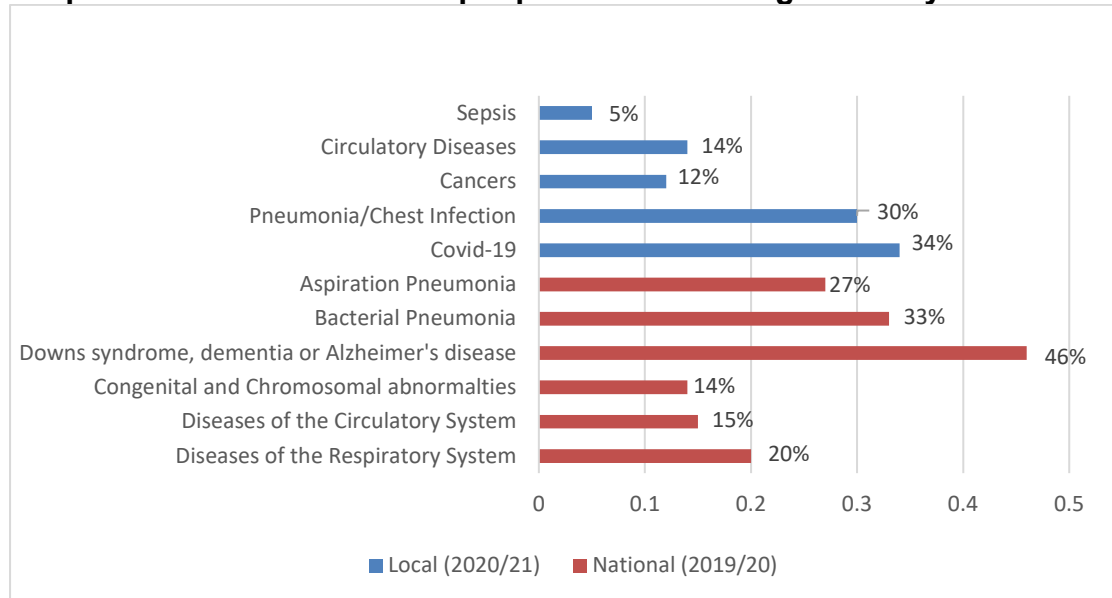
The national figures for 2020/2021 are not yet available to compare. However, in 2019/2020 national figures for people with learning disabilities reported the most frequent causes of death by ICD-10 chapter were diseases of the respiratory system (20%), diseases of the circulatory system (15%) and congenital and chromosomal abnormalities (14%). Other causes of death mentioned in Part 1 of the MCCD for people whose underlying cause of death was attributed to Down's Syndrome, Dementia or Alzheimer's Disease (46%), Bacterial Pneumonia (33%) and Aspiration Pneumonia (27%) (Bristol University 2019).

NB these figures are pre Covid-19 which will have a great bearing on causes of death.

##### **Local causes of death for people with a learning disability (2020/2021)**

- 34% of known causes of deaths were attributed to Covid-19
- 30% of known causes of deaths were attributed to Pneumonia/chest infections
- 12% of known causes of deaths were attributed to cancers
- 14% of known causes of deaths were attributed to circulatory diseases
- 5% of known causes of deaths were attributed to Sepsis.
- Other causes of death certified included epilepsy, peritonitis, perforation of the bowel, Alzheimer's Disease and choking.

**Graph 10: Cause of death for people with a learning disability**



#### **4.9 The use of Antipsychotic Medication**

Stopping over medication of people with a learning disability, autism or both (STOMP) is a national project to prevent the overprescribing of psychotropic medicines.

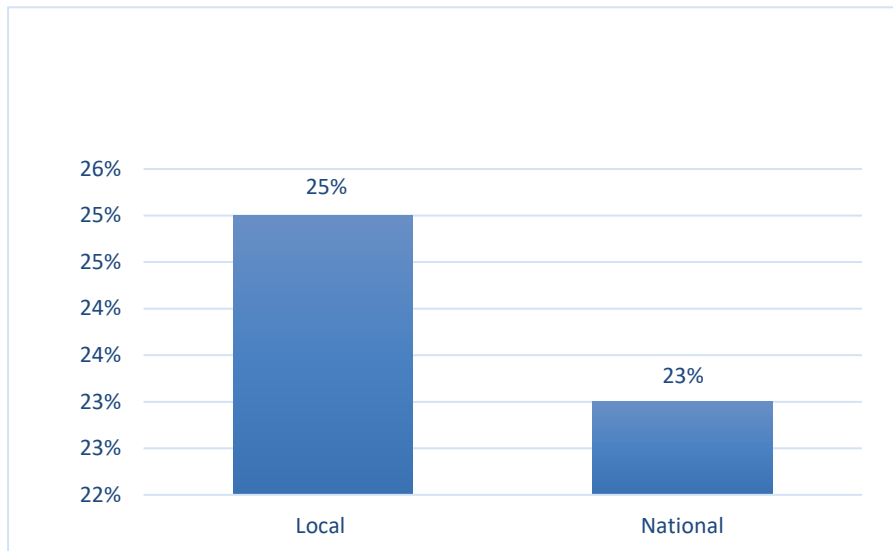
Psychotropic medicines are used to treat psychosis, depression, anxiety, sleep problems and epilepsy. However, they can also be used in people whose behaviour is seen as challenging and presenting a risk to themselves or others. People with a learning disability, autism or both are more likely to be given these medicines than others.

Public Health England reports that every day about 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines, without a diagnosis of the above specific health conditions. Children and young people are also reported to have been prescribed these medications. Psychotropic medicines can cause a number of side effects and have a negative impact on long-term health. <https://www.england.nhs.uk/learning-disabilities/improving-health/stomp>

There have been several local initiatives to reduce the prescribing of antipsychotic medications under the STOMP/STAMP agenda. These include Webinars for practitioners, connectivity with the Annual Health Check; ensuring medications and alternative therapy/support is available to individuals. Resources for professionals/carers and Advocates in an Easy Read format is available on the CCGS website.



**Graph 11: Was the person prescribed an antipsychotic drug?**

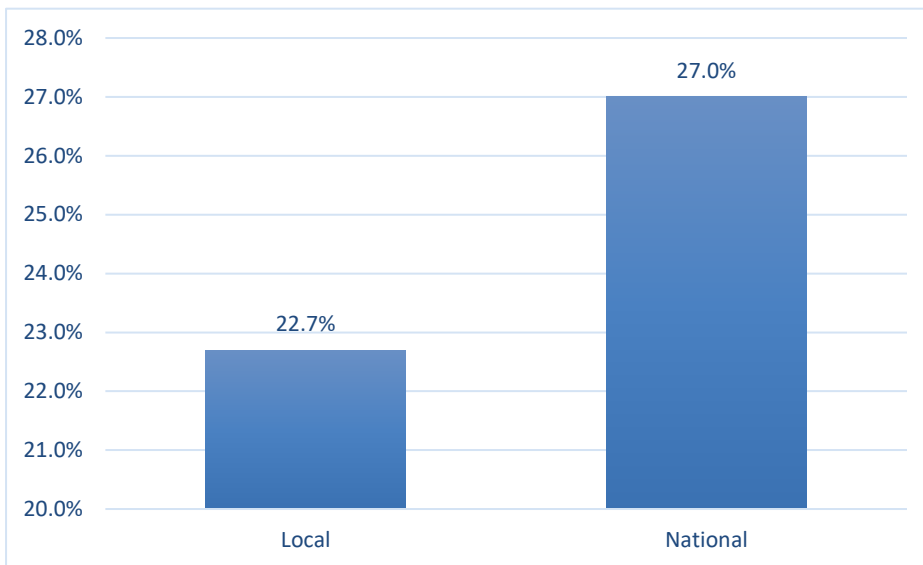


The latest national figure indicated that 23% of cases reviewed were receiving antipsychotics.

Locally the figure was 25%, indicating 2% more than the national figure.

However, this is still a reduction of 7% from last year's local figures.

**Graph 12: Was the person prescribed anti-depressants?**

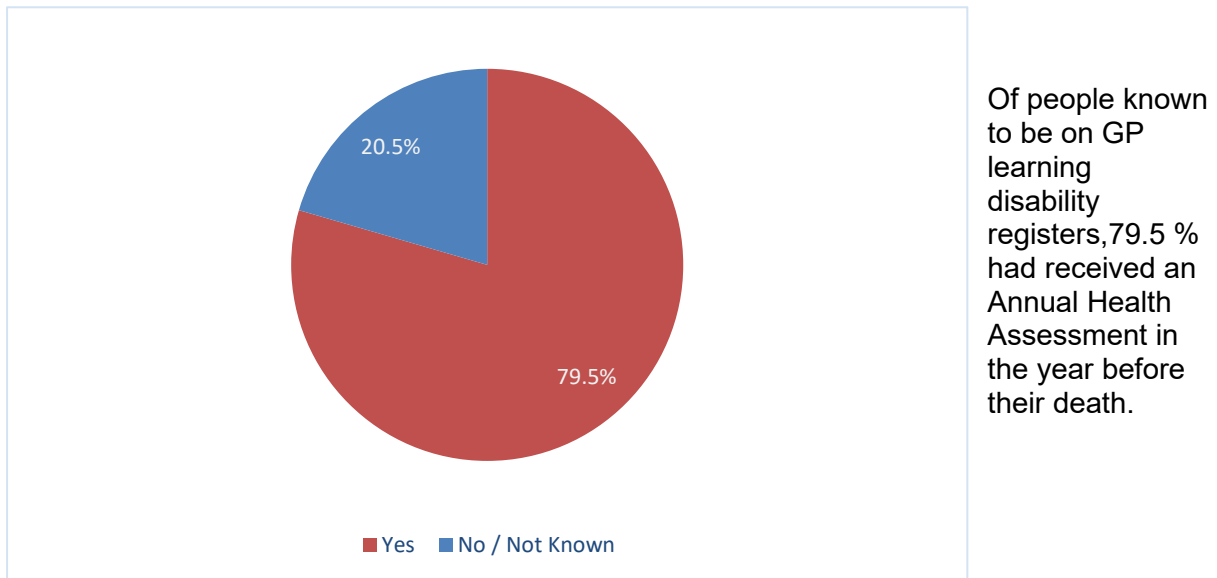


22.7% of the reviews identified the use of antidepressants; in all cases they were judged to have been used appropriately.

The latest national figure was 27%.

#### 4.10 Annual Health Checks

**Graph 13: Did the person receive an Annual Health Assessment within the last 12 months?**



The National Trajectory is set at 60% of people with a learning disability should have a comprehensive physical health check and be offered relevant interventions at least once a year. NHSE/I has published a variety of resources to increase AHC uptake and can be found via <https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/>

Locally work to increase the uptake of Annual Health checks to reach the National Trajectory includes: -

- Use of Care Coordinators and Social Prescribers to target harder to reach groups.
- Increased Health Care Assistant resource.
- Longer appointments and increased administration time.
- Help with attendance including the application of reasonable adjustments.
- Combination of AHC with Covid-19 vaccination.
- Proposed 'People First' Roadshows funded by LeDeR to include Annual Health Checks.

**Possible digital innovations in the community to be considered include: -**

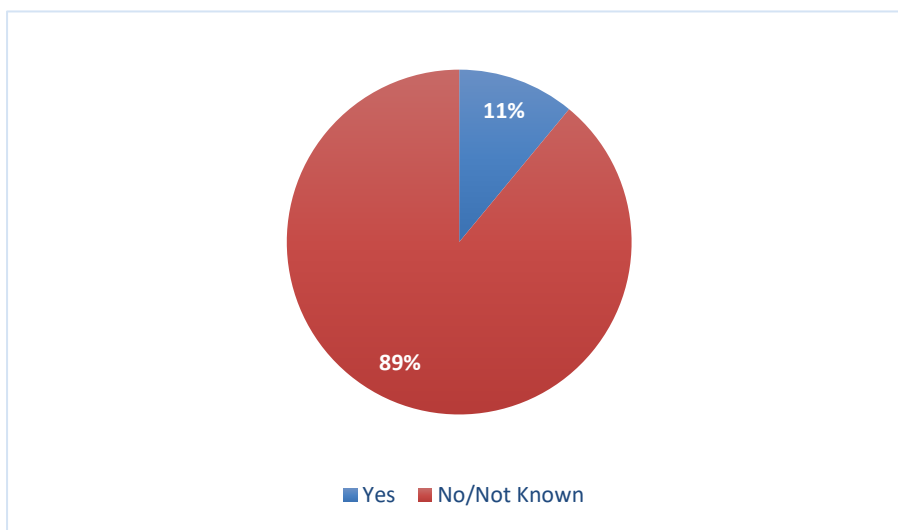
- ✓ To deliver checks in locations where patients are likely to be already such as existing appointments e.g., psychiatrists, clozapine clinics.
- ✓ To gather 'straight forward' data over phone/text/zoom.
- ✓ To investigate remote technology/provide portable equipment so checks can be conducted outside of clinics.
- ✓ To build flex into the system (no strict Did not Attend policies) so patients are catered for who do not feel able to attend on the day of an appointment.

The NHSE/I Learning Disability and Autism Programme DNA/CPR Task and Finish Group members are considering a series of training webinars/roadshows for professionals and people with lived experience delivered by professionals and people with lived experience to explain Annual Health Checks.

#### 4.11 Safeguarding Concerns

It must be acknowledged that people with a Learning Disability are more vulnerable and far less likely to self-report abuse or neglect.

**Graph 14: Was the person subject to Significant and/or Continuing Safeguarding Concerns in the Last 12 Months?**

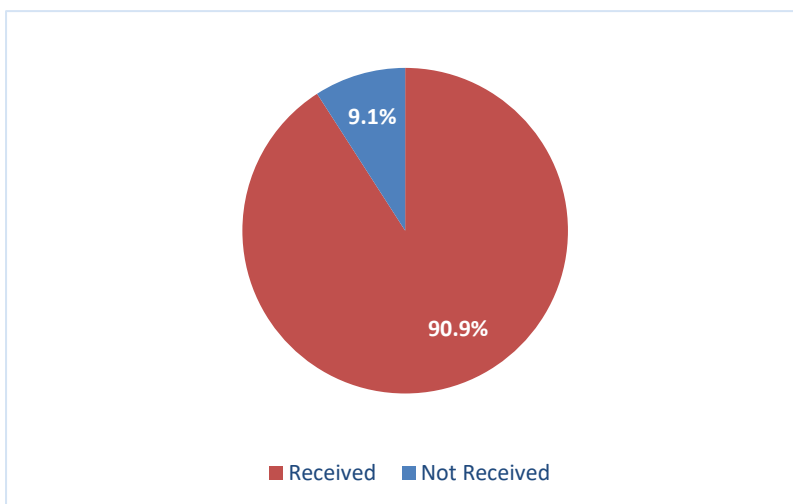


11% of the reviews identified that safeguarding concerns had previously been raised.

All Safeguarding enquiries had been reviewed by the Local Authority with appropriate actions being taken.

#### 4.12 Medication reviews

**Graph 15: Did the person receive a Medication Review within the last 12 Months?**



90.9% of people had received a medication review within the last 12 months prior to their death. This data is interesting in comparison to the completion of Annual Health Checks (79.5%).

It is reasonable to think that these may be completed at the same appointment. Medication Reviews may not have been carried out face-to-face with the patient.

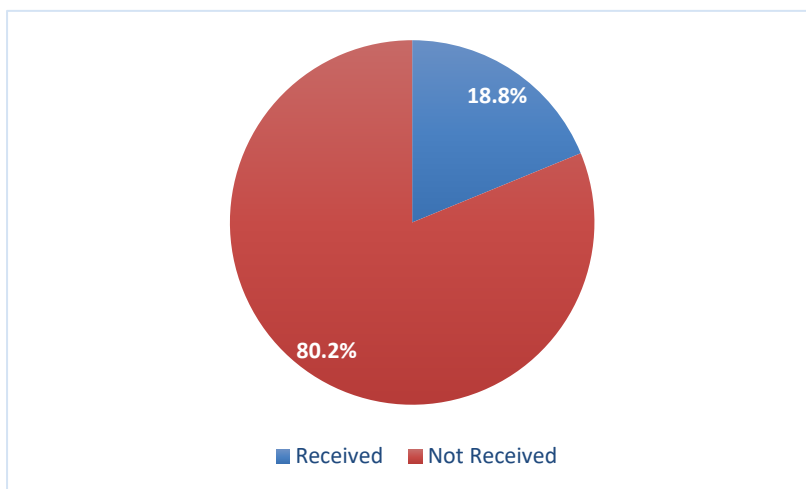
### 4.13 Generic Screening

People with learning disabilities have poorer health and are more likely to die at a younger age than people in the general population, in part because of poor access to health services. People with learning disabilities are also reported to have a poorer uptake of cancer screenings compared to the general population. The Equality Act 2010 states that you must make reasonable adjustments for people with a learning disability to have equal access to healthcare.

For example, some reviews found that there was a lack of reasonable adjustments on the use of standard invitation letters as well as recording of non-attendances, without consideration of the need for people to be supported to attend appointments.

Concerningly many reviews found a lack of reasoning as to why a person had not participated in the National Bowel Screening Programme.

#### Graph 16: Did the person receive generic screening in the last 12 months?



18.8% of people eligible had received generic cancer screening. In some cases, for example breast and cervical cytology, there was some evidence in the patients records that a decision was taken that it was not in the patient's best interests to perform the screening. However, in some cases the correct documentation regarding this was lacking.

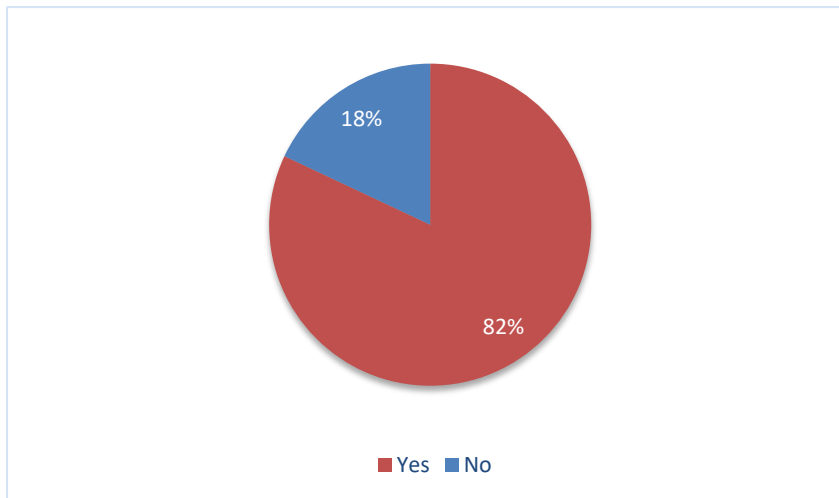
A guidance and resource pack has been developed by partners for care providers to support people to access health screening [http://www.northerncanceralliance.nhs.uk/wp-content/uploads/2019/08/LDN\\_cancer\\_pack\\_2.pdf](http://www.northerncanceralliance.nhs.uk/wp-content/uploads/2019/08/LDN_cancer_pack_2.pdf)

### 4.14 Family Involvement in the Review

Involving families in the review process is an important part of the work of the local reviewer. Families (or in the event of no family involvement, someone who knew the person well) are encouraged and supported to be involved in the review process as much as they feel able or want to be involved.

Contacting and involving families is undertaken in a timely, sensitive and respectful way, however, being sensitive to their needs may result in reviews commencing later when they feel better able to engage in the process.

### Graph 17: Was there Family Involvement in the Review?



There was family involvement in 82% of reviews, 18% declined to take part in the process.

### 4.15 End of Life Care

In accordance with NHS England's End of Life Care <https://www.england.nhs.uk/eolc> persons receiving end of life care are afforded the opportunity of having choice, with more supported planning around the place where they are looked after at the end of their life.

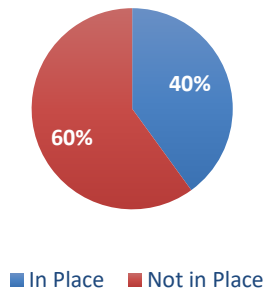
Within the LeDeR review there is a requirement to understand if end of life care planning was in place for those where death was expected. This was the case for 54.5 % of local reviews. To put this figure in context, some deaths were unexpected, therefore the chance to plan for end of life was not appropriate. Reviews found examples of timely involvement of the Palliative Care Teams.

One local initiative by the Learning Disabilities service has implemented 'My future wishes' list that helps professionals and carers discuss with someone with a learning disability what they wish to happen at the end of their lives in appropriate situations.

### Graph 16: Did the person have a Do Not Attempt Cardio Resuscitation (DNACPR) in place at time of death?

Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing explicitly states that decisions about DNACPR must not be based on assumptions related to the person's age, disability or the professional's subjective view of a person's quality of life. <https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr>

## Did the person have a DNACPR in place at time of death?



The review identifies if a Do Not Attempt Cardiopulmonary Resuscitation order was in place or not. 40% (22) had completed DNACPRs.

Reviewers felt that the majority of these were appropriate, correctly completed and followed following the ReSPECT Agenda

<https://www.resus.org.uk/respect>

It was concerning that one review revealed that Downs Syndrome was indicated as a reason for a DNACPR decision. In May 2019 Professor Stephen Powis, National Medical Director sent a letter to Senior Clinicians reminding them that terms such as Learning Disability and Downs Syndrome should never be used as a reason for issuing a DNACPR. As per LeDeR process this learning was shared with the individual as well as locally via the local Steering Group.

### 4.16 Reasonable Adjustments

Under the requirements of the Equality Act 2010, organisations have a duty to make reasonable adjustments if someone is at a disadvantage due to their disability. This means by law healthcare providers must make reasonable adjustments to ensure that people with a learning disability have equal access to health services.

Reviews identified many examples of reasonable adjustments including:

- ✓ End of clinic appointments when departments were less busy.
- ✓ Double appointments, enabling clinicians to spend more time with the patient.
- ✓ Relatives or carers attending appointments with patient.
- ✓ Nursed in a side ward whilst in hospital by carers that they knew.
- ✓ Easy Read health information.
- ✓ 1 to 1 continuous care whilst in hospital.

## Section 5 – Quality of Care Provided

### 5.1 Quality of Care

At the end of a review, having considered all the information available to them, reviewers are asked to provide an overall assessment of the care provided to the individual and provide a grade. The table below shows the grading of care and the LeDeR reviewers' overall assessment of the care received:

Not all reviews generate learning, with a significant number of reviews demonstrating good care throughout the life, and end of life, of the individual.

**Table 5.2: Grading/Quality of Care**

Grading/Quality of Care (completed cases)			
Grading of Care in Adult Cases		Number of Reviews	%
1 =	This was excellent care (it exceeded expected good practice)	6	13.6
2 =	This was good care (it met expected good practice)	16	36.3
3 =	This was satisfactory care (it fell short of expected good practice in some areas, but this did not significantly impact on the persons wellbeing)	16	36.3
4 =	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to cause of death	2	4.5
5 =	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death	3	6.8
6 =	Care fell short of expected good practice and this contributed to the cause of death	0	0

**NB** Child deaths do not receive a grading of care.

Everyone should expect to receive care that meets good practice, this was the case for 86.2% of local reviews.

However, it is important to note that 6.8 % fell short of satisfactory practice. Where the care fell short of satisfactory practice 14% were deemed to have an adverse effect on the individual, although care did not directly contribute to the cause of death. The lessons learned from this feedback have formed part of the Action Plan for 2020/21.

**The LeDeR Quality Review Panel noted areas of good practice including:**

- ✓ Flagging of hospital records.
- ✓ Support whilst an inpatient from the Hospital Learning Disability Nurse.
- ✓ Relatives or carers attending appointments with patient.
- ✓ Easy Read health information.
- ✓ Nursed in a side ward whilst in hospital by carers that they knew.
- ✓ Early referral to the Palliative Care Team.
- ✓ Smooth transition from assisted living to a nursing home by the Community Learning Disability Team.
- ✓ End of clinic appointments. Double appointments.
- ✓ Emergency Admission to Hospital packs.
- ✓ Hospital Passport.
- ✓ 1 to 1 continuous care whilst in hospital.

**The LeDeR Quality Review Panel noted areas where practice fell short of expected good practice including:**

- Failure to identify Covid-19 infections early enough to prevent spread amongst residents and staff (very early in first pandemic wave).
- Lack of provision of healthy living management /advice including weight management in clinically obese patients.
- Poor discharge planning in complex cases.
- Lack of early identification of the deteriorating patient.
- Lack of Annual Health Checks.
- Lack of Person-Centred Care.
- Lack of application and documentation of the Mental Capacity Act (MCA).
- Routine cancer screening not offered or followed up when not attended.

## **Section 6 – Deaths of Children**

### **6.1 Child Deaths Overview Panel (CDOP)**

Local Safeguarding Children Partnerships are required to review the deaths of all children who normally reside in their area. The regulations are outlined in Working Together to Safeguard Children and the CDOP statutory and operational guidance. Closer working relationships between local LeDeR processes and the CDOP have been established. Any learning is shared through the LeDeR programme network in the usual way.

The purpose of the Child Death Review Process is to collect and analyse information about the death of each child who normally resides in North Yorkshire and Vale of York CCG with a view to identifying any matters of concern or risk factors affecting the health, safety or welfare of children, or any wider public health concerns. There are a number of national programmes which centre on the review of deaths or particular types of child death including the LeDeR process. As such, CDOPs are advised to complete the child death review process rather than the LeDeR review.

Where the child had a learning disability and comes under the remit of the LeDeR programme the completed child death report is then uploaded to the LeDeR system and effectively forms the LeDeR review.

During the review period 5 cases were notified to the LeDeR platform, which related to the death of a child with learning disabilities. Due to the small number of cases, specific demographic data has been withheld to prevent inadvertent identification of the individuals.

## **Section 7 – Learning into Action**

Undertaking a review of a death is helpful, but it is the lessons learned from a review that are vital in sharing best practice and making recommendations as to how services could improve to prevent health inequalities.

Local learning themes are shared with the Steering Group members and also contribute to the NHS Long-Term Plan, through the prevention and health inequalities agenda. Individual Steering Group partners will take relevant learning back into their organisations to address recommendations and are responsible for ensuring learning identified is acted upon in their own areas. The CCG records all evidence of learning into action from reviews.

A summary of common themes is detailed below:



## Learning into Action

<b>Learning Theme</b>
Lack of Annual Health Checks (AHC)
<b>Summary</b>
<p>Annual Physical Health Checks (including the resulting interventions and follow up activity) are a key way to manage comorbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality. The NHS Long Term Plan includes priorities to increase the number of people receiving physical health checks for people living with severe mental illness and learning disability, and for across the NHS, to do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives, and that physical health checks will also be introduced for autistic people.</p> <p>GP Surgeries have been advised by NHSE/I that there is a national expectation that Learning Disability and Severe Mental Illness annual physical health checks should still be completed during this time of Covid-19. However, completing AHCs in primary care is undoubtedly a challenging ask due to current pressures.</p> <p>The better use of Health Passports will improve information exchange between services. This will ensure guidance on person centred care goes with the individual across their care pathways</p>
<b>Recommendations from reviews</b>
<ul style="list-style-type: none"><li>• CCG training sessions for Primary Care staff to improve the Annual Health Check uptake.</li><li>• Prompts on systems to ask whether someone has had an Annual Health Check</li><li>• AHCs along with Covid-19/Influenza vaccinations</li></ul>

<b>Learning Theme</b>
Lack of Person-Centred Care
<b>Summary</b>
<p>It was clear from reviews that Hospital Passports are used when provided to wards. However, these were not always provided on admission and/or were not updated. (It should also be noted that a Hospital Passport is not compulsory and therefore has to be agreed with if possible, with the person involved).</p>

### Recommendations from reviews

- The promotion of Hospital Passports shared through local partners and their respective bulletins.
- Hospital Passports to be provided on admission and/or were not updated.
- The use of social stories and more specific tailored information to support access to healthcare.
- Banks of easy read leaflets available for staff to access.
- The use of Pictocom communication books, also available electronically.
- Invites to carers to continue safely accompanying a person through hospital admission throughout the Covid-19 pandemic.
- Offering pre-op visits to meet staff and understand what will happen in theatre
- Prompts to offer a Hospital Passport included in the inpatient admission initial assessments.
- Hospital Passports which identify 'most appropriate' person to be consulted and an opportunity to provide two further key people.
- Prompt letters from services to GP Practices to add people to LD registers and offer Annual Health Checks.

### Learning Theme

Lack of application and documentation of the Mental Capacity Act (MCA)

### Summary

A common theme across all mainstream services is the need for increasing the confidence and competency in working with people and their families in relation to the application of the MCA. The MCA is not consistently being applied in a way that supports and protects the rights of individuals. There is not always evidence of how capacity is being assessed and how a "Best Interests" decision is being made. The phrase 'Best Interests' sometimes appears to be used as a clinical shorthand, possibly for an arbitrary decision, rather than indicating a specific process undertaken within the framework of the MCA with associated record of this in the care notes. In other instances, expressed wishes and feelings appear to be being equated with capacity.

There is room to make much better use of Independent Mental Capacity Advocates (IMCA) as an independent voice for people with learning disabilities, particularly when in hospital.

Several reviews found instances where no evidence of Mental Capacity Assessments took place, particularly where there was poor concordance with health interventions.

### Recommendations from reviews

- Local services strengthen their governance in relation to adherence to the MCA and provide training and audit of compliance on the ground so that professionals fully appreciate the requirements of the Act in relation to their own role.

- Development of electronic Capacity Assessment and Best Interest forms in Acute Trusts.
- Development of electronic Best Interests forms which prompt consultation with key people, including Advocates.

### **Learning Theme**

Lack of the early identification of the deteriorating patient

### **Summary**

Several reviews have found problems with timely and appropriate responses related to changes in presentation and need. There is evidence of missed opportunities for escalation leading to poor outcomes in all settings including hospital; nursing and residential homes; and people's own homes. Contributory factors include the person being unable to communicate their discomfort due to communication impairment or opportunities to communicate; lack of consideration of capacity and best interests when the person has 'declined' interventions; and diagnostic overshadowing.

### **Recommendations from reviews**

- The consistent application of NICE Guidance 51: Sepsis: recognition, diagnosis and early management by health professionals
- The promotion of the CCGs Simons Story presentation that raises the awareness of Sepsis for Advocates and Self Advocates

### **Learning Theme**

Lack of provision of healthy living strategies/advice including weight management.

### **Summary**

Several reviews identified that although a high Body Mass Index (BMI) had been identified, particularly within Primary Care, there was no interventions discussed or recommended.

### **Recommendations from reviews**

- NICE Guidance 53: Weight management: lifestyle services for overweight or obese adults should be followed on identification of a BMI of over 25.
- Banks of easy read leaflets/aides available for staff to access.

<b>Learning Theme</b>
Routine cancer screening not offered or followed up when not attended.
<b>Summary</b>
<p>Routine cancer screening saves lives by detecting cancers at an early stage.</p> <p>Several reviews found that such screening was either not offered or not followed up when someone did not attend. As stated earlier, some reviews found that there was a lack of reasonable adjustments on the use of standard invitation letters as well as recording of non-attendances, without consideration of the need for people to be supported to attend appointments. However, bowel cancer screening in particular was found to be very poor in uptake, even though it is a non-invasive process often relying on a carer to acquire the stool specimen for testing. Reviews indicated that non-compliance was not followed up by the GP Practice.</p>
<b>Recommendations from reviews</b>
<ul style="list-style-type: none"> <li>• The use, when appropriate of reasonable adjustments on the use of standard invitation letters; recording of non-attendances (e.g., did not attend) without consideration of the need for people to be supported to attend appointments.</li> <li>• Clear documentation of the use of the Mental Capacity Act if it is in the patient's best interests not to be offered cancer screening.</li> <li>• GPS to have/use an effective system in place to follow up non-compliance.</li> </ul>

## Section 8 – Future Priorities, Acknowledgements and References

### 8.1 Future Priorities

Following the implementation of the new LeDeR Policy, CCGS are required to produce a 3-year LeDeR Strategy that will demonstrate how the ICS Care System will act strategically to tackle those areas identified in aggregated and systematic analysis of LeDeR reviews and national findings. The Strategy will be shared with NHS England and NHS Improvement's Regional Team and updated annually in June each year. The document will be localised via the Local LeDeR Steering Group.

## **8.2 Acknowledgements**

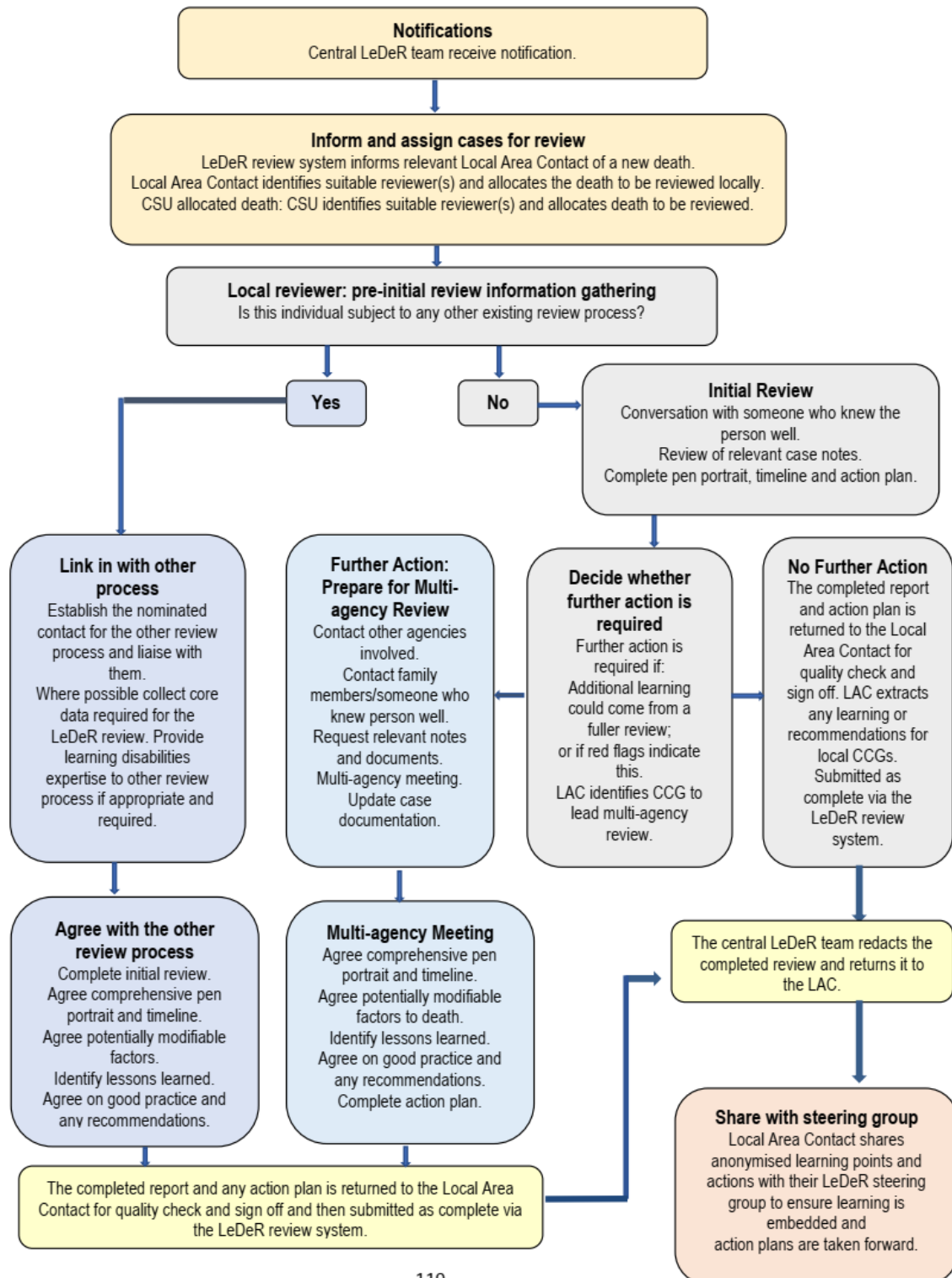
The data presented in this report represents individuals who were loved and supported by their families, friends and carers. On behalf of the CCGs, the local LeDeR team would like to pass on sincere condolences to those who are bereaved and also express grateful thanks for the contributions they have made to helping us make improvements in our services to support the lives of others.

## **8.3 References**

1. Deaths of People identified as having learning disabilities with Covid 19 in England in the Spring of 2020. Public Health England.
2. <https://www.resus.org.uk/respect>
3. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/CO/60-letter-DNACPR.pdf>.

## Section 11 - Appendices

### Appendix 1: The LeDeR Review Process



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**NORTH YORKSHIRE AND YORK CCG'S**  
**LEARNING DISABILITIES MORTALITY REVIEW STEERING GROUP**  
**TERMS OF REFERENCE**

The Steering Group has been formed to ensure the LeDeR process is implemented and embedded across the North Yorkshire and York Clinical Commissioning Groups (CCG's). The Steering Group adheres to the guidance provided by NHS England and Improvement.

The Steering Group will operate within the North Yorkshire and York CCGs Constitution and will at all times comply with the relevant CCGs policies and procedures. The Long-Term Plan sets out how the NHS will strengthen its contribution to prevention and health inequalities. This includes accelerating the Learning Disability Mortality Review (LeDeR) Programme to identify common themes and learning points and provide targeted support to local areas. The Long-Term Plan also states that the whole NHS will work together to improve the health and wellbeing of people with a learning disability.

The aim of the LeDeR programme is to drive improvement in the quality of health and social care service delivery for people with learning disabilities. It identifies the causes of premature mortality in this population, through case review. These findings support health and social care professionals and Policy makers to identify key recommendations for improvement. NHS England and Improvement publishes action from learning, in an annual report and via NHS Futures, to support local teams to make a difference to the health and wellbeing of people with a learning disability in their areas. Each CCG is a member of a LeDeR Steering Group, which is responsible for ensuring learning is identified and acted upon in its area.

**MEMBERSHIP**

Membership of the steering group is determined and approved by the Chairperson.

Membership will comprise of:

- Director of Quality and Governance North Yorkshire CCG (or representative)
- Commissioning Lead for Mental Health and Learning Disability NY CCG.
- CCG Designated Professional's for Safeguarding Adults representative.
- NHS Provider organisations representatives
- Director for Public Health, North Yorkshire County Council (or appropriate representative)
- Director for Public Health, City of York Council. (Or appropriate representative)
- CCG Designated Doctor for the Child Death Overview Panel (corresponding member)
- Child Death Overview Panel representative (corresponding member)
- North Yorkshire Safeguarding Adult Board representative.
- City of York Safeguarding Adult Board representative.
- North Yorkshire Safeguarding Children Partnership representative
- City of York Safeguarding Children Partnership representative.
- North Yorkshire County Council Assistant Director, Care and Support
- Service user representative (to be confirmed).
- GP lead for Learning Disabilities (Corresponding member).



- NHS England and Improvement, Health Inequalities Senior Manager -NEY & Leder Regional Coordinator )LeDeR Reviewers may attend with the agreement of the Chair.
- Yorkshire Ambulance Service representative
- Specialist Practitioner/Local Area Contact

Other members may be co-opted into the meeting as required.

### **Role of Members**

Members review the programme direction and make decisions to make sure that:

- Partners work together to support the success of the programme and make sure that no single interest will undermine the programme.
- All members are equally valued and supported effectively to contribute. This includes compensating for their time and travel costs for participating in the work of the Steering Group, unless they decline such compensation.
- All risks are assessed and managed well, putting in place actions and contingency plans for all high impact risks.
- The time and resources needed for the programme objectives are available.
- Recording of programme information is accurate and coherent.
- Support is available for the Local Area Contacts.
- The progress of the overall programme is monitored, and any remediable action is undertaken.
- Representatives will be responsible for providing feedback via their respective organisational networks.
- Among other matters, the meetings may establish time specific working groups to focus on specific issues, which may be delegated to resolve/approve specific actions.
- To ensure agreed protocols are in place for information sharing, accessing case records and keeping content confidential and secure. To ensure that the data is appropriately handled to ensure security and confidentiality in line with the programme's CAG S251 approval.

## **ATTENDANCE AND QUORACY**

The meeting will be quorate if 3 members attend from separate agencies including the Chair. Members will demonstrate a commitment to attend meetings and ensure completion of allocated work within the agreed timescales. If a quorum has not been reached, then the meeting may proceed if those attending agree but any record of the meeting should be clearly indicated as notes rather than formal minutes, and no decisions may be taken by the non-quorate meeting of the steering group.

## **DECISION MAKING**

The steering group is not a decision-making body. The Chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action.

## **AIMS & OBJECTIVES**

The main aims of the steering group are to:

- Ensure local learning is acknowledged, shared appropriately with key stakeholders, and acted upon if appropriate.
- Ensure local reporting of deaths to the LeDeR programme.
- Work with a multi-disciplinary approach in mind and communicate effectively across the health and social care economy.
- Ensure system wide learning by sharing good practice as well as supporting and implementing identified improvements.
- Ensure the effective steering of the LeDeR programme across North Yorkshire and York. Develop the LeDeR Programme across North Yorkshire and York.
- To receive regular updates from the Local Area Contact about the progress and findings of reviews.
- To ensure that any learning, recommendation and actions arising from reviews of deaths is acted upon, as appropriate, using locally agreed governance structures and in collaboration with local stakeholders and commissioners.
- To ensure plans for action from learning are applied using Annual Health Checks and consequential health action plans for each person, medication reviews for individuals, applying the Learning Disability Improvement Standards and ensuring reasonable adjustments are made to local pathways in line with the needs of individuals.
- To work in partnership with the CCG lead responsible for LeDeR (in most cases it will be the Local Area Contact):

- To support the initial review of all deaths of people with learning disabilities (aged 4 years and over) in their area as per agreed process.
- To help interpret and analyse the data submitted from local reviews, including areas of good practice in preventing premature mortality, and areas where improvements in practice could be made.
- To ensure that the data is appropriately handled to ensure security and confidentiality in line with the programme's CAG S251 approval.
- To share anonymised case reports pertaining to deaths or significant adverse events relating to people with learning disabilities to enhance local understanding of learning points and recommendations

## **CONFIDENTIALITY**

Due to the complex and multi-agency nature of the reviews it is important that information sharing is in line with expectations regarding confidentiality and the appropriate use of received information. Stakeholders across all care sectors need to work together positively to enable open information sharing for the purpose of achieving good quality reviews, in accordance with the Information Sharing Agreement.

All reviews presented will be anonymised.

## **MANAGEMENT AND REPORTING**

Assurance will be provided that all known deaths of people with learning disabilities receive a review of the circumstances leading to death as indicated by the LeDeR methodology.

Representation on the North Yorkshire and York LeDeR Steering Group from the Local Safeguarding Children's Board and Local Safeguarding Adult's Board ensures local and national learning regarding deaths where a person has a defined Learning Disability, is shared and acted upon within the multi-agency arena.

The Child Death Overview Panel will share their completed Form C review document with the LeDeR programme in North Yorkshire and York in place of a LeDeR review, and if safeguarding is a feature these will be escalated to the Local Safeguarding Children's Boards relevant sub groups;

Completed adult LeDeR Reviews where safeguarding is a feature will be shared with the relevant Local Safeguarding Adult's Board Review subgroups.

The North Yorkshire and York LeDeR Steering Group will provide the minutes of the meetings to a representative of the North Yorkshire Transforming Care Partnership to provide assurance; any outstanding issues will be escalated to the North Yorkshire Transforming Care Partnership by exception. The North Yorkshire Transforming Care Partnership will share

The minutes and papers from this meeting will not be routinely made available to the public and will not be included in the CCGs Publication Scheme. Any formal request for the minutes and papers from this meeting will, however be carefully considered under the Freedom of Information Act 2000.

- The Steering Group is accountable to the local Transforming Care Partnership Board.
- The Steering Group reports to the ICS Partnership Board
- The Steering group reports via the Local Area Contact to the local Health Task Group.
- The LeDeR Steering Group reports on a quarterly basis to the Yorkshire and Humber Executive Steering Group.
- The process for selecting members is transparent.
- Terms of Reference will be reviewed in 12 months.

## **ADMINISTRATION**


Administration for meetings will be undertaken by a personal assistant from the CCG. The secretary of the steering group shall be a person approved by the group as having the requisite knowledge and experience, and will be responsible for:

- Supporting the Chair in the management of the Steering Group's business (including setting the Agenda, collation of papers and highlighting conflicts of interest);
- Maintaining a record of matters arising, issues to be carried forward and minutes of the meetings.
- Maintaining an attendance register.
- Electronic papers for the steering group will, where possible, will be issued one week ahead of the meeting.

## **FREQUENCY**

The Steering Group will meet quarterly.



<b>Item Number: 11</b>	
<b>Name of Presenter: Michelle Carrington</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – North Yorkshire and York CCGs Safeguarding Children and Children in Care Annual Report 2020/21</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b>	
<b>Reason for Report</b>  This report provides assurance to the Governing Body that the CCG has fulfilled its statutory responsibilities to safeguard the welfare of children, including those that are Looked After.  The report was also received at the Quality and Patient Experience Committee on 9 September.	
<b>Strategic Priority Links</b>  <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b>  <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	

**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- |  |   |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment         | <input type="checkbox"/> Equality Impact Assessment       |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

**Risks/Issues identified from impact assessments:**

N/A

**Recommendations**

Governing Body is asked to receive the report.

**Decision Requested (for Decision Log)**

Report received.

**Responsible Executive Director and Title**

Michelle Carrington: Executive Director of Quality and Safety / Chief Nurse

**Report Author and Title**

Designated Professionals

# SAFEGUARDING CHILDREN AND CHILDREN IN CARE ANNUAL REPORT 2020 - 2021



North Yorkshire CCG and Vale of York CCG



# Contents

1. Introduction
2. Safeguarding Children: Achievements, Challenges and Priorities
3. Children in Care: Achievements, Challenges and Priorities
4. Integrated Care Systems: Achievements, Challenges and Priorities
5. Summary and Moving Forward
6. References

Welcome to the North Yorkshire and York CCGs Safeguarding and Looked After Children Annual Report for 2020 - 2021 – our ninth report to CCGs and partners. This report summarises some of the key achievements and challenges which the team have faced during the unprecedented events of the past twelve months.

It is impossible to underestimate the impact that Covid and the accompanying restrictions have had on the lives of children and young people:

- vulnerable families locked down with little access to support, particularly those with young babies
- children who have lost family members and carers through Covid
- children in the care system unable to have direct contact with their birth family
- children experiencing the impact of increased and unrecognised domestic abuse in their homes
- children limited in terms of access to education and deprived of the support of friends and teachers

Reports tell us that children are experiencing high levels of emotional distress and mental health problems, and that numbers of children coming into the safeguarding and looked after systems are increasing. This has certainly been our experience in North Yorkshire and the City of York. Additionally, we have seen levels of physical abuse to young infants which have not been seen for many years, together with increasing levels of complexity of cases. A number of these cases have led to Child Safeguarding Practice Reviews commissioned by our Safeguarding Partnerships.

Throughout the year, the team has worked with partner agencies to understand the risks to children and young people and to develop new processes and responses in mitigation, within the limits imposed by the pandemic. Evaluation of those new practice changes will help to shape our practice going forward.

It is also important to acknowledge the impact of the pandemic on safeguarding and children in care specialist health practitioners. The need to quickly modify working practices and the increased workload has resulted in significant challenges. The Designated Professionals have worked closely with colleagues in provider organisations to facilitate additional support and supervision, in order to secure ongoing resilience and minimise the impact of vicarious trauma.

At the start of a new year and the last in the current NHS structure, the team look forward to developing safeguarding structures and processes across the ICS. We will be further developing the existing ICS Network of Designated Professionals to strengthen our response to those children and young people who are the most vulnerable and needing additional support to achieve their full potential.

The Designated Professionals Team



# SAFEGUARDING CHILDREN

*'Nothing is more important than children's welfare. Children who need help and protection deserve high quality and effective support as soon as a need is identified' (DfE 2018. p.6)<sup>1</sup>*

## Achievements

Rapid responses developed to changing Covid situation & national guidelines

New processes agreed with partner agencies & implemented quickly

Development and promotion of 'Safeguarding at a distance' guidance to support front-line practitioners

Development of awareness and support materials around domestic abuse: locality-based initiatives to include information about resources at testing sites; 'place of safety' and 'Ask Ani' campaigns

Movement of safeguarding training to online platforms in primary care

Practice guidance for safe management of child protection medical assessments during Covid

Engagement of national and regional safeguarding professional Covid forums

Development of Safeguarding Summary Bulletins for providers to minimise email traffic and support specialist practitioners redeployed to frontline clinical care

Development of national ICON for premature infants and accompanying teaching resource

Revision of multi-agency procedures in line with new national guidance

## Challenges

Increasing number of Child Safeguarding Practice Reviews – Designated Professionals lead on Case Review Groups in both NY and CoY so this has impacted significantly on workload

Increasing activity levels in terms of safeguarding cases which impacts on provider teams' capacity and resilience – Des Profs provide support and supervision

Impact of changes to North Yorkshire 0-19 Healthy Child Service on safeguarding arrangements

Rapid requirement to move to home-based working and virtual meetings has led to challenges with IT technology and differing platforms

Increasing number of reported Domestic Abuse incidences and related increases in MARACs resulted in challenges for safeguarding partners to support Domestic Abuse processes

Supporting safeguarding practitioners to prevent vicarious trauma and burnout through supervision processes held virtually

## Priorities

Working with partner agencies to understand current demand and reasons for referrals in order to better shape future services

Reviewing practice over past year to determine which elements to retain and which to change

Developing and delivering the action plan to support 'Protect and Prevent' approach to reducing Sudden Unexpected Death in Infancy in families with pre-existing vulnerabilities

Re-establish safeguarding assurance processes with relevant provider organisations

Working with Public Health commissioners to manage safeguarding risks associated with revised Healthy Child Service in NY

Reviewing and developing the North Yorkshire and York joint pathway for managing safe and timely discharge from paediatrics of children who self-harm

Recruiting to Primary Care Safeguarding Team to support new and existing roles

Ongoing review of health resource in the Multi-Agency Safeguarding Hub (CoY) and Multi-Agency Screening Team (NY)

# CHILDREN IN CARE

*'Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences' (DH, 2015 p:8)<sup>2</sup>*

## Achievements

Practice guidance for safe management of virtual Initial Health Assessments for Children in Care

Collaborative working to identify gaps in provision of Review Health Assessments undertaken in other local authority areas where children in care were placed

Practice guidance for safe management of virtual Review Health Assessments for Children in Care and continuation of same despite national guidance indicating these could be deferred until after the pandemic

Agreed processes between primary care, both local authorities and legal teams for management of Adult Health Medicals for prospective adoptive/foster carers

Finalising agreement between contracting and commissioning teams regarding 'Risk Share' agreement for payment of health assessments – this ensures that such assessments can be progressed in a timely fashion

Working in conjunction with the Specialist Nursing Team for Children in Care and Public Health commissioners to secure robust arrangements for meeting the health needs of Children in Care.

Templates developed in NYY for Adult Health Medicals adopted nationally by CoramBAAF

## Challenges

Supporting timeliness of initial and review Health assessments with increasing numbers of children entering care

Supporting providers to manage health assessments in line with revised guidance and in light of Covid restrictions and staffing pressures

Close collaboration with partner agencies to support the needs of foster and alternative carers and to provide health advice regarding the management of potential risks associated with Covid.

## Priorities

Finalisation of Service Specification for HDFT Children in Care Specialist Nursing Team

Working with Public Health commissioners and HDFT service leads to ensure that revised Healthy Child Service in NY delivers a quality service to Children in Care

Development of training programme for all paediatricians providing Initial Health Assessments to ensure consistently high-quality assessments which support the health of Children in Care

'Health Passports' - work with partner agencies to ensure Children in Care and their carers have access to relevant health information to support positive health choices

Establishment of 'Promoting Health Needs of Children in Care' group in City of York

To work in collaboration with the local authorities in respect of Unaccompanied Asylum-Seeking Children who will be placed in North Yorkshire and the City of York



# INTEGRATED CARE SYSTEMS

*'ICSs should support joint working around responsibilities such as safeguarding through new and existing partnership arrangements; and health and care strategies and governance should account for the needs of children and young people' (NHS E & NHS I, 2021)<sup>3</sup>*

## Achievements

Implementation of 'ICON: Babies Cry, You Can Cope' across ICS footprints

Rapid implementation of weekly meetings across HCV and WYH ICSs to support practice and identify any emerging themes and trends

Weekly ICS 'Hot Spot' reporting to NHS E/I

Agreement regarding key ICS safeguarding children priorities and development of associated workplan

Acknowledgement and peer support around impact of vicarious trauma at time of significantly increased safeguarding activity

Ongoing support to Designated Professionals new to role

Agreed Terms of Reference for HCV ICS Designated Professional Network

All practice guidance documents developed during Covid shared for use across the ICS footprint



## Challenges

Both Priority and challenge is the development of agreed safeguarding governance structure across the ICS which will ensure that the ICS is best placed to meet its new statutory requirements in respect of both safeguarding and Children in Care

Providing peer support to Designated Nurses across the ICS who are new into post as they adapt to both their new role and the CCGs begin the transition to ICSs

Working across multiple ICS safeguarding systems (Humber, Coast and Vale, West Yorkshire and Harrogate, North East and North Cumbria, Lancashire and South Cumbria) to support and influence developments critical to safeguarding and Children in Care practice in North Yorkshire and York

## Priorities

Development, agreement and embedding of new safeguarding and Children in Care governance structures across HCV ICS

Alignment of Designated Professionals to ICS workstreams to provide expert advice and support regarding safeguarding and children in Care provision

Implementation of agreed safeguarding workplan

Continuing to provide support to new Designated Nurses across the ICS

Supporting strategic Partnerships such that the changes within the CCGs are understood and assurance provided that strong partnership working will continue



## Summary and moving forward

This report demonstrates that, despite the significant challenges presented by the Covid 19 pandemic, there continues to be robust arrangements in place to support the CCGs to deliver on their statutory responsibilities with regard to safeguarding children and Looked After Children.

Throughout the year the Designated Professionals team have continued to work across the health economy and with partner agencies to swiftly respond to the unprecedented demands and emerging risks in the safeguarding system.

As we move from CCGs to the HCV ICS, the Designated Professionals look forward to sharing their expertise in order to develop and embed new governance structures that not only ensure the ICS meets its statutory responsibilities with regard to safeguarding and Looked After Children but also strive for improved services for our most vulnerable children

Key strategic priorities for the year ahead are summarised in the table opposite.

<b>Safeguarding during the recovery from the pandemic</b>	<p>Learning from the pandemic to ensure practice developments that have led to improved service delivery are maintained.</p> <p>Work with partners to respond to any surge in safeguarding activity</p>
<b>Health engagement in the CoY MASH and NY MAST</b>	<p>Further develop health engagement in the City of York Multiagency Safeguarding Hub and North Yorkshire Multiagency Screening Team to support effective information sharing and decision making regarding vulnerable children</p>
<b>Audit programme</b>	<p>Work with health providers to establish assurance that practice innovations are effectively supporting improvements in safeguarding activity</p>
<b>Working across the ICSs</b>	<p>Provide expert guidance and leadership in establishing safeguarding governance structures across the ICS</p> <p>Ensure emerging commissioning and provider structures reflect and prioritise the ICS's statutory responsibilities with regard to safeguarding children and Looked After Children</p>
<b>Children in Care</b>	<p>Continue to strengthen arrangements within health which aim to improve the health outcomes for Looked After Children</p> <p>Work with CCG colleagues and HDFT to review and agree the Service Specification for the Specialist Children in Care Team to ensure the CCG continues to meet its statutory responsibilities</p>

## References

<sup>1</sup> **Department for Education** ' Working Together to Safeguard Children' (2018) accessible at:

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

<sup>2</sup>**Department of Health:** 'Promoting the health and wellbeing of Looked After Children – statutory guidance for local authorities, clinical commissioning groups and NHS England' (2015) accessible at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf)


<sup>3</sup> **NHS England and NHS Improvement** ' Integrated Care Systems: design framework' (2021) accessible at:

<https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf>

**If you would like any additional information or detail in relation to this report, please email the team at [scrccg.safeguarding-adminteam@nhs.net](mailto:scrccg.safeguarding-adminteam@nhs.net)**

### Report authors

Designated Professionals for Safeguarding Children, Children in Care, Child Deaths, and Safeguarding in Primary Care

<b>Item Number: 12</b>			
<b>Name of Presenter: Michelle Carrington</b>			
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>		
<b>Report Title – City of York Safeguarding Children Partnership Annual Report 2020/21</b>			
<b>Purpose of Report</b> <i>(Select from list)</i> <b>To Receive</b>			
<b>Reason for Report</b> <p>This report describes the work undertaken by partners and sub groups of the City of York Safeguarding Children Partnership from 1 April 2020 to 31 March 2021, including key achievements.</p> <p>The report was also received at the Quality and Patient Experience Committee on 9 September.</p>			
<b>Strategic Priority Links</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Strengthening Primary Care  <input type="checkbox"/> Reducing Demand on System  <input type="checkbox"/> Fully Integrated OOH Care  <input type="checkbox"/> Sustainable acute hospital/ single acute contract </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care  <input type="checkbox"/> System transformations  <input type="checkbox"/> Financial Sustainability </td> </tr> </table>		<input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract	<input checked="" type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability
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<b>Local Authority Area</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> CCG Footprint  <input checked="" type="checkbox"/> City of York Council </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> East Riding of Yorkshire Council  <input type="checkbox"/> North Yorkshire County Council </td> </tr> </table>		<input type="checkbox"/> CCG Footprint <input checked="" type="checkbox"/> City of York Council	<input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council
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<b>Impacts/ Key Risks</b> <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>		
<b>Emerging Risks</b>			



**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- |  |   |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment         | <input type="checkbox"/> Equality Impact Assessment       |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

**Risks/Issues identified from impact assessments:**

N/A

**Recommendations**

Governing Body is asked to receive the report.

**Decision Requested (for Decision Log)**

Report received.

**Responsible Executive Director and Title**

Michelle Carrington: Executive Director of Quality and Safety / Chief Nurse

**Report Author and Title**



City of York Safeguarding Children Partnership

# Annual Report

2020/2021



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## ■ Executive Summary

This is the second annual report of the City of York Safeguarding Children Partnership (CYSCP). This annual report covers the period from 1st April 2020 to 31st March 2021 and sets out the work that has been undertaken by partners and the subgroups of the CYSCP during that time including its key achievements.

During the past year, we have gone from strength to strength as a Partnership. We commissioned an external review of our partnership arrangements which has seen the implementation of a new streamlined governance structure. In addition, we were pleased to welcome Dr Maggie Atkinson in September 2020 as the new Independent Scrutineer. Dr Maggie Atkinson brings a wealth of experience to role, having served as the Children's Commissioner for England between 2010 and 2015, after having roles in teaching and local government.

At the beginning of March 2020, we faced the start of a global pandemic, which saw a new virus Covid-19. Nationally, the country was put into a lockdown and meant that people had to remain at home. As a Partnership, we responded quickly and adapted our ways of working by working remotely and virtually. During 2020/21, we have continued to work together, learn from each other and have shared best practice.

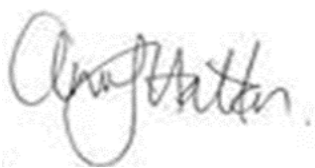
As well as maintaining our links with other Boards and Partnerships to ensure that **'Safeguarding is Everyone's Business'** (Working Together, 2018), an excellent example of where Partners, Boards and Partnerships came together virtually was during Safeguarding Week in 2020.

Our greatest asset during this challenging period has been our incredible safeguarding workforce, whom have tirelessly worked throughout these difficult times. All of our services have adapted to ensure that children, families and communities have been supported throughout.

We have ensured that schools have remained open for those children whom are vulnerable and for those children whose parent/carer is a key worker staff. Partners have also worked together to ensure that there have been bespoke support packages for those children who are vulnerable and at most risk.

We are now currently working towards our recovery phases and our ways of working will continue to adapt during the easing of lockdown restrictions.

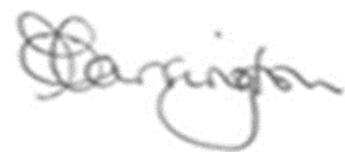
As a partnership, we recognise the progress that has been made during 2020/21 and we will continue to work together to meet our priorities during 2021/22.



**Amanda Hatton**  
Director of Children's  
Service, City of York Council



**Annette Anderson**  
Assistant Chief Constable,  
North Yorkshire Police



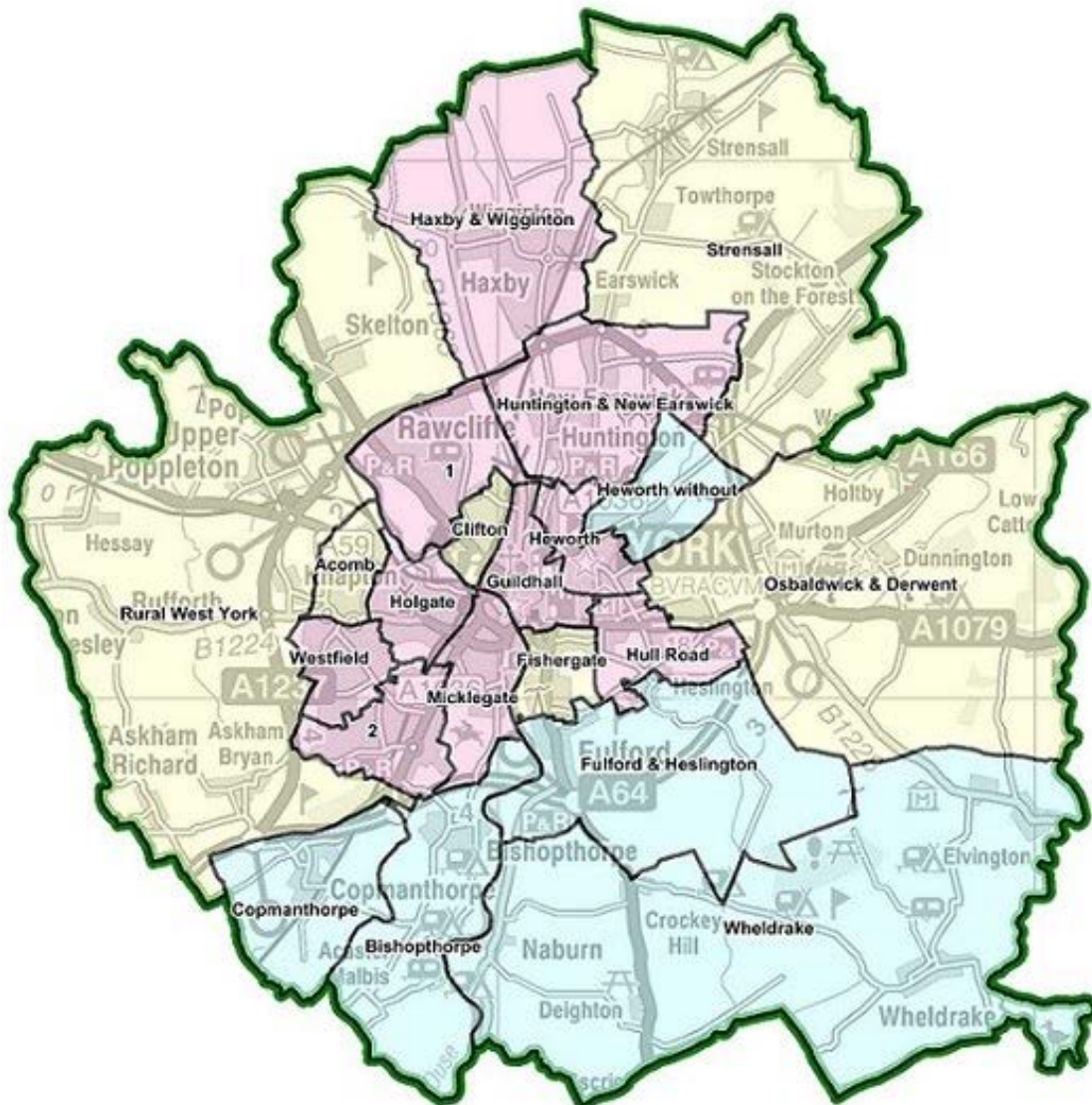
**Michelle Carrington**  
Executive Director of Quality  
and Nursing, NHS Vale of York  
Clinical Commissioning Group

## ■ Introduction

York is a cathedral city and unitary authority area in North Yorkshire. Located at the confluence of the Rivers Ouse and Foss, it is known for its famous historical landmarks such as York Minster and the city walls, as well as a variety of cultural and sporting activities, which makes it a popular tourist destination. The local authority is the City of York Council, a single tier governing body responsible for providing all local services and facilities throughout the city.

The population of the council area which includes nearby villages is 210,618 ([ONS population estimates](#)).

- Children aged 0 – 15 years = 32,822 (15.6%)
- Median age = 37.7
- Density per sq KM = 775
- Hectares = 27,201



## ■ Overview of Data

### Education

**69 schools**

**31** academies   **51** primaries   **9** secondary   **6** independent   **2** special   **1** PRU

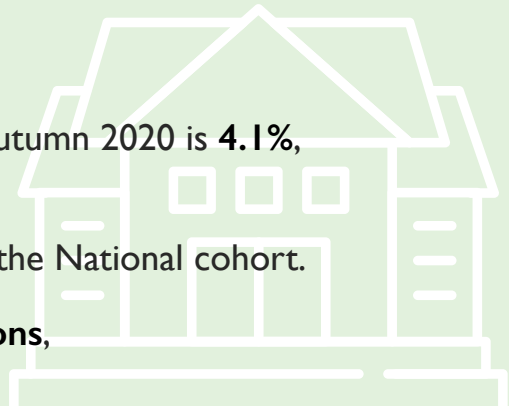
% pupils attending good or outstanding schools = **91%**

% year 12 – 13 NEETS = **1.9%**

The overall absence from the City of Yorks schools for autumn 2020 is **4.1%**, which is **0.9% lower** than the national average of **5.0%**.

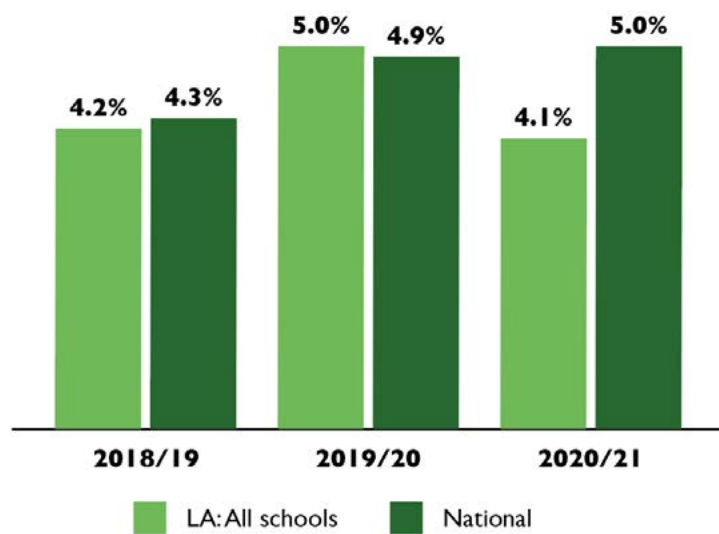
This is equivalent to **26,250 fewer** missed sessions than the National cohort.

Pupils within City of York missed an average of **5.2 sessions**, this is **1.1 fewer** than the Nationals cohort.



City of York schools have been better than the National average **2 times** in the last 3 academic year(s) for Overall Absence.

### Absence - Autumn: Overall Absence | Trend



### Safeguarding

During 2020/21 there were **7624** contacts to Children's Services via the Multi Agency Safeguarding Hub (MASH).

2018/19 = **5523**   2019/20 = **7777**   2020/21 = **7624**

**Children subject to a Child Protection Plan per 10,000**

2017/18 = **45**   2018/19 = **43.51**   2019/20 = **64.59**   2020/21 = **33.51**

**Children in Care per 10k**

2017/18 = **53**   2018/19 = **56.22**   2019/20 = **70.81**   2020/21 = **75.68**

The impact of Covid-19 on demand has been significant throughout 2020/2021. During the initial onset of Covid-19 and subsequent lockdowns, Children's Services saw an initial decrease in referrals with subsequent spike in referrals directly after lockdown measures eased.

- During the first lockdown (from March 2020), there was a significant drop in referrals to Children's Social Care. Over the course of the first lockdown and into the autumn, the number of referrals steadily increased. The increase in referrals in this time broadly matched trajectories expected in the modelling undertaken at this time (National Performance and Information Managers Group NPIMG data). Demand for early help increased significantly during this time but this may have also reflected other forms of early help not being as available during the first lockdown period.
- During the second lockdown (Dec 2020), the number of referrals dipped slightly. The drop may have only been slight as a result of schools remaining open during this lockdown period. Referrals did increase in December 2020, as is normal for this time of year, however they were below typical levels.
- With the onset of the third national lockdown and closure of schools, the number of referrals dropped significantly again. However, the dip was not as pronounced as in the first national lockdown. As in the first lockdown, referrals increased month on month throughout the lockdown. In the most recent lock down, an increase in referrals has occurred at a faster rate. Beyond the number of referrals, there is feedback from the MASH that suggests the complexity of referrals has also increased over the course of the year.

There is no sign of demand reducing at the MASH or the complexity of some cases coming and it is felt that this could be attributed to Covid-19 as not all children and young people have been visible to all universal services.

Beyond Covid-19, we can see the impact of our continuing improvement activity. This system recalibration has seen some changes in the composition of where and how children are supported in the system. Initially, this saw a reduction in the number of children on Child in Need plans and an increase in the number of children on child protection plans. These were young people who had experienced drift and were not receiving the correct level of service at a Child in Need level and as such have had to step-up. Following this phase of our recalibration, the number of children on child protection plans has reduced and is now back within target ranges. We are currently now experiencing a higher than normal number of children and young people in our care system. This increase is attributed to our improvement activity and has now levelled out.

#### **Percentage of Child Protection Plans due to:**

Neglect = **50%** Sexual Abuse = **12.9%** Emotional abuse = **35.48%** Physical Abuse = **7.26%**

The Partnership is aware of the high incidence of neglect being the cause of a Child Protection Plan being issued, and has engaged on a review and re-write of the multi-agency neglect strategy.



### Factors identified in single assessments - totals for year:

Other = 824	Learning disability = 91	Young carer = 12
Mental Health = 424	Physical Disability = 60	Missing = 12
Domestic Abuse = 300	Sexual Abuse = 43	Gangs = 8
Emotional Abuse = 227	Socially unacceptable behaviour = 38	UASC = 4
Physical Abuse = 180	Self-Harm = 29	Privately fostered = 3
Drug misuse = 175	Child Sexual Exploitation = 19	Abuse linked to faith or belief = 3
Alcohol misuse = 168		FGM = 1
Neglect = 139		Trafficking = 1

## ■ Key Achievements 2020/21

The CYSCP have continuously worked together throughout 2020-21 and have progressed a number of key pieces of work, including:

- Review of the Partnership
- Learning Practices from Covid-19
- Review of CYSCP communications
- Child Exploitation including the development of the [Adolescent Strategy](#)
- Trusted Relationships Programme
- Harmful Sexual Behaviour

Further information about our achievements can be found within this report.

## Review of the Partnership Arrangements

The Children Act 2004, as amended by the Children and Social Work Act 2017 and the associated statutory guidance Working Together to Safeguard Children (2018) replaced Local Safeguarding Children Boards (LSCBs) with new local multi-agency safeguarding partnership arrangements (MASA).

The new MASA arrangements placed new duties on the three Statutory Safeguarding Partners (namely: the Local Authority, the Police and the Clinical Commissioning Group) in local areas, to make arrangements to work together and with other relevant agencies locally, to safeguard and promote the welfare of all children in their area.



Within the City of York, the three partners were identified as:

- City of York Council
- North Yorkshire Police
- Vale of York Clinical Commissioning Group

Each local area had to inform the Department of Education (DfE) of their MASA arrangements and publish these by September 2019. The City of York were part of the national Early Adopter's scheme which meant that the CYSCP was established in April 2019; the CYSCP has been in existence longer than many other Partnerships in England.

The CYSCP subsequently commissioned an Independent Consultant to undertake a review of the Partnership. The Terms of Reference for the review focussed on how well the new requirements are currently fulfilled, one full year into the Partnership's operation; and to advise on any necessary improvements and adjustments that may be required.

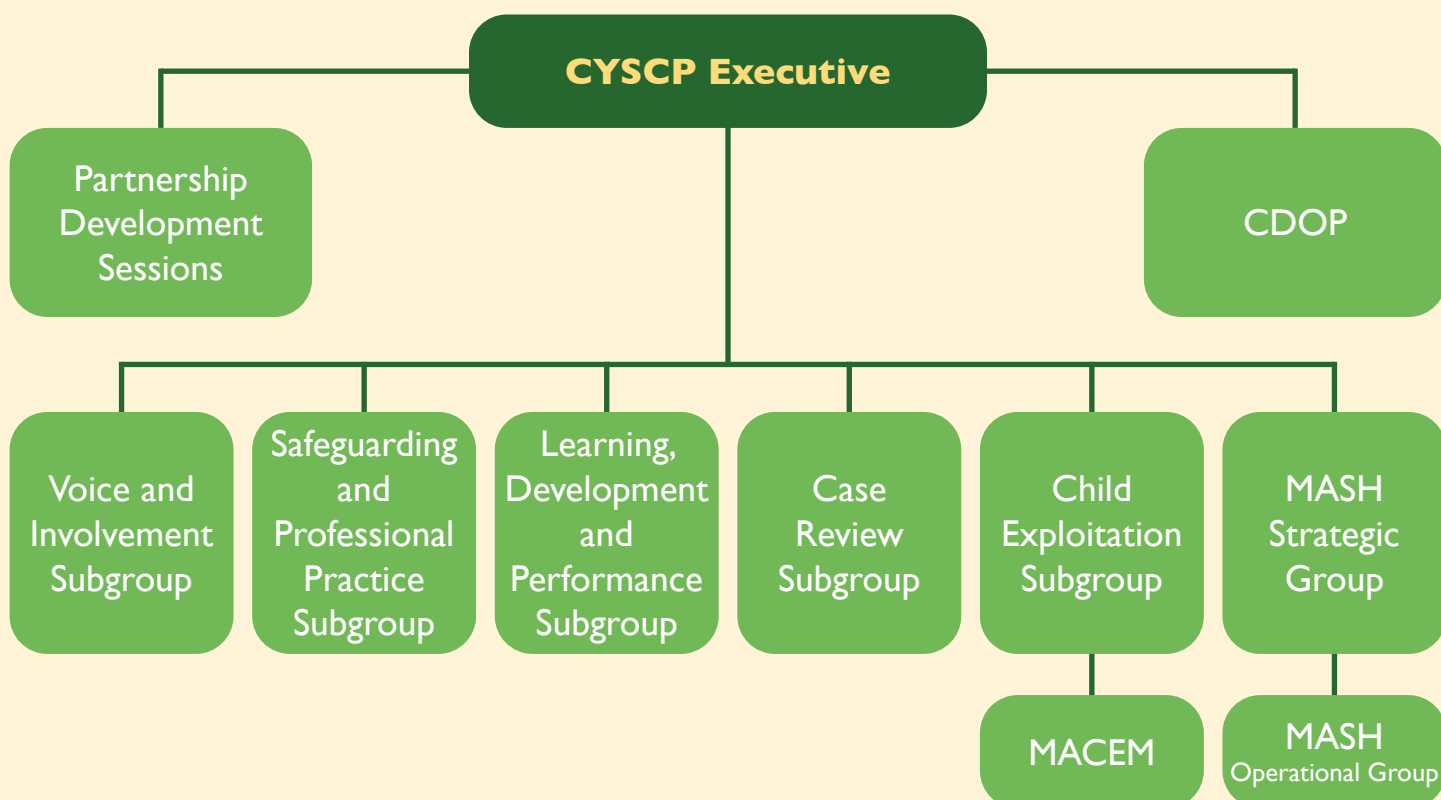
The final review report was presented at the Partnership Meeting in April 2020 which outlined areas of strengths and areas of improvement. Within the report, a number of recommendations were made which the Partnership agreed to take forward and implement. This included a review of the over-complex governance arrangements of the CYSCP.

The three statutory partners agreed for the CYSCP Interim Business Manager to progress the review of the current governance structure. As part of the review of the governance structure, feedback was sought from partners about the current safeguarding arrangements and the interface between the various Boards and Partnerships within the City of York.

A consultation with partners and stakeholders took place between April 2020 and July 2020 where further feedback from partners was gained. The Interim Business Manager, CYSCP also observed a further cycle of CYSCP meetings during Quarter one and reviewed the recommendations from review of the CYSCP.

The final draft governance re-structure proposal was circulated to partners for feedback/ comments between July 2020 and August 2020 and the final report was presented at the Partnership meeting in October 2020 where it was ratified. With the addition of MASH Strategic and MASH Operational Groups aligned within the CYSCP structure in May 2021.

The new structure is outlined below:



Following agreement of the new CYSCP structure, an implementation period took place between October 2020 and December 2020 which included:

- the dis-establishment of the previous structure and ensuring any outstanding actions were transferred to the new structure
- identifying new chairs for the subgroups
- developing new terms of reference including membership
- setting up new cycle of meetings
- developing assurance templates
- updating of CYSCP documents

The first round of meetings within the new structure took place in January 2021.

## Development Days

As part of the new governance structure, the CYSCP saw the introduction of twice yearly CYSCP Development Days which provides an opportunity for all relevant agencies of the CYSCP to come together. The first Development Day was held virtually on 27th November 2020. This event was well attended and was represented by approx 45 multi-agency partners. A presentation was given by the Chair of the Care Leavers Forum and the event consisted of breakout sessions which asked attendees to discuss what had worked well as a partnership and what they envisaged the key priorities should be for the CYSCP Business Plan.

## ■ Systemic Practice

Within the City of York, it is now over 12 months since we began our journey in developing and implementing our practice framework. We chose to focus on systemic practice and on training the whole of the social work workforce in systemic theory and models by 2022 and to include our partners and the families we work with in understanding systemic practice ensuring that we are all consistently 'speaking the same language'.

Since January 2020 we have:

- developed and agreed our practice framework,
- developed a systemic pledge, which now appears in our recruitment page and in other significant documents.
- Undertaken an initial survey monkey to identify what knowledge colleagues have around systemic practice in order to support the development of our implementation plan and measure our success in the future.
- Established a multi-agency implementation group.
- Delivered a report to Children's Social Care Improvement Board with contributions from all focus group members which included the implementation timeline.
- Delivered a presentation of the implementation plan and practice framework to extended senior management team.
- Trained two cohorts of over 50 employees, including Social Workers, Managers, Independent Reviewing Officers and Senior Managers in systemic practice.
- Included systemic practice sessions into our social work academy.
- Delivered 7 systemic practice workshops to colleagues and partners.
- Shared our knowledge, systemic tools and our understanding of how systemic practice impacts positively on our work with families and importantly on outcomes.
- Developed a web page for partners sharing our knowledge of systemic practice, on the [CYSCP website](#).
- Updated Children's Social Care audit tool to ensure that it includes systemic language and prompts to identify systemic practice.
- Updated personal/professional supervision template to ensure that it captures improved outcomes as the result of systemic practice.
- We are currently updating the multi-agency referral form to include systemic thinking.
- Supported 2 POD's of student social workers in 2020/21 (10 students).
- Welcomed 5 systemically trained NQSW into the workforce and have recently secured agreement for two PODs for 2021/22.

## ■ Covid-19

At the beginning of March 2020, we faced the start of a global pandemic, which saw a new virus Covid-19. Nationally, the country was put into a lockdown and meant that people had to remain at home.

As a Partnership, we responded quickly and adapted our ways of working by working remotely and virtually. During 2020/21, we have continued to work together, learn from each other and have shared best practice.

The CYSCP meetings continued to meet as all face to face meetings were moved to be hosted on virtual platforms. The majority of our partners worked from home and continue to do so. Organisations adapted their service offer in order to ensure that children, young people and their families were continued to be supported. Examples include:

- Schools remained open to those who were deemed vulnerable and for key worker children
- Home visits still continued/practices remained the same to ensure that those most vulnerable were safeguarded
- Services explored different social media platforms to engage with children and young people such as WhatsApp and the use of telephone communication with young people increased
- Increased attendance by both professionals and families at meetings, including Child Protection Meetings, as these were being held virtually
- Some agencies reported that the implementation of telephone assessments/triage meant that this freed up capacity
- Organisations reported partnership communication, knowledge of partner's services and continuation of safeguarding arrangements as being a benefit during the pandemic

## Priority for 2021/22

As we continue to navigate through the pandemic it is important that we learn as a partnership. Therefore, it has been agreed for the CYSCP to undertake an evaluation of the impact of Covid-19, gaining the views of professional, young people and their families in order to understand the benefits, challenges and next steps. An evaluation is planned to take place between 26th April 2021 and 18th May 2021 and the findings will be shared once completed.



## ■ Young People Working Throughout the Pandemic

### Show Me That I Matter (SMTIM) and I Still Matter (ISM)

When the global Covid-19 pandemic struck in March 2020, there was concern around the safeguarding implications of children and young people being 'locked down' and hidden from the view of practitioners. There was also concern around the 'hidden harms' of the virus on children and young people – the impact on their mental health and wellbeing of both the isolation of lockdown and anxiety about living through a global pandemic.

However, our partners have found that children and young people are far more resilient than was imagined and that some positive outcomes have come out of the past year.

When lockdown was introduced on 23rd March 2020, The Show Me That I Matter (SMTIM) and I Still Matter (ISM) both continued operating but remotely. Young people requested an increase in frequency of the meetings and, during the strict lockdown from March to June 2020, meetings were taking place on a weekly basis.

In June 2020, the frequency was reduced to once every 2 weeks and from September 2020 the meetings returned to once monthly.

The SMTIM and ISM forums used the pandemic as an opportunity to review the quality of support children and young people in care or care leavers receive and to share their views with decision makers.

The impact of Covid-19 has remained a standing item on the agenda for SMTIM and ISM meetings. In April 2021, the following feedback gathered between January 2021 and April 2021 was shared with decision makers:

- SMTIM feel well supported by social workers and can't think of anything they should be doing differently.
- Care leavers feel they've had good support from the Pathway Team.
- Young people in care and care leavers value the phone calls and video calls from workers.

In April 2020, SMTIM together with Speak Up, Children's Rights and Advocacy Service, launched the Hidden Heroes campaign. The purpose of the campaign was to give young people the opportunity to say thank you and raise awareness of the roles and individuals who may be were not receiving publicity during the pandemic. Young people were encouraged to create a piece of artwork for their hidden hero which was then shared on social media. The campaign was very successful and saw young people thank their families, foster carers, dance teachers, advocates, independent visitors, sixth form teachers, pathway workers and more.



## York SEN and Disability Information Advice Support Service (SENDIASS)

York SEN and Disability Information Advice Support Service (SENDIASS) listened to the voices and needs of young people to provide flexible forms of support that allowed them to also engage in ways that suit them. As a result, SENDIASS have embraced new ways of connecting with children and young people through using interactive platforms such as WhatsApp. This has proved particularly useful for harder to reach young people, who don't always feel confident with face to face conversations and discussing their emotions and this is a participation tool which will continue to be offered when the pandemic is over.

SENDIASS have learnt a number of things about engaging young people online which has helped successful engagement and found that it's important to agree with young people what they feel most comfortable with before the meeting. Some young people start with joining audio only and then video and others prefer to use the text or speech function.

Work has also been carried out to develop a selection of alternative resources and methods of communication so that the SENDIASS team can seek, value and act upon the views and wishes of children and young people with learning disabilities that are often harder to reach and excluded from consultation, so that they can contribute to decisions and processes that impact their lives.

### Mind of My Own App

Mind of My Own App is a co-designed, user-friendly app recently commissioned by City of York Council that helps children and young people express their views, wishes and feelings in a fun, interactive and digital way. The app is an innovative way to gather children and young people's views with SEND using digital questions and visual representation which helps children and young people with communication difficulties to communicate more effectively. Data can be viewed and downloaded for their My Support Plan or EHC Plan.

York SENDIASS have also joined Instagram, [@sendiassny](#) to connect with as many young people in York as possible to offer alternative methods of seeking support and advice with regards to SEN matters and to provide them with a safe, inclusive and confidential space to share their views.

## ■ Social Media

### Twitter

The CYSCP Twitter account provides regular updates on local and national news, resources, initiatives, policy and guidance which you can find by following us on Twitter [@YorkSCP](#).

The CYSCP Twitter account has over 1030 followers which includes professionals, schools, businesses, other safeguarding children partnerships and members of the public. The CYSCP's Twitter feed is used to provide important information such as changes to policies and procedures as well as links to information and resources. It also promotes campaigns and activities of partners and other safeguarding organisations. Over the past year, CYSCP tweets have been viewed over 400,000 times by users and the [@YorkSCP](#) twitter account has promoted various children's safeguarding themes.

## E-Newsletter

A new CYSCP newsletter was launched in September 2020. This electronic monthly newsletter is now sent out monthly and contains useful information for professionals with contributions from our partner agencies. Previously, the newsletter was sent out in word format on a quarterly basis.

However, due to the pandemic and current working practices, the CYSCP Business Unit reviewed the way in which we communicate and disseminate information to our partners, stakeholders and members of the public.

The aim of the newsletters is to improve our communication and engagement with our partners, professionals and stakeholders across the city of York and to keep them up to date with the latest developments in safeguarding children and young people in York. Professionals need to [sign up](#) to receive the newsletter via the CYSCP website and at the present time approximately 540 individuals have signed up to receive this.

Further information, including how to receive the CYSCP Newsletter can be found on the [CYSCP website here](#). Partners can also contact the CYSCP Business Unit for content to be included within our newsletter at: [CYSKP@york.gov.uk](mailto:CYSKP@york.gov.uk).

## CYSCP Website

During 2020/21, the CYSCP website has been updated and improved. All information on the professional's webpages have been reviewed. There is now a latest news section which is regularly updated and this information is promoted also on twitter and via the newsletter. The CYSCP website contains a wealth of information and averages approximately 25,900 hits per month. The Concerned about a Child page alone averages over 1850 hits per month. During 2010/21, the CYSCP have also continued to support a number of campaigns. Some of these include:

- MASH Awareness Week
- Partnership Information Sharing Form
- Back to School Safely
- The Children's Society Look Closer Campaign
- Modern Day Slavery Week
- NSPCC Look Sing Say Play
- Hate Crime Awareness Week
- Systemic Practice 'Every Conversation Starts with a Child'
- Adolescent Week 'My teenage years'
- Wellbeing Week



The CYSCP Business Unit have made significant progress to review and update the content on the CYSCP website. A number of pages have required a full refresh and some of the pages are still under review. New pages have been developed such as the [Coronavirus Pages](#), [Bereavement Page](#) and the [York Services for Children and Young People Page](#).

The CYSCP Business Unit have linked in with the City of York, Youth Council who have reviewed the [young person's mental health & wellbeing page](#) and the [young person's child exploitation page](#) on the CYSCP website. It has been agreed that the Youth Council will also review other pages within the children & young people's section on the website.

The CYSCP Business Unit have made improvements to the way in which we communicate with our partners, stakeholders and members of the public. Examples of the changes are below:

- A [CYSCP Latest News page](#) has been created which provides information/updates about the latest developments in safeguarding children & young people in the City of York.
- A new [CYSCP Campaigns Page](#) which provides information pertaining to various national and local campaigns the CYSCP and wider partners have supported and continue to support.

## ■ Campaigns

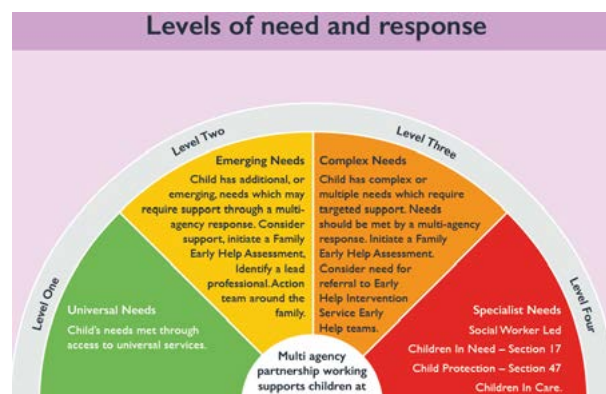
In addition to improving communications the CYSCP have supported and developed a number of campaigns during 2020/21:

### York MASH: Safeguarding Children Together Campaign (1st June – 5th June 2020)

Monday 1st June - Friday 5th June 2020 saw the virtual launch of the York MASH: Safeguarding Children Together Campaign. The partnership developed a series of key messages, a briefing pack for wider dissemination by partners and a COMMS Plan which supported the virtual launch of this campaign. The awareness campaign aimed to highlight the work of the MASH in York, the new multi-agency level of needs document (threshold document), the multi-agency referral form and the multi-agency response form.

The campaign was evaluated and following visits were made to the CYSCP webpages and twitter:

- The MASH Awareness tweets were seen on the CYSCP Twitter account by over 74,000 users visits to the landing page on the CYSCP website
- 2000 visits to the CYSCP Landing Page
- 1,400 visits to the 'concerned about a child page' on the CYSCP website
- The Threshold document has been downloaded 3892 times until the end of March 2021.
- The referral form has been downloaded 3723 and the referral response form has been downloaded 968 times until the end of March 2021.





## Safeguarding Week (22nd June – 26th June 2020)

The North Yorkshire and City of York Safeguarding Adults Boards, Safeguarding Children Partnerships and Community Safety Partnerships worked together to deliver a virtual awareness raising campaign on how to report abuse of children, young people and adults. Safeguarding Week has previously involved local events for professionals and members of the public, however this is the first year that only a virtual campaign has taken place, due to restrictions around Covid-19.

During the week (22nd - 26th June), social media was used to promote awareness to the public and professionals, to remind people that “**Safeguarding is everybody’s business**” and that concerns about abuse or neglect should continue to be reported to the respective Local Authority as normal during the Covid-19 pandemic.

A coordinated social media campaign made use of, and sign posted to, existing resources. As part of this **#TellUsYourConcerns** was used during Safeguarding Week 2020.

The weekly schedule across North Yorkshire and York had a consistent theme, “*How to report a concern*” on social media each day, and also focused on a different safeguarding area as follows:

- How to report a safeguarding concern
- Domestic Abuse
- Keeping Safe Online: Fraud/Scamming, and online abuse
- Radicalisation, Extremism and Prevent
- County Lines/ Cuckooing
- Mental health and Wellbeing

The CYSCP put out 14 tweets for Safeguarding Week with the hashtags **#TellUsYourConcerns**, **#LetsTalkAboutIt** and **#YorkMASH** on [@YorkSCP](https://twitter.com/YorkSCP)

The campaign resulted in:

- 10390 impressions (i.e. times when tweets appeared to Twitter users) during the 5-day period
- 7 links being followed, an average of 1 per day
- 13 retweets, an average of 3 retweets per day
- 3 likes, an average of 1 like per day
- An engagement rate during the week of 0.7%

## Partnership Intelligence Form Campaign (6th July – 10th July 2020)

The Partnership Intelligence Form gives professionals a safe and direct way to share information with Police. This information is critical in developing a clear picture of local issues and wider community related problems, which can inform Police and Partner actions to reduce threat, risk and harm. This form has been recently reviewed and updated and is used across North Yorkshire and City of York Children Partnerships and Adult Boards. A task and finish group across North Yorkshire and City of York Children Partnerships was established to develop a COMMS Plan around the promotion of the Intelligence Sharing Form. The virtual launch took place during Monday 6th July – Friday 10th July 2020.

## Back to School Safely (31st August – 4th September 2020)

The City of York Council ran a campaign promoting Back to School Safely week commencing 31st August 2020. The CYSCP supported this campaign during this week.

## The Children's Society Look Closer Campaign (14th September – 20th September 2020)

The Children's Society ran the #LookCloser campaign during the week 14th – 20th September 2020 to raise public awareness of child exploitation and abuse, with a particular focus on public spaces. The CYSCP supported this campaign, which raised public awareness, informed the public how to identify exploitation and how to report it.

## Modern Slavery Campaign (14th October – 20th October 2020)

Anti-Slavery Day, 18th October 2020, provided an opportunity to raise awareness of human trafficking and modern slavery, and encourage government, local authorities, companies, charities and individuals to do what they can to address the problem.

The North Yorkshire and City of York Modern Slavery Partnership ran a campaign between Wednesday 14th and Wednesday 20th October 2020 to raise awareness regarding human trafficking and modern slavery.



## NSPCC Look Say Sing Play (15th October 2020)

The NSPCC launched their Look, Say, Sing, Play Campaign on **Thursday 15 October 2020, online via Zoom.**

The campaign was aimed at parents to help them build their baby's brain and promote positive attachment. The CYSCP supported this campaign to try and reach all professionals working with babies, young children and families to share the campaign resources, to talk more about the brain science behind this initiative and to inform you as to how the campaign will be rolled out across the city.



## Hate Crime Awareness Week Campaign – #helpnothate2020 (Monday 12th October – Friday 16th October)

Hate Crime Week is a national week of action to encourage local authorities, key partners and communities affected by hate crime to work together to tackle local hate crime issues.

The North Yorkshire and the City of York Hate Crime Working Group (HCWG) utilised this week, Monday 12th October – Friday 16th October, to promote and raise awareness on how to report Hate Crime/Mate Crime incidents, along with supporting projects and services available to those who may suffer incidents of Hate Crime/Mate Crime in North Yorkshire and the City of York.



## Systemic Practice “Every Conversation starts with the Child” (Monday 2nd November – Friday 6th November)

Monday 2nd November 2020 – Friday 6th November saw the virtual launch of the Systemic Practice Framework Document. The awareness campaign aimed to highlight Systemic Practice and the newly developed practice framework guidance.

Although this is a City of York Council Children's Social Care document, it was developed with Multi-Agency Partners and envisaged that partners will adopt the framework and embed the principles to ensure the best outcomes for children and young people in the City.

Regular Systemic Practice blogs are added to the CYSCP website for all professionals and front line workers to access.



## Adolescent Week “My Teenage Years” (Monday 23rd November – Friday 27th November 2020)

The CYSCP ran a campaign for Adolescent Week during Monday 23rd November 2020 – Friday 27th November 2020. This campaign also launched the newly developed Adolescent Strategy.

In addition, during that week safeguarding partners held a series of workshops/briefings for professionals working with teenagers including:

- A Young Person presenting ‘What makes a difference to young people, communication and relationships from their lived experience’
- Working with teenagers with autism
- Teenagers impacted by drug and alcohol use
- Young people who go missing
- Adolescent Strategy
- Working with Adopted Teenagers
- Preparing for Adulthood for young people with additional needs including Q&A
- Graded Care Profile Training, including new resources for working with adolescents
- Supporting Young people to reduce sexually transmitted infection risk.
- Contextual Safeguarding with Teenagers - What does it mean in reality?
- The Adolescent Brain and an overview of the School Nursing Service
- Young People and Pregnancy
- A Q&A on Independent Visitors and The Trusted Relationships Programme



Dez Holmes from Research in Practice also provided a key note speech on Adolescent Safeguarding.

All the workshops/events were free and open to all our multi-agency partners within the City of York.

## Wellbeing Week (Monday 18th January – Friday 22nd January 2021)

City of York Council promoted the importance of wellbeing for staff, week commencing Monday 18th January 2021.

To coincide with this, sessions took place which were also available and open for partners. These included:

- Physiological Wellbeing – The Biology behind too much stress which was delivered by North Yorkshire Police
- Mindfulness delivered by City of York Council
- Thinking about wellbeing when working with families delivered by Institute of Family Therapy



## ■ Voice of the Child

### Every Conversation Starts with the Child

During 2020/21 the Voice and Involvement group focussed on:

- Adapting existing voice mechanisms to operate in line with Covid-19 restrictions.
- Reviewing collectively how the Voice and Involvement Group should operate in line with Covid-19 restrictions.
- Developing work to ensure children and young people are involved and have a voice any Covid-19 recovery work

Many partners adapted existing groups to meet successfully virtually. There was a mixed picture from partners about the tools available to them to enable this happen and it was also reported that some families had challenges of ensuring equipment for remote engagement was available.

In some cases, engagement work had not been able to be adapted to virtual delivery and work continued as to how these could be adapted or safely reintroduced in line with updated Covid-19 guidance.

Work progressed to fully roll out use of remote engagement through the Mind of My Own app, to enhance the remote engagement of children and young people at an early help and social care level.

A task and finish group was established to review delivery of the current strategy and to draft a refreshed strategy.

Members of the Voice and Involvement group examined how individually and collectively we understood if children and young people felt safe. There was a mixed picture of how different services and agencies approached this issue.

In some cases, it was clearly part of individual direct work with children and young people and, in some service areas, not directly providing safeguarding interventions individual assessments did not explore children's perceptions of safety.

The group agreed to develop a city wide set of principles to help develop a more common approach to gathering views on children and young people's perceptions of being 'safe'.

## CYSCP Voice and Involvement Strategy Task and Finish Group

A Voice and Involvement Strategy task and finish group was established in September 2020 to review and update the existing City of York Voice and Involvement Strategy 2017 – 2020, which sets out a commitment to ensuring that children and young people have a voice and are involved in decision-making, planning, commissioning, design and delivery of services.

It was agreed that partners, children and young people be given the opportunity to evaluate the existing Voice Strategy and that this feedback would aid the development of the new Strategy and that the new Voice Strategy should be developed using a rights based approach.

A Survey Monkey tool was developed to evaluate how well partners across the city have delivered against the priorities set out in the current strategy. Partners are asked to rate progress against commitments made at the beginning of the strategy. A simplified Survey Monkey tool was developed for Children and Young People to feedback on the headlines of the strategy and was circulated to youth groups and schools including Early Years settings.

Work is ongoing to get support from the CYSCP Executive to progress a three year programme of work across the partnership to deliver this strategy and realise a shared rights respecting approach for York.

## Priorities for Voice 2021/22

### Pre and Non-verbal Resources Task Group

Engaging with pre and non-verbal children and young people has been identified as an area of weakness from feedback and audit and so the CYSCP Voice and Involvement Group tasked the CYSCP Business Unit with establishing a Pre and Non-verbal Resources Task Group.

This group was established in March 2021 and included representation from the Deaf and Hearing Support Team, Special Educational Needs Service, Children's Rights and Advocacy Service, Early Years, Local Area teams, the Speech and Language Therapy Service and the CYSCP Business Unit.

This group over the next few months aims to:

- Identify where the gaps in pre and non-verbal expertise currently exist;
- Understand where our experts in this are and how we can share their expertise or resources across the partnership;
- Ultimately develop a toolbox on the CYSCP website of resources to engage pre/non-verbal children or jointly develop a training package using some identified experts;
- Promote those resources or development sessions across the Partnership, to change mind set and culture around pre and non-verbal children and young people.

## ■ Child Exploitation

The Child Exploitation (CE) Sub Group is responsible to the Safeguarding Children Partnership for overview of inter-agency working in all areas of CE including Contextual Safeguarding and County Lines. The Group is also responsible for the development and implementation of the Safeguarding Children Partnership CE and Adolescent Strategy Work Plan.

### What we did

In 2019 – 20, the Exploitation team was set up within Children Social Care, to ensure those at risk of exploitation receive a targeted response with a high level of support and intervention. We updated the Strategy and Work Plan, the CE Group received regular reports and updates from the MACEM meeting, which considers some of our most at risk children and young people and reports from the risk management Missing Panel, that meets weekly to consider children and young people who go missing from home, the reasons why they go missing and what we can do to try and keep them safe. We continue to pilot the HMO Trusted Relationship Mentor support scheme and have been successful in a new bid to work with the Home office around the NRM multi-agency process.

### What we will do

In 2020/21, we will continue to conduct regular audits of cases where children and young people have been exposed to or at risk of CE. We will continue to assess the local risks that our children and young people are facing, including Harmful Sexual Behaviour and we will make sure all our partners and people that work for them are aware of what CE is and for them to be constantly vigilant so that we can keep our children and young people as safe as possible.

## North Yorkshire and City of York Trusted Relationships Project

### Emerging Outcomes and Achievements:

Over the course of 2020/21, there has been the emergence of some outstanding outcomes, good practice examples and the project has attracted both local and national acclaim:

**Independent Evaluation:** An overarching aim of local Trusted Relationships projects is to strengthen the evidence base on what works to protect young people from exploitation and abuse to improve services over the course of the programme and beyond.

A key finding from the independent evaluation report (published autumn 2020) states:

*“The key outcome of engagement in the intervention was the development of the trusted relationship, which was described as young people having someone they trust with whom they can talk to about their day and any challenges they are facing, while receiving advice and support. Despite it being still too early to know definitively about the long-term impact on the young person’s risk of sexual or criminal exploitation, staff and young people reported a range of positive intermediary outcomes on one or more areas in the young person’s general personal development, relationships, education and employment”.*

Alongside the evaluation, a catalogue of good practice case studies has been compiled that illustrate how the project has made a real difference in the lives children and young people at risk of or subject to CCE.

**Risk Reduction:** Although it is still relatively early to report on longer-term outcomes and/or benefits realised through the project, local data reporting indicates that in 49.25% of closed episodes, the Trusted Relationships service has supported a reduction in the child exploitation risk level associated with the case, illustrating the impact of the service. In addition, in 47.76% of cases the exploitation risk has remained at the same level, indicating that support through Trusted Relationships has helped prevent increased exposure to child exploitation risk.

**Local Government Association (LGA) – Case Study:** We are delighted that the North Yorkshire and City of York Trusted Relationships project was identified and included as a case study within the LGA’s ‘taking a public health approach to tackling serious violent crime’ publication. Within the publication, the LGA have pulled together a series of case studies to highlight some examples of best practice across local government. The case studies also highlight how councils have been working in partnership to deliver early interventions that help to prevent children and young people from becoming involved in serious violent crime.

**Government Tackling Child Sexual Abuse (CSA) Strategy:** This strategy, published in January 2021, is the first of its kind in setting out the government’s vision for preventing, tackling and responding to CSA in all its forms. The Tackling CSA Strategy is centred around 3 objectives:

1. Tackling all forms of child sexual abuse and bringing offenders to justice;
2. Preventing offending and re-offending; and
3. Protecting and safeguarding children, and supporting all victims and survivors.

Relationships projects are included within the strategy as a positive example of targeted support to children and young people who are at-risk of child sexual exploitation or abuse, as well as criminal exploitation and peer-on-peer abuse. The case study included within this section of the strategy relates to a case from the North Yorkshire and York project, recognising the excellent practice delivered by local Trusted Relationships services.



## ■ Harmful Sexual Behaviour

During 2020, a Harmful Sexual Behaviour (HSB) Task Group was established to progress work around Harmful Sexual Behaviour. To date the group have:

- Rewritten the [HSB procedure](#)
- The [HSB webpage](#) was reviewed and rewritten.
- Successfully secured funding from North Yorkshire Police, Fire and Crime Commissioner Community Safety Fund for the Youth Justice Service to receive NSPCC 'Train the Trainer' training.
- The City of York was the first local authority to receive this training and this was held virtually. The training was delivered to Youth Justice Service staff, including seconded staff from North Yorkshire Police, National Probation Service, Children's Social Care including the Exploitation Team Manager.
- Developed a HSB action plan following an NSPCC audit. The CYSCP Business Unit coordinated a multi-agency virtual event which enabled attendees to discuss the audit findings and to identify any barriers, issues etc. they wanted feeding into the HSB Action Plan. The HSB Action Plan was produced as a result of this multi-agency engagement.

### AIM 3 Training

In addition, the Youth Justice Service have funded 16 members of staff within YJS and the Exploitation Team and a social worker from the Permanence team to receive AIM 3 Intervention Training. Additionally a member of the YSJ team has secured a place on the digital assisted technology course with the Aim project. A new CAMHS practitioner has also started in post and to deliver clinical supervision around HSB to the YJS.

### Child P LLR Training

Multi-agency training workshops, on learning from the Child P case, were held virtually in early 2021. A 7 point briefing has also been developed on the case which will complement these workshops and be available for practitioners via the CYSCP website. Further information regarding these is within the Training section.

### Brook Traffic Light Tool

Whilst preparing for Child LLR Training, it was highlighted that Brook are no longer permitting organisations to use the latest version of the Brook Traffic Light Tool for free. The task group met to address the issue in February 2021 where it was agreed to remove the tool from the website. The CYSCP multi-agency documents including the HSB procedure was updated. The CYSCP are advising professionals to use the Hackett Continuum until a longer term solution is agreed.

The HSB Task Group is continuing to meet to ensure the remaining actions from the HSB Action Plan are achieved.

It is envisaged for this training to be rolled out across the Local Authority and wider partnership.

## ■ **CYSCP Private Fostering Steering Group**

The CYSCP Private Fostering Steering Group was formed in July 2020, and its function is to ensure that Privately Fostered children are safeguarded and that their welfare is promoted. The group is responsible for raising awareness of the notification requirements which will be promoted by all agencies and in the wider local community within the City of York.

The Private Fostering Steering Group has:

- Consulted with York Youth Council on what private fostering resources children or young people felt would be useful, as well as how they felt these could be disseminated.
- Amended Private Fostering information/resources on the CYSCP website.
- Created a Private Fostering for Professionals webpage on the CYSCP website
- Created a Looking After Someones Else's Child webpage for Parents and Carers on the CYSCP website
- Created a Private Fostering for Children and Young People on the CYSCP website
- Developed a narrated powerpoint training resource
- Review a thematic audit of case records of children privately fostered undertaken by Children's Social Care
- Updated Practice Guidance which included multi-agency input and the Statement of Purpose
- Created a Private Fostering Checklist
- Created a One Minute Guide for professionals in regard to Private Fostering

During September 2021, this group will also be running a Private Fostering Awareness Week over social media to publicise the new resources, training and webpages.

## ■ **Safeguarding in Education**

During the period covered by this report, schools in the city have worked collaboratively with partners to address the many challenges presented by the Covid-19 pandemic. The York Schools and Academies Board (YSAB) has met on a regular basis throughout to find solutions and agreed approaches, which have enabled schools to continue to deliver education and support to their pupils and families safely. A keen focus has been placed on meeting the needs of vulnerable pupils throughout. The School Safeguarding Advisor has continued to provide advice and support to schools in implementing and reviewing their policies and procedures, in line with updated guidance, and in responding to the circumstances created by the pandemic.

The School Safeguarding Advisor and colleagues from schools have continued to work in partnership with and have actively contributed to, a number of multi- agency activities undertaken by the CYSCP over the period. These include:

- development of the Harmful Sexual Behaviour (HSB) guidance and the participation in the NSPCC HSB audit
- development of the Multi- Agency Safeguarding Hub (MASH) and contribution to multi- agency audits
- development of the Adolescent Strategy
- work supporting prevention of Child Exploitation by attending the MACEM meetings and regular risk assessment meetings with partners

The Young People's Social Media Project has been completed. The aim of the project was for it to be led by young people and their views, in order to develop a Young People's Guide to Safe Social Media Use, together with teaching resources, to help young people navigate their social media interactions safely and protect their wellbeing. The project, a collaboration between safeguarding partners and the University of York St John, worked with young people across the city to develop the guide and resources. The resources can be used in schools to form part of their on-line safety and relationships education provision. These resources are due to be launched during Safeguarding Week in June 2021.

Further information can be found on the CYSCP website: [www.saferchildrenyork.org.uk/young-persons-social-media-guide.htm](http://www.saferchildrenyork.org.uk/young-persons-social-media-guide.htm)

## ■ Case Review Group (CRG)

The purpose of the Case Review Group (CRG) is to carry out the functions of the City of York Safeguarding Children Partnership (CYSCP) as described in Chapter 4 of Working Together to Safeguarding Children 2018 for improving child protection and safeguarding practice.

In January 2021, as part of the restructure of the CYSCP the CRG ceased to take responsibility for the undertaking of multi-agency audits which are now in the Terms of Reference (TOR) of the CYSCP Learning, Development and Performance Group. The TOR for the CRG were updated in 2021 to reflect the restructure of the City of York Safeguarding Partnership, changes in Working Together 2018 and the guidance from the National Panel. One of the key aspects of the new TOR is the addition of consideration of the 'Child's Voice/ lived experience' which the group considers to be an essential addition to ensure that the group remains focused on children and improving outcomes for them.

## Child Safeguarding Practice Reviews

The CRG reviews serious child safeguarding cases, at both local and national level to identify improvements to be made to safeguard and promote the welfare of children. The CRG is the means by which the CYSCP makes arrangements for commissioning and publishing local Child Safeguarding Practice Reviews.

The CRG undertook three Rapid Reviews over the period 2020-21, one of which it was recommended that the child's placing authority undertake a Local Safeguarding Child Practice Review and two of which a LSCPR has been commissioned locally.

The themes from these reviews included:

- Self-Harm / Children in Care particularly those from out of area
- Child Sexual Exploitation
- Injuries to non-mobile babies.

During 2020-21 the group reviewed progress against the actions plans from a Learning lessons review and Single Agency review.

The themes from these reviews included:

- Harmful Sexual Behaviour (HSB)
- Sudden unexpected death in infancy

## Learning / Actions from Reviews by CYSCP

Recommendations and actions from the LSCPR, LLR and Single Agency Reviews will be monitored through 2021-22. Actions include:

- Raising awareness of the need for holistic assessment of families where there are or have been safeguarding concerns and where there is a new baby in the family.
- Development of new pathways for information share particularly in relation to fathers.
- Reiteration of messages about prevention of SUDI.
- Reiteration of ICON messages about coping with crying.
- Review of Child exploitation processes including 'sticking with' young people who may be subject to forms of exploitation, support for their siblings and parents and professionals being alert to forms of grooming.
- Raising awareness of Escalation procedures for professional disagreement and complex case procedures.
- HSB strategy launched, training, delivered and seven point briefing developed.
- Partner training on referrals to Children social care which clearly describe the impact of the concerns on the child or young person.
- Training across the partnership outlining the importance of consideration of child voice and lived experience including importance of seeing young people by themselves is included in all referrals, assessments and plans.
- **Need for PROFESSIONAL CURIOSITY!**

## ■ Multi Agency Audit up to December 2020

(prior to CYSCP restructure)

During 2020, the sub-group undertook a multi-agency audit relating to Initial Child Protection Conferences (ICPC) and Core Group (CG). Key areas of learning from this audit include concerns:

- membership of both ICPC and CG
- child voice and plans and assessments
- analysis assessment and planning to address risk

### Learning / Actions by partnership

The actions from this audit are being monitored by the Learning Development and Improvement. Actions include:

- Review of processes to ensure that all relevant agencies are invited to ICPC and Core Group meetings
- Training across the partnership to ensure that consideration of child voice (including pre verbal/ non-verbal child) and lived experience is included in all referrals, assessments and plans
- Group and the audit will be repeated in 2021

### Key Priorities for 2021-22

An immediate priority for the Case Review sub-group is to review the case review process and accompanying paperwork to ensure it is fit for purpose and to enable the Partnership to collate information effectively.

Another key priority is for the Case Review sub-group to proactively disseminate learning from cases working together with the Learning, Development and Performance Sub-group.

The Partnership plan to hold a termly CYSCP Learning Masterclass event to share learning which practitioners will be invited to attend. A focus for the Partnership is also to produce One Minute Guides and 7 point briefings for professionals which will be available on the CYSCP website and to promote learning via the CYSCP Twitter account and the CYSCP Newsletter.

## ■ CYSCP Training and Development

### Multi-Agency Training, Learning and Development

#### Online training

During 2020/21, the City of York Safeguarding Children (CYSCP) E-Learning Awareness course has continued to be available to any practitioners and volunteers working with children and young people via the City of York Council's MyLO Learning Management System. During 2020/21, 3666 learners have passed the course, the majority of the users of this training are from Education and Early Years/Childcare.

#### Virtual training

During 2020/21, the CYSCP's training offer had to adapt and change rapidly due to Covid-19. The Workforce Development Advisor (CYSCP Business Unit) worked with training providers to change how all CYSCP courses were being delivered. Thus meaning that all our previous face to face courses were reviewed and updated to virtual delivery. By September 2020, all CYSCP's courses were being delivered virtually through live Zoom sessions. This still provided trainers and delegates the opportunity to interact with each other ensuring multi-agency discussion, which is so valuable, could still take place. The majority of learners on these courses were from City of York Council, followed by Education and Early Years/Childcare.

CYSCP Multi-Agency courses delivered in 2020/21	Sessions	Attendees
Safeguarding Children: Working Together A	7	138
Safeguarding Children: Shared Responsibilities and Procedures - Working Together B	8	162
Safeguarding Children: Awareness of Neglect in Children and Young People	3	35
Safeguarding Disabled Children	5	51
Safeguarding Children: Understanding Domestic Abuse and Children	3	33
Introduction to Child Protection Conferences and Core Groups	2	21
Safeguarding Children: Harmful Sexual Behaviour and Learning Disabilities - Sharing Learning from a Learning Lessons Review	6	97
<b>Total</b>	<b>34</b>	<b>537</b>

## Workshops on Child P Learning Lessons Review (LLR)

Workshops sharing the lessons learnt from Child P LLR case were delayed due to Covid-19 and had to be reworked to be delivered virtually. Overall six workshops were delivered by a range of partners from Health, Youth Justice Service, City of York Schools Safeguarding, Children's Social Care and North Yorkshire Police and was well attended by over 90 practitioners from a range of organisations. The feedback from these workshops will be carried forward into future training on Harmful Sexual Behaviour (HSB).

## Partner training

During this challenging year, there has been an important emphasis on the availability of virtual and e-learning training. At the start of the pandemic the CYSCP [Learning and Development Pages](#) on the CYSCP website was reviewed and updated to ensure that information pertaining to training was up to date and relevant. In addition, links to other free e-learning provision and virtual training opportunities available through partners were also promoted to practitioners and volunteers via the CYSCP through partners, twitter, CYSCP newsletter and Newsfeed. This included training on:

- PAMIC tool
- Learning from Child P case
- ICON campaign and resources
- Suicide Awareness
- Systemic Practice
- Child Death Review training
- Early Help and Family Early Help Assessment (FEHA) training

## Staff Wellbeing

In response to the continuing Covid-19 situation, wellbeing sessions were delivered to partners.

In January a wellbeing week campaign was held which included sessions for practitioners covering physiological wellbeing and stress delivered by North Yorkshire Police, mindfulness sessions delivered by the City of York Council chaplain and wellbeing when working with families delivered by the Institute of Family Therapy.

All sessions proved popular and in March 2021, three more sessions covering physiological wellbeing and stress were again delivered by North Yorkshire Police. 114 practitioners attended these sessions and the feedback was very positive.



## Evaluation of training, learning and development

### E-learning evaluation Learners' ratings of e-learning

Evaluation data from 2753 learners shows that 99.5% of learners stated the course either fulfilled or exceeded their expectations and 99.5% stated they would be able to apply what they learnt in their work. Ratings of the specific course elements also score highly.

### Virtual training evaluation

Evaluation returns show that the majority of attendees highly rate the quality of various course aspects. Evaluation returns also show that 86% of learners were “likely” to “very likely” to change the way they do things in the future as a result of the training commissioned by the Partnership.

### Impact of training, learning and development

During 2020/21, a short survey has been used to capture examples from course attendees about the impact of training on their working practices 3-6 months after training has taken place. The data for 2020/21 collected to date only covers quarters 1 and 2 which covers the initial lockdown period due to the pandemic and the main training taking place was the e-learning, and therefore the responses are limited.

31% of respondents said they had changed something in their working practice as a result of the learning they undertook through CYSCP. This included being more aware of safeguarding and safeguarding responsibilities, being more aware of what action to take, understanding children's needs better, observing children's behaviour more and review safeguarding policies and practices.

Whilst this leaves a majority of respondents not changing anything in their working practice, the reasons provided below give assurance that the training still offers value and impact by ensuring learners are receiving relevant and up to date information:

- Many respondents undertake the course as refresher learning
- Due to their role or the pandemic they have not had opportunity to apply the learning
- Respondents' working practices and processes are already reflecting the content of the training.

### Impact on children and young people

Practitioners were also asked to provide examples of where their learning had directly and positively impacted on a child or young person. Several responses include generic examples about increased staff awareness of safeguarding issues, what to action to take and more confidence. One practitioner identified a particular example where they supported a young person who made a disclosure and sought further help for them from appropriate professionals.



## Training developments for 2021/22

- Virtual training is expected to continue in place of face to face training.
- Virtual Private Fostering training resources have been developed for delivery.
- The Safeguarding Children E-Learning Awareness course will be moved to a new platform during the year to enable learners to be charged to cover the cost of providing this course.
- The Partnership's Training, Learning and Development Strategy will be reviewed and updated.

## ■ CYSCP documentation

### Policies, Procedures and Practice Guidance

In 2020/21 the CYSCP Business Unit a review of all partnership documentation. The following procedures and guidance's were reviewed and rewritten:

- [HSB Procedure](#)
- [LADO Procedure](#)
- [Non Recent, Organised and Complex Abuse Procedure](#)
- [CYSCP Procedure for Child Protection Conferences and Core Group Meetings](#)
- [Exploitation Guidance](#)
- [CYSCP Female Genital Mutilation Guidance](#)
- [CYSCP Guidance on Resolution of Disputes or escalation of concerns](#)

### Tools and Forms

The following tools and forms were reviewed and rewritten:

- [The City of York Safeguarding Children Partnership Child Criminal Exploitation \(CE\) \(including Sexual Exploitation\) Screening Tool](#) was reviewed and updated.
- [LADO Referral Form](#)
- [North Yorkshire and City of York Partnership information Sharing Form](#)
- [Child Protection Conference Agency Report Form](#)

## One Minute Guides

During 2020/21, the CYSCP created One Minute Guide's which would capture all information on a particular topic in one useful downloadable document.

To date the following One Minute Guide's have been produced:

- [Child Protection Conference](#)
- [Child Protection Core Group](#)
- [Forensic CAMHS](#)
- [Forced Marriage and Honour Based Violence](#)
- [Harmful Sexual Behaviour \(HSB\)](#)
- [Private Fostering](#)
- [Systemic Practice](#)

Work is ongoing to identify and produce further One Minute Guide's which will be useful for professionals and frontline workers.

## 7 Point Briefings:

Two 7 point briefings have also been produced following a learning lesson review and a single agency review.

- [Child P](#)
- [Baby Thomas](#)

## CDOP

The York and North Yorkshire Child Death Overview Panel (CDOP) reviews the death of every child under the age of 18 years. Fortunately, there are very few of these but every death is a tragedy. The panel is made up of professional experts from different local organisations.

The aim of the CDOP is to identify anything which might prevent something similar happening in the future. In York and North Yorkshire, the Child Death Review process is administered by the North Yorkshire Safeguarding Children Partnership, on behalf of both York and North Yorkshire and the CDOP reports to the Safeguarding Children Partnerships in York and in North Yorkshire. York and North Yorkshire work closely with regional colleagues to ensure lessons are learned from any themes emerging across the region.

You will find full details of figures and priorities for the last year in the York and North Yorkshire CDOP Annual Report 2020/2021. The priorities which were around sudden and unexpected deaths in infancy (SUDI) and Suicide Prevention will continue into 2021/2022 to ensure the robust implementation of all actions identified across agencies to assist in the prevention of SUDI's and Suicides in children and young people across the region.

Further information in respect of Child Deaths and CDOP can be found on the [CYSCP website](#).

## ■ Finance 2020/21

The CYSCP budget is derived from contributions from a number of partners. As well as direct funding the CYSCP is also provided with services in kind by a number of agencies.

Expenditure	2020/21 (£)	Income	2020/21 (£)
Staffing	£184,480	Balance Brought Forward 20/21	£32,409
Training Commissioning 2020/21	£12,974	CYC Children's Services	£82,738
Training Commissioning 2019/20 Underspend	£5,491	Health	£78,991
Other	£1,739	Police	£33,011
Independent Chair	£15,525	Probation	£811
Child Death Review Grant	£16,693	CRC	£1,400
Management charges	£18,840		
<b>Total Expenditure</b>	<b>£237,276</b>	<b>Total Income</b>	<b>£196,951</b>

## **Appendix A:**

# **Independent scrutineer contribution to City of York Safeguarding Children Partnership (CYSCP) Annual Report 2020-2021.**

**Maggie Atkinson, Independent Scrutineer**

### **Introduction**

This report:

1. Reflects on the content, appropriateness and quality of the CYSCP's Annual report covering the financial year 2020-2021.

and

2. Comments on what I have observed as Independent Scrutineer of the CYSCP in the same period, whilst noting that I took up the role at mid-year point in September 2020, and was both appointed in an online process and have undertaken all my work to date through the same means rather than by having a physical presence in the city.
3. Outlines issues for imminent and future close attention in 2021-2022 including, where I perceive there are any, risks to the stability and progress of CYSCP working to its maximum potential in complex and changing times.

Inevitably my Independent Scrutineer's report is influenced by work undertaken by all agencies to ensure the safety and wellbeing of children and young people during the continuing and now-evolving Covid 19 pandemic. It concerns itself with work that has been done, in Partnership terms though not in single services, undertaken by partnership representatives working with each other largely remotely rather than face to face. It also, however, reports on non-Covid-19 related matters as CYSCP was a statutory partnership before, and will continue to be so in the years after, the pandemic.

I can confirm that as per the requirements of the statutory guidance "Working Together To Safeguard Children" 2018 and amendments to it in 2020, I am assured that broadly, City of York Council, the city's CCG, North Yorkshire Police Service, and the many relevant agencies in York have done far more than simply stand by their children and young people in 2020-2021's challenging times. They have reconfigured how CYSCP works at subgroup and Executive levels, and worked hard to keep children and young people as safe as possible – often for longer hours than normal given there was no travel to meetings involved and people have moved from meeting to meeting in an unbroken string throughout their working days. Staff and leaders are aware that gains to practice and partnership, as well as challenges, have arisen during the pandemic. They are determined to hold onto the gains of remote working and the efficiencies it brings, and determined to work on a longer-term programme that accepts ways of working need to go on developing in "hybrid" models. Covid 19 may be with us for a long time in an endemic rather than pandemic phase as 2021-2022 continues. The work services do both with each other and with children and young people must carry on regardless, however its delivery is amended to fit new circumstances.

The CYSCP's model of Partnership and its subgroups, the terms of reference for and meetings schedules of the Executive and those subgroups, are all available on the Partnership's website at [www.saferchildrenyork.org.uk](http://www.saferchildrenyork.org.uk)

In 2020, government asked Sir Alan Wood to review how well the new arrangements were working, notwithstanding that this review was launched less than a year after most MASA launch dates, and was undertaken and has now been published in the midst of a pandemic which inevitably meant that what Sir Alan was reviewing was to at least some degree not "business as usual." His report sets out his opinion on some of the lessons that have emerged. It should be considered alongside this CYSCP Annual Report. So should the Annual Report from the National Children Safeguarding Panel, hosted by the Department for Education. I consider that CYSCP's development and practice are well within the range of what both Sir Alan and the National Panel consider are good practice.

### **My work as scrutineer, set against national requirements on the CYSCP**

Multi Agency Safeguarding Arrangements (MASAs) such as CYSCP are bound by statutory guidance in "Working Together the Safeguard Children" (2018, updated but not radically changed in 2020.) This is clear the MASA does not work in isolation but is part of any locality's broader, all-agency means of ensuring citizens' wellbeing. The central tenets are below.

#### **"Working Together" 2018, Chapter 3 states:**

The purpose of local arrangements is to support and enable local organisations and agencies to work together in a system where:

- children are safeguarded and their welfare is promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account effectively
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- information is shared effectively to facilitate more accurate and timely decision making for children and families.

In order to work together effectively, the safeguarding statutory partners, with other local organisations and agencies, should develop processes that:

- facilitate and drive action beyond usual institutional and agency constraints and boundaries
- ensure the effective protection of children is founded on practitioners developing lasting and trusting relationships with children and their families

Effective arrangements link to other strategic partnership work locally that supports children and families, including other public boards: Health and Wellbeing Boards, PFCCs' boards and panels, Adult Safeguarding Boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs. (This list is not exhaustive.)

Strong leadership is critical for arrangements to be effective in bringing together organisations and agencies. It is important that the lead representative from each of the three safeguarding partners plays an active role. The lead representatives for safeguarding partners are: the local authority chief executive, the accountable officer of a clinical commissioning group, and a chief officer of police.<sup>1</sup>

All three safeguarding partners have equal and joint responsibility for local safeguarding arrangements. In situations that require a clear, single point of leadership, all three safeguarding partners should decide who would take the lead on issues that arise.

Should the lead representatives delegate their functions they remain accountable for any actions or decisions taken on behalf of their agency. If delegated, it is the responsibility of the lead representative to identify and nominate a senior officer in their agency to have responsibility and authority for ensuring full participation with these arrangements.

The representatives, or those they delegate authority to, should be able to:

- speak with authority for the safeguarding partner they represent
- take decisions on behalf of their organisation or agency and commit them on policy, resourcing and practice matters
- hold their own organisation or agency to account on how effectively they participate and implement the local arrangements

## The CYSCP scrutiny role

Independent scrutiny provides assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children, including arrangements to identify and review serious child safeguarding cases. Independent scrutiny is part of a wider system which includes independent inspectorates' single assessment of individual safeguarding partners, and the programme of Joint Targeted Area Inspections. Safeguarding partners should ensure scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement. The independent scrutineer considers how effectively arrangements are working for children and families as well as for practitioners, and how well safeguarding partners provide strong leadership and agree with the safeguarding partners how this will be reported.

<sup>1</sup> Sir Alan Wood in his recently published report remains of the opinion that Chief Executives of LAs, Chief Constables and Accountable Officers of CCGs should sit on Partnership Executives in person. It is my view that this is untenable given the breadth, depth and coverage of their respective roles; and that the levels of delegation to very senior Officers who lead the actual work is appropriate, so long as they can assure each other and me that their Chief Executive level post-holders are kept regularly and clearly informed of the CYSCP's work.

CYSCP appointed me as its Independent Scrutineer commencing in September 2020. Partners have acknowledged throughout that the independent scrutineer cannot be the sole provider of feedback or reflection. Working Together 2018 is clear that mutual holding to account, support and challenge are part of how statutory partners and relevant agencies must operate to ensure the partnership and its impacts are clear, co-owned, and contribute to progressively improving children and young people's lives. The scrutiny is a key part of judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children.

I provide critical appraisal of safeguarding arrangements, providing challenge to and ongoing, clear and evidenced appraisal of the partnership in York, by attending key meetings, meeting vital groups including children and young people, and then feeding back. I chair bi-annual all-partners and all-agencies development days, part of which also include my feedback on progress. At present all of this work is done through virtual means.

I was appointed to:

- Assess how well organisations work together to safeguard and promote the welfare of children and to hold each other to account for effective safeguarding
- Contribute to the content of the partnership's annual report on the effectiveness of safeguarding arrangements, their performance and the effectiveness of local services
- Assess the effectiveness of the help being provided to children and families including through universal and early help services
- Assess whether the three statutory safeguarding partners are fulfilling their statutory obligations
- Scrutinise the quality assurance activity (including reviewing statutory and local reviews, the results and findings of multi-agency case file auditing, and North Yorkshire's processes for identifying lessons to be learned from tragedy and crises in children's lives)
- Scrutinise the effectiveness of training, including multi-agency training, whose aim is to equip staff to safeguard and promote the wellbeing and welfare of children
- Assess the effectiveness of safeguarding arrangements in North Yorkshire
- Provide a rigorous, evidence based and transparent assessment of the extent to which partners and relevant agencies are fulfilling their statutory duties to keep children safe
- Evaluate arrangements for the operation of the safeguarding partnership and attend a range of meetings and activities including visits to partner and relevant agencies
- Support the implementation of findings and outcomes from safeguarding reviews
- Assess whether effective performance management, audit and quality assurance mechanisms are in place within partner organisations which will support the three safeguarding partners to fulfil their statutory objectives, and which will enable the partnership to identify and measure its success and impact
- Ensure that the voices of children, young people and their families are appropriately represented and heard in the work of the partnership.



My contribution to the CYSCP Annual Report enables CYSCP to comply with the requirement to publish such a Report on its activities, successes and continued or newly developing challenges which will go on into the 2021-2022 year which has now commenced. My section is focused on how, and how well, the work of the CYSCP is undertaken, and what the quality of the Executive's and the subcommittees' activities is as 2020-2021 is closed and attention turns to 2021-2022. This contribution reflects on the following broad themes, and captures risks or areas for attention.

1. CYSCP having been an Early Adopter of a new MASA model, the partnership reached a consensus that “blank sheet of paper” thinking was not necessary in moving from a LSCB to a Safeguarding Children Partnership. The former LSCB, and ongoing CYSCP activity, together provide a foundation for York agencies' future practice, not least because although the nature of the inter-agency body changed, in York's case in 2018-19, many of the people central to work undertaken by the LSCB continue to ensure the CYSCP is progressing.
2. The 3 statutory partners have created, and agencies' governance and scrutiny bodies and staff groups agreed, a model that serves the city, its many and far more varied communities than outsiders imagine, and organisations that work for and with children and young people across the schools and other universal services in early years, education, health, housing, youth organisations, Early Help teams, a wide range of statutory services, faith, community and voluntary bodies. A new Partnership structural model following consultancy in March 2020 is a model that is now operating well, reflecting a strong shared commitment to working and learning in partnership. Given early adopter funding was strongly connected to facilitating working with schools on their safeguarding practice within a CYSCP setting, the partnership is also looking again at how well connectivity between education and safeguarding works in the interests of all children and young people, including those with any of a wide range of additional and special educational needs (SEN), with or without a disability (SEN/D.)
3. The configuration, terms of reference, membership and attendance of subgroups, the work undertaken in them which is a reflection of the fact that without a Board like the LSCB, the ownership of and work done on safeguarding across all agencies has moved far closer to service front lines, where they are delivered and children and young people experience them. Those services are represented on, and report to, CYSCP subgroups and contribute to themed or project-based working, and task and finish groups. The March 2020 consultancy report which informed the change of structure and ways of working reflected on the fact that making the Partnership the single statutory accountability body for children and young people means the work is now “held” and to a high degree driven, by the subgroups, accounting to the CYSCP Executive. That the Executive's member bodies also account to each other, and hold themselves to account for their safeguarding work, is central to CYSCP's continuing success. The pledges renewed across the partnership, and by professionals from a wide range of organisations who have contributed to several partnership development sessions during 2020-2021, reflect well on what has happened during the year and help shape both strategic and operational plans for future work.



4. Two Improvement Boards (IBs) also operate in children and young people's services in York: one addresses the need for improvements in the practice models and ways of working in Children's Social Care (CSC) services identified by inspectors. The second works to answer similar challenges for development, also informed by inspection, in Special Educational Needs and Disability (SEN/D) services in education, health and social care. The work of both Boards is vital. In 2021-2022, however, formal links should be firmly established between these important but non-statutory Boards, and CYSCP as York's statutory accountability body covering all services, and all work done, for children and young people. Such links could be achieved by, for example, data and reports presented at the Improvement Boards being added to the agendas of and noted by the Partnership Executive and at CYSCP Development Days. The risks in such vital formal links not being made rest largely in the fact that services working with the two Improvement Boards may be tempted to believe that they do not account for their work to CYSCP, when in law, they do.

The main body of CYSCP's 2020-2021 Annual Report appropriately covers what has been achieved, and what remains to be done. It reads informatively and includes the three Statutory Partners' assurance of their compliance with "Working Together" (2018, minor amendments 2020.) It contains the required details on activities undertaken to fulfil the intentions captured in strategic and operational plans. It reflects on the fact that the new way of working through strong subgroups with "buy-in" and leadership from staff across agencies allows services to take ownership for getting safeguarding right. Work undertaken by CYSCP is accessibly recorded in the Annual Report, capturing a year of activity from 2020-2021 that has largely been both positive and productive.

This Annual Report, and my contribution to it, are inevitably influenced by the effects of and responses to the Covid 19 pandemic as its effects on both joint and single service working continue. The potential for threats to stability and the work done to ameliorate those threats, and the potential for positive developments in partnership working to continue even when the pandemic passes, have all, rightly, been on the minds of all involved in the Partnership. They are all now turning their thinking towards what a Recovery phase will look like given, notwithstanding the current uncertainty about further waves of the virus as a serious disruptor of society and services alike, given the success of the vaccination programme the likelihood is that it will be an endemic presence with residents being ill, but not seriously so. The corollary is that services can begin to plan for a "new normal" likely to go on involving some working from home for many staff, but a return to face to face activity for at least some of their work.

As Independent Scrutineer it is my duty to present assurances that safeguarding is proceeding as it should, or where things have changed or problems arise why that might be, what degree and what kind or risks are attached, and what lessons need to be learned. I am pleased to give this Assurance as part of this Annual Report, and to close my section of the Report with a formal statement of that assurance.

## A still-important issue for CYSCP, and me as Independent Scrutineer: Covid 19.

The effects of almost a year and a half to date of the Covid 19 virus cannot be over-stated. The results of the need to respond to an extraordinary and unprecedented, now long-lived and exhausting crisis have included at least the following for CYSCP:

- Staff both of the CYSCP and the partner bodies are largely working from home, use of office accommodation being reserved for those who either cannot do so or who strictly need occasional office time. Staff ensure regular online KiT meetings, and continue to work in efficient and facilitative business support. CYSCP leaders also contribute to regular citywide strategic discussions regarding how the response to the pandemic, and plans for the future, are coordinated and assured. Some agencies (police, emergency services, Children's Social Care, many health bodies, many schools, housing and other services) are of course, and through the pandemic have been, engaged in work in as near a "business as usual" fashion as possible albeit with virus protection and minimisation measures as part of their work.
- The CYSCP Business Manager and her small team administrator continue to keep me, and partner agencies, apprised of developments and any issues for discussion or concern, and facilitates my presence at 3-Statutory-Partner, Executive and CYSCP subgroup meetings as a participant observer, so that assurance can be stated clearly as my role requires.
- The Partnership's Executive meets six times a year, enabling it both to hold all others to account and to direct the Partnership's work both in reaction to the pandemic, and so that safeguarding work does not lose pace or focus. The Executive calls on the presence and expertise of senior staff from across agencies and relevant partners for these meetings including through taking Assurance and Activity reports as part of its agenda, so that the CYSCP can take forward what is decided and will be required of services and agencies across the city.
- There have been several whole-partnership Development Days held online during the pandemic, giving all concerned the opportunity to reflect on progress to date, what challenges Covid 19 has presented, what non-Covid challenges continue to be, how they should all be dealt with, what support children and young people continue to need, and what might happen next in the CYSCP's ongoing development. Whilst the virtual environment and technology create challenges, the attendance at these sessions is good, and colleagues clearly value the opportunity to maintain their connections with and support for each other, and thereby children, young people, families and communities. The hope for an ability to meet face to face once a "new normal" can be and is established is palpable at these sessions, and remains a driver of the partnership's continued thinking and activities.
- The Partnership's themed subgroups meet virtually to an already agreed schedule, having decided as the Covid 19 situation clearly proved to have longer life than was at first expected that suspending business and waiting for an end to it could not be justified. The work done in these groups centres on what can and should be learned, across the Partnership, about how well the work of safeguarding is proceeding and what may need to go on being developed so that practice and partnership will match the best.

- As Scrutineer I have attended all CYSCP subgroups, including the shared CDOP and CDRP that runs across North Yorkshire and York at least once during the part of 2020-2021 for which I have been Scrutineer, though I only took up my post in September 2020 so was not present at the start of the year. I am pleased to confirm that they are all well run, their agendas are clear, partners step in to chair or to lead pieces of their work appropriately so that the weight of leadership is shared across the CYSCP's agencies, and the business done is appropriate and helps to drive practice forward. Also in line with a cyclical reporting schedule, individual partners on the CYSCP also report their progress, and their challenges, to the Executive, so that awareness is raised across all parts of the Partnership and safeguarding agendas become ever more jointly owned and driven.
- Where reviews have had to be undertaken, whether at Rapid Review or Local Safeguarding Children Practice Review levels, there has been in every case a professional willingness to engage across all agencies concerned. Honest and detailed information sharing has been enabled, robust reports have been written and accepted, and agencies can evidence where learning has taken place and what changes in practice have resulted. Briefings are included in a steadily improving CYSCP website. Reviews are seen as learning opportunities by all concerned, and the work that arises from them is deliberately and professionally threaded through agencies' responses to difficult issues and sadly sometimes tragedies in the lives of vulnerable children and young people.
- Subgroups' attendance and actions lists, and the minutes of each group, illustrate that partners remain committed, attending virtually during the pandemic, finding work-arounds for technology challenges that arise from time to time. Chairs and the business support team construct agendas, ensure meetings are recorded appropriately, send out actions for completion, and ensure the Executive is kept closely informed. It is clear that the business the subgroups do continues to need to be done, and that the Partnership needs to go on developing their ability to inform and steer the work done with York's children and young people, as well as using the subgroups and the Executive to hold all concerned to account.
- The Partnership continues both its audit activity, and its learning and development activity, albeit again all online. Section 11 multi-agency and Section 175 schools' safeguarding audit cycles are agreed annually, some are done in partnership with the neighbouring LSCP in North Yorkshire to add to the shared practice that then arises, and it is clear that audits are done as a means of providing assurance on the quality of practice. The business support team sends out updates and newsletters both on Covid 19 related issues, and safeguarding more generally. Partners and relevant agencies value these updates. Examples can be found on the CYSCP website, where a wealth of other information, guidance and professional support materials, along with materials that children families and parents or carers can also use.

- The CYSCP remains keen to ensure support on safeguarding is given to schools, and that where necessary challenges and suggestions for improvement can also be provided. Throughout the pandemic and school part-closures, an adequate number remained open, at the very least to provide “hub” services, particularly for vulnerable children and children of keyworkers, of whom there are substantial numbers in some communities. When fuller opening took place, and despite some “stop-start” effects on already hard pressed and tired staff and bewildered children and families, the city has supported schools to ensure such changes have been handled in as seamless a way as possible to support families and ensure their children were safe to return. Every school has thereby been supported in their safeguarding work, despite the additional workload experienced by school staff creating “blended” learning as the pandemic continued, and since Christmas 2020 dealing with anxious children and worried families in rising numbers.
- Schools have taken a proportionate approach by sending home only immediate contacts whenever possible. Support to their work has been valued by schools, which have, like schools across the country, been less well and less clearly supported by central government and the many changes and last minute guidance and support sent out to heads and their teams. Though committed to safeguarding, schools and particularly their leaders are also struggling with tiredness, and the responses of a minority of families who will not, or consider they cannot, send their children back in. Schools will go on needing support and their issues are regularly discussed, the strength and resilience of the Assistant Director for education functions in York being a trusted and strategic adviser, aiding that support and allowing for future planning to gather pace.
- Face-to-face safeguarding training ceased after the pandemic began. CPD offers and increased amounts of guidance and professional information have all continued virtually, both at Partnership level and within individual agencies. The Partnership’s “lessons learned” and 7 minute briefing materials continue to be added to, as do other offers to ensure as many of the workforce as possible can access up to date safeguarding training, including through the City of York Council’s training platform. The upgrade and refresh of the CYSCP website have been welcomed for the high quality of support and advice it provides, and for the ease of accessing its content by professionals, parents, children and young people alike.
- The CYSCP team has contributed advice and guidance for ongoing Coronavirus planning, handling, and services’ offers to communities, given agencies across the city may still be faced with disclosures or allegations of issues regarding the wellbeing of children and young people, with which some of them may be unfamiliar. The CYSCP and its many partner bodies are also working with the strong community of volunteers and voluntary agencies in the city which need ongoing information and support - and which are Relevant Agencies in Working Together 2018 terms.

- Early Help services continue to target work across York, and to respond to requests for early intervention and lower-level social care interventions in line with the city’s agreed and adopted Early Help Strategy. Rates of referral are monitored, especially where they may be concentrated in less affluent communities where families and their children can live challenged lives. Early Help reaches out in relevant Wards, making it clear that even in the pandemic period, services have remained available to help families avoid or avert crises. The intention is that Early Help, early intervention and prevention, should go on “keeping the heat out of the top of the system,” given social care services are answerable to an Improvement Board as well as to CYSP, and the goal is to ensure families attract and receive support that keeps them together. Intervening early and appropriately will no doubt continue to be a theme of work for children and young people, once the pandemic’s ongoing restrictions are lifted. That Early Help is not solely the province of social care teams but relies on schools, early years, youth, health and other services, is and will remain a vital part of that offer.
- The CYSCP team is also involved in work underway on Domestic Abuse/Domestic Violence which includes many Relevant Agencies in voluntary, community, and survivor-led and focused bodies. Such a focus on a vital issue for some children and young people is a marker of partners’ insistence that vital work must go on no matter what, and it is hoped that its positive effects will be felt by children and their families who may be at risk. Given Royal Assent was given to the Domestic Abuse Act 2021 in late April, the York is looking to ensure a way forward enabling it to carry its new statutory duties in its own right rather than in a single partnership across North Yorkshire and York. Discussions will then take place regarding continued joint implementation work with North Yorkshire in commissioning and providing DA/DV services. This determination to ensure a York-specific strategic drive whilst ensuring that where possible approaches to delivery are standardised, is to be commended.

## What next for the partnership?

New issues may surface as Covid 19 restrictions continue to be lifted. These issues may last for the longer term, even once future planning is implemented and its results can be seen. The Partnership is keenly aware that many staff have given a great deal since early 2020 and are now tired and stressed; that post-pandemic there may be problems that have been in the wings since march 2020 that will come to the fore and need to be addressed; and that the CYSCP needs the energy, time and resources to think and plan as far ahead as possible. Current circumstances are extraordinary, though CYSCP members are also aware they have taught services and leaders a great deal about working together and facing contingencies that could not have planned for. These challenges, and the response that have been made to them, should be used to set new patterns for and ways of working in the future.

Partners are also aware that post-pandemic times are likely to give rise to different demands, needs, challenges and opportunities, not least if the economy struggles to revive and takes a long time to enter sustained recovery – a situation which could place some families’ lives under severe challenge. The issues discussed below will undoubtedly present challenges to every agency and statutory partner.



## Post-pandemic

Once the pandemic subsides and especially in light of the success of the vaccination programme, the period of “Afterwards” is likely to present circumstances that will not be what we remember as “normal” in pre-Covid 19 days. Deciding as a Partnership what to do about what arises is accepted by CYSCP members as unlikely to be simple, quick, or cheap.

There are then several areas of potential risk or pressure to which close attention and creative solution finding will need to be applied.

- Schools are now fully and successfully open, but educational professionals are aware that circumstances in Summer 2021 are not as they were prior to March 2019. Exam and testing regimes are likely to come under continued scrutiny from here on in, placing at least some candidates and teachers into further uncertainty and stress. Schools are also aware that children from some vulnerable families have been slow to return and that some have not yet done so, and that both sporadic attendance and elective home education are on the rise. This is an ongoing issue that partners are aware will need to be addressed vigorously, potentially for the long haul. These issues are national as well as local.
- Rates of referrals into some higher-level services were initially lower than in pre-pandemic times. Trends manifested themselves in lower levels of children seen, or reported as being, caught up in County Lines activity, in lower referral and self-referral patterns in mental health services, and lower reported cases of domestic abuse and violence. However, all have now resurfaced. Partners are prepared for an expected further rise, potentially involving a greater than usual focus on higher end and crisis level safeguarding activity. There may well in York as elsewhere in England, be a rise in the need for intervention in a minority of families which did not need help before, needed help but struggled behind their own closed doors and did not ask for help during lockdowns, or turned help away using Covid 19 as an excuse.
- Reductions in some areas of work are now being matched by rises in others, including a developing trend of families coming to services’ notice with very complex needs when they were not “on the radar” of specialist teams at all pre-pandemic. The increase in family poverty likely to be caused by adults’ ongoing job loss or uncertainty as the economy makes an uneven recovery, added to some families dealing with state benefits difficulties being in still-worsening poverty, and the likely or already manifest poorer prospects for some in the workforce within a recovering economy where that recovery may take a long time to bear fruit, are all likely to affect some children’s lives more than others.
- In schools, there is an ongoing tension between confused and contradictory notions of catching up on supposedly lost learning, and re-orienting, supporting and dealing with recorded rises in both staff and student anxiety and uncertainty. There are children and young people who craved coming back to school and schools reporting a steady and happy re-settlement into routines; and those who would rather not have returned, or who did not and even longer term may not return. There are also, as national analyses also indicate, children and young people with special educational needs with or without disabilities, who need support beyond the resources available, whose situation may have been exacerbated by restrictions during the Covid 19 pandemic. There may be some whose planned appointments with medical staff were stood down whilst health services dealt with the pandemic, who will not recover as they might had services been available as they were before. It will take time for the picture to clarify, but these matters are already on the agenda of the SEN/D Improvement Board in York.

- If referrals discussed in previous sections rise as predicted, but financial resources paid by central government to fund services and agencies stay at pre-pandemic levels, there will be ever harder decisions to make and potentially a growth in unmet needs – itself a predictor of safeguarding difficulties for some children and young people. Decision makers, policy and service shapers, and workers in agencies, will need to be kept aware both of these externally driven but locally felt circumstances, and the need to shape services so that inter-agency and multi-disciplinary learning is retained and indeed built on. This will require sustained commitment across all services, and may not be easy to maintain once the post-pandemic period is properly underway. Many agencies' resources will have been depleted during 2020-2021. This includes voluntary sector bodies whose losses in funding may mean their ability to be delivery partners is curtailed. It is clear from national and international analyses that Covid 19's economic effects could be long lasting and negative, particularly if families cannot meet their financial responsibilities and seek recourse to ever more scarce and tightly regulated support.
- What will need to happen to address these many issues could be complex, and will require the input of leaders, staff and citizens. It is clear detailed planning, and a readiness to act as swiftly and in as close a partnership as has become the hallmark of Covid 19's ways of working, will be needed.

### **Additional risks or issues that will need to be dealt with include all of the following:**

Who will Chair the Executive from Summer 2021? This is a question arising from the following four key circumstances in partner bodies which oversee the CYSP's activities at all levels.

- The City Council has undergone a restructure at senior levels so that there is now one People's Directorate rather than a children's and an adults' pairing of Directorates. The new People's Directorate runs under a very senior officer who is therefore effectively doing two large, statutory, weighty and difficult jobs. There is therefore no capacity in that senior colleague's diary to step in to chair the CYSCP Executive. A Deputy Director for Safeguarding has recently been appointed, an experienced City of York Council Assistant Director (Adults) by background. He will need to immerse himself, rapidly and determinedly and possibly initially solely, in children's issues, including but not exclusively about safeguarding as such, if his remit is to be all-age. Decision making and executive powers will need to be clear given CYC is a statutory partner on both CYSCP and CYSAB. Further discussions will be necessary regarding who represents and accounts for CYC on CYSCP and to the partners who sit on it. As this report is completed, meetings between the new postholder and me as Scrutineer are being sought so that the situation of representation, leadership and schemes of delegated authority can be shared with me so I can give the required assurance on the safety of the system in York.

- Similar discussions will be needed if, as is now under consideration, a single Business Support Team is configured to support CYSAB and CYSCP. The latter Partnership has more subgroups, a good deal more data, more accountability to a wide range of inspectorates (Ofsted, CQC, HMICFRS, HMIP all of which inspect strands of activities with and for children and young people) and inspection requirements than the former, but the former deals with vulnerabilities at least as complex as those seen in children and young people. Strong schemes of accountability, governance, delegation and regulation will be needed so that neither vulnerable adults' issues nor a wider range of children's ones are lost in any merged arrangements that might result at Business Support levels. Not least, dedicated data analysts are needed if both CYSCP and CYSAB are to act from the basis of knowing enough about demographics, need and aspiration, and how services should adapt to meet them all.
- CCGs and provider networks across the Health economy in England are about to undergo a further period of radical, professionals describe it as seismic, change, as Integrated Care Systems (ICSs) over a far larger footprint than York as a City, allied to different models of delegation and decision making on both commissioning and provision, and models of accountability, all have to be developed, implemented and then delivered in the longer term. This is all being undertaken by senior professionals who are already more than fully occupied, many of whom are approaching the ends of their careers and may not be present as new ways of delivering health services to the population come about. This has already been recognised as the creator of a recordable risk on CYSCP's risk register, and will need to be taken very fully into account in at least 2021-2022, and probably in future years beyond that. At present, the senior staff trying to steer the change and involve partners so that what results is fit for purpose are not being told enough, in timely enough fashion, by NHS England to make the coming changes work. Given childhood physical and mental health are complex and there are already acknowledged gaps in provision of some services, and that ICSs will cover very large territories, the risks of matters going awry in the process are clear, and acknowledged by the Partnership. There is no capacity in the CCGs as they move towards ICSs, to chair the Executive.
- North Yorkshire Police is also undergoing considerable change. Its accountability is now to a new Police Fire and Crime Commissioner (PFCC) elected in May 2021. Senior officers, including the ACC who has been Chair of the Executive and a strong contributor on the Chief Constable's behalf to the LSCPs in both York and neighbouring North Yorkshire, retires in July 2021 and will be replaced on an interim basis by one of the county's Area Commanders with a background and considerable strengths in safeguarding work but who will need to "learn the way in" to the Partnership at executive level. There is no capacity in North Yorkshire Police as things stand, for a senior officer to step in as Executive Chair.



## The Scrutineer's work in 2021-2022

Notwithstanding the risks and issues noted in the section immediately above, the work I am engaged in continues. A pattern of meetings was established in diaries beginning in September 2020 (the start of my contract) and has worked well to date. In 2021-2022 I will continue to attend, observe at, and note the contents of and decisions made at meetings of both the CYSCP Executive and every subgroup, on a cycle matched to busy diaries. For as long as work goes on being done on a virtual basis, there will inevitably be limits on what else could be done with the remainder of days on which the Executive or subgroups meet. Were visits and scrutineer days taking place in York face to face, there would be greater potential to undertake additional meetings in the other halves of days. Such meetings, which may be possible to replace with virtual ones if virtual working continues, could usefully take place with:

- Those at Chief Executive or equivalent decision-making levels in Statutory Partner bodies, as envisaged in Sir Alan Wood's Spring 2021 review of the new Partnership arrangements and as Working Together 2018 also envisages.
- Relevant Agencies' leaders, governance, and managerial staff: principals and head teachers, governors, leaders in community or faith organisations, those working in programme, service or team manager roles in services, and so on.
- Representatives of children and young people, particularly when they are involved in decision making.
- Others as partners and agencies deem fit.

I will continue to facilitate full CYSCP Partnership Days. These will be virtual events for the duration of Covid 19 regulations and for however long afterwards partners see fit given returns to face to face event-based or large group meetings will take time to return. They will, as they do now, consist of all-participant co-appraisals of the Partnership's progress, and Partnership members' reflections on it, plus opportunities for all attendees to be part of learning and information exchanges.


## Concluding remarks and Independent Scrutineer's assurance statement

**As Independent Scrutineer, I present this end of year report as a snapshot in time, not as a definitive document. I have attended as an active observer, through Microsoft Teams, both the Executive and every subgroup. All are running well, and the commitment to ensure they do so has not broken stride despite the pressures under which every service and team are working. I have also kept track of CYSCP website and its offers of support and guidance to all who may need it. I conclude that the Partnership and the agencies and services which belong and account to it are compliant with Working Together 2018. All concerned are aware that communications, both within and between partner bodies, need to be a focus for continuous improvement, to avoid duplication, create efficiencies, and ensure all key safeguarding themes are in the consciousness, and influence the work, of all services and agencies.**

I conclude by being able to give my assurance that the Partnership is running as it should, that people remain committed to making it work and to do so successfully. I look forward to continuing to work with and scrutinise the Partnership and help it to steer ways through the identified risks and challenges cited earlier, and express my hope that in 2021-2022, on whatever limited a basis, at least some of our work can take place face to face, given the known limitations of the virtual environment which is efficient but not conducive to real connections between people. Partnership members have expressed a similar wish, given that although online working is proving productive, there is a great deal missing when the human factor of being in the same space to tackle the same issues is lost.



**Professor Maggie Atkinson**  
Independent Scrutineer,  
City of York Safeguarding Children Partnership (CYSCP)

<b>Item Number: 13</b>	
<b>Name of Presenter: Simon Bell</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – Financial Performance Report Month 5</b>	
<b>Purpose of Report For Information</b>	
<b>Reason for Report</b>  To update members on the financial performance of the CCG, achievement of key financial duties, and forecast outturn position for H1 2021/22 as at the end of August 2021.  To provide details and assurance around the actions being taken.	
<b>Strategic Priority Links</b>  <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input checked="" type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b>  <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input checked="" type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	

**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- |  |  |
|--|--|
| <input type="checkbox"/> Quality Impact Assessment         | <input checked="" type="checkbox"/> Equality Impact Assessment |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment      |

**Risks/Issues identified from impact assessments:****Recommendations**

Governing Body is asked to note the financial performance to date and the associated actions.

**Decision Requested (for Decision Log)**

Governing Body noted the report.

**Responsible Executive Director and Title**

Simon Bell, Chief Finance Officer

**Report Author and Title**

Natalie Fletcher, Head of Finance

# Finance and Contracting Performance Report – Executive Summary



April 2021 to August 2021  
2021/22 Month 5

# Financial Performance Headlines

## ISSUES FOR DISCUSSION AND EMERGING ISSUES

- 1. Reported position against plan** – At the end of August 2021 the CCG is reporting a small Year to Date (YTD) underspend, and a breakeven forecast position, in line with plan, when adjusted for anticipated allocations.
- 2. North Yorkshire and York Partnership financial management approach** – the North Yorkshire and York (NY&Y) geographical partnership has agreed an additional allocation to the CCG of £2.0m resourced from national Covid funding, which will be transacted in September. Throughout H1 the CCG has been monitoring risks relating to overspends in prescribing and CHC, which represented a risk of around £1.5m to delivery of the H1 financial plan. In addition, movement in system wide ERF forecasts have resulted in additional financial pressure on the CCG's situation. The NY&Y agreement represents a joint approach to ensuring that all organisations and the partnership as a whole are able to deliver a balanced financial position for H1.
- 3. Hospital Discharge Programme (HDP)** – Forecast spend on HDP continues to be carefully monitored through regular meetings with stakeholder organisations including City of York Council and York and Scarborough Teaching Hospitals NHS Foundation Trust and jointly agreed plans are in place to mitigate spend if required. The HDP is funded Outside of Envelope and via a retrospective additional allocation and based on the overall ICS spend against its notified budget of £17.6m. Having previously forecast a £863k overspend at Month 4, at Month 5 the ICS was predicting an £61k overspend. The CCG is forecasting spend £765k higher than it's indicative share of the system allocation, however this remains in line with the value included in the CCG's financial plan for H1. As the overall ICS forecast spend is in line with allocated budget the CCG's position is expected to be reimbursed.
- 4. Prescribing** – The YTD prescribing position is overspent by £1.22m, with a forecast overspend of £1.49m. This includes a prior year overspend of £167k. The Medicines Management Team (MMT) have agreed a final medicine switch list and near final standard operating procedure documentation. Once Optum have agreed a start date and start engaging with practices, they will meet with MMT weekly to discuss, savings report, issues, incidents, declined switches and any patients that switch back.

# Financial Performance Summary

## Summary of Key Finance Statutory Duties

Indicator	Year to Date				Forecast Outturn			
	Target £m	Actual £m	Variance £m	RAG rating	Target £m	Actual £m	Variance £m	RAG rating
In-year running costs expenditure does not exceed running costs allocation (see note)	2.8	2.4	0.4	G	3.3	2.9	0.4	G
In-year total expenditure does not exceed total allocation	229.1	230.2	(1.1)	R	274.5	276.7	(2.1)	R
Better Payment Practice Code (Value)	95.00%	99.77%	4.77%	G	95.00%	>95%		G
Better Payment Practice Code (Number)	95.00%	98.06%	3.06%	G	95.00%	>95%		G
CCG cash drawdown does not exceed maximum cash drawdown					274.4	274.4	0.0	G

- In-year total expenditure is currently showing as exceeding allocation because Outside of Envelope expenditure is included as follows:
  - Hospital Discharge Programme £1.09m YTD and £2.06m forecast
  - Elective Recovery Fund £0.05m YTD and £0.05m forecast
  - COVID-19 vaccination costs – reducing inequalities £0.02m forecast

# Financial Performance Summary

## Summary of Key Financial Measures

Indicator	Year to Date				Forecast Outturn			
	Target £000	Actual £000	Variance £000	RAG rating	Target £000	Actual £000	Variance £000	RAG rating
Running costs spend within plan	2.8	2.4	0.4	G	3.4	2.9	0.4	G
Programme spend within plan	226.4	227.9	(1.5)	R	271.2	273.7	(2.5)	R
Cash balance at month end is within 1.25% of drawdown	514	66	448	G				

The running costs plan (£3.4m) is higher than the running costs allocation (£3.3m). This is due to allocation received to fund an ICS post which has been categorised as programme however the post is in running costs.

- In-year total expenditure is currently showing as exceeding allocation because Outside of Envelope expenditure is included as follows:
  - Hospital Discharge Programme £1.09m YTD and £2.06m forecast
  - Elective Recovery Fund £0.05m YTD and £0.05m forecast
  - COVID-19 vaccination costs – reducing inequalities £0.02m forecast



# NHS Vale of York Clinical Commissioning Group Financial Performance Report

## ***Detailed Narrative***

Report produced: September 2021

Financial Period: April 2021 to August 2021 (Month 5)

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### 1. Summary of reported financial position

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

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

The CCG's financial plan submission for H1 was a break-even position against allocation. Outside of allocation there are two key areas of funding as outlined in previous reports – Hospital Discharge Programme (HDP) and Elective Recovery Fund (ERF).

- Forecast spend on HDP continues to be carefully monitored through regular meetings with stakeholder organisations including City of York Council and York and Scarborough Teaching Hospitals NHS Foundation Trust and jointly agreed plans are in place to mitigate spend if required. The HDP is funded Outside of Envelope and via a retrospective additional allocation and based on the overall ICS spend against its notified budget of £17.6m. Having previously forecast an £863k overspend at Month 4, at Month 5 the ICS was predicting a £61k overspend. The CCG is forecasting spend £765k higher than its indicative share of the system allocation, however this remains in line with the value included in the CCG's financial plan for H1 and as it is within the ICS budget is expected to be reimbursed.
- Independent Sector (IS) activity for April to August is above plan by £483k, however due to the threshold adjustment to the 2019/20 baseline used for ERF the CCG anticipates total ERF allocation of £558k, £513k of which has already been received. However, as a system Humber Coast and Vale ICS is not forecasting to exceed baseline in Q2 resulting in no additional funding. For H1 in total the CCG is forecasting an overspend on IS activity of £688k with an associated ERF reimbursement remaining at £558k – a net pressure of £130k. The figures included here are after a risk share agreement has been applied across the ICS, because funding is based on ICS aggregated performance and allocated at ICS level. The reduced financial benefit in the H1 forecast figure when compared to YTD is partly because the threshold for reimbursement of Q2 activity changed from what was originally planned (up from 85% of 2019/20 activity to 95%, notified at the end of Q1), partly as a result of difficulty in maintaining elective capacity (workforce pressures, non-elective admission pressures), and partly due to the profile of the ICS risk share adjustment.

In July the CCG received a retrospective allocation for HDP and ERF expenditure; £1.34m in respect of Month 1 to Month 3 HDP expenditure and £92k for April and 90% of May's ERF. Expenditure in the financial position relating to HDP and ERF still to be reimbursed are shown in an 'Outside of

Envelope' column in the YTD and forecast tables that follow, to allow a comparison of CCG financial performance against plan excluding these items.

## 2. Key issues and developments since the previous report

Through the system wide approach to financial management and risk, the North Yorkshire and York (NY&Y) geographical partnership has agreed an additional allocation to the CCG of £2.0m resourced from the partnership's share of the national Covid funding, which will be transacted in September. Throughout H1 the CCG has been monitoring risks relating to overspends in prescribing and CHC, which represented a risk of around £1.5m to delivery of the H1 financial plan. In addition, movement in system wide ERF forecasts have resulted in additional financial pressure on the CCG's situation. The NY&Y agreement represents a joint approach to ensuring that all organisations and the partnership as a whole are able to deliver a balanced financial position for H1.

The YTD prescribing position is overspent by £1.22m, with a forecast overspend of £1.49m. This includes a prior year overspend of £167k. The in-year overspend is now based on the trend seen in April to June figures. The Medicines Management Team (MMT) have agreed a final medicine switch list and near final standard operating procedure documentation and are meeting with the contracting teams to review the Optum contract and arrange a start date. Once Optum have started engaging with practices, they will meet with MMT weekly to discuss, savings report, issues, incidents, declined switches and any patients that switch back.

The CCG continues to report a significant overspend Continuing Healthcare packages (£1.41m forecast overspend for H1), however this overspend has been of a consistent value since first identified in Month 2.

The CCG continues to review and challenge all other areas of spend, including historic liabilities and potential investments, as part of the established approach to in-year financial management. The CCG received confirmation in August that there was no further liability for VAT reclaimed against the commissioner support contract with eMBED, which has allowed release of prior year accruals totalling £621k.

### 3. Year to Date position

The year-to-date position in the table below covers April to August. The first three columns show the position as per the CCG's financial ledger. Individual lines have been adjusted for outside of envelope spend that is expected to be reimbursed. The 'Outside envelope' column includes £1.09m in relation to HDP and £45k for ERF.

	YTD Position (£000)					Comments
	Ledger Position			'Outside envelope'	Adjusted variance	
	Budget	Actual	Variance			
Acute Services	116,543	116,460	83	45	128	£30k underspend on independent sector activity, offset by £45k expected additional YTD adjustment for ERF - net benefit £75k. £70k underspend on RSS team
Mental Health Services	25,186	25,253	(67)	0	(67)	Overrspend on S117 placements (£55k) and on MH NCAs (£35k)
Community Services	13,682	13,836	(154)	213	60	£213k HDP spend, reimbursement to follow. £126k underspend due to release of prior year Property Services accrual, offset by £60k grants to Martin House from CYP transformation allocation - funding received in 2020/21 and to be reprovided in 2021/22 through arrangements with partner organisations (to be transacted later in financial year)
Continuing Healthcare	14,798	16,094	(1,296)	877	(419)	£877k HDP spend, reimbursement to follow. YTD overspend on CHC packages of £1.11m due to increases in fast track and fully funded cases, partly offset by £632k underspend on FNC
Other Services	7,396	7,193	203	0	203	£114k underspend due to prior year NHS Property Services benefit
Prescribing	22,511	23,727	(1,216)	0	(1,216)	£167k overspend due to impact of prior year prescribing figures (i.e. February and March actuals higher than 2020/21 year end accruals). £995k in year overspend based on April-Jun prescribing data
Primary Care	4,288	3,735	553	0	553	£486k underspend due to release of prior year accrual for GP IT historic VAT liability
Primary Care Delegated Commissioning	22,110	21,662	448	0	448	£65k income relating to GP returners in 2020/21. £130k underspend on PMS premium payments, offset on Primary Care line above. Underspend of £247k on reserve in delegated budgets
Running Costs	2,787	2,398	389	0	389	£132k due to release of prior year accrual for commissioner support historic VAT liability. Underspend on various vacancies and non-pay budgets across CCG
Unidentified QIPP	0	0	0	0	0	
Reserves	(165)	(109)	(56)	0	(56)	£109k prior year credit note received from IS provider relating to 2019/20. £85k Covid funding in plan, currently in forecast position only. £250k slippage on SDF funding included financial plan, assumed in forecast but not in YTD position
<b>YTD Financial Position</b>	<b>229,137</b>	<b>230,249</b>	<b>(1,112)</b>	<b>1,136</b>	<b>23</b>	

#### 4. Forecast

The forecast outturn position in the table below covers H1 (April to September). The first three columns show the position as per the CCG's financial ledger. Individual lines have been adjusted for outside of envelope spend that is expected to be reimbursed. The total amount of £2.12m in the 'Outside envelope' column is made up of £2.06m HDP, £45k ERF and £16k for COVID-19 vaccination costs - reducing inequalities.

	Forecast Position (£000)					Comments
	Ledger Position			'Outside envelope'	Adjusted variance	
	Plan	Forecast	Variance			
Acute Services	139,665	139,798	(133)	45	(88)	£175k overspend on independent sector activity, offset by £45k expected additional adjustment for ERF - net impact £130k. £80k underspend on RSS team, £47k prior year benefit on IS providers, £77k overspend on ultrasound activity at YHS
Mental Health Services	30,374	30,532	(158)	0	(158)	Overspend on S117 placements (£128k), overspend on MH non-contracted activity (£35k) due to increased activity through Psychiatry UK
Community Services	16,336	16,494	(158)	285	127	Forecast £285k HDP related spend, reimbursement to follow. £126k underspend due to release of prior year Property Services accrual
Continuing Healthcare	17,518	19,903	(2,386)	1,771	(614)	Forecast £1.77m HDP spend, reimbursement to follow. The CHC forecast based on current information from QA is an overspend of £1.41m which relates to increased patient numbers on fully funded and fast track packages, and an increased average cost of fast track packages. This is partly offset by an underspend of £736k on Funded Nursing Care and £59k on vacancies in the CHC Clinical Team
Other Services	8,875	8,657	218	0	218	£114k underspend due to prior year NHS Property Services benefit
Prescribing	27,013	28,502	(1,489)	0	(1,489)	£167k overspend due to impact of prior year prescribing figures. £1.25m in year overspend based on April - June prescribing data - Q1 increased spend is now reflected in the forecast figures for Q2
Primary Care	5,135	4,568	567	16	583	£486k underspend due to release of prior year accrual for GP IT historic VAT liability
Primary Care Delegated Commissioning	26,619	26,164	455	0	455	£65k income relating to GP returners in 2020/21. £156k underspend on PMS premium payments, offset on Primary Care line above. Underspend of £250k on reserve in
Running Costs	3,353	2,924	429	0	429	£132k due to release of prior year accrual for commissioner support historic VAT liability. Underspend on various vacancies and non-pay budgets across CCG
Unidentified QIPP	(501)	0	(501)	0	(501)	Forecast position no longer assumes delivery of unidentified QIPP in H1
Reserves & Contingency	155	(885)	1,040	0	1,040	Forecast underspend in reserves represents an allocation adjustment to be transacted in month 6 as part of the North Yorkshire and York Partnership approach to financial management
<b>H1 Forecast Financial Position</b>	<b>274,540</b>	<b>276,657</b>	<b>(2,117)</b>	<b>2,117</b>	<b>0</b>	

## 5. Allocation

The allocation as at Month 5 is as follows:


Description	Value
<b>Allocation at Month 4</b>	<b>£273.35m</b>
ERF further allocation	£0.42m
Long Covid treatment and care	£0.29m
Primary Care long covid funding	£0.18m
SDF – H1 crisis funding	£0.15m
Mental Health Support Teams 2021/22	£0.15m
<b>Total in-year allocation at Month 5</b>	<b>£274.54m</b>

## 6. Balance sheet / other financial considerations

There are no material concerns with the CCG's balance sheet as at 31<sup>st</sup> August 2021.

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

The CCG achieved its month end cash holding target.

<b>Item Number: 14</b>	
<b>Name of Presenter: Simon Bell</b>	
<b>Meeting of the Governing Body</b>	
<b>Date of meeting: 7 October 2021</b>	
<b>Report Title: Update to Detailed Scheme of Delegation</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Approval</b>	
<b>Reason for Report</b>	
<p>The Detailed Scheme of Delegation (DSoD) was last approved by the Governing Body in March 2020. In response to the COVID-19 pandemic, the Executive Committee approved some temporary emergency changes to the DSoD to allow the CCG to respond quickly to the ever-changing requirements of the Government and NHSEI. These changes are set out in Annex 1 - Emergency changes to Detailed Scheme of Delegation in response to the COVID-19 pandemic.</p> <p>As we return to business as usual, the emergency changes have been reviewed and revoked with permanent changes made to the DSoD as appropriate. The suggested updates to the DSoD are shown in Annex 2 – Updated Detailed Scheme of Delegation October 2021.</p> <p>Summary of amendments:</p> <ul style="list-style-type: none"> <li>• The inclusion of a general directive which allows delegated authority to be passed to a nominated deputy in the case of absence.</li> <li>• 'Finance Manager (Financial Accounts)' has been replaced by 'Financial Accountant'.</li> <li>• The addition of two new specific non pay expenditure items in section 3 to allow complex care and continuing healthcare packages up to £2,000 per week to be approved by the Mental Health Clinical Case Manager and CHC Clinical Team Leader respectively.</li> <li>• Authorisation of Primary Care monthly contract payments from Delegated funds to be delegated to Head of Finance from Deputy Chief Finance Officer.</li> <li>• Thresholds for non-healthcare related goods and services amended so that expenditure up to £1,000 requires 1 written quote and between £1,001 and £25,000 requires 3 written quotes.</li> <li>• The addition of text in respect of expenditure against hypothecated or ringfenced funding.</li> <li>• A change to the monetary limits in section 5. Authorisation for Payment reducing the upper limit from £150,000 to £100,000. Deputy Chief Finance Officer to be able to substitute for payments over £100,000 as necessary.</li> </ul>	

<b>Strategic Priority Links</b> <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b> <input checked="" type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b> <input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	
<b>Impact Assessments</b> Please confirm below that the impact assessments have been approved and outline any risks/issues identified. <input type="checkbox"/> Quality Impact Assessment <input type="checkbox"/> Data Protection Impact Assessment <input type="checkbox"/> Equality Impact Assessment <input type="checkbox"/> Sustainability Impact Assessment  <b>Risks/Issues identified from impact assessments:</b> N/A	
<b>Recommendations</b> The Governing Body is asked to approve the updated Detailed Scheme of Delegation.	
<b>Decision Requested (for Decision Log)</b> To approve the updated Detailed Scheme of Delegation	
<b>Responsible Executive Director and Title</b> Simon Bell, Chief Finance Officer	<b>Report Author and Title</b> Caroline Goldsmith, Deputy Head of Finance

## Changes to the Detailed Scheme of Delegation in response to COVID-19

### Background

The Detailed Scheme of Delegation sets out clear limits of approval for unbudgeted expenditure as follows:

- Up to £250,000 – Executive Committee (which must include CFO or DCFO), reported to F&PC
- Over £250,000 – Governing Body (which must include CFO or DCFO)

On 18 March 2020, the Executive Committee approved emergency changes to the Detailed Scheme of Delegation in response to the COVID-19 pandemic. The changes were made to allow the CCG to respond quickly to the ever-changing requirements of the Government and NHS England and were as follows:

- Approval for unbudgeted expenditure in relation to COVID-19 was delegated to the Executive Director of Primary Care and Population Health and Executive Director for Quality & Nursing.
- The types of expenditure that the purchase card can be used for were relaxed to allow the CCG to purchase unusual items of expenditure which may have been needed for the COVID-19 response. The limits were also amended to a maximum of £5,000 per month and £1,000 in any one transaction. All COVID-19 expenditure purchased via the purchase card had to be approved by the Executive Director of Primary Care and Population Health or Executive Director for Quality and Nursing by purchase order. Finance signatories for the approval of purchase card expenditure were increased to include the Head of Finance and Deputy Head of Finance.

To ensure that staffing arrangements supported the COVID-19 response should staff not be available, the following changes were approved on 20 March 2020:

- 3. Non Pay Expenditure - Specific Non Pay Expenditure
  - Complex Care incl. Continuing Healthcare (up to £250,000 per annum and within overall complex care budget) – Authority delegated to Executive Director of Transformation, Complex Care and Mental Health, in their absence delegated to Anita Griffiths, CHC Team Leader and in their absence Karen Harrison, Case Manager.
  - Authorisation of Primary Care monthly contract payments from Delegated funds (within Delegated funds budget) – Authority delegated to Deputy Chief Finance Officer, in their absence Head of Finance.

- 5. Authorisation for Payment

Where non-healthcare related goods and services have been procured in line with the above procedures (Sections 3 and 4) then authorisation of invoices for payment will be as follows:

- Over £100k – Authority delegated to Chief Finance Officer or Accountable Officer (Deputy Chief Finance Officer able to substitute as necessary). Head of Finance for expenditure in line with signed or nationally mandated contract values, with a



signed PO by an appropriate budget holder (to note PO number in approval notes) or with an approval email from a member of the Executive Team (name and date to be noted on approval notes, email to be filed on network for record).

- Where staffing levels are impacted by sickness due to COVID-19, staff will be moved up the hierarchy as necessary. For example, if a Deputy Director is unable to approve invoices due to sickness, their Head of Department will move up a level to cover the limits delegated to the Deputy Director.
- 8. Accounts Receivable Authorisation  
Invoices raised up to £500k – Authority delegated to Deputy Head of Finance  
Invoices raised over £500k – Authority delegated to Deputy Chief Finance Officer or Head of Finance

In October 2020, further changes to the Scheme of Delegation were approved as follows:

- Approval for unbudgeted expenditure in relation to COVID-19 Hospital Discharge Programme phase 2 was delegated to the Executive Director for Quality & Nursing, Director of Transformation (Mental Health & Complex Care) and Assistant Director Joint Commissioning (with the involvement of the City of York Council's Assistant Director, Adult Social Care).

In H1 of 2021/22, several categories of COVID-19 expenditure remain, including the Hospital Discharge Programme (scheme 3), asylum seekers contingency service, COVID-19 vaccination programme related items and any other CCG agreed COVID-19 items. Although guidance is not yet available, it is expected that the Hospital Discharge Programme will continue into H2 along with any other COVID-19 schemes as determined by NHSEI.

### **Proposal**

It is proposed that approval for specific reimbursable areas of expenditure in relation to COVID-19 remains delegated from the Executive Committee to the Executive Directors as follows:

- Hospital Discharge Programme within the nominal value - Executive Director for Quality & Nursing, Director of Transformation (Mental Health & Complex Care) and Assistant Director Joint Commissioning (with the involvement of the City of York Council's Assistant Director, Adult Social Care)
- Other COVID-19 categories within reimbursable values - Executive Director of Primary Care and Population Health and Executive Director for Quality & Nursing.

Expenditure in relation to COVID-19 will continue to be reported the CCG's Finance and Performance Committee on a monthly basis as part of regular finance reporting.

The amendments to the purchase card be rescinded. That is, the types of expenditure that the purchase card can be used for will revert to those allowed prior to the pandemic, the limits will be reduced to pre-pandemic levels and Finance signatories to be reduced.

In respect of COVID-19 staffing arrangements, the following changes are proposed:

- The COVID-19 specific changes in relation to Complex Care expenditure be withdrawn. Additional delegated limits for Complex Care patients and Continuing Healthcare be added to the Scheme of Delegation on a permanent basis, such that expenditure up to £2,000 per week can be approved by the Mental Health Clinical Case Manager and CHC Clinical Team Leader respectively.
- The authorisation of Primary Care monthly contract payments from Delegated funds (within Delegated funds budget) to be permanently delegated to the Head of Finance.
- Section 5. Authorisation for Payment - the changes to the limits to be made permanent along with the Deputy Chief Finance Officer being able to substitute as necessary. Changes to the Head of Finance limits to be revoked.
- A generic statement be added permanently to the Scheme of Delegation such that in the absence of the delegated role due to sickness, authority be delegated to a nominated deputy with the approval of the Finance department. Staff can also delegate authority to their deputies if they are on annual leave again with the approval of the Finance department. If this is not possible, delegation can be passed to the Deputy Chief Finance Officer.
- Change to section 8. Accounts Receivable Authorisation to be made permanent.

#### **Risk**

The majority of COVID-19 expenditure in H1 and H2 of 2021/22 is expected to be reimbursed by NHSEI. Expenditure on the Hospital Discharge Programme is expected to be managed across the local system and so there is a risk that not all expenditure will be reimbursed.

#### **Recommendation**

The Executive Committee is asked to approve the suggested changes to the Scheme of Delegation as set out above.



**Vale of York**  
Clinical Commissioning Group

# Detailed Scheme of Delegation

**Section A – Financial Issues**  
**Section B – Human Resources Issues**  
**Section C – Other**

Updated: September 2021

## NHS Vale of York CCG - Detailed Scheme of Delegation

The delegations set out in the detailed scheme of delegation represent the lowest level to which authority for that specific issue has been delegated. In the case of unplanned absence of the delegated role, authority can be delegated to a nominated deputy with the approval of the Finance department. In the case of planned absence, staff can delegate authority to a nominated deputy with the approval of the Finance department. If this is not possible, delegation is automatically passed to the Deputy Chief Finance Officer. All items concerning Finance must be carried out in accordance with Prime Financial Policies in Appendix E and Standing Orders (SO) in Appendix C of the NHS Vale of York Constitution and the Detailed Financial Policies. Where it is believed that the matter or decision being taken under these arrangements has far reaching implications then this must be reported to the Accountable Officer and / or Chief Finance Officer. The Deputy Chief Finance Officer may substitute for the Chief Finance Officer if necessary.

This detailed scheme of delegation refers only to services or activity for the corporate offices, equipment and employees, contractors and Lay Members of NHS Vale of York Clinical Commissioning Group and not for activity, offices, equipment or employees of any member practice.

### SECTION A - FINANCIAL ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
<b>1.</b>	<b>Management of Budgets</b>		Detailed Financial Policies (DFP) Section 3
	Responsibility for maintaining expenditure within budget:		
	a) At individual budget level (Pay and Non Pay)	Head of Department	
	b) Department Budgets	Assistant/Deputy Director	
	c) Financial Reserves and Provisions	Deputy Chief Finance Officer	
	Where it is necessary for expenditure to be approved that is outside of an approved budget either in value or in terms of what the budget was originally intended for, this can only be done with approval of the Chief Finance Officer and will require an appropriate business case in line with the approval process.		
	Budget virement:		
	a) Approval of annual budget	Governing Body	
	b) Budget transfer within budget holders area - no limit	Head of Finance	
	c) Budget transfer between budget holders		
	• Up to £100,000	Head of Finance	
	• Up to £500,000	Deputy Chief Finance Officer	
	• No limit	Chief Finance Officer	
	d) Budget transfer from reserve codes – no limit	Head of Finance	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	e) Transfer of budget via RTF	Head of Finance	
<b>2.</b>	<b>Maintenance / Operation of Bank Accounts</b>		DFP Sections 3, 4 & 8
	a) Day to day operation of organisational bank accounts	<del>Finance Manager (Financial Accounts)</del> Financial Accountant and Financial Controller of Shared Business Services	Financial Procedure Note (FPN) 3 – Cash Drawdown
	b) Authorisation for cash limit drawdown	Deputy Chief Finance Officer or Chief Finance Officer	FPN 4 – Accounts Payable
	c) Authorisation for cheque requests		
	• up to £10,000	Head of Finance	
	• up to £150,000	Deputy Chief Finance Officer	
	• over £150,000	Chief Finance Officer or Accountable Officer	
<b>3.</b>	<b>Non Pay Expenditure</b>		DFP Sections 3, 8, 9, 10 & 12
	<b>Expenditure on existing budgeted expenditure (as per GB approved annual budget as amended)</b>		Governing Body approved plan
	For most healthcare services, expenditure should be included on a contract, service level agreement (SLA) or memorandum of understanding (MoU)		
	• Signing of contracts / SLAs / MoUs	Chief Finance Officer	
	Except for:		
	<b>Specific Non Pay Expenditure Items</b>		
	• Complex Care incl. Continuing Healthcare (up to £250,000 per annum and within overall complex care budget)	Executive Director of Transformation, Complex Care and Mental Health	
	• Complex Care incl. Continuing Healthcare (over £250,000 per annum and within overall complex care budget)	Executive Director of Transformation, Complex Care and Mental Health and Chief Finance Officer	
	• <u>Complex Care patients, incl. 117 and transforming care up to £2,000 per week and within overall complex care budget</u>	<u>Mental Health Clinical Case Manager</u>	
	• <u>Continuing Healthcare up to £2,000 per week and within overall CHC budget</u>	<u>CHC Clinical Team Leader</u>	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<ul style="list-style-type: none"> <li>Authorisation of Primary Care monthly contract payments from Delegated funds (within Delegated funds budget)</li> </ul>	<del>Deputy Chief Finance Officer</del> <u>Head of Finance</u>	
	<ul style="list-style-type: none"> <li>Community Equipment and Wheelchairs – where individual items have been supported through the relevant clinical review and approval processes and are the equivalent or less financial value (within community equipment and wheelchairs budget)</li> </ul>	Relevant Contract Manager	
	<ul style="list-style-type: none"> <li>Non-contracted activity (purchase of healthcare - within budget)</li> </ul>	NCA team at NECS to check VoY patient	
	<ul style="list-style-type: none"> <li>Agreement of new Primary Care Local Enhanced Services or GP incentive schemes (within LES budget)</li> </ul>	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> <li>Primary Care discretionary payments (including Local incentive Schemes, returner/retainers and other ad-hoc payments not covered by Section 96) up to £10,000 (within Delegated funds budget)</li> </ul>	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> <li>Primary Care discretionary payments (including Local incentive Schemes, returner/retainers and other ad-hoc payments not covered by Section 96) over £10,000 (within Delegated funds budget)</li> </ul>	Primary Care Commissioning Committee then Executive Committee	
	<ul style="list-style-type: none"> <li>Actual/notional Primary Care rent changes under £5,000 (within Delegated funds budget)</li> </ul>	Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> <li>Actual/notional Primary Care rent changes over £5,000 (within Delegated funds budget)</li> </ul>	Primary Care Commissioning Committee	
	<ul style="list-style-type: none"> <li>Prescribing expenditure</li> </ul>	Primary Care Commissioning Committee	
	<b>Before orders are placed for non-NHS <del>healthcare related</del> provided goods and services the following conditions must be complied with:</b>		DFP Section 10
	a) Confirmation that budgetary provision is available <b>and</b>	All	NHS Vale of York CCG Procurement Policy
	b) Where competitive tendering or competitive quotations are not required ( <del>as per the thresholds below</del> ) <del>e.g. below £5000 then in the first instance the NHS Supply Chain and any published framework contracts can be accessed as an alternative to formal quotation of tendering exercise</del> <del>must be used. In the</del>		

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<del>event that NHS Supply Chain are unable to supply the goods or services then the following procedure, for which documentary evidence must be kept, will be followed:</del>		
	<ul style="list-style-type: none"> <li>up to <del>£4,999</del><b>£1,000</b> a minimum of <del>1 written quote</del><b>2 verbal quotations have been sought</b></li> </ul>	Assistant/Deputy Director	
	<ul style="list-style-type: none"> <li>between <del>£5,000-001</del> and £25,000 a minimum of 3 written quotations have been sought</li> </ul>	Assistant/Deputy Director	
	<ul style="list-style-type: none"> <li>between £25,001 and £49,999 a minimum of 5 written quotations have been sought</li> </ul>	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	<ul style="list-style-type: none"> <li>for orders in excess of <b>£50,000</b>, competitive tendering will apply, the form of which is dependent on the precise goods or services involved. Therefore for all orders above £50,000 the advice of the Chief Finance Officer must be sought.</li> </ul>		
	<b>Note that most non-healthcare <u>related goods and services</u> expenditure should be covered either via a contract, SLA or MoU.</b>		
	<ul style="list-style-type: none"> <li>Signing of contracts / SLAs / MoUs</li> </ul>	Chief Finance Officer	
	<b>If the value is less than £25,000 this may be covered by a purchase order. Purchase orders must be approved as follows:</b>		
	<ul style="list-style-type: none"> <li>Up to £10,000</li> </ul>	Head of Department	
	<ul style="list-style-type: none"> <li>£10,001 to £25,000</li> </ul>	Assistant/Deputy Director	
	The total value of requisitions that cover more than a 12 month period or that are open ended need to be considered as a total value, not just the cost for the 12 month period. E.g. a 2 year contract which has an annual value of £3,000 will require 3 written quotations. Where the number of years is not specified or open ended (from year to year) a 3 year period should be assumed for the purpose of this calculation.		
	<b>New unbudgeted expenditure</b>		
	Authority to approve business cases that commit the organisation to a new, unbudgeted level of investment or a change to an existing area / level of spend is as follows:		
	<ul style="list-style-type: none"> <li>Up to £250,000</li> </ul>	Executive Committee – which must include the Chief Finance	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
		Officer or Deputy Chief Finance Officer – and reported to Finance and Performance Committee	
	<ul style="list-style-type: none"> <li>Over £250,000</li> </ul>	Governing Body – which must include the Chief Finance Officer or Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> <li>Up to £250,000 for Individual Funding Requests</li> </ul>	IFR Panel	
	<ul style="list-style-type: none"> <li>Over £250,000 for Individual Funding Requests</li> </ul>	IFR Panel and Executive Committee	
	<b>Hypothecated NHS funding or funding related to a specific bid</b>		
	<u>With due regard to the procurement policy, expenditure can be made in line with the ringfence requirements/specific bid with existing contract providers. Should expenditure be directed to a new provider, it must be done so with regard to the procurement policy and consideration to the requirement for single tender waivers.</u>	<u>Head of Department</u>	
<b>4.</b>	<b>Tendering &amp; Contract Procedures (including Leases)</b>		DFP Section 9
	a) Waiving of requirement to obtain quotations and tenders subject to the Detailed Financial Policies	Audit Committee	CCG Procurement Policy
	b) Opening of Tenders	Head of Department plus witness	
	c) Authorising annual procurements and individual procurement approach. Awarding, authorisation and responsibility for contracts for non-pay expenditure including purchase of healthcare services agreed in line with the Financial Plan and subsequent variations, extensions or rolling over.		
	<ul style="list-style-type: none"> <li>Up to £500,000</li> </ul>	Finance and Performance Committee	
	<ul style="list-style-type: none"> <li>Over £500,000</li> </ul>	Governing Body (must include the Chief Finance Officer or Deputy Chief Finance Officer and requires the signature of the Chief Finance Officer or Accountable Officer)	
	d) Awarding External Audit contracts	Governing Body (on advice from Audit Committee)	

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Ref	Delegated Matter	Authority Delegated To	Reference Documents
	All contracts awarded should be reported to the Audit Committee and the Governing Body with a responsible officer delegated to manage each contract.		
<b>5.</b>	<b>Authorisation for Payment</b>		DFP Section 8
	Where non-healthcare related goods and services have been procured in line with the above procedures (Sections 3 and 4) then authorisation of invoices for payment will be as follows:		FPN 4 – Accounts Payable
	<ul style="list-style-type: none"> <li>up to £10,000</li> </ul>	Head of Department	Oracle User Hierarchy
	<ul style="list-style-type: none"> <li>up to £50,000</li> </ul>	Assistant/Deputy Director	
	<ul style="list-style-type: none"> <li>up to <del>£50</del>100,000</li> </ul>	Deputy Chief Finance Officer, Executive Director of Quality and Nursing (Chief Nurse), Executive Director of Transformation, Complex Care and Mental Health, Executive Director of Primary Care and Population Health	
	<ul style="list-style-type: none"> <li>over <del>£450</del>100,000</li> </ul>	Chief Finance Officer or Accountable Officer ( <u>Deputy Chief Finance Officer able to substitute as necessary</u> )	
	The above values represent the maximum permitted. Where appropriate, lesser values may be stipulated by the Head of Department / Assistant/Deputy Director / Executive Director / Chief Finance Officer / Accountable Officer. Where lesser values are sought this must be approved by the Finance Directorate.		
	For healthcare commissioned services on contract authorisation of invoices for payment within the approved budget will be as follows:		
	<ul style="list-style-type: none"> <li>up to £25,000,000</li> </ul>	Deputy Chief Finance Officer	
	<ul style="list-style-type: none"> <li>over £25,000,000</li> </ul>	Chief Finance Officer or Accountable Officer	
<b>6.</b>	<b>Capital Schemes</b>		DFP Section 6

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	Approval of Property Vacation Notices for void properties	Chief Finance Officer and Accountable Officer (and reported to Primary Care Commissioning Committee or Finance and Performance Committee)	
	Capital schemes in line with capital resource limit	Chief Finance Officer	
	Capital PIDs for NHSE funding	Chief Finance Officer	
<b>7.</b>	<b>Setting of Fees and Charges</b>		DFP Section 5
	a) Income Generation (Including recharges to other NHS bodies & Local Authorities)	Chief Finance Officer	
	b) Price of NHS Contracts. Charges for all NHS Contracts be they block, cost per case, cost and volume, spare capacity	Chief Finance Officer	
<b>8.</b>	<b>Accounts Receivable Authorisation</b>		DFP Section 5
	a) Invoices raised		
	• Up to £500,000	<u>Deputy</u> Head of Finance	
	• Over £500,000	<del>Deputy Chief Finance Officer</del> <u>Head of Finance</u>	
	b) Credit memos		
	• Up to £500,000	<u>Deputy</u> Head of Finance	
	• Over £500,000	<del>Deputy Chief Finance Officer</del> <u>Head of Finance</u>	
<b>9.</b>	<b>Engagement of Staff Not on the Establishment</b>		DFP Section 11
	Managers must check with the Finance Department regarding HMRC implications where consultancy/agency staff are considered self-employed. Finance staff must then check the employment status for tax using the HMRC Employment Status Indicator so that the correct employment status is determined.		
	Booking of Consultancy, Bank or Agency Staff		
	a) Non-Medical Consultancy Staff		
	The delegated limits regarding non-medical consultancy are in line with current national NHS England guidelines which form the underlying guiding principle for these limits.		
	• Below £600 per day	Executive Committee	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<ul style="list-style-type: none"> <li>£600-£799 per day</li> </ul>	The relevant NHS England Director of Commissioning Operations and their Director of Finance	
	<ul style="list-style-type: none"> <li>£800-£899 per day</li> </ul>	The relevant Regional Director and Regional Director of Finance	
	<ul style="list-style-type: none"> <li>£900 and over per day</li> </ul>	The relevant Regional Director and Regional Director of Finance and NHS England Commercial Executive Committee	
	b) Medical Locums, Nursing, Admin and Clerical and other temporary staff	Executive Committee	
<b>10.</b>	<b>Agreements / Licences</b>		
	a) Extensions to existing leases	Chief Finance Officer	
	b) Approval of rent based on professional assessment (District Valuer rent assessments)	Primary Care Commissioning Committee	
<b>11.</b>	<b>Condemning &amp; Disposal</b>		DFP Section 14
	<ul style="list-style-type: none"> <li>Approval of disposals and condemnations up to £50,000</li> </ul>	Chief Finance Officer (reported to Audit Committee)	
	<ul style="list-style-type: none"> <li>Approval of disposals and condemnations of £50,001 and above</li> </ul>	Chief Finance Officer and Accountable Officer (reported to Audit Committee)	
<b>12.</b>	<b>Losses, Write-offs &amp; Compensation</b>		DFP Sections 13 and 14
	a) Bad debts, losses and special payments up to £50,000	Chief Finance Officer (reported to Audit Committee)	
	b) Bad debts, losses and special payments over £50,000	Chief Finance Officer and Accountable Officer (reported to Audit Committee)	
<b>13.</b>	<b>Petty Cash Disbursements and Credit Card Expenditure</b>		DFP Sections 8 and 10 CCG Credit Card Policy
	Petty Cash		
	a) Expenditure up to £75 per item	Head of Department	
	b) Expenditure over £75 per item	Chief Finance Officer or Deputy Chief Finance Officer	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	Credit Card	Deputy Chief Finance Officer or Chief Finance Officer or Accountable Officer (for expenditure requested by the Chief Finance Officer)	
	Credit card expenditure is limited to:		
	• Catering and catering supplies		
	• Clubs/Associations		
	• Training and Education		
	• Travel		
	• Hotels and Accommodation		
<b>14.</b>	<b>Maintenance &amp; Update of Financial Procedures</b>		
	Maintenance and update of financial procedures	Deputy Chief Finance Officer	
<b>15.</b>	<b>Implementation of Internal and External Audit Recommendations</b>		
	Implementation of Internal and External Audit recommendations	All	
<b>16.</b>	<b>Primary Care Rebates</b>		NHS Vale of York CCG Policy on Primary Care Rebate Schemes
	Acceptance of primary care rebates	Chief Finance Officer	

#### SECTION B – HUMAN RESOURCE ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
<b>17.</b>	<b>Personnel and Pay</b>		
	a) Authority to fill funded post In line with establishment with permanent staff, subject to finance approval as part of the Organisational Procedure	Executive Committee or Remuneration Committee for VSM and Governing Body posts (or outside of committees – 2 Executive Directors which is then ratified at the relevant committee)	
	b) Renewal of fixed term contract	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	c) Job Description Review All requests for Job Description Review shall be dealt with in accordance with Organisational Procedure and Agenda for Change Matching Process.	Line Manager and approved by A4C Matching Panel	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	d) Establishments Additional staff to the agreed establishment with specifically allocated finance in accordance with Organisational Procedures.	Executive Committee (to include Chief Finance Officer or Deputy Chief Finance Officer)	
	e) Pay		
	• Authority to complete standing data forms affecting pay, new starters, variations and leavers	Head of Department	
	• Authority to authorise overtime	Assistant/Deputy Director	
	• Authority to authorise travel & subsistence expenses	Head of Department (for Continuing Healthcare expenses only – CHC Clinical Team Leader)	CCG Travel and Expenses Policy
	f) Leave		CCG Annual Leave Policy
	• Approval of annual leave	Line Manager	CCG Other Leave Policy
	• Annual Leave – in exceptional circumstances approval of carry forward up to maximum of 1 working week	Line Manager	CCG Maternity, Maternity Support, Paternity, Adoption and Parental Leave Policy
	• Compassionate leave up to 6 days	Line Manager	
	• Special leave arrangements		
	• Paternity leave – up to 10 days	Line Manager	
	• Carers leave – up to 5 days	Line Manager	
	• Parental leave – up to 4 working weeks pa	Line Manager	
	• Leave without pay	Line Manager after consulting HR	
	• Time off in lieu	Line Manager	
	• Shared Parental Leave – paid and unpaid	Automatic approval with guidance from HR	
	g) Sick leave		CCG Management of Attendance Policy
	• Extension of sick leave on half pay up to three months	Assistant/Deputy Director in conjunction with HR	
	• Return to work part-time on full pay to assist recovery on advice from Occupational Health in conjunction with HR	Assistant/Deputy Director	
	• Extension of sick leave on full pay	Assistant/Deputy Director in conjunction with HR	
	h) Study leave		CCG Learning and Development Policy
	• Study leave outside the UK	Executive Committee	

Ref	Delegated Matter	Authority Delegated To	Reference Documents
	<ul style="list-style-type: none"> <li>All other study leave (UK)</li> </ul>	Deputy Directors	
	i) Removal Expenses, Excess Rent and House Purchases		CCG Relocation Assistance Policy
	Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		
	<ul style="list-style-type: none"> <li>up to £8,000</li> <li>over £8,000</li> </ul>	Chief Finance Officer Remuneration Committee	
	j) Grievance Procedure		CCG Grievance Policy
	All grievance cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of HR	Assistant/Deputy Director in conjunction with HR	
	k) Mobile Phone Users		
	Requests for new posts to be authorised as mobile users	Head of Legal and Governance	
	l) Staff Retirement Policy		
	Authorisation of extensions of contract beyond normal retirement age	Assistant/Deputy Director and Remuneration Committee in conjunction with HR	
	m) Redundancy	Chief Finance Officer and Accountable Officer in conjunction with HR and as per CCG's policies	
	n) Ill Health Retirement	Chief Finance Officer and Accountable Officer in conjunction with HR	
	o) Dismissal	Accountable Officer in conjunction with HR	
	p) Salary Sacrifice Schemes (HMRC supported)	Executive Committee	
	q) Facilities for staff not employed by the Trust to gain practical experience		CCG Work Experience Policy
	<ul style="list-style-type: none"> <li>Professional Recognition, Honorary Contracts &amp; Insurance of Medical Staff</li> </ul>	Executive Director of Quality and Nursing	
	<ul style="list-style-type: none"> <li>Work experience students</li> </ul>	Executive Director	

## SECTION C – OTHER ISSUES

Ref	Delegated Matter	Authority Delegated To	Reference Documents
18.	<b>Authorisation of Sponsorship Deals</b>	Accountable Officer and Chair of the Governing Body	CCG Sponsorship Policy
19.	<b>Authorisation of Research Projects</b>	Accountable Officer and Executive Director of Quality and Nursing	CCG Conflicts of Interest Policy
20.	<b>Insurance Policies</b>	Accountable Officer or Chief Finance Officer	NHS Resolution membership
21.	<b>Reporting Incidents to the Police</b>		CCG Anti-fraud, Bribery and Corruption Policy
	a) Where a criminal offence is suspected	On Call Manager or Assistant/Deputy Director	
	b) Where a fraud is involved	Chief Finance Officer and Local Counter Fraud Specialist (LCFS)	
22.	<b>Receiving Hospitality and Gifts</b>		CCG Conflicts of Interest Policy
	Applies to both individual and collective hospitality receipt items in excess of £25 per item received Gifts over £6, whether accepted or not	Declaration required in CCG's Register of Gifts and Hospitality	

### Chair's Report: Audit Committee

Date of Meeting	15 July 2021
Chair	Phil Goatley

#### Areas of note from the Committee Discussion

- Unlike the two previous meetings of the Audit Committee this meeting oversaw the beginning of the new (2021/22) audit year. As such, there was little by way of completed internal or external audit work to scrutinise.
- For internal auditors most of the work streams in the Audit Plan are either not yet due or at the planning stage. A single audit assignment has been completed since the Committee last met on the CCG's Data Protection and Security Toolkit. This has been awarded the highest level of assurance for the arrangements the CCG has in place and all ten areas assessed in the toolkit produced excellent assurance results. CCG staff were also separately assessed by our auditors to have completed the self-assessments required by the toolkit to a high level of accuracy, completeness and integrity. Overall this is an excellent result that continues the pattern of high assurance level auditor assessments across the CCG.
- On the implementation of previous audit recommendations there are currently no overdue improvement actions and all outstanding actions had substantive updates on them for Audit Committee Members to read.
- Audit Committee were told that Helen Kemp-Taylor who leads the internal audit service provided to us by Audit Yorkshire is soon to retire. The Chair undertook to write to Helen expressing our thanks for her role in promoting a constructive working partnership between the CCG and its internal auditors which has improved significantly in recent years and that this must be to the benefit of both patients and taxpayers.
- Audit Committee completed the annual review of the Internal Audit Charter and Working Together Protocol as required by Public Sector Internal Audit Standards. These foundation documents underpin the reciprocal relationship between auditors and their clients. In particular the protocol sets out what behaviours and approach CCG managers can expect from Internal Audit and what internal auditors and the Audit Committee can expect from CCG managers. These were re-approved by Audit Committee Members.
- Audit Committee reviewed the response to Freedom of Information Act requests and were pleased to see that overall there were only a small number of breaches. All of



these had substantive reasons set out for why each breach had occurred and none were thought to be major breaches. A very similar position was reported with Safeguarding Incidents recorded in the CCG's Risk Management System.

- Finally Audit Committee received the minutes of Executive, Finance and Performance and Quality and Patient Experience Committees from January to June 2021. It was notable from these just how much business as normal is being conducted across the CCG at the same time as everybody is coping with the continuing challenges of the COVID pandemic. It was also very clear in doing this how high standards of corporate governance are being maintained across the CCG which is both reassuring and highly commendable.

**Areas of escalation**

N/A

**Urgent Decisions Required/ Changes to the Forward Plan**

N/A



**Chair's Report: Executive Committee**

Date of Meeting	23, 30 June, 7, 20, 28 July, 4, 25 August, 1, 8, 15 and 22 September 2021
Chair	Phil Mettam

**Areas of note from the Committee Discussion**

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

**Areas of escalation**

N/A

**Urgent Decisions Required/ Changes to the Forward Plan**

N/A

**Chair's Report: Finance and Performance Committee**

Date of Meeting	24 June, 22 July and 26 August 2021
Chair	David Booker

**Areas of note from the Committee Discussion**

*24 June*

- The Committee approved the recommendation for the Urgent Care Practitioner Contract.

*22 July*

- The Committee gained full assurance regarding the process undertaken and gave approval to the Community Eye Care Services contract award.
- The Committee noted the growing pressures facing health care regionally and nationally. The increasing demands being placed on staff, in a traditionally quiet summer period, are of great concern. These include the over stretching of staff energy and resources and the distraction created by the emergence of new organisational structures. Vale of York CCG Audit Committee and Quality and Patient Experience Committee are asked to maintain vigilance regarding probity and to maintain a focus on services for patients over coming months.

*26 August*

- The Committee expressed concern regarding the continuing reliance on non-recurrent funding to achieve financial balance in the short term within the NHS. A robust longer term financial plan is needed as the Integrated Care System becomes operational from April 2022. This will not least free up the necessary financial headroom to underpin innovation in patient services. The Audit Committee is asked to maintain vigilance.
- In approving contracts, NHS Vale of York CCG will continue to place the interests of patients before the convenience of providers. The Committee hopes to see genuine collaboration, between all partner agencies, to achieve the aims of NHS reconfiguration.

**Areas of escalation**

As described above.

**Urgent Decisions Required/ Changes to the Forward Plan**

N/A

### Chair's Report: Primary Care Commissioning Committee

Date of Meeting	22 July 2021
Chair	Julie Hastings

#### Areas of note from the Committee Discussion

- The Committee received the full Primary Care dashboard, from which we can clearly identify the importance of population health information and how it enables us to plan services for the future. Our Quality Outcomes Framework (QOF) shows that the Vale of York CCG are better or equal to the rest of the country in terms of their results and also linking into the importance of population health.
- Care Quality Commission ratings are good or excellent. The Ipsos MORI GP Patient Survey reports that we are placed around the national average, except for the patient experience measure, which is a little below par, but scoring well around managing long term conditions and disabilities, noting last year's QOF around learning disability checks and the hugely positive outcome.

Confidence in out of hours GP care was good but some work needs to be done around patient access to daytime GP services. Performance round people with severe mental illness could be better although this did relatively well against the national average and has been identified as QOF for next year. Double vaccination rates are good for the over 50s cohort. In respect of our workforce, we have a good proportion of GPs compared with the rest of England, with the Additional Roles recruitment progressing well. Primary care appointments are broadly back to pre-COVID-19 levels, but we are seeing an increasing demand. To mitigate this digital technology and NHS apps are being promoted which will hopefully free up phone lines and improve access for vulnerable people who may not have IT resources.

- Although vaccine take up is going well concerns were raised for the York and Selby areas, both having a higher percentage in respect of our younger population, and where vaccine take up for this cohort has been lower than was hoped. We are assured that our PCNs continue to work to reverse this trend providing the open offer, information, and reassurance. Colleagues have also set up "pop-up" clinics in the workplace enabling easy access for our working age adults, boosting opportunities to receive their vaccinations. High immunisation rates of both first and second vaccinations are reported for our citizens with learning disabilities, with those remaining un-vaccinated in single digits. Identifying a lower uptake with those experiencing mental health inequalities and being aware that more work needs to be done here. Work has been undertaken to identify 'ghost' patients who might not

be in the country now, these have been removed from GP lists, enabling us to have sight of a more accurate baseline. We are currently waiting for additional information in respect of 'flu vaccinations for the over 50 age group which we expect imminently.

**Areas of escalation**

N/A

**Urgent Decisions Required/ Changes to the Forward Plan**

N/A

### Chair's Report: Quality and Patient Experience Committee

Date of Meeting	10 June, 8 July and 9 September 2021
Chair	Julie Hastings

#### Areas of note from the Committee Discussion

##### *10 June*

- We continue to have huge concerns around the resilience of and pressures on our PCNs (Primary Care Networks) as we see expectations on them rise incrementally, not only around patient consultations and care, but also delivery of the successful COVID vaccination programme to date and the anticipated booster vaccination programme alongside a likely expanded 'flu vaccination programme moving forward, the extra time in supporting both new and existing colleagues and roles. We discussed risk and where that lies; is it with PCN or the CCG?
- The Committee continued to discuss the recent report published by Healthwatch North Yorkshire especially around access to GP appointments, how to build accessibility and develop ways to ensure our vulnerable population has equitable access to care. Access to primary care was a key theme as we heard a positive and negative story and the powerful impacts on both patients. The use of technology, telephone systems and digital access, were seen as both positive and negative depending on experience, capacity, health inequalities - sight or hearing impaired, our rough sleepers, those experiencing emotional distress. We asked ourselves what does good look like, how do we become proactive not reactive, what will stop us from a failure and demand scenario, how do we embed population health methodology and focus on need rather than wants or cost? Have we done enough to get patient feedback to enable us to provide equitable safe access and mitigate patients attending Emergency Departments unnecessarily?
- We have already begun to explore progression at the Primary Care Commissioning Committee with responses/actions from primary care, which could be managed through the CCG Primary Care Team and the Engagement Team. Our care homes all have a GP attached and we have a clinical lead in place. OPEL (Operations Pressure Escalation Levels) reporting for GPs has been positive and has enabled us to pick up key themes. The Engagement Team continues exploring and planning to enable us to reach our wider community, currently working in partnership with Healthwatch York and Lollipop to undertake a questionnaire. We discussed the importance of encouraging self-care working alongside our pharmacies and

consequently how to support and enable them to have direct access to GP support and referrals. The overarching challenge remains that demand is outstripping available capacity – both of which considerably exceed the pre pandemic activity.

### *8 July*

- The Committee heard a patient story that raised many issues for our non-English speaking population and the receipt of appropriate translation services which enable them to receive accurate information and safe access to healthcare. We learned of a 14 year old child who was inappropriately asked to translate for his father whilst the consultant delivered medical information. Sadly, this was a cancer diagnosis and neither the father nor the son had awareness prior to this. Ensuing discussions raised concerns about the morality, efficacy, accuracy around the translation of medical terminology, associated impact upon consent to ongoing treatment and possible safeguarding issues involved. York Hospital is looking into this case. We are aware that York Hospital is in the process of distributing electronic handheld tablets to enable patients to be linked with appropriate skilled translators and that there are also some hospital staff onsite who can step in to help interpret for patients. We are going to invite Refugee Action York to facilitate a Protected Learning Time event which would be extremely helpful to our practitioners. The Committee felt that this would be a very helpful intervention. In addition to the issues identified within this story a wider discussion ensued surrounding the challenges people face when they have fallen out of the system and difficulties re-accessing at the point relevant to their healthcare needs.
- It was reported that predictions from NHS England and NHS Improvement lead us to anticipate an early surge in RSV respiratory virus in children and infants, possibly as soon as August/September which may add to the already rising attendances to A&E departments. We discussed the need for education in respect of the increasing number of parents who use A&E as their first point of contact sometimes inappropriately before accessing other services, what are the reasons, possible solutions, how do we educate and enable parents to seek medical support in other ways. Following on we heard of the recent learning around the link between poor digital literacy and increased long-term conditions. We currently do not have a vaccination programme in place for children although there is one vaccine which is safe to be administered to children as young as 12 years. As lockdown eases the infection rates are expected to spike increasing concerns around the implications to our clinically vulnerable young children who have not been vaccinated and the ensuing concerns around long COVID.
- The response to the Ockenden recommendations (maternity services) will be overseen by the Integrated Care System (via the Local Maternity System). The assessment against the recommendations for York have identified significant gaps in assurance and therefore need to improve at pace. Additional local concerns have been raised and we were informed that our nursing Executives are working closely with York maternity colleagues, and their Chief Nurse. There are concerns around cultural behaviours and further worries hearing that staff have not seized the opportunity to speak up at monthly walkabouts by the Chief Nurse, Executive teams or Lay Member Maternity Champion. We are informed that they are currently understaffed in respect of obstetricians, working with 22 less midwives and occasionally need to call colleagues in from the community to cover shifts. This



poses a risk to existing services and the ability to make progress with maternity transformation that is aimed at improving safety i.e. continuity of carer.

- Our Safeguarding Children's Lead reported that they are seeing an increasing complexity of cases and a large rise in domestic abuse. We heard details of forthcoming changes relating to how often cases will be heard at MARAC (Multi-Agency Risk Assessment Conference) and the added value to the consistency of those proceedings. Yesterday the Independent Scrutineer for the City of York Safeguarding Children Partnership had given very positive feedback to the system leaders regarding the partnership working and improvements being made under the 'performed well safeguarding children category'.

### *9 September*

This month's patient story shares the positive impact that the population health methodology can have. The ex-military gentleman was recently the victim of redundancy from his engineering role and with recognised health inequalities was one of those identified, contacted through the Social Prescribing services, and supported to explore his lifestyle, address the negative physical and emotional impact, encouraged, and enabled to take control of his own life, lost weight, regained his fitness level and gained his self-worth.


The whole system is under pressure, creaking. We heard concerns regarding the impact on York Hospital. The major worry is not the attendances but more fears about the resilience of our staff, exhaustion, sickness/COVID and striving to keep everything running whilst also trying to fit in their holiday entitlement. The particular pressures the independent care sector is facing came in to sharp focus with resultant quality and safety issues and this also directly impacts on discharges from hospital.

### **Areas of escalation**

N/A

### **Urgent Decisions Required/ Changes to the Forward Plan**

N/A

<b>Item Number: 20.1</b>	
<b>Name of Presenter: Stephanie Porter</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – Medicines Commissioning Committee Recommendations June 2021</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Information</b>	
<b>Reason for Report</b>  These are the latest recommendations from the Medicines Commissioning Committee – June 2021.	
<b>Strategic Priority Links</b>  <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> System transformations <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Financial Sustainability <input type="checkbox"/> Sustainable acute hospital/ single acute contract	
<b>Local Authority Area</b>  <input type="checkbox"/> CCG Footprint <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> City of York Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	

**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- |  |   |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment         | <input type="checkbox"/> Equality Impact Assessment       |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

**Risks/Issues identified from impact assessments:**

**Recommendations**

For information only

CCG Executive Committee have approved these recommendations

**Decision Requested (for Decision Log)****Responsible Executive Director and Title**

Stephanie Porter  
Executive Director of Primary Care and  
Population Health

**Report Author and Title**

Faisal Majothi – Senior Pharmacist  
Callie Turner – Pharmacy Technician


## Recommendations from York and Scarborough Medicines Commissioning Committee June 2021

Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
<b>CCG commissioned Technology Appraisals</b>				
1.	<p><a href="#">TA694: Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia</a></p> <p><b>Commissioning: CCG, tariff included.</b></p>	<p>Bempedoic acid with ezetimibe is recommended as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if:</p> <ul style="list-style-type: none"> <li>• statins are contraindicated or not tolerated,</li> <li>• ezetimibe alone does not control low-density lipoprotein cholesterol well enough, and</li> <li>• the company provides bempedoic acid and bempedoic acid with ezetimibe according to the commercial arrangement.</li> </ul> <p>Bempedoic acid with ezetimibe can be used as separate tablets or a fixed-dose combination.</p>	Decision deferred to confirm with NICE place in therapy in those whose dose of statin cannot be increased to usually max recommended dose.	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing this TA in England will be less than £5 million per year (or £9,000 per 100,000 population). This is because the technology is a further treatment option and the overall cost of treatment will be similar.</p> <p>Bempedoic acid and 2 of the other treatment options have discounts that are commercial in confidence.</p> <p>Bempedoic acid and bempedoic acid–ezetimibe costs £55.44 per 28 day pack, excluding VAT (NHS List Price)</p> <p>Based on NHS List price per patient:</p> <ul style="list-style-type: none"> <li>• Bempedoic acid and bempedoic acid–ezetimibe = £721 pa</li> <li>• Evolocumab or Alirocumab = £4368 - £4432 pa</li> <li>• Statins = £16 - £33 pa depending on dose on statin used</li> <li>• Ezetimibe = £33 pa</li> </ul>
2.	<p><a href="#">TA697: Andexanet alfa for reversing anticoagulation from apixaban or rivaroxaban</a></p> <p><b>Commissioning: CCG</b></p>	<p>Andexanet alfa is recommended as an option for reversing anticoagulation from apixaban or rivaroxaban in adults with life-threatening or uncontrolled bleeding, only if the bleed is in the gastrointestinal tract, and the company provides andexanet alfa according to the commercial arrangement.</p> <p>Andexanet alfa is recommended only in research for reversing anticoagulation from apixaban or rivaroxaban in adults with life-threatening or uncontrolled bleeding in the skull (intracranial haemorrhage; ICH), in the form of an ongoing randomised trial mandated by the regulator.</p>	Change to RED drug and add link to NICE TA.	<p>The list price for andexanet alfa is £11,100 per 4-vial pack of 200 mg of powder for solution for infusion (excluding VAT, BNF online accessed March 2021). The average cost of a course of treatment at list price is £15,000 per patient.</p> <p>The company has a commercial arrangement. This makes andexanet alfa available to the NHS with a discount. The size of the discount is commercial in confidence.</p> <p>In Vale of York NICE expect 8 patients to get low dose andexanet per year and 2 patients to get high dose andexanet per year.</p> <p>In North Yorkshire NICE expect 10 patients to get low dose andexanet per year and 2 patients to get high dose andexanet per year.</p>
<b>NHSE commissioned Technology Appraisals – for noting</b>				
3.	<p><a href="#">TA696: Tafamidis for treating transthyretin amyloidosis with cardiomyopathy</a></p> <p><b>Commissioning: NHSE</b></p>	Tafamidis is not recommended, within its marketing authorisation, for treating wild-type or hereditary transthyretin amyloidosis with cardiomyopathy (ATTR-CM) in adults.	<p>Add link to NICE TA and change to NOT APPROVED drug.</p> <p>(Red previously via Early Access Scheme).</p>	No cost impact to CCGs as NHSE commissioned.

3.	<a href="#">TA698: Ravulizumab for treating paroxysmal nocturnal haemoglobinuria</a>  <b>Commissioning: NHSE</b>	<p>Ravulizumab is recommended, within its marketing authorisation, as an option for treating paroxysmal nocturnal haemoglobinuria in adults with haemolysis with clinical symptoms suggesting high disease activity, or whose disease is clinically stable after having eculizumab for at least 6 months, and the company provides it according to the commercial arrangement.</p>	<p>Add link to NICE TA and add as RED drug.</p>	<p>No cost impact to CCGs as NHSE commissioned.</p>
4.	<a href="#">TA699: Ofatumumab for treating relapsing multiple sclerosis</a>  <b>Commissioning: NHSE</b>	<p>Ofatumumab is recommended as an option for treating relapsing–remitting multiple sclerosis in adults with active disease defined by clinical or imaging features. This is only if the company provides ofatumumab according to the commercial arrangement.</p>	<p>Add link to NICE TA and add as RED drug.</p>	<p>Add link to NICE TA and add as RED drug.             No cost impact to CCGs as NHSE commissioned.</p>
5.	<a href="#">TA700: Selinexor with low-dose dexamethasone for treating refractory multiple myeloma (terminated appraisal)</a>  <b>Commissioning: NHSE</b>	<p>NICE is unable to make a recommendation about the use in the NHS of selinexor with low-dose dexamethasone for treating refractory multiple myeloma. This is because Karyopharm Therapeutics has confirmed that it does not intend to make an evidence submission for the appraisal and will not be launching the technology in the UK.</p>	<p>No action required.</p>	<p>No action required.             No cost impact to CCGs as NHSE commissioned.</p>
6.	<a href="#">TA701: Crisaborole for treating mild to moderate atopic dermatitis in people 2 years and older (terminated appraisal)</a>  <b>Commissioning: NHSE</b>	<p>NICE is unable to make a recommendation about the use in the NHS of crisaborole for treating mild to moderate atopic dermatitis in people 2 years and older. This is because Pfizer withdrew its evidence submission. The company has confirmed that it does not wish to make an evidence submission for the appraisal because currently the technology will not be launched in the UK.</p>	<p>Add link to NICE TA and add as NOT APPROVED DRUG.</p>	<p>No cost impact to CCGs as NHSE commissioned.</p>
7.	<a href="#">TA702: Ibrutinib with obinutuzumab for untreated chronic lymphocytic leukaemia and small lymphocytic lymphoma (terminated appraisal)</a>  <b>Commissioning: NHSE</b>	<p>NICE is unable to make a recommendation about the use in the NHS of ibrutinib with obinutuzumab for untreated chronic lymphocytic leukaemia and small lymphocytic lymphoma. This is because Janssen has confirmed that it does not intend to make an evidence submission for the appraisal. Janssen considers that the technology is unlikely to be a cost-effective use of NHS resources.</p>	<p>Add link to NICE TA and NOT APPROVED for this indication.</p>	<p>No cost impact to CCGs as NHSE commissioned.</p>
8.	<a href="#">TA703: Ibrutinib with rituximab for untreated chronic lymphocytic leukaemia (terminated appraisal)</a>  <b>Commissioning: NHSE</b>	<p>NICE is unable to make a recommendation about the use in the NHS of ibrutinib with rituximab for untreated chronic lymphocytic leukaemia. This is because Janssen has confirmed that it does not intend to make an evidence submission for the appraisal. Janssen considers that there is unlikely to be enough evidence that the technology is a cost-effective use of NHS resources for this population.</p>	<p>Add link to NICE TA and NOT APPROVED for this indication.</p>	<p>No cost impact to CCGs as NHSE commissioned.</p>

9.	<a href="#">TA704: Trastuzumab deruxtecan for treating HER2-positive unresectable or metastatic breast cancer after 2 or more anti-HER2 therapies</a>  Commissioning: NHSE	Trastuzumab deruxtecan is recommended for use within the Cancer Drugs Fund as an option for treating HER2-positive unresectable or metastatic breast cancer in adults after 2 or more anti-HER2 therapies. It is recommended only if the conditions in the managed access agreement are followed.	Add link to NICE TA and add as NOT APPROVED drug.	No cost impact to CCGs as NHSE commissioned.
<b>Formulary applications or amendments/pathways/guidelines</b>				
10.	<b>Heart Failure Medicines Pathway and Dapagliflozin Prescribing Information.</b>	<p>Local pathway and prescribing guideline to support implementation of NICE TA659 Dapagliflozin for treating chronic heart failure with reduced ejection fraction as approved by MCC.</p> <p>The NICE TA advises to start dapagliflozin after each of the other HF drugs have been optimised. However, MCC decided that with the evidence showing a benefit within the first 30 days of initiation, dapagliflozin should be started depending on signs and symptoms the patient presents with. This mirrors positioning elsewhere in England and Wales. This way the management is cost-effective as it will save time for HF team in optimising medicines and reduce hospitalisations.</p>	Approved as AMBER SR in May 2021 MCC recommendations	Will be further cost impact if used earlier in pathway outside of NICE but these costs may be offset by time saved in optimising medicines in heart failure earlier in pathway and therefore potentially reducing hospital admissions.
11.	<a href="#">NG196: Atrial fibrillation: diagnosis and management</a>	<p>This guideline includes new and updated recommendations on:</p> <ul style="list-style-type: none"> <li>• detection and diagnosis</li> <li>• assessment of stroke and bleeding risks</li> <li>• stroke prevention</li> <li>• rate control</li> <li>• left atrial ablation</li> <li>• preventing recurrence after ablation</li> <li>• preventing and managing postoperative atrial fibrillation</li> </ul> <p>Key recommendations in NG196:  <b>1. Section 1.2.2; Assessment of bleeding risk</b>          Prior to this guidance the recommended bleeding risk tool to be used when considering prescribing anticoagulation was HAS-BLED, which is integrated into all GP clinical systems and is accepted practice. NG196 now recommends the use of ORBIT bleeding risk score: NICE However recognise that change in practice is unlikely until it is embedded in clinical pathways and electronic systems.          Use the ORBIT bleeding risk score because evidence shows that it has a higher accuracy in predicting absolute bleeding risk than other bleeding risk tools. Accurate knowledge of bleeding risk supports shared decision making and has</p>	All relevant drugs on formulary with not preference specified.	<p>Likely to have a significant financial impact and the potential for changes in the way anticoagulation monitoring is managed.</p> <p>The expected impact on drug expenditure within North Yorkshire of this recommendation is expected to be around £1.17 million over the next 5 years and Vale of York of this recommendation is expected to be around £1.01 million over the next 5 years. For the full details of cost impact over time see the NICE resource impact template. These drug costs may be offset by the reduction in anticoagulant monitoring service costs –see below</p> <p>NICE have estimated that for the population of North Yorkshire, there may be savings of £530,000 in anticoagulation monitoring services over the next 5 years. NICE have estimated that for the population of Vale of York, there may be savings of £456,000 in anticoagulation monitoring services over the next 5 years.</p>

		<p>practical benefits, for example, increasing patient confidence and willingness to accept treatment when risk is low and prompting discussion of risk reduction when risk is high. Although ORBIT is the best tool for this purpose, other bleeding risk tools may need to be used until it is embedded in clinical pathways and electronic systems. This recommendation is unlikely to have a financial impact but will take some time to implement into routine practice.</p> <p><b>2. Section 1.6.3; Anticoagulation</b>  NICE now recommend a direct oral anticoagulant (DOAC) as the first line treatment for AF, reserving vitamin K antagonists for when DOACs are not tolerated, are contraindicated, or not suitable. Patients already taking a Vitamin K antagonist should be offered the opportunity to switch treatment at their next routine appointment. The inference that even if their anticoagulation is stable with warfarin they should be switched to a DOAC if appropriate.</p> <p><b>3. Anticoagulation monitoring</b>  Given NICE are recommending DOACs as first line and advocating a switch (where appropriate) from vitamin K antagonists to DOACs, there is likely to be a reduction in the number of patients requiring attendance at anticoagulation monitoring clinics. This may necessitate a review of the commissioned services in each area, ensuring that the patients who must continue to be treated with a vitamin K antagonist still have access to the service.</p> <p>CCGs asked to note the commissioning implications of this guidance and in particular think about the implications for their current anticoagulant monitoring service.</p>		
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<b>Item Number: 20.2</b>	
<b>Name of Presenter: Stephanie Porter</b>	
<b>Meeting of the Governing Body</b> <b>Date of meeting: 7 October 2021</b>	 <b>Vale of York</b> <b>Clinical Commissioning Group</b>
<b>Report Title – North Yorkshire and York Area Prescribing Committee Recommendations July and August 2021</b>	
<b>Purpose of Report</b> <i>(Select from list)</i> <b>For Information</b>	
<b>Reason for Report</b>  These are the latest recommendations from the North Yorkshire and York Area Prescribing Committee (APC) – July and August 2021. Also included are the following documents approved by the Executive Committee in August 2021: Terms of Reference for the APC, APC guidelines on defining red, amber, green drug status, APC new product request form	
<b>Strategic Priority Links</b>  <input type="checkbox"/> Strengthening Primary Care <input type="checkbox"/> Reducing Demand on System <input type="checkbox"/> Fully Integrated OOH Care <input type="checkbox"/> Sustainable acute hospital/ single acute contract <input type="checkbox"/> Transformed MH/LD/ Complex Care <input type="checkbox"/> System transformations <input type="checkbox"/> Financial Sustainability	
<b>Local Authority Area</b>  <input type="checkbox"/> CCG Footprint <input type="checkbox"/> City of York Council <input type="checkbox"/> East Riding of Yorkshire Council <input type="checkbox"/> North Yorkshire County Council	
<b>Impacts/ Key Risks</b>  <input type="checkbox"/> Financial <input type="checkbox"/> Legal <input type="checkbox"/> Primary Care <input type="checkbox"/> Equalities	<b>Risk Rating</b>
<b>Emerging Risks</b>	



**Impact Assessments**

Please confirm below that the impact assessments have been approved and outline any risks/issues identified.

- |  |   |
|--|---|
| <input type="checkbox"/> Quality Impact Assessment         | <input type="checkbox"/> Equality Impact Assessment       |
| <input type="checkbox"/> Data Protection Impact Assessment | <input type="checkbox"/> Sustainability Impact Assessment |

**Risks/Issues identified from impact assessments:**

**Recommendations**

For information only

CCG Executive Committee have approved these recommendations and documents.

**Decision Requested (for Decision Log)****Responsible Executive Director and Title**

Stephanie Porter  
Executive Director of Primary Care and  
Population Health

**Report Author and Title**

Faisal Majothi – Senior Pharmacist  
Callie Turner – Pharmacy Technician

## Recommendations from North Yorkshire & York Area Prescribing Committee July 2021

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
<b>CCG commissioned Technology Appraisals</b>					
1.	<p><a href="#">TA694: Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia</a></p> <p><b>Commissioning: CCG, tariff included.</b></p>		<p>Bempedoic acid with ezetimibe is recommended as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if:</p> <ul style="list-style-type: none"> <li>• statins are contraindicated or not tolerated,</li> <li>• ezetimibe alone does not control low-density lipoprotein cholesterol well enough, and</li> <li>• the company provides bempedoic acid and bempedoic acid with ezetimibe according to the commercial arrangement.</li> </ul> <p>Bempedoic acid with ezetimibe can be used as separate tablets or a fixed-dose combination.</p>	<p>Decision deferred to confirm with NICE place in therapy in those whose dose of statin cannot be increased to usually max recommended dose.</p>	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing this TA in England will be less than £5 million per year (or £9,000 per 100,000 population). This is because the technology is a further treatment option and the overall cost of treatment will be similar.</p> <p>Bempedoic acid and 2 of the other treatment options have discounts that are commercial in confidence.</p> <p>Bempedoic acid and bempedoic acid–ezetimibe costs £55.44 per 28 day pack, excluding VAT (NHS List Price)</p> <p>Based on NHS List price per patient:</p> <ul style="list-style-type: none"> <li>• Bempedoic acid and bempedoic acid–ezetimibe = £721 pa</li> <li>• Evolocumab or Alirocumab = £4368 - £4432 pa</li> <li>• Statins = £16 - £33 pa depending on dose on statin used</li> <li>• Ezetimibe = £33 pa</li> </ul>
2.	<p><a href="#">TA708: Budesonide orodispersible tablet for inducing remission of eosinophilic oesophagitis</a></p> <p><b>Commissioning: CCG, tariff included</b></p>		<p>Budesonide as an orodispersible tablet (ODT) is recommended as an option for inducing remission of eosinophilic oesophagitis in adults.</p> <p>Although budesonide ODT has a marketing authorisation for both inducing and maintaining remission in eosinophilic oesophagitis, at the time this appraisal started it was only licensed for induction. So, the company's evidence is for inducing remission only (with treatment of up to 12 weeks) and the committee is unable to make recommendations for maintenance treatment.</p> <p>There is currently no standard care for inducing remission in eosinophilic oesophagitis. Fluticasone is one treatment option, but it is an asthma treatment that is not easy to use for eosinophilic oesophagitis. Dietary changes are also an option, for example the 6-food elimination diet, which involves cutting out the known allergens milk, eggs, nuts, wheat, soy and seafood from your diet. These treatments can be difficult to access and adhere to. And people often have no treatment at all, so there is an unmet need for this condition.</p> <p>Clinical trial evidence shows that budesonide ODT improves the signs and symptoms of eosinophilic oesophagitis compared with placebo. There is no direct evidence for budesonide ODT compared with fluticasone or the 6-food</p>	<p>RED for this indication as short-term treatment course</p>	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or approximately £9,000 per 100,000 population, based on a population for England of 56.3m). This is because the overall incremental cost of treatment is low and eosinophilic oesophagitis is a rare condition affecting around 13,000 people in England.</p> <p>The list price is £323 per pack of 90 one-mg tablet 1mg bd for 6-12 weeks = £301 to £603 per patient.</p>

		elimination diet and the results of an indirect comparison with these treatments are very uncertain.		
3.	<p><a href="#">TA711: Guselkumab for treating active psoriatic arthritis after inadequate response to DMARDs</a></p> <p><b>Commissioning: CCG, tariff excluded</b></p>	<p>Guselkumab, alone or with methotrexate, is recommended as an option for treating active psoriatic arthritis in adults whose disease has not responded well enough to disease-modifying antirheumatic drugs (DMARDs) or who cannot tolerate them, only if they have:</p> <ul style="list-style-type: none"> <li>peripheral arthritis with 3 or more tender joints and 3 or more swollen joints</li> <li>moderate to severe psoriasis (a body surface area of at least 3% affected by plaque psoriasis and a Psoriasis Area and Severity Index [PASI] score greater than 10)</li> <li>had 2 conventional DMARDs and at least 1 biological DMARD.</li> </ul> <p>Guselkumab is recommended only if the company provides it according to the commercial arrangement.</p> <p>Assess the response to guselkumab from 16 weeks. Stop guselkumab at 24 weeks if psoriatic arthritis has not responded adequately using the Psoriatic Arthritis Response Criteria (PsARC; an adequate response is an improvement in at least 2 of the 4 criteria, 1 of which must be joint tenderness or swelling score, with no worsening in any of the 4 criteria). If PsARC response does not justify continuing treatment but there is a PASI 75 response, a dermatologist should decide whether continuing treatment is appropriate based on skin response. Take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the PsARC, and make any appropriate adjustments. Take into account how skin colour could affect the PASI score, and make any appropriate adjustments.</p>	RED	<p>Add as a RED drug for this indication and add link to NICE TA. NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option and is available at a similar price to the current treatment options. Guselkumab has a commercial arrangement (simple discount patient access scheme). This makes guselkumab available to the NHS with a discount. The discount that is commercial in confidence.</p>
<b>NHSE commissioned Technology Appraisals – for noting</b>				
4.	<p><a href="#">TA705: Atezolizumab monotherapy for untreated advanced non-small-cell lung cancer</a></p> <p><b>Commissioning: NHSE</b></p>	<p>Atezolizumab is recommended, within its marketing authorisation, as an option for untreated metastatic non-small-cell lung cancer (NSCLC) in adults if their tumours have PD-L1 expression on at least 50% of tumour cells or 10% of tumour-infiltrating immune cells, their tumours do not have epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) mutations and the company provides atezolizumab according to the commercial arrangement.</p>	RED	<p>No cost impact to CCGs as NHSE commissioned.</p>

5.	<a href="#">TA706: Ozanimod for treating relapsing–remitting multiple sclerosis</a> <b>Commissioning: NHSE</b>	Ozanimod is not recommended, within its marketing authorisation, for treating relapsing–remitting multiple sclerosis in adults with clinical or imaging features of active disease.	BLACK	No cost impact to CCGs as NHSE commissioned.
6.	<a href="#">TA707: Nivolumab for previously treated unresectable advanced or recurrent oesophageal cancer</a> <b>Commissioning: NHSE</b>	Nivolumab is recommended, within its marketing authorisation, for treating unresectable advanced, recurrent or metastatic oesophageal squamous cell carcinoma in adults after fluoropyrimidine and platinum-based therapy. It is recommended only if the company provides nivolumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHSE commissioned.
7.	<a href="#">TA709: Pembrolizumab for untreated metastatic colorectal cancer with high microsatellite instability or mismatch repair deficiency</a> <b>Commissioning: NHSE</b>	Pembrolizumab is recommended as an option for untreated metastatic colorectal cancer with high microsatellite instability (MSI) or mismatch repair (MMR) deficiency in adults, only if pembrolizumab is stopped after 2 years and no documented disease progression, and the company provides pembrolizumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHSE commissioned.
8.	<a href="#">TA710: Ravulizumab for treating atypical haemolytic uraemic syndrome</a> <b>Commissioning: NHSE</b>	Ravulizumab is recommended, within its marketing authorisation, as an option for treating atypical haemolytic uraemic syndrome (aHUS) in people weighing 10 kg or more who have not had a complement inhibitor before or whose disease has responded to at least 3 months of eculizumab treatment. It is recommended only if the company provides ravulizumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHSE commissioned. Provided at Tertiary centres.
<b>Formulary applications or amendments/pathways/guidelines</b>				
9.	Minoxidil 5% foam for hair loss – to add to formulary as NOT APPROVED.	To add to DNP list as a cosmetic product and not a good all use of NHS resources. All other topical forms of minoxidil are blacklisted in the Drug Tariff. Patients can buy OTC or be prescribed privately.	BLACK	No cost impact to CCGs expected.
10.	TEWV STOMP medication pathway	Approved. Designed to enhance the national guidance providing greater advice for primary care	-	No cost impact to CCGs expected.
11.	TEWV Depression pathway (updated)	Updated version approved.	-	No cost impact to CCGs expected.
12.	TEWV Anxiety pathway (updated)	Updated version approved.	-	No cost impact to CCGs expected.

13.	TEWV Adult ADHD algorithm (updated)	Final approved updated version received for information.	-	No cost impact to CCGs expected.
14.	TEWV Childrens ADHD algorithm (updated)	Final approved updated version received for information.	-	No cost impact to CCGs expected.
15.	Psoriatic arthritis pathway	Updated version approved to include of guselkumab as per NICE TA.	-	No cost impact to CCGs expected.

## Recommendations from North Yorkshire & York Area Prescribing Committee August 2021

	Drug name	Indication	Recommendation, rationale and place in therapy	RAG status	Potential full year cost impact
<b>CCG commissioned Technology Appraisals</b>					
1.	<p><a href="#">TA694: Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia</a></p> <p><b>Commissioning: CCG, tariff included.</b></p>		<p>Bempedoic acid with ezetimibe is recommended as an option for treating primary hypercholesterolaemia (heterozygous familial and non-familial) or mixed dyslipidaemia as an adjunct to diet in adults. It is recommended only if:</p> <ul style="list-style-type: none"> <li>• statins are contraindicated or not tolerated,</li> <li>• ezetimibe alone does not control low-density lipoprotein cholesterol well enough, and</li> <li>• the company provides bempedoic acid and bempedoic acid with ezetimibe according to the commercial arrangement.</li> </ul> <p>Bempedoic acid with ezetimibe can be used as separate tablets or a fixed-dose combination.</p>	Decision deferred to confirm with NICE and local lipid specialists place in therapy in those whose dose of statin cannot be increased to usually max recommended dose.	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing this TA in England will be less than £5 million per year (or £9,000 per 100,000 population). This is because the technology is a further treatment option and the overall cost of treatment will be similar.</p> <p>Bempedoic acid and 2 of the other treatment options have discounts that are commercial in confidence.</p> <p>Bempedoic acid and bempedoic acid–ezetimibe costs £55.44 per 28 day pack, excluding VAT (NHS List Price)</p> <p>Based on NHS List price per patient:</p> <ul style="list-style-type: none"> <li>• Bempedoic acid and bempedoic acid–ezetimibe = £721 pa</li> <li>• Evolocumab or Alirocumab = £4368 - £4432 pa</li> <li>• Statins = £16 - £33 pa depending on dose on statin used</li> <li>• Ezetimibe = £33 pa</li> </ul>
2.	<p><a href="#">TA715: Adalimumab, etanercept, infliximab and abatacept for treating moderate rheumatoid arthritis after conventional DMARDs have failed</a></p> <p><b>Commissioning: CCG, tariff excluded</b></p>		<p>Adalimumab, etanercept and infliximab, all with methotrexate, are recommended as options for treating active rheumatoid arthritis in adults, only if:</p> <ul style="list-style-type: none"> <li>• intensive therapy with 2 or more conventional disease-modifying antirheumatic drugs (DMARDs) has not controlled the disease well enough and</li> <li>• disease is moderate (a disease activity score [DAS28] of 3.2 to 5.1) and</li> <li>• the companies provide adalimumab, etanercept and infliximab at the same or lower prices than those agreed with the Commercial Medicines Unit.</li> </ul> <p>Adalimumab and etanercept can be used as monotherapy when methotrexate is contraindicated or not tolerated, when the criteria in 1.1 are met.</p> <p>Continue treatment only if there is a moderate response measured using European League Against Rheumatism (EULAR) criteria at 6 months after starting therapy. If this initial response is not maintained at 6 months, stop treatment.</p> <p>If more than one treatment is suitable, start treatment with the least expensive drug (taking into account administration</p>	RED	<p>Estimated locally 35 patients across both HRFT and YFT however impact is less than predicted when the filgotinib NICE TA came out in February 2021.</p> <p>NICE estimate the following:</p> <ul style="list-style-type: none"> <li>• VoY CCG = 55 patients getting Adalimumab, etanercept, infliximab for filgotinib for moderate arthritis by Year 3. (previous Filgotinib TA estimate 27 patients by year 3).</li> <li>• NY CCG = 63 patients Adalimumab, etanercept, infliximab for filgotinib for moderate arthritis by Year 3. (previous Filgotinib TA estimate 32 patients by year 3).</li> </ul> <p>Biosimilars of these agents are available and will be used which are more cost-effective than originator agents.</p> <p>Anti-TNFs are more cost-effective than filgotinib so will be used earlier in the pathway as first line options. Companies have each agreed a regional or nationally available price reduction for adalimumab, etanercept and infliximab with the Commercial Medicines Unit. The prices are commercial in confidence.</p>

		<p>costs, dose needed and product price per dose). This may vary because of differences in how the drugs are used and treatment schedules.</p> <p>Take into account any physical, psychological, sensory or learning disabilities, or communication difficulties that could affect the responses to the DAS28 and make any appropriate adjustments.</p> <p>Abatacept with methotrexate is not recommended, within its marketing authorisation, for treating moderate active rheumatoid arthritis in adults when 1 or more DMARDs has not controlled the disease well enough.</p>		<p>Given the availability of biosimilars, a competitive market for biologics in RA and likely off-set costs from earlier use of biologics (e.g. fewer hospital admissions related to poor disease control and wider societal benefits) this guidance is unlikely to have a significant resource impact.</p>
3.	<p><a href="#">TA718: Ixekizumab for treating axial spondyloarthritis</a> <b>Commissioning: CCG, tariff excluded</b></p>	<p>Ixekizumab is recommended as an option for treating active ankylosing spondylitis that is not controlled well enough with conventional therapy, or active non-radiographic axial spondyloarthritis with objective signs of inflammation (shown by elevated C-reactive protein or MRI) that is not controlled well enough with non-steroidal anti-inflammatory drugs (NSAIDs), in adults. It is recommended only if tumour necrosis factor (TNF)-alpha inhibitors are not suitable or do not control the condition well enough, and the company provides ixekizumab according to the commercial arrangement.</p> <p>Assess response to ixekizumab after 16 to 20 weeks of treatment. Continue treatment only if there is clear evidence of response, defined as a reduction in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score to 50% of the pre-treatment value or by 2 or more units, and a reduction in the spinal pain visual analogue scale (VAS) by 2 cm or more.</p>	RED	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option, the overall cost of treatment will be similar and we do not think practice will change substantially as a result of this guidance.</p> <p>Ixekizumab and some of the other treatment options have discounts that are commercial in confidence.</p>
4.	<p><a href="#">TA719: Secukinumab for treating non-radiographic axial spondyloarthritis</a> <b>Commissioning: CCG, tariff excluded</b></p>	<p>Secukinumab is recommended as an option for treating active non-radiographic axial spondyloarthritis with objective signs of inflammation (shown by elevated C-reactive protein or MRI) that is not controlled well enough with non-steroidal anti-inflammatory drugs (NSAIDs) in adults. It is recommended only if tumour necrosis factor (TNF)-alpha inhibitors are not suitable or do not control the condition well enough and the company provides secukinumab according to the commercial arrangement.</p>	RED	<p>NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option, the overall cost of treatment will be similar and we do not think practice will change substantially as a result of this guidance.</p> <p>Secukinumab and some of the other treatment options have discounts that are commercial in confidence.</p>

		Assess response to secukinumab after 16 weeks of treatment. Continue treatment only if there is clear evidence of response, defined as a reduction in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score to 50% of the pre-treatment value or by 2 or more units and a reduction in the spinal pain visual analogue scale (VAS) by 2 cm or more.		
<b>NHSE commissioned Technology Appraisals – for noting</b>				
5.	<a href="#">TA712: Enzalutamide for treating hormone-sensitive metastatic prostate cancer</a> <b>Commissioning: NHSE</b>	Enzalutamide plus androgen deprivation therapy (ADT) is recommended, within its marketing authorisation, as an option for treating hormone-sensitive metastatic prostate cancer in adults. It is only recommended if the company provides enzalutamide according to the agreed commercial arrangement.	RED	No cost impact to CCGs as NHSE commissioned.
6.	<a href="#">TA713: Nivolumab for advanced non-squamous non-small-cell lung cancer after chemotherapy</a> <b>Commissioning: NHSE</b>	Nivolumab is recommended as an option for treating locally advanced or metastatic non-squamous non-small-cell lung cancer (NSCLC) in adults after chemotherapy, only if their tumours are PD-L1 positive, and it is stopped at 2 years of uninterrupted treatment, or earlier if their disease progresses, and they have not had a PD-1 or PD-L1 inhibitor before. It is recommended only if the company provides nivolumab according to the commercial arrangement.	RED	No cost impact to CCGs as NHSE commissioned.
7.	<a href="#">TA714: Dasatinib for treating Philadelphia-chromosome-positive acute lymphoblastic leukaemia (terminated appraisal)</a> <b>Commissioning: NHSE</b>	NICE is unable to make a recommendation about the use in the NHS of dasatinib for treating Philadelphia-chromosome-positive acute lymphoblastic leukaemia in children and adults because Bristol Myers Squibb does not intend to make a submission for the appraisal. Bristol Myers Squibb considers that there is not enough evidence to provide an evidence submission for this appraisal.	BLACK	No cost impact to CCGs as NHSE commissioned.
8.	<a href="#">TA716: Nivolumab with ipilimumab for previously treated metastatic colorectal cancer with high microsatellite instability or mismatch repair deficiency</a> <b>Commissioning: NHSE</b>	Nivolumab plus ipilimumab is recommended, within its marketing authorisation, as an option for treating metastatic colorectal cancer with high microsatellite instability (MSI) or mismatch repair (MMR) deficiency after fluoropyrimidine-based combination chemotherapy. It is recommended only if the company provides nivolumab and ipilimumab according to the commercial arrangements.	RED	No cost impact to CCGs as NHSE commissioned.



9.	<a href="#">TA717: Duvelisib for treating relapsed follicular lymphoma after 2 or more systemic therapies (terminated appraisal)</a> <b>Commissioning: NHSE</b>	NICE is unable to make a recommendation about the use in the NHS of duvelisib for treating relapsed follicular lymphoma after 2 or more systemic therapies. This is because Secura Bio has confirmed that it does not intend to make an evidence submission for the appraisal at this time. Because of limited resources, Secura Bio has chosen to focus on the greater unmet need for duvelisib in treating chronic lymphocytic leukaemia.	BLACK	No cost impact to CCGs as NHSE commissioned.
<b>Formulary applications or amendments/pathways/guidelines</b>				
10.	Lacri-lube eye ointment – to delete from formulary as discontinued	Currently listed as GREEN drug. Alternatives: Xailin Night eye ointment (contains white soft paraffin, white mineral oil and lanolin alcohols) HYLO NIGHT (formerly VitA-POS) (contains retinol palmitate (vitamin A), liquid paraffin, light liquid paraffin, wool fat and white soft vaseline)	Delete from formulary.	No cost impact to CCGs expected.  Xailin night = £2.60 for 5g Hylo Night = £2.75 for 5g  Been long term supply issue with lacrilube.
11.	Indapamide modified release	APC approved adding Indapamide 1.5mg modified release tablets to the formulary as a GREEN drug as an alternative option to indapamide immediate release where hypokalaemia is an issue with the immediate release formulation.  Indapamide standard release and indapamide modified release (MR) are both once daily preparations.  There appears to be no difference in anti-hypertensive efficacy between the two formulations but the modified release preparation has a lower incidence of hypokalemia.	GREEN	No cost impact to CCGs expected as current levels of local prescribing not expected to change. Around 25% of indapamide prescribing is the modified release preparation for both CCGs.  <u>Drug tariff July 2021</u> Indapamide 5mg tab, 28 = £1.85 = 6.6p per tablet Indapamide MR 1.5 mg tab, 30 = £3.40 = 11.3p per tablet
12.	Dapagliflozin for heart failure – final guideline	Final version approved to support local implementation of NICE TA 679.	-	Addition to formulary for this indication already approved previously by Y&S MCC in May 2021 recommendations.
13.	Biologics pathway for moderate rheumatoid arthritis	Updated version approved. Includes Adalimumab, etanercept and infliximab as per NICE TA above.	-	No cost impact to CCGs expected.
14.	Biologics pathway for Axial Spondyloarthritis and non-radiographic axial spondyloarthritis (updated)	Updated version approved. Includes secukinumab and Ixekizumab as per NICE TA above.	-	No cost impact to CCGs expected.

15.	Estring 7.5micrograms/24hours and Ring Pessaries	Approved for addition to the formulary in line with VoY CCG Referral Support Service GY17 Prolapse document.	GREEN	No cost impact to CCGs expected as already being prescribed. 12-month (June 2020-May 2021) usage and spend (VoY): Estring: £1315 PA, 45 items Ring pessaries: £4955, 1842 items
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# Terms of Reference

## North Yorkshire & York Area Prescribing Committee

### 1. Role

The North Yorkshire and York Area Prescribing Committee has been formed to provide an effective and efficient way of sharing and collaborating with commissioners, trusts and providers across North Yorkshire and York footprint.

The Area Prescribing Committee will be responsible for the clinical decision making and advice in relation to prescribing and medicine management in services commissioned NHS North Yorkshire CCG plus NHS Vale of York CCG and provided by Harrogate & District NHS Foundation Trust (HDFT), York Teaching Hospitals NHS Foundation Trust (YFT), South Tees Hospitals NHS Foundation Trust (STHFT), Tees Esk and Wear Valley NHS Foundation Trust (TEWVFT), North Yorkshire County Council and City of York Council, and all general practice members of the CCGs. This will allow safe and equitable access to medicines across North Yorkshire and York.

### 2. Remit

- Ensure that processes underpinning local decision-making about medicines and treatments are consistent with the NHS Constitution and in line with NICE guidance “Developing and updating local formularies good practice guidance on formularies.”
- To develop and maintain a shared formulary across participating organisations.
- To make decisions on the most appropriate place for prescribing of named drugs (RAG status) using set criteria and ensuring that decisions made are based on safety, cost effectiveness and monitoring requirements.
- To ensure that all applicable medicines with current NICE Technology Appraisals (NICE TAs) are available to patients and correctly listed on the APC formulary and to provide advice to the CCGs to support the implementation of NICE guidance and other national guidance where it relates to the use of medicines.
- To establish and maintain a system for new medicine requests or of new indications for existing drugs from healthcare professionals. Requests will be assessed on patient safety, clinical effectiveness, cost effectiveness or resource impact, strength of evidence, place in therapy relative to available treatments, national guidance and priorities, local health priorities, equity of access, stakeholder views.
- Consider the impact of MHRA Alerts, patient safety alerts and other guidance on medicines usage.
- To consider recommendations made by the Regional Medicines Optimisation Committees (RMOCs)
- Consider patient pathways and work with commissioners and contractors to ensure that systems are in place to manage high-risk medicines and treatments, within the context of existing (and future) contracting arrangements with primary care contractors and other providers.
- To review and maintain existing shared care agreements plus identify and develop any new shared care agreements.
- To instruct the audit/review of formulary decisions as appropriate to ensure that any conditions stipulated as part of the formulary approval have been adhered to.
- Horizon scan, plan for and manage the introduction of, and disinvestment in, medicine in the local health economy within available resources.

- Ensure that decisions taken about medicines usage are consistent with wider commissioning frameworks where appropriate for the local population, for example, the annual commissioning round and prioritisation frameworks.
- Highlight to commissioners and providers, the potential impact (cost saving or cost generation) of medicines usage.
- To liaise with other groups/committees in participating organisations, as necessary, including those responsible for clinical governance, clinical effectiveness, clinical audit, clinical risk and education and training.
- To liaise with local Medical and Pharmaceutical committees (LMC and LPC) as appropriate.
- To liaise with local authorities on medicines related issues that relate to services that they commission.
- To support and co-ordinate responses to recommendations on medication safety made by stakeholder organisations as part of an overall risk management strategy.
- To monitor the uptake and adoption of any recommendations made by the APC, and address any variation as necessary.

### 3. Membership

3.1 The Area Prescribing Committee will co-ordinate prescribing and medicines optimisation at the interface between primary, community and secondary care across the following organisations:

- NHS North Yorkshire CCG
- NHS Vale of York CCG
- Harrogate and District NHS Foundation Trust
- York Teaching Hospitals NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- City of York Council
- North Yorkshire County Council.

3.2 The membership will be drawn from senior positions within each organisation represented and must fulfil the following responsibilities:

- Represent the view of their constituent organisations and professional groups.
- Ensure adequate consultation has been undertaken within their organisation where appropriate.
- Ensure that decisions agreed by the committee are communicated and implemented by their organisation and professional groups.
- Commit to attend meetings regularly
- Nominate a deputy if they cannot attend.
- Contribute to agenda items.
- Come to meetings prepared with all documents read and ready to contribute to the debate.
- Declare any outside financial or personal conflicts of interest at the start of each meeting.

Organisation	Role
<b>Core Membership – Voting membership (Reps as advised by Trusts/Local Authorities/Organisations):</b>	
Independent	Lay/patient representative
North Yorkshire CCG	Head of Medicines Optimisation (or deputy) GP Prescribing Lead GP
Vale of York CCG	Head of Medicines Optimisation (or deputy) GP Lead for Acute Service Transformation GP
Harrogate and District NHS Foundation Trust	Present APC chair Chief Pharmacist (or deputy) Consultant
York Teaching Hospitals NHS Foundation Trust	Drug and Therapeutics Committee Chair Chief Pharmacist (or Deputy) Consultant
South Tees Hospitals NHS Foundation Trust	Chief Pharmacist (or Deputy) Consultant
Tees, Esk and Wear Valleys NHS Foundation Trust	Chief Pharmacist (or deputy) Consultant Psychiatrist
North Yorkshire County Council	Public Health representative
City of York Council	Public Health representative
	Finance representative - 1 member representing all stakeholder CCGs
	Contracting representative – 1 member rep representing all stakeholder CCGs

Organisation	Role
<b>In attendance (non-voting membership):</b>	
North Yorkshire CCG	Lead Medicines Management Pharmacist: Commissioning and Formulary
Vale of York CCG	Medicines Optimisation Pharmacist
York Teaching Hospitals NHS Foundation Trust	Formulary Pharmacist

Harrogate and District NHS Foundation Trust	Medicines Effectiveness & Formulary Pharmacist
LPC Representative	1 members all representing stakeholder LPCs
LMC Representative	1 member representing all stakeholder LMCs
RDTC representative & Professional Secretary	

- 3.3 All nominated members to have delegated authority from employing/representative organisation to attend and participate in decision making.
- 3.4 The Chair and Vice Chair positions should be elected by the Area Prescribing Committee from different organisations and represent both provider and commissioner organisations (i.e. if the Chair is a commissioner member then the Vice Chair should be a provider member, or vice versa).
- 3.5 The quorum is reached when at least two thirds of voting members are present. An appropriate spread of members' interests is also required for the quorum to be valid. It is advisable that, at least one member from Harrogate & District NHS Foundation Trust (HDFT), one member from York Teaching Hospitals NHS Foundation Trust, one member from each CCG, and a sufficient presence of members with an appropriate clinical knowledge need to be present. TEWVFT to be present for any items pertaining to mental health on the agenda. South Tees Hospitals Foundation Trust to be present for any items relating to services provided by them for North Yorkshire patients.
- 3.6 All members of the committee will be expected to sign up to the relevant policy on declaration and register of interests.
- 3.7 Members may be excluded from decision making, where declarations of conflict of interest may compromise neutrality.
- 3.8 Other advisory specialists may be invited to attend where specific issues relating to their respective areas of responsibility are discussed (e.g. those submitting papers or pathways for approval) as agreed following discussion between the Co-Chairs and Professional Secretary.
- 3.9 The Area Prescribing Committee may agree to co-opt other clinicians or managers as and when necessary.
- 3.10 The Regional Drugs and Therapeutics Centre will nominate a Senior Pharmacist to act as professional secretary. Responsibilities of Professional Secretary:
- Coordinate agenda, minutes and actions
  - Prepare evidence for consideration by the meeting if appropriate
  - Facilitate the agreed work programme

- 3.11 The success of the group will depend strongly upon members working voluntarily together to innovate, solve problems of mutual concern and coordinate solutions and implementation plans.
- 3.12 Members may resign from the committee at any time by communicating this to the Chair or Professional Secretary.
- 3.13 All members attending APC to represent an organisation or present a paper do so in a professional capacity, and all participants should be treated with courtesy, respect and consideration. Participants should only speak when they are invited by the chair and should raise a hand to be recognised as having something to say. A person should not be interrupted while speaking or asking a question.

## 4. Attendance

- 4.1 Participating organisations should appoint deputies to represent them when they are their nominated member(s) is/are unable to attend.
- 4.2 APC members are expected to attend at least 9 out of 12 meetings.
- 4.2 Other representatives may attend as and when agreed with the Chair.
- 4.3 Members may be co-opted as appropriate with the agreement of the majority of the current APC membership via email prior to the APC meeting if necessary
- 4.4 If a member is late or leaves early, a record must be made in the minutes as this could affect quorum. If the meeting becomes non-quorate then all decision from that point forwards will require ratification via email post-meeting from those members who left the meeting.

## 5. Declaration of Interests

- 5.1 Members and regular attendees must complete a 'declarations of interest' form on joining the group and renewed annually in September.
- 5.2 In addition members and attendees are required to declare any relevant interests relating to the agenda at each meeting.
- 5.3 Members may be excluded from decision making (to be judged by the Chair) where appropriate.
- 5.4 Members should also highlight where their organisation may have a potential conflict of interest with an agenda item.
- 5.4. Declarations of Interest will also be required from all those submitting papers, formulary application, and guidelines to the APC.

## 6. Decision Making

- 6.1 Recommendations will take into consideration both clinical and cost-effectiveness relative to other interventions commissioned for the population, as well as affordability and consequences of implementation. The group will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients and is affordable; it will not recommend a treatment that is shown to be ineffective.
- 6.2 Commercially agreed discounts or rebate schemes will only be considered once a decision based on clinical effectiveness is reached as per current policy on primary care rebates.
- 6.3 Decisions will be made on the best available evidence; ideally this will be fully published trial data only. Abstracts, conference posters, or clinical opinion, will not be used as the sole basis of a recommendation.
- 6.4 Recommendations are reached by consensus, taking into account declarations of interest. Any dissent against a recommendation will be noted.

## 7. Voting

- 7.1 It is recognised that there are very few occasions when recommendations are not unanimous and therefore the requirement for the group to vote may not be necessary. If there are conflicting opinions within the group, the recommendation will be put to a majority vote of quorate members present who are eligible to vote. An appropriate spread of stakeholder representation and members' interests is also required for the vote to be valid.

## 8. Appeals

- 8.1 Anyone who wishes to appeal against the decision making process of the group with regard to the decision in question will be required to present substantial evidence as to the reasons behind their appeal.
- 8.2 Appeals will only be accepted from clinicians within stakeholder organisations of the APC.
- 8.3 The right to an appeal will be at the Chair's discretion following discussion with the Professional Secretary.
- 8.4 Grounds for appeal are:
  - Significant new clinical evidence available to support application or submission not considered as part of original decision making process.
  - Decision appears to be based on inaccurate or incomplete information in formulary application or papers submitted to APC.



- **Decision is based on upon incomplete presentation of formulary application, guideline or agenda item to APC.**
  - The process for the handling of new drug requests has not been followed.
- 8.5 Applications for a medicine on which a decision has already been made can only be resubmitted to the group if substantial and significant new evidence becomes available, or one of the grounds for appeal is met.
- 8.6 The Professional Secretary should be contacted in the first instance.
- 8.7 Appeals against APC decisions will not be accepted directly from pharmaceutical industry.
- 8.8 The clinician submitting the appeal may be invited to attend the APC in support of the appeal.

## **9. Adoption of NICE Technology Appraised Drugs into the Formulary**

- 9.1 If there is more than one NICE-approved medicine for a condition, the APC will not recommend that any one of them is used routinely in preference to the others (unless an order of preference is stated in the TAs or HSTs).
- 9.2 The APC will not recommend that a medicine that has not been assessed by NICE is used routinely in preference to a NICE-approved medicine.
- 9.3 The committee may however suggest to healthcare professionals that a particular medicine is preferred locally. Reasons for this could include cost, if a medicine is cheaper than other options, to reflect local clinical expert opinion or to achieve optimal stock control. Any such local recommendation must only be taken into account, however, after a patient and prescriber have discussed all treatment options and only if they have no preference about which medicine they want to use.
- 9.4 To ensure that medicines with a positive NICE TA recommendation are available for patients, when deemed the appropriate clinical choice for them, no later than 90 days post NICE publication. Medicines with a positive NICE TA recommendation with a 30 day implementation period will be considered by Chair's Action/email with APC membership if needed prior to coming to next available MCC meeting for information to ensure timely adoption.
- 9.5 The APC will not make a recommendation on any drug due a NICE TA in the next 6 months, and no decision will be based on draft NICE Guidelines or Technology Appraisals.

## 10. Accountability arrangements

- 10.1 The Committee will report to the management executives of the North Yorkshire CCG and the Vale of York CG, and the respective Trust Boards.
- 10.2 The Committee will have delegated authority for decision-making from the respective constituent CCGs and Trusts. Currently the VoY CCG constitution does not allow joint committees to make decisions, so all still needs to pass through their CCG Executive Committee irrespective of the financial value.
- 10.3 When considering formulary submissions or guidance that might impact financially (including NICE), the agreed financial limits that the APC will work to will be a maximum of £10,000 per 100,000 population per year impact per intervention considered. The North Yorkshire and York APC has delegated authority to authorise new medicines with an estimated total yearly cost up to £10,000 per 100,000 population per annum from North Yorkshire CCG. . Above this threshold, authorisation will be by the North Yorkshire CCG Finance, Performance, Contracting and Commissioning Committee and Vale of York CCG Executive committee. (N.B. Currently VoY CCG constitution does not allow joint committees to make decisions, so all still needs to pass through their CCG Executive Committee irrespective of the financial value.)
- 10.4 The Committee will receive the minutes of stakeholder Trust D&Ts and any local Primary Care Prescribing Committees
- 10.5 The Committee will provide an annual report to the constituent organisations.

## 11. Communication

- 11.1 An agenda will be produced and circulated electronically together with accompanying papers at least 7 days prior to the meeting.
- 11.2 Draft minutes, Decision Summary and updated Action Log will be circulated after the meeting to the members within 2 weeks and the minutes confirmed in the subsequent meeting.
- 11.3 Once confirmed, minutes will be posted on the APC Website.
- 11.4 The Decision Summary including formulary changes and guidelines approved at the meeting will be posted on the APC Website.
- 11.5 The majority of communication will be via the website and through membership to their locality, through D+TC secretaries to their trusts, facilitated by the local medicines management team.
- 11.6 All media enquiries relating to outputs from the APC will be dealt with by the Chair of the Group and the professional secretary (after consultation from membership if necessary).

## 12. Confidentiality

- 12.1 All members and attendees agree to keep detailed discussions confidential to allow free and full debate to inform unencumbered decision making. Discretion should be used when discussing meetings with non-attendees and papers should not be shared without agreement of the chair or professional secretary, to ensure confidentiality is maintained.

## 13. Frequency of meetings

- 13.1 Meetings will be held every months on the 1<sup>st</sup> Wednesday of the month 2pm-4.30pm via Microsoft Teams. Additional meetings may be arranged if deemed necessary.
- 13.2 A minimum of ten meetings will be held a year

## 14. Pharmaceutical Industry

- 14.1 The APC does not accept requests from the pharmaceutical industry to attend meetings or to present information to group members. Applications must be submitted by an NHS healthcare professional working within the North Yorkshire and Vale of York health economy. Matters of inaccuracy may be reported to the Professional Secretary

## 15. Review

- 15.1 These Terms of Reference will be reviewed on an annual basis.

## Guidelines on defining **RED/AMBER/GREEN/BLACK/GREY** MEDICINE Status

### Summary of Traffic light formulary classifications for North Yorkshire and York Drug formulary

Green	Medicines suitable for initiation and routine use within primary, secondary and tertiary care. Primary care prescribers take full responsibility for prescribing.
Amber Specialist recommendation	Medicines recommended by a specialist; this could offer a valuable alternative/addition to the patients' treatment. These are considered suitable for GP prescribing following specialist recommendation. Little or no monitoring is required. A brief prescribing guidance document may be available for these, but there is no requirement for full shared care guideline. No formal Shared Care Guideline is required.
Amber Specialist Initiation	Items initiated by a specialist where there is not a need for ongoing monitoring other than for general adverse effects (as listed in the BNF and SPC). These are considered suitable for GP prescribing following specialist initiation, including titration of dose and assessment of efficacy where appropriate. No formal Shared Care Guideline is required.
SCG	Medicines that should be initiated by a specialist in secondary/tertiary care, and which require significant monitoring on an ongoing basis. After a successful initiation period, including titration of dose and assessment of efficacy, a transition to primary care prescriber care can take place. Full agreement to undertake prescribing for each specific patient must be reached under the amber shared care agreement, and guidance must be provided to the primary care prescriber (available online). The amber shared care guidance will outline the specialist and primary care prescriber responsibilities (including monitoring requirements) and basic prescribing information.
Red	Medicines for hospital use only. The responsibility for initiation and monitoring treatment should rest with an appropriate hospital clinician. The drug should be supplied by the hospital for the duration of the treatment course. Primary care prescriber initiation or continuation of treatment is not recommended.
Black	Medicines which the North Yorkshire and York Area Prescribing Committee has reviewed and does not recommend for use at present based on a review of clinical and/or cost effectiveness data in either primary or secondary care.
Grey	Medicines which the North Yorkshire and York Area Prescribing Committee have not yet reviewed. Initiation by primary or secondary care for grey listed drugs is not supported and request to use should come via NY&Y APC.

### Background

The **Red Amber Green (RAG)** classification offers guidance on the prescribing of drugs initiated in primary and secondary care and reinforces the basic premise that:

“When decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. It is therefore **essential** that a transfer involving medicines with which GPs would not normally be familiar should not take place without **full local agreement**, and the **dissemination of sufficient, up-to-date information to individual GPs**. If the GP considers him- or herself unable to take on this responsibility, then this should be discussed between the relevant parties so that additional information or support can be made available, or alternative arrangements made.”

NHS England: Responsibility for Prescribing between Primary and Secondary/Tertiary Care, 29<sup>th</sup> January 2018

Inherent in any shared care agreement is the understanding that participation is at the discretion of the GP subject to their clinical confidence.

**AIM:** The “traffic light” system defines where responsibility for prescribing between primary and secondary care should lie through categorising individual drugs as **red, amber shared care, amber SI/SR, green, or black**. The system provides a framework for the safe use of medicine for patients.

The list provides a framework for defining where clinical and therefore prescribing responsibility should lie through categorisation of individual drugs. The criteria used for defining status is based on the **specialist nature of the drug**, the **complexity of the assessment and monitoring** arrangements required for the care of the patient, **clinical responsibility and competency** associated with the prescribing of a medicine and is not based on the cost of a medication.

***It is important to note that these are not rigid guidelines and the RAG category assigned to a drug is advisory. Where necessary, secondary and primary care prescribers should discuss the appropriate management of individual patients personally taking into account monitoring requirements, drug interactions, frequency of routine patient visits to the Consultant and the specialist nature of the condition being treated. Clinical judgement should be used to arrive at the most reasonable outcome and consider where prescribing is best managed. On occasions both parties may agree to work outside of this guidance. However, if it is not possible to reach a consensus or a specific issue has arisen, please submit an application to the APC to assess or re-assess the RAG status.***

In the interests of safety the group recommends that prescribing and monitoring of a drug should be carried out by the same prescriber (e.g. prescribing of a drug should not be carried out in primary care whilst monitoring is carried out in secondary care).

Some drugs may have several indications which may require a different status decision depending on the monitoring and assessment required.

### **Unlicensed medicines**

For unlicensed medicines the prescriber, patient and GP should be aware of the unlicensed nature of the drug. In general, the prescribing of unlicensed medications should not be transferred to primary care; however, there are many situations where a unlicensed medicine may be used for routine practice and continuation by GP may be entirely appropriate. Off-label/unlicensed use may be suitable for transfer if there is a widespread acceptance of a national body of recommended opinion. Off label use for an indication where there is no established evidence base should not be transferred to primary care under any circumstances.

*Please note if an indication is not stated on the RAG list then the classification relates to the licensed indication unless specifically defined on the list.*

### **Paediatric Medicines**

Approved: August 2021  
Review date: August 2023

Where there is a substantial body of evidence to support the use of an unlicensed medicine or a licensed medicine outside of its licence for example in paediatrics the GP may be asked to prescribe. However the GP must be fully informed and made aware of the licensing status. The GP should refer to the [Children's BNF](#) as a guide for prescribing of unlicensed medicines / licensed medicines outside of licence. The full agreement of the GP concerned must be obtained before prescribing is transferred.

Prescribers may wish to access the GMC guidance on prescribing off-label or unlicensed medications: [http://www.gmcuk.org/guidance/ethical\\_guidance/14327.asp](http://www.gmcuk.org/guidance/ethical_guidance/14327.asp)

## **Guideline for Classification**

### **GREEN DRUGS**

**GREEN** Traffic Light – These GREEN medicines are appropriate for initiation/prescribing in primary, secondary, and tertiary care. Prescribing is appropriate within their licensed or recognised unlicensed indication in accordance with nationally recognised formularies e.g. BNF, BNF for Children, Palliative Care Formulary, national guidelines (e.g. NICE) or within local recommendations. Primary care prescribers take full responsibility for prescribing.

#### **Guidelines for “Green” classification**

**Green** Medicines must satisfy both of the following criteria:

1. Medicines for which Primary Care prescribers are able to take full responsibility for initiating and on-going prescribing. Local prescribing guidelines or NICE guidance may apply.
2. Medicines are in routine use and can be prescribed within Primary Care with no special restrictions, specialist knowledge or experience.

### **AMBER SPECIALIST RECOMMENDATION DRUGS**

**AMBER Specialist Recommendation** Traffic Light – these medicines are considered suitable for GP prescribing following specialist recommendation of therapy, with ongoing communication between the primary care prescriber and specialist, if necessary. AMBER SR medicines require no specific shared care guideline as no or little monitoring is required. Ongoing prescribing by primary care includes titration of dose and assessment of efficacy. There is no need for ongoing monitoring other than for general adverse effects as listed in the BNF & SPC. However GPs must still be familiar with the drug to take on prescribing responsibility or must obtain the required information from the initial prescriber specialist.

#### **Guidelines for “AMBER Specialist Recommendation” classification**

These medicines are considered suitable for primary care prescribing following varied levels of specialist input as described below:

- Amber Specialist Recommendation requires specialist assessment and recommendation to GP to prescribe in Primary Care

Amber Specialist Recommendation medicines must meet both of the following:

1. Requires specialist assessment to enable patient selection.

2. Following specialist assessment, the medicine is suitable for prescribing in Primary Care.

## AMBER SPECIALIST INITIATION DRUGS

**AMBER Specialist Initiation** Traffic Light – these medicines are considered suitable for GP prescribing following specialist initiation of therapy, with ongoing communication between the primary care prescriber and specialist, if necessary. AMBER SI medicines require no specific shared care guideline as no or little monitoring is required. Ongoing prescribing by primary care includes titration of dose (if appropriate) and assessment of efficacy. There is no need for ongoing monitoring other than for general adverse effects as listed in the BNF & SPC. Patients should ideally be initiated on therapy with a minimum of 28 days supply before transfer to primary care. However GPs must still be familiar with the drug to take on prescribing responsibility or must obtain the required information from the initial prescriber specialist.

### Guidelines for “AMBER Specialist Initiation” classification

These medicines are considered suitable for primary care prescribing following varied levels of specialist input as described below:

- Amber Specialist Initiation requires specialist initiation of prescribing. Patients should ideally be initiated on therapy with a minimum of 28 days supply before transfer to primary care. In some circumstances prescribing to be continued by the specialist until stabilisation of the dose is achieved and the patient has been reviewed by the specialist.

Amber Specialist Initiation medicines must also meet both of the following:

1. Requires specialist assessment to enable patient selection.
2. Following specialist assessment, the medicine is suitable for prescribing in Primary Care.
3. Requires short to medium term specialist prescribing and monitoring of efficacy or toxicity, or depending on the drug until the patient's dose is stable.

## AMBER SHARED CARE DRUGS

**AMBER SHARED CARE** Traffic Light - These medicines are considered suitable for GP prescribing following specialist initiation of therapy and patient stabilisation, with ongoing communication between GP and Specialist. AMBER with Shared Care medicines require significant monitoring and to qualify must be designated so by the APC. GPs are advised not to take on prescribing of these medicines unless they have been adequately informed by letter of their responsibilities with regards to monitoring, side effects and interactions and are happy to take on the prescribing responsibility. A copy of the locally approved shared care guideline should accompany this letter which outlines these responsibilities. GPs should then inform secondary care of their intentions as soon as possible by letter, and then arrange the transfer of care as necessary.

RMOC defines medicines considered suitable for shared care as those which should be initiated by a specialist, but where prescribing and monitoring responsibility may be transferred to primary care. Due to their potential side effects, shared care medicines usually require significant regular monitoring and/or regular review by the specialist is needed to determine whether the medicines should be continued.



An example shared care template can be found on the APC website.

### Guidelines for “**AMBER SHARED CARE**” classification:

Circumstances which meet all of the following criteria may allow a product to be used as part of a shared care arrangement following agreement by both prescribing parties involved. Implicit in any shared care agreement is the understanding that participation is at the discretion of the Primary Care prescriber subject to their clinical confidence.

- A shared care guideline has been drawn up following joint discussion and agreement of the parties using the RMOG approved template (if available).
- The shared care guideline:
  - ◊ Provides a comprehensive summary of treatment
  - ◊ To say prescribing transferred after a defined time period individual to the SCG for the drug in a particular condition
  - ◊ Defines the responsibility of the consultant and the GP for monitoring and adjusting treatment
  - ◊ Defines the referral procedure from hospital to GP
  - ◊ Defines the back-up facilities available to the GP from hospital with which the agreement is made.
- The GP is satisfied that he/she has all the information and support needed to prescribe and monitor the patient

### Principles for shared care

- Patients should obtain care through their local GP practice whenever possible, where it is convenient for them to attend and the patients’ illnesses and current medicines are best known.
- Care should be provided by the doctor who is best placed to provide it safely and this can sometimes be in either primary or secondary care.
- Consultants should usually advise on care rather than manage it and General Practitioners should usually manage their patients and their patients’ illnesses and medicines.
- By improving the communication between primary and secondary care the variability in approaches to treatment will diminish.
- Prior research and discussion should enable a shared understanding and ensure that the optimum quality of evidence-based treatment is available to all patients.
- It would not normally be expected that GPs should be asked to participate in a shared care arrangement where no appropriate guideline exists or where the drug or disease process falls out with the criteria defined as being suitable for inclusion in a shared care agreement.
- Where there is dispute over arrangements for prescribing, responsibility for prescribing remains with the consultant until resolved.
- Where community nurse involvement is required in the administration of drugs under a shared care guideline, they should be provided with adequate information and guidance by the prescriber or the hospital and arrangements should be made in good time for any potential problems to be resolved before patient care is compromised

When assigning Amber Shared Care status to a drug then the APC will follow the principles and recommendations laid out in the RMOG - Shared Care for Medicines Guidance: A Standard Approach document.



## RED DRUGS

**RED** Traffic Light – Medicines for hospital use only. The responsibility for initiation and monitoring treatment should rest with an appropriate hospital clinician. The drug should be supplied by the hospital for the duration of the treatment course. Primary care prescriber initiation or continuation of treatment is not recommended.

Where patients are already receiving a RED medicine from their primary care prescriber, and their primary care prescriber has particular specialist knowledge or prior experience of prescribing this drug, the primary care prescriber may continue prescribing in primary care provided their primary care prescriber is happy to continue to take on the prescribing responsibility. Primary care prescribers may prescribe RED medicines in exceptional circumstances to patients to ensure continuity of supply while arrangements are made to obtain usual supplies from secondary care.

### Guidelines for “Red” classification:

**RED** status will be allocated if **any one** of the following applies:

1. Unlicensed products, indications or doses without acceptance of authoritative body of recommended opinion
2. Medicines without a substantial wholesale body of support unless in BNF or Children's BNF
3. Medicines by manufacturer's recommendation or with wholesale opinion as being specialist only
4. Medicines whose monitoring or control remains within secondary care
5. Primary Care is unable to monitor therapy sufficiently to oversee treatment or adjust the dose where necessary to ensure safety
6. IV drugs agreed as not an appropriate drug for primary care prescribing (some of these can appropriately be waived in certain situations e.g. palliative care, paediatrics or cystic fibrosis).
7. Where the administration requirements of a medicine makes it unsuitable for use in Primary Care.
8. Medicines for which the funding is levied out with primary care e.g. PBR excluded drugs, NHSE Commissioned Drugs
9. The specialist medicine, dressing or appliance is only available through a hospital.
10. Requiring long-term, on-going specialist monitoring of toxicity/efficacy (because the side-effect profile necessitates rigorous supervision by the hospital consultant or, the full range of possible side-effects, particularly long-term effects needs to be established)
11. That are hospital indicated clinical trial materials

*When assigning Red status to a drug then commissioning implications should be considered. For example commissioning of provision of the drug from secondary care needs to be included as part of the pathway of care.*

## BLACK (NOT APPROVED) DRUGS

**BLACK (NOT APPROVED)** - These are medicines that have been reviewed and have been deemed less suitable for prescribing, and are therefore not recommended in primary, secondary or tertiary care. This may be due to the lack of good clinical evidence, cost-effectiveness, or due to the availability of more suitable alternatives (in addition to all medicines with a “not NHS” or “DLCV” classification in the BNF, those agents as included within the NICE “Do not do” list, and those agents included with the NHS England: Items which should not routinely be prescribed in primary care).

### Guidelines for “BLACK” classification

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Review date: August 2023

**BLACK** status will be allocated if **any one** of the following applies:

1. Lack of data on clinical effectiveness compared with standard therapy
2. Lack of data on safety compared with standard therapy
3. Known excess of significant adverse events compared with standard therapy
4. Lack of data on cost-effectiveness compared with standard therapy
5. Less cost-effective than current standard therapy
6. Not accepted as cost effective compared to other service development opportunities
7. No significant advantage over currently supported therapy
8. Negative NICE Technology Appraisal
9. Negative NHS England Commissioning Policy (if applicable)

## **GREY DRUGS**

**GREY** - No formal commissioning position at present

### **Guidelines for “GREY” classification**

Medicines which the North Yorkshire & York APC have not yet reviewed. This usually means that an application is in progress. These drugs are not normally considered appropriate for prescribing in North Yorkshire & York until such time that a decision is taken by the APC on their formulary status. Initiation by primary or secondary care for grey listed drugs is not supported and request to use should come via NY&Y APC.

## **References**

NHS England Guidance: Responsibility for Prescribing between Primary and Secondary/Tertiary Care; 29<sup>th</sup> January 2018.

Shared Care for Medicines Guidance – A Standard Approach (RMOC) – 19<sup>th</sup> March 2021

## Appendix

There is some variation of existing definitions of RAG status across the previous Area Prescribing committees across the locality. These are as follows:

### York and Scarborough MCC

Green	May be initiated and continued in primary, secondary and tertiary care
Amber	Requires initiation or recommendation by a specified member of the Hospital Specialist Team. Suitable for continuation by a GP, with appropriate supporting documents. No written shared care agreement necessary.
SCG	As for Amber, but suitable for continuation by a GP within written and agreed shared care frameworks, and according to the agreed process for transfer of care of those drugs
Red	Can only be prescribed by a hospital specialist
Black	Not routinely commissioned.
Grey	No formal commissioning position at present.

### Harrogate and Rural District CCG

Green	Medicines suitable for routine use and can be prescribed within primary care within their licensed indication in accordance with nationally recognised formularies e.g., BNF, BNF for Children, Palliative Care Formulary. Primary care prescribers take full responsibility for prescribing.
Amber	Medicines which are suitable to be prescribed in primary care only after specialist recommendation. Ongoing prescribing by primary care includes titration of dose and assessment of efficacy. There is no need for ongoing monitoring other than for general adverse effects as listed in the BNF & SPC.
SCG	Medicines which are suitable to be prescribed in primary care only after specialist recommendation only under a shared care protocol once the patient has been stabilised. Prior agreement must be obtained by the specialist from the primary care provider before prescribing responsibility is transferred. The shared care protocol must be approved by the Harrogate & Rural District Area Prescribing Committee (HaRD APC).
Red	Medicines for hospital use only. The responsibility for initiation and monitoring treatment should rest with an appropriate hospital clinician. The drug should be supplied by the hospital for the duration of the treatment course. Primary care prescriber initiation or continuation of treatment is not recommended.
Black	Medicines which the Harrogate & Rural District Area Prescribing Committee (HaRD APC) has reviewed and does not recommend for use at present based on a review of clinical and/or cost effectiveness data.
Grey	Medicines which the Harrogate & Rural District Area Prescribing Committee (HaRD APC) have not yet reviewed.

### County Durham and Tees Valley

Green Drug	Can be initiated and prescribed in all care settings. Green Alternative = Second line / alternative green drug
Green+ drug	Can be recommended by a specialist for initiation in primary care; or be initiated by a specialist and transferred to primary care once the patient stabilised. In some cases, there may be a further restriction for use outlined - these will be defined in each case. These drugs do not require a shared care guideline so are sometimes referred to as Amber No Shared Care.
Amber Shared Care drug	These are specialist drugs which must be initiated by the specialist, but with the potential to transfer to primary care within written and agreed shared care protocols and according to the agreed process for transfer of care.
Red drug	Drugs that should remain under the total responsibility of the specialist. Usually considered as "hospital only" drugs. For any RED NICE TA drugs automatically added to the formulary by virtue that they are NICE TA prescribers need to ensure local Trust pharmacy processes are followed before prescribing these drugs to ensure stock is available plus Trust new drug governance procedures are followed.
Not Approved	Drugs that have been considered by the APC or other approved body and are not approved for prescribing within County Durham & Tees Valley.
Not Reviewed	Drugs that haven't been reviewed by the APC yet. This usually means that an application is in progress. These drugs are not normally considered appropriate for prescribing in County Durham & Tees Valley until such time that a decision is taken by the APC on their formulary status.

## APPLICATION FOR NEW PRODUCT TO BE APPROVED FOR USE ACROSS NORTH YORKSHIRE AND YORK

This form is to be used for applications for new drugs, new formulations and extensions to previously agreed uses for drugs and other relevant pharmaceutical products including medicated dressings, prescribable nutritional products, borderline substances and pharmaceutical medical devices.

### 1. Guidance on completing the form

- Your submission should be comprehensive and indicate which, if any, information has been supplied by a pharmaceutical company. The manufacturer/ supplier may provide information supporting the application, but the application must come from a clinician working within one of the APC stakeholder organisations.
- The application must be completed with the input from the Lead Pharmacist in your speciality or area.
- The application must reflect consensus from your directorate, speciality or area.
- Submissions for high cost medicines must be reviewed by the relevant Clinical Director.
- Full clinical evidence does not to be submitted or completed for NICE TA approved drugs just the sections on finance and how introduction of the drug will be managed locally.
- Email an electronic copy to the relevant Lead Pharmacist for review and submission to: [nuth.nyrdtc.rxsupp@nhs.net](mailto:nuth.nyrdtc.rxsupp@nhs.net)

### 2. Submission to NYY APC

- APC meetings are usually scheduled for the 1<sup>st</sup> Wednesday of each month.
- Applications must be submitted at least two weeks before the meeting wherever possible otherwise the submission is likely to go to the following APC meeting.
- The Formulary Lead Pharmacist/Technician will notify you of the date of the meeting when the application will be considered.
- Incomplete applications will not be considered by the APC.

### 3. The decision making process

#### 3.1 NYY APC will base their decisions on the following key areas:

- Clinical effectiveness
- Cost effectiveness / resource impact
- Strength of evidence
- Patient safety
- Place in therapy relative to available treatments
- National guidance and priorities
- Local health priorities
- Equity of access
- Stakeholder views

#### 3.2 Decision Summary

This will be recorded by the APC. Each organisation is then responsible for cascading the decision to its clinicians and other relevant parties.

#### 4. Application for a new product to be added to the formulary

##### 4.1 Clinical / drug details

Drug name (generic and brand)	Generic name	
	Brand name	
Manufacturer		
Manufacturer signed up to All Trials Petition?		
Formulation		
Licensed Indication		
Intended Clinical indication – give brief detail, highlight if unlicensed.		
Dose / strength / frequency of administration		
Route of administration		
Duration of treatment: one off / fixed period / long term / other		
Reason for request Please tick all boxes that apply	Therapeutic advantage over existing treatment <input type="checkbox"/> Cheaper than alternative treatment <input type="checkbox"/> Improved compliance <input type="checkbox"/> No alternative <input type="checkbox"/> New formulation <input type="checkbox"/> Other (please specify below):	
What are the other current treatment options?	1) 2) 3)	
Place in therapy relative to alternative treatments listed above		

Does this product replace a medicine already on the formulary? If so, which one?		
List any additional benefits of the new product (route, side effects, reduced need for community input)		
Potential disadvantages		
Side effect profile		
Significant drug interactions		
Monitoring requirements		
Safety / Pharmacovigilance		
<p>Traffic light list classification</p> <p>Tick relevant box</p> <p>(see NY&amp;Y APC RAG Definitions and Guidelines for full definitions)</p>	Green (Both Primary & Secondary Care prescribing)	
	Amber Specialist Recommendation	
	Amber Specialist Initiation (Hospital initiation, then refer to GP)	
	Amber with shared care (Hospital initiation, then refer to GP under shared care protocol)	
	Red (Hospital only)	
<p>Stakeholder views (if available)</p> <p>Stakeholders = specialist doctors, patients, public, manufacturers)</p>	<p><b>Consultants:</b></p>   <p><b>Specialist Groups:</b></p>	

**4.2 Evidence base & medicine status (please include copies of supporting evidence as PDFs with completed application form)**

NICE (state if TA):	
Scottish Medicines Consortium (SMC):	
All Wales Medicines Strategy Group (AWMSG):	
Other local commissioning positions where known	Durham and Tees Valley  Leeds  HERPC
National clinical reviews: e.g. MTRAC, UKMI, RDTC, Cochrane	
Summary of clinical trial evidence (only where no national reviews / guidance available). Please add additional sheet as necessary. State whether compared with placebo or standard therapy.	

**4.2 Change process**

How would change or implementation of new therapy be communicated?	
Will the product be incorporated into relevant policies, protocols, pathways?	
How and when would you propose to audit/monitor use of the new therapy? (Pharmacy will usually prompt a 6 month review)	
Other processes / approval required before use (e.g. antimicrobial subgroup etc.)	



## 5. Financial impact

Drug name and pack size	Dosage	Monthly cost £	Annual Cost
<u>Requested product</u>			
<u>Comparator product</u>			

### Cost implications (product)

Budget holder	Patients/ year (a)	Product cost / year (£) (b)	Total cost per year (£) (a x b)	Comparative product cost / year (£)	Comments
Secondary care					
Primary Care					

### Other costs and considerations

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### Commissioning (In Tariff / Excluded from Tariff)

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## 6. References

Please give details here of any references used / referred to in the submission (include copies of supporting evidence as PDFs with completed application form).

**7. Declaration of conflict of interest**

<p>Do you have any conflict of interest to declare?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <li>Consultancy with the drug company</li> <li>Department receives research funds from the drug company</li> <li>Staff within the department are funded by the drug company</li> <li>You or your staff receive funding for attendance at scientific meetings from this company</li> </ul>	<p>Please tick only one box below</p> <p><input type="checkbox"/> No – I have no conflict of Interest.</p> <p><input type="checkbox"/> Yes – Please give details:</p> <p>.....</p> <p>.....</p> <p>.....</p>
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<b>Applicants Details / Counter-signatory Details</b>	
<b>Name of requesting Clinician or Independent Prescriber:</b>	
<b>Department / Specialty:</b>	
<b>Name of Organisation</b>	
<b>Date:</b>	
<b>Clinical Director Informed (for high cost medicines):</b>	
<b>Date:</b>	
<b>Support by Lead Clinical Pharmacist / Medicines Optimisation Pharmacist:</b>	
<b>Date:</b>	

**List of those consulted on this formulary application**

Date	Name	Organisation	Job Title	Via meeting, email etc