NHS
Calderdale
Clinical Commissioning Group

NHS CALDERDALE CLINICAL COMMISSIONING GROUP

ANNUAL REPORT 2020/21

ABBREVIATIONS USED IN THIS REPORT

A & E	Accident and Emergency
AEDB	Accident and Emergency Delivery Board
ABI	Alcohol Brief Interventions
ADHD	Attention Deficit Hyperactivity Disorder
AQP	Any Qualified Provider
ASD	Autistic Spectrum Disorder
CCCP	Calderdale Collaborative Community Partnership
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CIP	Cost Improvement Programme
CKWCCGs	Calderdale, Kirklees and Wakefield CCGs
COPD	Chronic Obstructive Pulmonary Disease
CPMSC	Commissioning Primary Medical Services Committee
CQC	Care Quality Commission
DATIX	Clinical incident review system
DHSC	Department of Health and Social Care
DNACPR	Do not attempt cardiopulmonary resuscitation
DPI	Dry Powder Inhaler
DSPT	Data Security and Protection Toolkit
EAP	Employee Assistance Programme
EIA	Equality Impact Assessment
ERD	Electronic Repeat Dispensing
FTE	Full Time Equivalent
GBAF	Governing Body Assurance Framework
GP	General Practitioner
HR	Human Resources
HRI	Huddersfield Royal Infirmary
IAF	Improvement and Assessment Framework
ICE	Integrated Commissioning Executive
IRMF	Integrated Risk Management Framework

LCFS	Local Counter Fraud Specialists
LD	Learning Disabilities
LeDeR	Learning Disabilities Mortality Review
LTW	Lead The Way
MDI	Metered Dose Inhaler
NHS	National Health Service
NHSCFA	National Health Service Counter Fraud Authority
NHSCHC	NHS Continuing Healthcare
NHSE	NHS England
OMP	Open Minds Partnership
PALS	Patient Advice and Liaison Service
PCN	Primary Care Network
PEARS	Primary Eye-Care Assessment and Referral Scheme
PPE	Personal Protective Equipment
PSED	Public Sector Equality Duty
QIPP	Quality, Innovation, Productivity and Prevention
SABA	Short Acting B2 Agonist
SITREP	Situation Report
SMT	Senior Management Team
SNOMED	System of medicine coding
SWYPFT	South West Yorkshire Partnership Foundation Trust
VAC	Voluntary Action Calderdale
VSM	Very Senior Manager
WYHHCP	West Yorkshire and Harrogate Health and Care Partnership
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WY & H	West Yorkshire and Harrogate
WYUC	West Yorkshire Urgent Care

Contents

Performance Report

ROBIN TUDDENHAM

Accountable Officer

14 June 2021

Overview

This section of the Annual Report provides our Accountable Officer's view of the performance of the CCG over the past twelve months. It contains information about the CCG, including a summary of our purpose and activities and how we have performed during the year. It also highlights any key risks to the achievement of our strategic objectives.

NHS Calderdale CCG is a membership organisation consisting of 21 general practices. Further information about our members can be found on page 71.

Information about how the CCG fits into the NHS structure can be found at the link below.
Information about Calderdale Clinical Commissioning Group

The CCG is organised into a series of teams, each with a head. The teams are – primary care, service improvement, quality, finance, corporate, continuing healthcare and contracting/procurement.

Our purpose is to improve the health and lives of the estimated 222,000 people living in Calderdale and/or registered with a Calderdale GP practice.

Calderdale Cares is our approach to bringing together all those that commission and deliver our health in Calderdale. It supports our work to deliver our health and wellbeing strategy, and critically places our communities at the centre of what we do. In April 2021, we presented our revised model for Calderdale Cares to the Governing Body and this will also go to the Council's cabinet in June.

We work with our partners and stakeholders in Calderdale and as part of the West Yorkshire and Harrogate Health and Care Partnership to:

- Ensure that healthcare is available for anyone who needs it
- Keep people safe
- Ensure continued improvements in the quality of care
- Support people to maintain a healthy lifestyle

- Address health inequalities locally
- Ensure financial sustainability

The CCG has a number of different strategies that can be found at the link below
Calderdale CCG - key documents

The COVID-19 pandemic has had a significant impact on the work of the CCG (as with all partners). Staff have been directly involved in dealing with the emerging challenges of the pandemic, while continuing their important work to commission and assure high quality health and care for the local population.

The CCG and partners have worked quickly and tirelessly to make sure that local people have been supported and protected, and that as far as possible they were able to continue to receive the services they need to maintain and improve their health and wellbeing.

The pandemic has brought into sharp focus health inequalities experienced by different groups in the population. The CCG has worked with partners to identify and address these inequalities where possible. Examples of this are provided in the 'Reducing Inequalities' and 'Supporting and promoting Equality and Diversity' sections of the report (pages 42 to 44). In particular the CCG has focused on people with learning disabilities who have been significantly adversely impacted by COVID-19. More on this can be found on pages 28 to 34.

The CCG has also continued with its usual business, which is also described in the report. With our partners, we have:

- Worked closely with partners to continue to deliver the Calderdale Wellbeing Strategy Living a Larger Life – Calderdale 2019 to 2024 - building on the Single Plan for Calderdale and as part of Calderdale Cares
- Continued to strengthen the role of the Integrated Commissioning Executive as part of our future integrated commissioning system
- Continued to support the development of a community improvement agenda, which forms the basis of the Calderdale Collaborative Community Partnership

- Jointly led with the Council the implementation of population health management in our system, to enable us to plan integrated services better and improve health outcomes for local people
- Continued our strong partnership working on local safeguarding boards and the Community Safety Partnership
- Continued to improve emotional wellbeing for our children and young people, especially in the light of the significant impact of the pandemic on them, from the closure of schools, uncertainty and isolation from friends/family
- Continued to work with Greater Huddersfield CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) to ensure the local health system is resilient
- Continued to work with partners on the hospital change programme (Right Care, Right Time, Right Place)
- Continued to play a full and active role as part of the West Yorkshire and Harrogate Health and Care Partnership (our Integrated Care System)

Further information on our activities during the year can be found on pages 16 to 69.

Our in-year budget allocation was £343 million in 2020/21. We have used this to commission health and care services in the following areas - mental health, learning disabilities, continuing healthcare, emergency and urgent care, hospital and community services, primary care and services for children and young people. The 'Managing finances effectively' section of this report (see pages 66 to 69) contains further detail of our financial position and plan for 2021/22.

The issues and risks being experienced by the CCG reflect those across the system, the region and nationally. These risks together with the ongoing challenges to the resilience of the urgent care system are reflected in the high-level risks identified by the CCG in 2020/21 and onward for 2021/22. Risks arising from the COVID-19 pandemic have been recorded and managed through the same processes as other risks. Further detail on our approach to the management of risk can be found in the Governance Statement, and a summary of the risks classed as 'Serious' and 'Critical' on our Corporate Risk Register can be found in the Governance Statement: Appendix 2.

Overall the CCG and partners have dealt well with the challenge of increasing pressure in the system, which has affected all areas of the country. Whilst not all NHS Constitution standards and national targets have been achieved, we have continued to perform well on cancer waiting times and admissions through A & E.

The pandemic has led to new ways of working, for example the delivery of GP and hospital outpatient appointments through online and video consultations. The challenge for the CCG and partners is to lock in the benefits of these changes, while continuing to improve access as services and premises open up again.

The White Paper Integration and Innovation: Working together to improve health and care for all sets out significant changes to the way that local services will be commissioned in the future, with CCGs being disestablished by 31 March 2022, with their statutory responsibilities becoming the role of Integrated Care Systems subject to parliamentary approval.

Calderdale CCG is fully represented in this transitional work with the West Yorkshire and Harrogate Health and Care Partnership (our Integrated Care System) at all levels in terms of managerial and clinical leadership, and our Accountable Officer is a core part of the overarching leadership transition group. Calderdale CCG is developing its place based Integrated Care Partnership, through our model of Calderdale Cares, in collaboration our partners in our local system, and alongside other West Yorkshire CCGs and the ICS. We are also working closely with our workforce on engagement and consultation in advance of the statutory HR process for all staff later this year.

Finally, I would like to thank the CCG staff and all of our partners in the health and care system for their hard work and commitment during this very difficult year.

ROBIN TUDDENHAM
Accountable Officer

Performance

Performance reporting

Performance against the NHS Constitution standards and national targets is included in the CCG's finance, contracting and performance report. This is presented to the Governing Body at each of its meetings. The Quality, Finance and Performance Committee also scrutinises our financial recovery plans.

Quality and Safety reports, which focus on commissioned services and highlight any risks and mitigating actions are also presented at each Governing Body meeting and are scrutinised by the Quality, Finance and Performance Committee.

These reports, together with the high-level risk report, enable the Governing Body to receive the right level of assurance about the management of those risks.

System-wide ownership of performance management is enabled through the relevant partnership groups including the Partnership Transformation Board, the Integrated Commissioning Executive (ICE), the Accident & Emergency Delivery Board (AEDB) and the Contract Management and Quality Boards. The Senior Management Team provides operational oversight.

Further information about the operation and activities of the CCG's Governing Body and Committees, the Integrated Risk Management Framework, and anti-corruption and anti-bribery matters can be found in the Governance Statement (pages 79 to 110)

Performance against the NHS constitution and national targets

Performance against the NHS Constitution standards and national targets during the pandemic has been challenging. Despite this cancer waiting times have remained strong throughout the year and NHS services have made good progress with the restoration of access to services during the year. The tables below show the CCG's performance against the NHS Constitution and national targets.

Performance against NHS Constitution and national targets

Elective care – position at the end of March 2021

Indicator Details	Target	Value
Diagnostics - % waiting over 6 weeks	1% and below	27.3%
Referral to Treatment time - % waiting over 18 weeks	92% and above	N/A (see Note 1)
Referral to Treatment time – Number waiting over 52 weeks	0	1,917
Referral to Treatment Time – Number of people still waiting at the end of the month	0% growth at March 2019	18,846

Note 1: Calderdale and Huddersfield Foundation NHS Trust are part of a national pilot to develop new metrics to assess waiting times. During this developmental phase CHFT and related commissioners (Calderdale and Kirklees) are exempt from reporting Referral to Treatment time

Cancer waiting times – position at the end of March 2021

Indicator Details	Target	Value
Cancer - % seen within 2 weeks (breast symptoms)	93% and above	96.7%
Cancer - % seen within 2 weeks	93% and above	98.5%
Cancer - % treated within 31 days	96% and above	95.7%
Cancer - % treated within 31 days (Drugs)	98% and above	97.6%
Cancer - % treated within 31 days (Radiotherapy)	94% and above	100%
Cancer - % treated within 31 days (Surgery)	94% and above	96.9%
Cancer - % treated within 62 days (Screening)	90% and above	66.7%

Indicator Details	Target	Value
Cancer - % treated within 62 days	85% and above	88.5%

Ambulance and urgent and emergency care – position at the end of March 2021

Indicator Details	Target	Value
A&E - % waiting under 4 hours	95% and above	87.8%
A&E – No. waiting 12+ hours from Decision To Admit	0	0

Financial Duties

CCGs have a number of financial duties under the NHS Act 2006 (as amended). The CCG's performance against those duties is included in the 'Managing finances effectively' section on pages 66 to 69.

Key Activities during the year

Introduction

At the beginning of 2020/21 the world was in the grip of the COVID-19 pandemic, and the first England lockdown had begun.

This part of the report describes the part that the CCG and its staff played in the response to the pandemic, while continuing to deliver its usual duties. It is divided into three sections:

- Supporting local organisations in the new ways of working required by the pandemic
- Leading on the development of some pandemic-specific services
- Continuing to deliver its usual functions

Supporting local organisations

From the start of the pandemic, there was a huge amount of national, regional and local guidance issued on all aspects of health and care in the pandemic. CCG staff worked with partners through existing and newly established groups to identify what needed to be done and to develop and implement solutions to the challenges presented. The knowledge and experience of all teams in the CCG was critical in making things happen, from the implementation of new models of service to the enactment of changes to financial and contracting arrangements to support them.

The following sections describe what happened in each sector in response to the pandemic and how CCG staff were involved.

General Practice

Since 2019, GP practices have been working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs). Each PCN covers between 35,000 and 54,000 patients.

At the start of the pandemic, the PCNs moved quickly to ensure that people were still able to access the care they needed, despite practices having to close their premises to meet national requirements around social distancing and infection prevention and control.

Online and video consultations were introduced, and where patients needed a face to face appointment, a site was established in each PCN where this could be provided. This approach minimised the risk of transmission and ensured service resilience.

Collaboration between general practices to deliver services at a PCN level required the use of digital solutions to enable record sharing and safe service delivery. This was achieved at speed, including the provision of additional IT equipment where required. A GP communication toolkit was developed to assist with messaging to the public.

The CCG's primary care, quality, Information Management and Technology and communications teams provided support to enable these changes to take place. Its quality and equality teams adapted their impact assessment processes so that any negative impact of these and other changes could be quickly identified and actions put in place to reduce it.

PCNs also worked to ensure that, throughout the first and second wave of the pandemic, people who were at high risk and clinically extremely vulnerable were identified and received the support they required.

The CCG's medicines management teams provided support to practices and PCNs in a number of ways. The practice pharmacy team was redeployed to support practices with tasks such as medicines reconciliation and electronic repeat dispensing (ERD). ERD is a system where people can arrange for regular medication to be provided by their local pharmacy without needing to put in a prescription request every month or so. This reduces work for practices in dealing with requests and enables community pharmacies to plan their workload better.

The medicines optimisation team was initially redeployed to help with ERD. The team also provided guidance on changes to prescribing as a result of the pandemic, for example providing information on alternative choices for patients receiving injectable medicines to reduce the need for face to face appointments, and providing guidance on monitoring to ensure continued safe use of medicines. It also worked with local organisations to ensure that medication required for patients nearing the end of their life continued to be available during the pandemic and to resolve any issues or concerns.

Acute care and post-acute care

The number of hospitalisations for COVID-19 increased rapidly, and the NHS and independent sector hospitals worked together to make sure people were cared for appropriately. People who needed to be in hospital but no longer needed daily

consultant oversight were moved to the independent hospitals, where local GPs provided medical cover, with digital access to consultant advice where required. Anaesthetic machines were moved from the independent sector hospitals to be used as ventilators for the most poorly patients. This collaborative approach meant that the system had the bed spaces, oxygen and equipment needed to look after the most poorly patients at the height of the pandemic.

The need to remove beds on wards to maintain social distancing and reduced unnecessary contact led to new ways of working. This included introducing Trusted Assessment, where assessment that would usually be undertaken by community staff was undertaken by hospital staff according to a formal written agreement. This reduced the risk of transmission of infection and enabled people to be assessed in a timely manner so their ongoing care needs could be identified and support put in place.

The need to find beds for the rising number of people with COVID-19 requiring hospitalisation meant that there was a focus on safe and timely discharge from hospital. One of the nurses from the CCG's Continuing Healthcare (CHC) team was redeployed to work specifically on this task.

NHS England produced guidance including 'Reason to Reside criteria' which clearly outline when a person needs to be in hospital. The local system worked together to identify what could be put in place to support people to whom these criteria did not apply. A new funding stream was set up to support safe and timely discharge, which the CCG accessed.

Commitment was made to a 'Home First' approach where possible with any support required. A number of 'Discharge to Assess' beds were established in the community for those not able to go home yet. These beds enabled people to move from hospital into a more homely environment, and, following assessment, to be supported with rehabilitation and re-enablement. For these people, the approach meant shorter lengths of stay, reduced risk of de-conditioning (changes in ability to function following a period of inactivity) and better long-term outcomes.

A dedicated 24hr service consisting of an 18-bedded isolation unit was also developed in the community to support the discharge of COVID-19 positive patients from hospital and reduce the risk of spread of infection within care homes. Nurses from the CCG's quality and CHC teams were redeployed to work in this unit alongside existing care staff and with additional support from health and social care services.

This service provided specialist care and treatment for people who had contracted the virus and, and supported their families until they were able to return safely home. A great deal of positive feedback was received from individuals and families about the care and support they received whilst in these beds during such a difficult time.

The manager of the service stated "I am extremely proud to have been part of this, and as equally proud of my team who, where the fear of COVID was high, prioritised the care of others and without hesitation volunteered to work with the nursing staff".

The beds are still being commissioned, but with staffing provided entirely by the care provider, enabling quality and continuing healthcare staff to return to their CCG roles.

The CCG wanted to support patients in the community with confirmed/suspected COVID-19 who were at risk of future deterioration/admission, so it set up a COVID oximetry at home service, where people identified as being at high risk could receive an enhanced package of monitoring involving a pulse oximeter (a small piece of kit that can measure the level of oxygen in the blood) being made available to track oxygen saturation, which, when it identifies a problem, prompts the patient and/or their carer to make contact with a team of nurses, their local GP or 111/999 for advice. This provides reassurance to the patient and carer that the right help can be obtained quickly The CCG worked with the local voluntary service to get this equipment distributed to 1,500 service users.

The aim of the service is to focus on those at most risk, with a diagnosis of COVID and monitor them to detect early deterioration in the community with 'silent hypoxia'; and where clinically appropriate, escalate their care to reduce mortality, reduce hospital length of stay and potentially reduce the risk of 'long COVID'.

Multi-agency Discharge Events, which bring together the local health system to support improved patient flow across the system, have continued and have maintained lower numbers of people whose discharge from hospital is delayed and shorter lengths of stay.

Planned care

At the start of the pandemic people waiting for planned care were prioritised according to clinical need and length of wait using national standards, and arrangements were put in place so that those who needed urgent treatment could obtain it.

The hospitals moved quickly to offer virtual appointments to patients where this was possible and appropriate – this allowed them to access consultant led care while reducing risk of transmission.

Community Services were enhanced where possible to support patients to access care out of hospital. One example of this is the Primary Eye-Care Assessment and Referral Service (PEARS), where community optometrists provide initial consultation for minor eye problems. Prior to the pandemic, any subsequent treatment or follow-up would have been undertaken by the hospital eye service. However, in response to the pandemic, the arrangement was changed so that where appropriate people could have their treatment or follow-up with the optometrist in the community rather than having to go to the hospital.

In the second wave, and with a better understanding of the demand COVID-19 was placing upon hospitals, the independent sector hospitals carried on as elective sites, providing planned care. The CCG worked with the independent sector hospitals and the local hospitals to move patients with the greatest clinical need, or longest wait, wherever there was space.

Waits for planned care have increased significantly during the year due to the pandemic, and this presents a huge challenge for 2020/21 and beyond.

Cancer

At the beginning of the pandemic, there was a significant drop in fast-track cancer referrals from primary care. In addition, cancer screening services to detect breast, cervical and bowel cancer were suspended.

After the first wave, screening services were resumed, and plans are in place to reduce the backlog of people waiting for screening. Additionally, the numbers of cancer fast track referrals have returned to pre-pandemic levels as both the public and professionals adapt to the new ways of working.

Calderdale and Huddersfield NHS Foundation Trust (CHFT) have maintained cancer diagnostic and treatment services within or close to target throughout all waves of the pandemic. 'Super-green' areas have been established to ensure a safe, COVID-19-free environment for patients with reassurance to the public being given at each step in the pathway.

Professionals referring people with suspected cancer can ask for guidance from secondary care prior to making the referral, in addition to undertaking a number of pre-referral tests to ensure people are referred on the correct pathway and that there is as much information as possible to support the referral.

As with many other services video consultations have played an important part in delivering appointments across cancer services. A virtual patient focus group held following the COVID-19 peak at CHFT highlighted the benefits of video consultations over telephone conversations for several types of appointment.

The same patient focus group also helped the Macmillan Cancer Information Service develop an online patient education programme; this has improved cancer information available on the CHFT's website as well as providing a monthly virtual Question and Answer session for newly diagnosed cancer patients.

In order to lock in new ways of working, changes are being made to the dermatology pathway for suspected skin cancers. To maintain referrals throughout the pandemic, where face to face appointments were reduced to the most urgent, the public has been able to send images taken on their own phone to support a referral.

To further embed this the CCG has drawn down funding from the West Yorkshire & Harrogate Cancer Alliance to purchase a dermatoscope for every GP practice building; the scopes allow for a more detailed image to be taken of a skin lesion which allows for more effective triage when the referral is received by the hospital consultant. In turn this means that people will be given information more quickly about management and treatment of suspected skin cancer and for some ruling out cancer altogether.

Care Homes

Care homes were a subject of intense focus during the pandemic, due to the age and vulnerability of their residents and the numbers affected by COVID-19.

In response to a call by the Chief Nursing Officer for England to ensure that all care homes were supported to ensure that their systems of infection prevention and control, and use of personal protective equipment were as good as they could be to protect residents and staff, the CCG's quality team led the rollout of a training programme covering these areas. The programme involved the identification, training and assessment of 'Supertrainers' who would then train staff in local care homes.

The timescale for the implementation of the training was very tight, but the CCG was able to offer it to all local homes by the end of May 2020. 35 out of 48 open homes took up the offer. Several of the others already had their own training programmes and some homes were not able to accommodate the training within the timescale, but by September 2020, 46 of the 48 open homes had received training.

The CCG with colleagues from the council, Public Health and the hospital came together as Tactical Command. Their purpose was review of COVID-19 status for

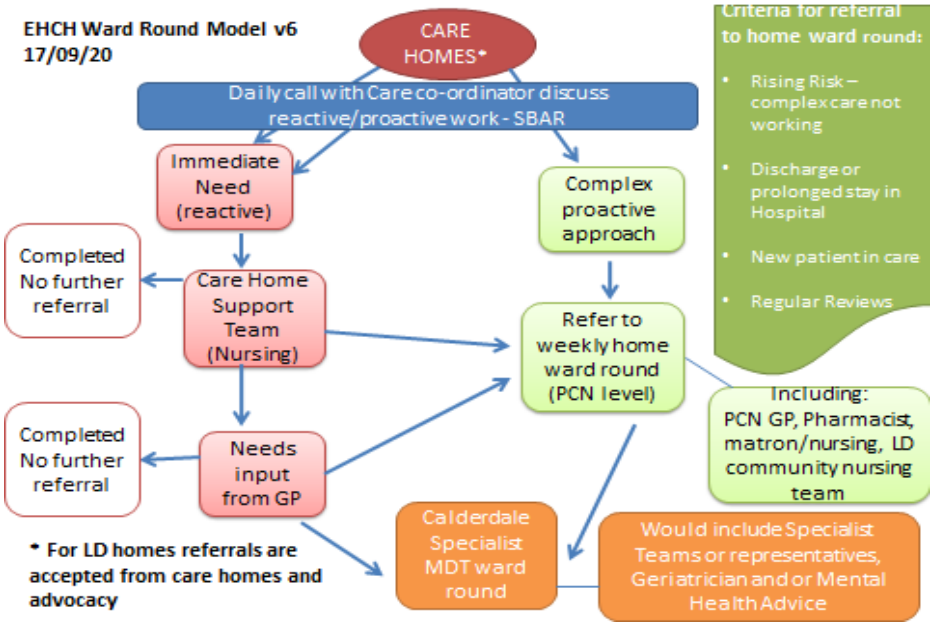
each home, early identification of risks and rapid deployment of appropriate resource to support the homes and protect residents and staff. This group of senior managers met daily at the height of the pandemic and continue to provide oversight and support when required.

To further support those living in care homes, a new model called Enhanced Health in Care Homes was rolled out. The model is delivered in partnership with primary care, secondary care, the local mental health trust, local provider services and local government services. It uses evidence-based interventions and best practice in a co-ordinated manner to improve services and outcomes for all people living in care homes.

The Calderdale model has been developed on the three principal aims of the national EHCH framework:

- To ensure the provision of high-quality care within care homes;
- To ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing; and
- To ensure that we make the best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and hospital bed days whilst ensuring the best care for residents.

The diagram below shows how the model works.



Continuing Healthcare

NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding, individuals have to be assessed by Clinical Commissioning Groups (CCGs) according to a legally prescribed decision-making process to determine whether the individual has a 'primary health need'. In Calderdale this function is carried out by the CCG Continuing Healthcare (CHC) team.

In March 2020, usual CHC processes of assessment and reviews were halted following the introduction of the NHS Discharge Requirements Guidance. COVID-19 funding was to fund care for individuals who would have undergone a CHC process prior to that time. This included any individuals who lived in a community setting that would have been referred to the Team via the CHC Checklist process for consideration of eligibility. In these circumstances, the extra support required was COVID-19 funded pending the re-introduction of the CHC process.

Between March and August 2020 the CHC team worked very differently in order to support the wider system and also to provide support for people in receipt of services commissioned by the team.

Part of the CHC team was redeployed to assist with the frontline response (see pages 19 and 20). A core CHC team remained, whose focus was to ensure contacts were made to all clients to see how they were coping and to check on their wellbeing. Alongside this the team focused on priority clinical work and case management of complex cases work.

Throughout this period of social isolation, staff from the CHC team have made regular calls to individuals and their families; this has enabled people to ask questions and receive support. Feedback from those receiving this contact is that it has been much appreciated.

The ‘Reintroduction of NHS continuing healthcare (NHS CHC)’ guidance published in August 2020 advised that all CHC processes would recommence from 1st September 2020. This has required the team to work closely with individuals, families and providers to develop a different approach to communication given that face to face meetings were not possible. Many people have been able to use or can be supported to access IT and virtual meetings but for others a different approach has been required that is right for them. This flexible approach is important to ensure that everyone is empowered to communicate effectively.

One of the key requirements of CCGs was that the backlog of assessments from March to September 2020 needed to be completed by 31st March 2021. This was achieved through a joint approach to close working between the CHC team and colleagues in Calderdale Council and supported by additional staff resources funded by NHS England. All deferred assessments were completed before the required deadline of 31st March 2021.

Mental health

It was recognised very early on that the fear and isolation of the pandemic would have a significant impact on the mental health and emotional wellbeing of local people, not just those already experiencing challenges to their mental health.

The CCG commissioned Overgate Hospice to provide a service called ‘Hear for You’, which offered telephone support to families and friends of people being treated for COVID-19 in any healthcare setting, and for families and friends bereaved by COVID-19. It also provided support for those working on the COVID-19 frontline. The support line operated between April and August 2020 (the height of the pandemic). This role has since been taken over by a West Yorkshire service called ‘Just Be’.

The CCG also extended its contract for the Employee Assistance Programme to cover workers in local health and care organisations, including the voluntary sector. The programme provides a 24/7 confidential helpline with access to counsellors and legal and financial specialists, e-mail and live chat, structured counselling sessions and an online wellbeing hub and app.

Plans for a 24-hr mental health helpline for adults, which had been under development before the pandemic were accelerated and this was in place across Calderdale and other local areas by the beginning of May 2020. The helpline provides information, advice and guidance to those with mental health needs. At the same time, 24 hour cover for Open Minds (CAMHS) was put in place for children and young people.

The CCG's service improvement team worked with partners including the council and the community and voluntary sector to provide information and support to people who were feeling the effects of the pandemic on their mental health. The CCG has also provided funding to extend the opening hours of Safespace, the community out of hours service providing emotional support for people in distress, so that it was (and continues to be) available seven evenings a week.

Local mental health services continued to provide services, although in different ways, with video and telephone consultations taking the place of face to face consultations in many cases.

The Open Minds Partnership (multi-agency partners including the CCG working together across Calderdale - OMP) continued to support children and young people and their families during the pandemic.

Open Minds (the new name for Children and Adolescent Mental Health Services) has continued to accept referrals throughout the pandemic. These are accepted via email, online and via telephone, but no longer through the post. This is a permanent change, made to safeguard vulnerable children and young people and ensure their needs are met as quickly and appropriately as possible, particularly those at highest risk, such as those with suicidal thoughts or emerging eating disorders.

The Partnership worked with young people to develop and share advice on COVID-19 and broader emotional wellbeing via the Open Minds Calderdale web site, including worry cards on returning to education. Developed by young people, these cards aimed to help decrease stress levels about any worries or queries students

might have, especially those who had not accessed formal education since March 2020.

The Partnership also developed bespoke return-to-school guides with, and for primary and secondary school children, parents, and school staff.

Calderdale Council, in collaboration with OMP partners, used a small Department for Education grant to deliver a 'Wellbeing for Education Return' project which began in the Autumn 2020 term. Building on existing local initiatives and using new training resources, this has provided additional support to staff in state-funded schools and colleges, so they can better support students returning to education during the pandemic.

Learning disabilities (LD)

During the pandemic, the CCG has undertaken work to reduce health inequalities for people with learning disabilities, who typically experience less positive health outcomes and have been significantly impacted by COVID-19.

As soon as the pandemic took hold, the CCG and partners put arrangements in place to support people with learning disabilities, their family/carers and service providers. Some examples are given below.

Keeping Connected in Calderdale

Lead The Way (LTW) received funding from West Yorkshire and Harrogate Health and Care Partnership to facilitate the ‘Keeping Connected in Calderdale’ project which aimed to keep people connected during COVID-19, particularly people who were not accessing other ‘traditional’ or ‘mainstream’ services.

LTW facilitated some remote cooking sessions – enabling people to set their own goals, for example healthy eating, learning a new skill, reducing risk of diabetes. It also facilitated regular welfare calls and incorporated Netflix parties and coffee and chat sessions to offer enhanced support and prevent social isolation.

Support for providers

A comprehensive offer of support has been given to all providers throughout the Covid-19 pandemic. Contact officers have maintained close contact with providers, offering advice and guidance both in terms of staff/ teams and those people who receive support. Providers have had access to a frequent supply of Personal Protective Equipment (PPE) to ensure that they can maintain good infection control measures. LD providers have also had access to Infection Control Funding in order to provide safe and effective care.

Where an outbreak occurred within a 24- hour setting, support was offered from the specialist LD health team. The LD health team have also carried out weekly welfare check phone calls to all registered care providers and monitored some of the non-registered supporting living providers. Where there have been positive cases, the team have provided advice on PPE, isolation requirements and the prevention of further spread within the setting.

COVID Vaccination

Vaccination is a very important part of health protection for people with learning disabilities. When the Government announced its national vaccination programme, the priority groups did not include people with learning disabilities. This meant that although some people were able to access a vaccination because they were in another priority group (for example due to underlying health conditions), others would not be able to access the vaccination until it reached their age group.

Calderdale wanted to make sure that everyone with learning disabilities was able to receive a vaccination as a priority and set up a multi-agency group to make this happen. Shortly afterwards, the Government announced that one of the priority groups would be extended to include everyone with learning disabilities.

Primary Care Networks (PCNs) worked hard to enable as many people with learning disabilities as possible to access their local vaccination clinics, in line with the local approach of supporting people with learning disabilities to access mainstream services where possible. However, it was recognised that some people needed a more personalised approach and the CCG has been leading work to put on bespoke clinics in the PCNs for people with learning disabilities.

In March, CHFT ran a weekend cinema-style experience with films, music and refreshments for people with learning disabilities (see pictures below). Thirty people with learning disabilities attended and received their vaccination in a safe and relaxed environment.

Main picture: Hospital matron lead for learning disabilities, Amanda McKie, and the vaccination team at a special clinic held at the weekend for people with learning disabilities.

Inset: Sam Wainwright and his dad Gerard after receiving his vaccination at the clinic

Annual health checks

The learning disabilities health check is an important tool for us in helping to reduce health inequalities.

Under the national GP contract, GP practices are able to offer an annual health check to all those aged 17 and over on the practice LD register. The learning disabilities annual health check is designed to pick up a range of unmet health needs and can also help people with learning disabilities to use health services better by understanding what their local GP service can provide for them and learning how to use it.

Historically, uptake of annual health checks has been low, so a new approach was taken during the year. There has been a focused effort across all GP practices to encourage people to have their annual health check. In order to support this and support people who may struggle to access primary care settings the CCG commissioned support from the SWYPFT Community Learning Disability Team to complete annual health checks.

Linking with practices two LD nurses have been able to reach out to people in their own homes to carry out their annual health check. Feedback so far has been very positive that people feel more comfortable and able to have meaningful and open conversations in their own homes.

Work has also been undertaken by Lead the Way and partners to encourage young people to take up the offer of an annual health check.

As a result of this focus, Calderdale's uptake of annual health checks at the end of 2020/21 was 81% against the national ambition of 67%.

There has been a lot of learning from the work this year, which will be used to set expectations for 2021/22 and to improve the quality of annual health checks and develop a consistent approach, which is what people have told us they want.

‘Share and Learn’ event

In recognition of the impacts of COVID-19 and to gain a wider understanding of how we can support people with learning disabilities and those who work with them a ‘Share and Learn’ event was held in January 2021. Over 40 people attended the event including Support Providers, Commissioners, GPs, the Adult Health & Social Care Portfolio Holder, staff from Adult Health and Social Care, Calderdale CCG and the Voluntary Sector.

The session focused on Annual Health Checks, Digital Inclusion, Supported Decision Making and Wellbeing and was preceded by a questionnaire to find out what people with learning disabilities and providers had found difficult during the pandemic and to highlight innovation that could be shared. Experts led each session and attendees were able to ask questions and discuss areas they would like further support with. An action plan was developed from the session and a further event was arranged to feed back to attendees and agree next steps.

Response to the University of Bristol report – ‘Deaths of People with Learning Disabilities from COVID-19’

The long-standing challenges around health inequalities relating to people with learning disabilities were brought into sharp focus through the publication in November 2020, of a report by the University of Bristol into the deaths of 206 people with learning disabilities in England since the start of the pandemic. The report

highlighted some good practice in the care of people with learning disabilities, but it also highlighted concerns in four areas:

- Identifying deterioration in health
- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions and learning disability as a cause of death
- Diagnostic overshadowing – when an assumption is made that a person's behaviour is part of their disability without exploring other causes
- Reasonable adjustments

Each local area has undertaken an exercise to identify actions already in place that are addressing these concerns, and any gaps.

In Calderdale, actions in place include:

- All homes for people with learning disabilities having a lead GP and care co-ordinator working closely with the home to ensure reactive and proactive needs are being met in a timely manner
- Recruiting an LD matron to provide a proactive service around physical health in LD homes
- Cloverleaf Advocacy and an expert by experience working to support individuals to access annual health checks and to support professionals with reasonable adjustments
- Recruiting a Strategic Health facilitator to work with practices across the PCNS and other agencies to improve the uptake and quality of annual health checks through the development of flexible service offers
- Supportive training sessions being offered to homes to help them recognise signs of deterioration in the health of residents
- DNACPRs for people with learning disabilities being reviewed by GP practices and audited by CHFT
- The University of Bristol report and a brief learning summary about diagnostic overshadowing produced with it being shared with GP practices

Whilst there has been much to be proud of this year, we know there is much more to be done. From an operational perspective, partners from all agencies meet weekly to make sure there is a joined-up approach to delivering improvements in services for people with learning disabilities.

As a system all partners agree that we must reduce health inequalities for people with learning disabilities. We have held a recent development session with participants of the Health and Wellbeing Board facilitated by the Council's Director of Adult Social Care to support our sustained focus on this issue over the next twelve months.

End of Life Care

Whilst continuing to provide its own services, Overgate Hospice reached out to provide education in various ways (presentations, youtube, etc.) on end of life care to staff working in the places where people affected by the pandemic were being treated and cared for. This was particularly important as some of those staff did not normally work in an environment where end of life care was part of their everyday work, and even those who did faced challenges in dealing with the number of deaths as a result of the pandemic.

Overgate's busy day hospice had to change its way of operating, and now functions fully through an online platform, an approach it is planning to keep post-COVID-19. Overgate has been able to access funding to provide practical support to enable people to participate.

The hospice also used the principle of death cafes as a way of reaching out to the general public especially the ethnic minority community who were very fearful of what is happening in our society and locality during the pandemic. Death cafes offer a safe, open environment for discussing thoughts and feeling about death and dying.

Learning from the pandemic

During the summer 2020 the CCG worked in partnership with Healthwatch Calderdale to gather feedback from anyone who had contacted or tried to contact health and care services during the COVID-19 outbreak. NHS and care services had to quickly change the way they work and deliver services in response to COVID-19.

The key themes from what people told us were:

- Access to services – limitations to face to face access, service closure and telephone access
- Digital access – the use of online booking systems and video call appointments
- Communication between staff and patients – the lack of information that has been made available about how services have changed, and missed opportunities to interact with people
- Quality of care – covering person-centred and flexible support

Feedback was mixed for all of these themes, with many people appreciating the necessity for change during the pandemic, but feeling that their experience could have been improved.

The CCG welcomed the publication of the engagement report Health and Care Experiences of People Living in Calderdale during Covid-19 Outbreak. The report was discussed by the CCG's Governing Body and was acknowledged as a comprehensive document.

NHS Calderdale CCG's response thanked Healthwatch Calderdale for leading on the delivery of the report, while working in partnership with the CCG, Calderdale Council and voluntary and community organisations across the area. The response sets out how the CCG and partners will be using the report and the outputs from other intelligence-gathering activities to take forward the learning from the pandemic in the development of new models of health and care for the people of Calderdale.

Leading on pandemic-specific programmes

During 2020/21, the CCG's service improvement team has taken the lead in the co-ordination of two key pandemic-specific programmes.

COVID-19 testing

Testing is a key part of the response to the pandemic and the CCG and partners acted quickly to establish a local satellite testing centre at King Cross in Halifax to complement the regional testing centres established by the Government, the closest of which was in Leeds.

Initially the centre focused on essential workers, supporting them to return to work as soon as possible. Focus then turned to care homes and GP practices, and a fortnightly service involving delivery of test kits and collection of completed tests was established. This helped to keep vulnerable people safe and ensure service resilience. This service remained in place until the establishment of the vaccination programme.

The centre also supported the local Public Health team in providing targeted testing in response to a number of local outbreaks.

The centre was managed by the CCG's service improvement team, and other staff from the CCG took on roles within it, particularly around deliveries and collections, until a more sustainable solution was found through Calderdale Council and hospital transport services and the local community and voluntary sector.

In December 2020, the centre was taken over by Locala, one of the local community service providers. It now provides intelligence-led testing for asymptomatic essential workers considered as high risk, for example taxi drivers, small independent shop workers etc.

COVID-19 vaccination

Calderdale CCG as local lead established a group to work at pace with partners to establish local delivery of the vaccination programme as “Team Calderdale”. The group steers the management and coordination of the programme, leading the strategy on the vaccine programme operations, deployment, reporting and escalation, and ensuring that risks and issues are managed and fed to NHS England.

The COVID-19 vaccination programme manager described how the work started “I recall the kick off meeting now, many giving up annual leave over half-term with enthusiasm and passion to ensure our residents were offered protection from COVID-19 as soon as possible.”

Teams from within the CCG have been and continue to be involved in supporting the development of the vaccination programme, ensuring it provides safe and effective services that are responsive to the needs of the local population and identifying opportunities to address or reduce health inequalities.

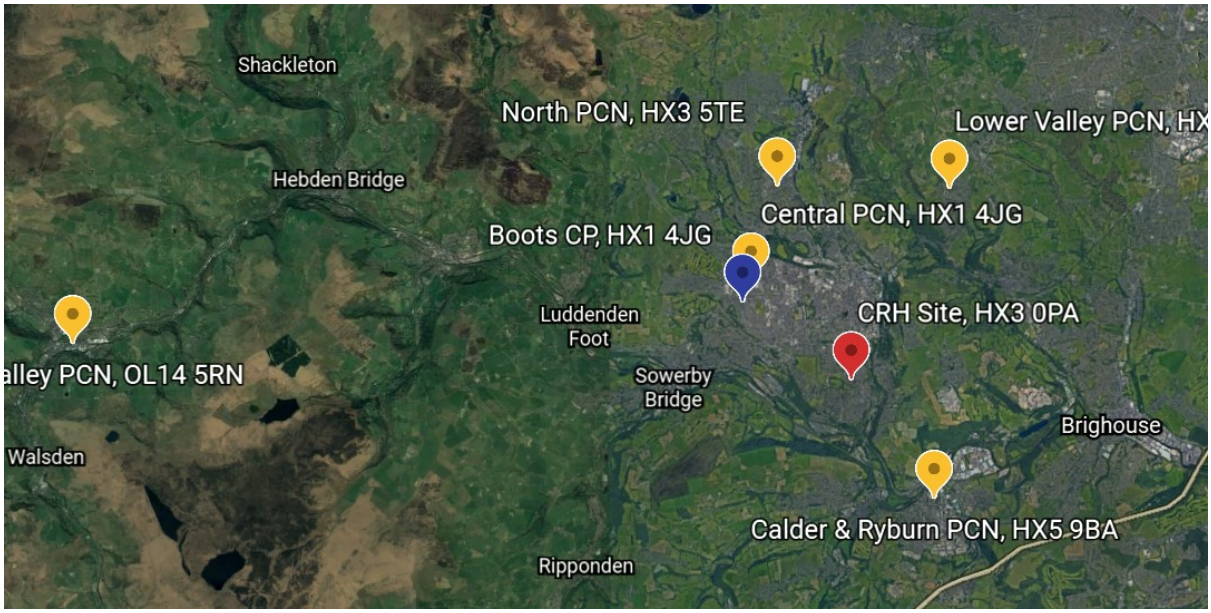
Calderdale began vaccinating on 14th December 2020, in line with Joint Committee on Vaccination and Immunisation priorities. Many residents and staff in care homes for older adults and over 80s (considered to be at highest risk of mortality and morbidity) were immediately prioritised for a vaccine.

Seven vaccination sites were established with a roving team to get vaccines out to residents who were housebound and faced barriers in attending a site. The sites were

- Calderdale Royal Hospital - to vaccinate frontline health and social care workforce
- Five PCN sites - Lower Valley (at Northowram Surgery), Upper Valley (at Todmorden Health Centre), Calder & Ryburn (at Bankfield Surgery, Elland), North Halifax (at Nursery Lane Medical Centre, Ovenden) and Central Halifax (at Spring Hall Group Practice)

- Boots Community Pharmacy in Halifax and Tesco Pharmacy in Brighouse, acting as Calderdale's community vaccination sites

The map below shows the location of the sites.



By the end of 2020/21, Calderdale had achieved many progress targets set by NHS England, having exceeded over 75% uptake for dose one, in all adults over 60 years; residents in care homes; and frontline health and social care workforce.

By the end of May 2021, over 125,000 adults had been vaccinated in Calderdale with dose one, over 70% of the adult population, the most at risk population in the borough having received some protection from COVID-19. Second dose vaccinations began on 1st March, and as of the end of May 2021 over 85,000 adults had been vaccinated with dose two.

The CCG has addressed possible COVID-19 vaccination inequalities to ensure the COVID-19 vaccination roll out does not exacerbate existing and emerging health inequalities. It is recognised that health inequalities are structured across three dimensions - wider determinants of health, protected characteristics and social exclusion. The CCG has worked with partners to ensure action has been taken to ensure many marginalised groups have already been and continue to be prioritised for a vaccination, including pop-up clinics in two local mosques.

Under this approach, almost 1,000 people with learning disabilities, over 1,000 unpaid carers and 32 people who are homeless or living street-based lifestyles had received at least one dose by the end of March 2021

Our partners have found creative ways to encourage particular groups of the population to attend, for example the cinema-style clinic for people with learning disabilities described on page 30.

All stakeholders and partners across Calderdale have played an amazing part in the programme and its success can be credited to all partners working to achieve the same goal, where nothing is impossible.

There have of course been challenges, one of the biggest being the weather, when ski gear became the new Personal Protective Equipment for the roving team and sites had to re-schedule appointments on many occasions and stay open late into the evening to work around the snow. Thanks to the Calderdale Council gritting team, most of the vaccinations went ahead as scheduled.

The picture below shows Dr Lisa Pickles on her way to vaccinate patients in their homes.

The extremely short timescales for receiving notification of vaccination allocations/ deliveries and stringent requirements around the storage and use of vaccines have also presented a huge challenge.

The constant risk has been the burnout and welfare of staff in the organisations involved, which continues to be a concern. One year into the pandemic, staff are showing amazing resilience in delivering one of the most important public health goals of this century - vaccination against COVID-19.

Delivering the CCG's usual functions

As well as responding to the challenges of the pandemic, the CCG has continued to deliver its usual functions, albeit in different ways where required. The following pages give a flavour of these.

Engaging People and Communities

NHS Calderdale CCG has a joint strategy for involving people across Calderdale which has been developed with our partners such as the Local Authority, Healthwatch, the Voluntary and Community Sector and our providers.

The Involving People Strategy is a shared set of principles with our partners for involving people across Calderdale, supporting the delivery of Calderdale Cares, and the White Paper Integration and innovation by working together to improve health and social care for all through its principles of voice, and influence, and addressing inequalities.

It is central in helping the CCG embed the voice of patients, carers, families, staff and the public in everything we do. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback. The duty to involve local people is set out in sections 242 and 244 of the Health and Social Care Act 2012, The NHS Constitution and the Equality Act 2010.

The strategy helps us to build place-based engagement and communication, and the principles of the strategy are the foundation by which local people can expect to be involved by organisations in Calderdale.

A more detailed statement of involvement report is also produced annually which provides more information about how the CCG, partners and providers that the CCG commission have involved local people in the development, design and delivery of services throughout the year. This also gives us the opportunity to shout out about the fantastic partnership engagement work that has taken place across Calderdale.

We recognise that the findings of any engagement and/or consultation can take several months or even years before any outcomes or changes can be reported on. Last year for the first time we asked colleagues for a progress update on previous activity where possible. We will also be asking again this year.

Due to COVID-19 we recognise that some of our usual activity may not have taken place but there will be lots of different activity that has, especially around COVID-19. It is really important that we capture the work that has happened over the last 12 months, during these really worrying and uncertain times. The annual statement of involvement for 2020/21 is currently in development and will be uploaded to the CCG website in July 2021.

The report will set out who has been involved, what people have told us and what has happened as a result (we asked, you told us, we listened). Each section is a summary account of activity with links to the published reports.

A key priority during 2020/21 for the CCG and partners has been acting on and implementing the principles of the 'Involving People' Strategy to create a strong collaboration for communications, engagement and equality across Calderdale, working in partnership and coming together to learn from and act on what people are telling us to improve the health and wellbeing of Calderdale population

The CCGs overall engagement approach and activity is subject to review through The NHS Oversight Framework Patient and Community Engagement Indicator. The NHS Oversight Framework for 2019/20 replaced the CCG Improvement and Assessment Framework (IAF) and the provider Single Oversight Framework, and informed assessment of CCGs in 2019/20.

The criteria are closely linked with the ‘key actions’ in the statutory guidance on patient and public participation in commissioning health and care and are grouped under five themed domains, as follows:

A. Governance

B. Annual reporting

C. Day-to-day practice

D. Feedback and evaluation

E. Equalities and health inequalities.

For 2019/20 we were rated ‘Outstanding’ with a score of 15 out of 15 - Green Star.

Reducing Inequalities

The CCG has set out within all its published strategic plans a clear intention to work with the local health and care partners to better integrate health and care services for the benefit of the people that we serve. We have taken this approach because when we have engaged and consulted with local people, they have been clear that we should work more effectively together to improve health and prevent illness and empower people to take control of their own health. This intention is in line with the commitments made in Calderdale Cares published in 2018.

The importance of gathering intelligence is being championed by system leaders and clinicians in Calderdale. All health and care settings are being encouraged to record and use ethnicity data to support the design and delivery of services. This approach is a feature in the elective and mental health programmes for Calderdale. Calderdale lobbied nationally for the recording of ethnicity data on death certificates, which was successfully achieved.

The PCNs have begun work to understand their populations and apply a Population Health Management approach. This work is focusing on a number of areas including diabetes and people at rising risk of frailty, and some work is also taking place with people who are homeless. This work will continue into 2021/22 and build on collaboration with partners within PCNs.

The PCNs have also taken a proactive approach to improving population health, examples being work with partners to increase the number of people with learning disabilities having an LD health check and health action plan (more information is provided on this work on pages 31 to 32) and work to increase the uptake of the flu vaccination, which has led to improved uptake on previous years across all patient cohorts, and in the case of the over 65s exceeding the required target of 75%.

Working with external partners, the CCG's primary care team have supported the PCNs in their work to address health inequalities through population health management, and have ensured this is in alignment with delivering Calderdale Cares.

Promoting and supporting Equality and Diversity

We are committed to improving the lives of local people by reducing health inequalities and making sure that we plan and commission local healthcare services to meet the needs of our diverse communities. To help us do this we continue to work collaboratively with our partners and our communities to make sure services meet local needs.

Our Equality and Inclusion Strategy outlines our commitment and intentions to promote equality, tackle health inequalities and improve health outcomes for our local people and communities.

During the year we have:

- Ensured that rapid service changes made as a result of the pandemic were reviewed for equality impact and mitigations put in place to prevent negative impact on communities.
- Supported the implementation of a reset action plan to support system recovery, which incorporates a range of actions designed to reduce health inequalities and improve leadership diversity.
- Developed a new Equality and Inclusion Strategy.
- Developed a workforce action plan that incorporates actions from the NHS People Plan 2020-21, the West Yorkshire and Harrogate (WY&H) Review to tackle health

inequalities for Black, Asian and minority ethnic communities and colleagues and the WY & H Race Equality Staff Network of Networks.

- Commissioned Unconscious Bias training for all CCG staff.
- Developed a full Equality Impact Assessment (EIA) to support the vaccination programme working with local partners.
- Listened to local communities and used their feedback to inform the delivery of the vaccination programme.
- Worked with partners and local communities to deliver our equality objectives including improving access to primary care for ethnic minority groups and carers.
- Supported the delivery of a Health Inequalities Grant Fund project led by Voluntary Action Calderdale, to reduce the impact of COVID-19 on the inequality in life expectancy through greater connectivity.
- Implemented the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) in shadow form.
- Encouraged staff to join the BAME Staff Network across CKW CCGs [please note that discussions are taking place about a possible name change for this Network]
- Implemented the recommendations of the WY&H Race Equality Staff Network of Networks.
- Developed best practice Accessibility Guidance Standards and training to support staff to create accessible content when writing reports, documents for publication, presentations, online surveys and online content.
- Commissioned a new website to make sure it is more accessible for our communities.
- Contributed to the WY&H Review on tackling health inequalities for Black, Asian and minority ethnic communities and colleagues. We are currently working with system partners to ensure that the recommendations and actions from the review are implemented locally.
- Reported performance against the delivery of our equality and diversity duties to the Quality Finance and Performance Committee bi-annually, with the Public Sector Equality Duty (PSED) annual report being submitted to the Governing Body.

The CCG's Public Sector Equality Duty Report 2020 can be found on its website.

Keeping people safe

Safeguarding

The CCG has a legal responsibility to ensure that the principles and duties of safeguarding children and adults at risk remain a priority for both the CCG and the providers from which it commissions services. Whilst some statutory duties under the Care Act 2015 were eased during the past year due to the COVID-19 pandemic, the duties relating to safeguarding remained.

The safeguarding functions continued, albeit some delivered in different ways:

- Supportive safeguarding advice: The CCG Safeguarding team offered advice to support professionals in the CCG or primary care and extended the offer to include staff in commissioned health providers
- Responding to urgent statutory safeguarding cases: Significant statutory safeguarding cases require responsive actions to ensure that any learning is shared quickly to protect children or adults who may be at risk. The CCG Safeguarding Team continued to support the work on these cases throughout the year.
- Work to support the Calderdale Safeguarding Boards/Partnerships: The Safeguarding Boards/Partnership Executive meetings continued and the CCG as a statutory member continued to attend and play a full role. Initially subgroups and work-streams of the Boards/Partnerships were suspended, but these were re-commenced via virtual processes and the CCG are in full attendance
- Supporting primary care and other partners with pertinent safeguarding information: Supportive guidance for both safeguarding and adherence to the Mental Capacity Act during the pandemic have been produced by the team and distributed to primary care colleagues.

Seeking assurance that commissioned providers continue to prioritise and deliver safe and effective systems for safeguarding children and adults, including provision for Children in Care and a Child Death Overview Panel, remains a key part of the CCG Safeguarding team role.

Learning Disability Mortality Review (LeDeR) Programme

The LeDeR programme was established in 2017. Locally the CCG leads the programme of retrospective reviews of the deaths of people with Learning Disabilities (LD) aged 4 to 74 across England, the key aim being to identify learning and best practice so that any recommendations for improvement can be taken forward.

NHS England requirements are that a trained LeDeR Reviewer must be allocated within 3 months and the review completed within 6 months. The most significant challenge for the CCG has been limited funding to support the delivery of reviews and the majority of Reviewers continue to complete these in addition to their substantive posts.

With the support of local Health Providers and Local Authority partners, a shared approach across Calderdale and Kirklees to complete the reviews was undertaken with success - all backlog cases for the two areas were completed by December 2020.

In November 2020 NHS England published a report analysing the LeDeR Reviews that had been undertaken of the deaths of 206 people with learning disabilities at the start of the pandemic. The report highlighted some good practice in the care of people with learning disabilities, but it also highlighted concerns. Information about the CCG's response to the report can be found on page 35.

Improving quality

During this challenging year the quality team has adapted its quality work by offering expert clinical and quality support to our provider colleagues, and it has adopted a proportionate, pragmatic approach to quality assurance.

The team has ensured that the CCG has fulfilled the requirement to assure itself on the quality and safety of service provision by:

- Further developing the strong working relationships with our providers through CCG quality attendance at all provider Quality committees.
- Maintaining robust insight on quality performance through the scrutiny of the quality and safety dashboards.
- Provision of an offer of 'Soft Signs-Recognition of deterioration' training to all care home providers including LD homes to assist staff in understanding how subtle, non-specific changes in residents can be important and how to obtain appropriate timely help.
- Participating in outbreak management processes and supporting any identified required quality improvements.
- Confirmation of organisational compliance from providers against the national Infection Prevention and Control Board Assurance Framework internal assurance as well as ongoing updates against the Trusts Infection and Control action plan.
- Provision of an offer of 'Fresh Eyes' Infection Prevention and Control support visits to primary care settings both proactively and in response to staff outbreaks.
- Continuing to progress both the Quality for Health assurance system developed by the CCG and Voluntary Action Calderdale (VAC) for the voluntary sector plus requesting scoping into provision and resilience of the local Third Sector to identify gaps in areas of CCG priority.
- Sharing patient stories at every Governing Body meeting in order to learn about experience of accessing health services including experience of COVID-19 vaccination.

Sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainable development means building sustainable communities, supporting healthy living for all and our workforce, the smart and efficient use of natural resources and spending public and other money well. By making the most of social, environmental and economic assets we can improve health both in the immediate and the long terms. This will also need to be reflected in the ways in which we work to deal with the problems of climate change.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We continue to carry out activities that contribute to sustainable development and we work locally with the Calderdale Council Climate Committee and other sub-regional and regional initiatives in order to implement new policies and ways of working. We have provided a flavour of those below:

Corporate approach

As a commissioning organisation and employer, we have a Governing Body lead for sustainable development and have a Sustainable Development Management plan which will be refreshed in 2021.

Travel and logistics

Our Expenses Policy sets out our commitment to sustainable development.

We assess the travel, transport and accessibility of locations for engagement and consultation meetings and follow up any events with a questionnaire to participants that informs future choice of venues – our preferred model is to go where people are, rather than expecting people to come to us. This is supported by working with our engagement champions. Engagement Champions are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. More information about our approach can be found here - Information on giving communities a voice

Year on year we continue to use technology to reduce the number of journeys being made by our staff, who are increasingly working across West Yorkshire as we develop collaborative working as part of the Health and Care Partnership. Reducing

the amount of travelling required contributes to an improvement in staff health and wellbeing, increases efficiency, reduces our impact on the environment and reduces running costs. Working from home during the pandemic with meetings taking place over Microsoft Teams has made a significant contribution to this ambition.

Resource usage in 2020/21

The table below shows the usage of resources by the CCG during 2020/21 compared to 2019/20.

Resource	Quantity (kWh) 2019/20	Quantity (kWh) 2020/21	tCO2 emissions 2019/20 (Note 1)	tCO2 emissions 2020/21 (Note 1)	Cost incl. VAT 2019/20	Cost incl. VAT 2020/21
Gas	55,160	49,528	10	9	2,445	2,507
Electricity	49,397	27,364	13	6	10,182	6,036
Water (Note 2)	--	--	--	--	--	--
General waste (note 3)	--	--	--	--	--	--
Recycling (including confidential waste)	--	--	--	--	2,569	1,170

Note 1: The tCO2 emissions have been calculated using conversion factors for greenhouse gas reporting for 2019 and 2020, published by the Department for Business, Energy and Industrial Strategy

Note 2: The charge for water usage is contained within the general service charge and is not separated out.

Note 3: General waste disposal forms part of the cleaning contract and is not separated out.

Business Travel

Type	Miles 2019/20	Miles 2020/21	Cost (inc. VAT) 2019/20	Cost (inc. VAT) 2020/21
Business Travel	48,019	3,135	26,891	1,755
Business Travel – Car Share	1,951	(Note 1)	97.00	(Note 1)

Note 1: It has not been possible to separate out car share miles and cost for 2020/21

Adaptation

Responding to the effects of climate change is embedded in our Emergency Planning, Resilience and Recovery (EPRR) work as part of fulfilling our responsibilities under the Civil Contingencies Act 2004. We work closely with partners across the system on business continuity planning, ensuring that Surge and Escalation Plans as well as heatwave and winter plans are in place. There is the intention for joint exercises to take place with health partners across the West Yorkshire footprint towards the end of 2021/22. This will help ensure that organisations are resilient and that their plans are robust.

We also take part in regular flood planning exercises with partners across Calderdale although these have been paused during the pandemic.

Sustainable care models

Building sustainable care models is central to all our work with partners across Calderdale as a Place, across Calderdale and Greater Huddersfield as a shared acute hospital footprint and across the West Yorkshire and Harrogate Health and Care Partnership. Sustainability principles are embedded in our commissioning plans. Details of our work on Calderdale Cares and Calderdale Collaborative Community Partnership can be found on pages 59 to 61.

We also have a sustainable engagement model in partnership with our local community which ensures the public voice is central to commissioning. (See the ‘Engaging People and Communities’ section on pages 40 to 42).

Climate emergency

Calderdale Council declared a climate emergency at the beginning of 2019 and as a response, the CCG has appointed Professor Peter Roberts as the Governing Body Champion for Climate Change with operational responsibility from the Corporate Systems Manager, Rob Gibson. The CCG supported the Climate Emergency Steering Group and Working Party at the Council in its ambition to reduce carbon dioxide emissions by 40% by 2020, which the Council successfully achieved. The CCG will also be supporting the Council's new target of having net zero emissions by 2038 with significant progress made by 2030.

The NHS contributes about seven per cent of carbon emissions through its estate, transport costs of staff and patients and its heating costs, and we aim to do all we can to become a leading CCG in our response to the climate emergency.

We are thinking how as individuals working at the CCG we can reduce our own carbon footprint in our individual lives, how we can use smarter ways of working through digital and other means to rescue our environmental impact and also how through leadership discussions and through contracting and procurement means we can influence the wider system.

With staff currently working from home due to the national lockdown, the CCG has been able to be more flexible in its approach to travelling to the workplace and to meetings at other locations. Even after lockdown has ended the CCG intends to continue to promote this new way of working and therefore reduce its impact on carbon emissions.

The CCG is currently undertaking a review of its accommodation. The intention is that the CCG will move to different premises in the centre of Halifax. This will encourage staff to consider different methods of transport including use of bicycles and public transport. Again, this will assist the CCG in reducing its environmental impact.

Our people – Encouraging a healthy workforce

Calderdale CCG's staff forum has, for many years, promoted and led activities that support the physical, social and psychological wellbeing of all staff.

In response to the COVID-19 pandemic, all staff have worked from home where it is safe and appropriate to do so. Although this has limited the range of activities the staff forum has designed and promoted, staff wellbeing has been at the heart of how the CCG has operated over the last year. Within days of staff having to work from home, wellbeing activities started being delivered online, with a 'Virtual Kitchen' replacing the physical hub previously accessed by staff.

Staff forum have continued meeting online to find ways of supporting colleagues grappling with the effects of working digitally from home, redeployment, home schooling, loss and bereavement and increased work demands. Our staff have accessed local, regional and national advice including information and resources to support their psychological, physical, social and financial wellbeing, and that of their friends, family and neighbours. Colleagues have worked hard to stay connected with each other at individual, team and organisational levels, and have kept each other and our communities safe.

Promoting Wellbeing

The CCG plays an active role on the Health and Wellbeing Board and in the promotion of wellbeing.

The Health and Wellbeing Board is attended by the Accountable Officer and Chair of the CCG. The CCG takes an active role in the delivery of the Wellbeing Strategy which builds on Calderdale Cares and is aligned to the Inclusive Economy Strategy as well as national policy and established good practice. The Strategy takes a life course approach to focus on activities that support: starting well, developing well, staying and working well, ageing well and dying well, alongside tackling wider determinants of health, reducing inequalities and improving health life expectancy.

The vision in the strategy has three strands:

- People are empowered to take greater control over their lives and outcomes – with improved health, so they are happier and better connected
- Resources and assets are used to address the wider determinants of health and support wellbeing
- The system shifts towards prevention, changing the ways in which organisations and their staff work

A set of outcomes have been developed to support delivery of the vision:

- Healthy mothers and healthy babies
- Parenting for a brighter future: All young children given a strong foundation
- Good mental health and wellbeing for children and young people
- Good mental health and wellbeing for working age adults
- Healthy lifestyles for working age adults
- Older people remaining physically active and independent
- Good support in older age and end of life

The Health and Wellbeing Board receives updates on different aspects of the strategy during its meetings. During 2020/21, it has received updates on actions relating four specific areas as follows:

Speech, Language and Communication Needs (SLCN) of children

- Calderdale is part of an SLCN training pilot upskilling health visiting staff in these areas
- Calderdale has launched ’50 things to do before you are 5’ app aimed at parents/carers with children under five years old
- Calderdale will be participating in a peer review process across the system about how children are being supported with speech, language and communication needs
- Calderdale is assessing children using the Ages and Stages Questionnaire at age 2 (with the Public Health Early Years Provider) and working with them to improve the data recording and SLC service pathways for families into supporting services

Physical activity

- Embedding physical activity into health and social care pathways
- Using local assets to enable more people to be physically active, for example Memory Lane Café (which works with people with dementia and their carers) adding dance and seated exercises to its support offer
- Working with local workplaces to encourage and support all staff to be active

Smoking

- Commissioning support for people to quit smoking, targeting priority groups such as routine and manual workers, pregnant women, etc.
- Promoting links across services
- Commissioning a West Yorkshire-wide service to tackle illicit tobacco
- De-normalising smoking via policy changes
- Working with the hospital trust to become smoke-free

Alcohol

- Treatment and recovery services looking at new ways of working to improve accessibility and provide patient-centred care
- Alcohol Brief Interventions (ABI) training rolled out across a number of areas and included in some service contracts
- Support to the providers of the NHS Health Check to aid ABI delivery

The impact of this work is tracked through long-range indicators.

Improving local services

Supporting the development of Primary Care Networks (PCNs)

Work has been taken forward to support the development of PCNs and delivery of their contracted requirements. This has included supporting the recruitment models and professional supervision offers for additional roles and encouraging collaboration with community providers to deliver the Enhanced Health in Care Home requirements and Learning Disability health check.

Developing Local Pharmacy Networks

The medicines optimisation team has supported the introduction of PCN Clinical Pharmacists with monthly meetings since June 2020 to facilitate the development of peer support and information sharing for this new staff group.

A wider stakeholder group, the Calderdale primary care pharmacy forum, has also been established to support improved communication and information sharing between the different pharmacy professionals in Calderdale including practice pharmacists, PCN Clinical Pharmacists, Community Services Pharmacists, Community Pharmacists, the practice pharmacy team and the CCG medicines optimisation team. This group met twice during 2020/21 and will meet on a quarterly basis going forward.

Adults' and older adults' mental health

During 2020/21 there have a number of developments to help improve the emotional wellbeing and mental health of adults and older adults:

- An increase in the opening hours of Safespace, which provides out of hours emotional support to people in distress, so that it now operates seven evenings a week
- The establishment of an Older Adults Intensive Support Team – providing intensive support within the community and reducing the need for inpatient care
- The establishment of a community mental health rehabilitation service for people who need rehabilitation due to the impact their mental health is having on their life. The aim is to re-establish the individual's abilities and independence in all aspects of their daily life and to support their recovery process

At the beginning of 2021 Calderdale secured funding from NHS England and Improvement to transform community mental health by creating a new, inclusive, generic community mental health offer. This is part of a wider transformation programme delivered across West Yorkshire and Harrogate Health and Care Partnership. It aims to:

- Provide better care to people already receiving mental health support in the community
- Increase access to these services
- Improve pathways for people with eating disorders, who have community rehabilitation needs and have a personality disorder
- Increase the number of people with Severe Mental Illness (SMI) receiving a comprehensive physical health check

The new offer for Calderdale will:

1. Be led by Voluntary and Community Sector, local authority and health representatives, working as a partnership
2. Be redesigned with, and for people in local areas, around and integrated with, Primary Care Networks
3. Take account of the wider social determinants affecting people's emotional wellbeing and mental health
4. Dissolve the traditional barriers between primary and secondary care and move away from systems designed on referral and discharge (which can lead to people being deemed not appropriate for services and being left without any support)
5. Aim to stop people falling between the gap in services, particularly where their need is higher than primary care/Improved Access to Psychological Therapies/Talking Therapies(IAPT) but they don't currently meet the criteria for secondary care (provided by South West Yorkshire Partnership Foundation Trust and Calderdale Council teams)

The funding will be used to invest in recruiting new members of the community mental health workforce from the local areas they will serve, and to commission services from the Voluntary and Community Sector (VCS). The transformation work starts in 2021 and will take place over a three-year period.

Children and young people's mental health

Commissioners, providers and wider partners have continued to meet regularly to identify and manage risks, ensure effective communication and provide support to children, young people, families, and professionals working with them.

Partnership updates on the current service offer, and the status of neurodevelopmental assessments (including for autism) have been provided regularly to partners, including colleagues in education and primary care.

Services and support for young people with Autistic Spectrum Disorder (ASD)

In February 2020, young people with ASD organised and led Calderdale's second Autism summit, 'Find Your Brave'. During the Summit, our Young People told participants their personal stories and what their dreams for Calderdale are. System leaders gave an update on the pledges made in January 2019 and partners celebrated the progress made since then. Participants identified together how we all can continue the autism journey together in transforming the way we think, organise and operate in Calderdale.

During spring 2020, the Calderdale ASD Steering Group held two virtual workshops to explore and build on the ideas and actions generated by Young People and other stakeholders at the Summit. The members of the Steering Group include young people, parent carer representatives, the voluntary and community sector, health, and local authority representatives.

The Steering Group developed a new Calderdale neuro developmental action plan, covering both ASD and Attention Deficit Hyperactivity Disorder (ADHD). The Plan takes a 'system' approach, covering the work of all partners. Actions are based on a 'needs-led' not 'diagnosis-based' approach and focus on shifting resources to provide early information, advice, support and interventions. The Plan is aligned to the 'Thrive' model of emotional wellbeing and mental health care for children and young people, which has been adopted in Calderdale.

In October 2020, NHS Calderdale CCG Governing Body members were delighted to have a full and frank conversation with the Young People who designed the 'Find Your Brave' Summit. They reminded the Governing Body of their expectations and urged them and other partners to maintain the momentum on delivering the Calderdale autism agenda.

Medicines Management

Antibiotic prescribing
Calderdale has been improving (steadily decreasing) on antibiotic prescribing over the last few years.

In 2020, the medicines optimisation team and communications team worked together to launch a local public facing campaign 'Let's Get a Grip on Antibiotics' with the aim of achieving a bigger impact on reducing antibiotic prescribing. The pandemic meant that the campaign had to be suspended.

However, despite this and the pressures from COVID-19 resulting in restricted access to face to face appointments in primary care, it is pleasing to note that antibiotic prescribing has continued to fall across West Yorkshire and has dropped at a higher rate in Calderdale than elsewhere in West Yorkshire.

For the first time in many years we are no longer in the worst prescribing quartile for total antibiotic prescriptions. 20 out of 21 practices in Calderdale CCG are now prescribing at or below the England target and so the CCG has achieved and exceeded the prescribing target set nationally.

However, it must be noted that Calderdale remains significantly above the England average for prescribing of antibiotics so there is still work to do.

Reducing the use of rescue medication in asthmatic patients
The NHS England Long Term Plan set out an ambition to reduce the use of rescue medication in asthmatic patients. The overuse of short-acting B2 agonist (SABA) inhalers and under-use of preventer medication were highlighted in a UK study as

key contributors to people experiencing an increased risk of exacerbations, asthma-related primary care consultations and asthma-related hospital outpatient consultations.

Prescribing data showed that approximately 30% of asthmatic patients in Calderdale were receiving 6 or more SABA inhalers in 12 months, which is significantly above the England average of 19%. The medicines optimisation team produced guidance to review SABA prescribing and resources to support practices in identifying patients overusing rescue medication.

Prescribing Audits
The practice pharmacy team carry out quality, safety and antibiotic audits every quarter in each GP practice. In 2020/21, these included acute sinusitis, COPD exacerbations and high dose opioids in chronic pain. The results from these audits are shared with individual practices and a CCG summary is discussed at the Medicines Advisory Group with key messages/learning shared with practices where appropriate.

Medicines action plan
The practice pharmacy team returned to their commissioned work in July 2020 and delivered a revised medicines action plan for the year, which supported the CCG's financial position through implementing cost effective prescribing measures.

Integrating services

Calderdale Cares
Calderdale Cares is a place-based approach to the delivery of health and social care, involving of a range of local organisations. It involves a shared vision of a sustainable health and care system for the people of Calderdale that delivers improved health outcomes, reduced health inequalities, greater independence and a lower need for hospital based care.

The approach is in line with the Department of Health and Social Care White Paper 'Integration and Innovation: Working together to improve health and social care for all'. The CCG is working with its partners to understand what work will be done at a West Yorkshire and Harrogate level, at a Calderdale level and at a locality level.

Calderdale Collaborative Community Partnership (previously Care Closer to Home)

The Calderdale Collaborative Community Partnership (CCCP) programme aims to give people in Calderdale access to the care they need in their localities, whether this be at home or in the community.

Since the development of the community prospectus in 2019, commissioners and providers have joined forces to deliver an integrated community and social care model which addresses the different health needs of each of Calderdale's five PCN populations by:

- Using population health data such as demographic, lifestyle, utilisation of health services to identify needs
- Promoting prevention and self-care
- Providing proactive holistic patient-centred care
- Reducing levels of unplanned care
- Enabling community providers to work more flexibly to meet the needs of individuals

In April 2020 a 'learn and reframe' process was established to move forward the collaborative community model for Calderdale as part of our COVID-19 Recovery plans. This reframe was based on:

- Our long-standing strategic ambition to integrate and improve our community health and care model
- The emergence of PCNs as a valuable part of that model
- The learning from the COVID-19 pandemic around:
  - potential for significant change at pace, with new service models and technology coming into play
  - increased appetite for risk

  - high levels of motivation
  - huge changes in the patterns of service utilisation and technology that demonstrate the potential for a sustainable change in out of hospital care
  - previous barriers around data being managed to enable the proactive support of vulnerable patients
- Plans for integration between partners increasing, pushing the integration of commissioning and provision and building on work done to develop an alliance of providers through Care Closer to Home

A clear set of collaborative principles has been developed across all partners, these are:

1. Person Centred
2. Place Based Integration, Investment and Provision
3. Channel Shift
4. Sustainable Place Based Workforce
5. Place Based Digital Maturity
6. Right Care, Right Time, Right Place

Five work streams have been developed:

- Enhanced Health in Care Homes
- Mental Health
- Rapid Response
- Digital Maturity / Population Health Management
- Workforce

Population Health Management is the driver and personalised care is the golden thread through all work streams.

The workstreams report into the Programme Board bi-monthly on progress against the goals and ambitions set out in their work plans, using Key Performance Indicators and more detailed information. The Board also provides a mechanism for the escalation of issues or barriers experienced that limit partnership ways of working.

Reconfiguring services

Right Time, Right Care, Right Place

The Strategic Outline Case for capital expenditure of £196.5 million to support implementation of the plans to reconfigure hospital services was submitted by Calderdale and Huddersfield NHS Foundation Trust (CHFT) to NHS England and NHS Improvement in April 2019 and approved in November 2019. The public and colleague involvement work to develop the 'Design Brief' that describes the principles which inform and support the development of detailed design and construction schemes at both Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) was concluded prior to the COVID-19 pandemic and is available on the CHFT website at CHFT Transformation Updates

Local people, key stakeholders and the Joint Health Scrutiny Committee continue to be fully involved in the next steps to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield. Since the development of the design brief the COVID-19 pandemic has necessitated many service changes forced by critical need and implemented at pace across the health and social care system. The findings from the pandemic will build on the design brief previously developed to incorporate opportunities for improvement and accelerated transformation in some areas. This will also ensure that further design elements that take account of best practice in building design regarding infection control and prevention are included.

The continued work to progress the design plans at CRH and HRI will be incorporated into an updated Design Brief for each site. The updated Design Briefs will include drawings and visualisations of the proposed builds and narrative that addresses key issues related to wider impact on factors such as: conservation, ecology, heritage, social value of the development, air quality, and sustainability. The Design Briefs are key documents to support the submission of the planning applications to Calderdale Council and Kirklees Council.

In March 2021, ahead of the submission of the formal planning applications to the Councils, CHFT commenced involvement of key stakeholders and local residents to explain the design and building plans and provide opportunity for comment.

The detailed design and appearance of the proposals at CRH and HRI has not yet been confirmed. Public input will be considered alongside other partners/stakeholders and statutory consultees and will be used to inform the design development discussions at this stage of the process and will also play a key part in the detailed design development at future stages. Feedback on the design of the proposals will be used to inform the final designs in a 'Design and Access Statement', which will be submitted with the planning applications. The planned date for submission of planning applications to Calderdale and Kirklees Councils is May 2021.

The timescale for the development and submission of future business cases has been adjusted to take account of the fact that the estate at HRI carries a high risk in relation to the condition and reliability of the existing buildings. It has therefore been agreed with NHSE and DHSC that to enable the commencement of estate improvement work as early as possible a Full Business Case for the investment at HRI will be developed and submitted for approval by NHSE and DHSC in 2021. For the investment at CRH an Outline Business Case will be developed and submitted in 2021 and, subject to NHSE and DHSC approval, a subsequent Full Business Case will be developed for approval by 2023.

Working with partners across West Yorkshire and Harrogate

West Yorkshire and Harrogate Health and Care Partnership (HCP) is made up of a wide range of organisations from health, Local Authorities, voluntary and the community sector. The partnership works closely together to plan services and address the challenges that face the health and care sector in the area. The CCG is fully involved in the Partnership's work.

Projects

Some examples of the projects we have worked on during 2020/21 are shown below.

Great Minds Collaborative Project

This is part of the Partnership's broader suicide prevention work. It is aimed at men, helping them to work through various mental health issues that challenge their equilibrium. It is being delivered in partnership with State of Mind Sport. The project is also working on this with a variety of clubs across West Yorkshire and Harrogate including super-league and community clubs.

Staff suicide prevention initiative

This is aimed at more than 100,000 health, care and voluntary and community services working in organisations large and small across the area and includes the development and maintenance of a mental health wellbeing hub for all staff working in health and care services. The hub provides a range of services, from intensive, individual treatment to resources that can support people to help themselves cope with feelings of bereavement, burnout, stress and trauma.

Health and Care Champions Project

This project has trained a group of more than 40 people with learning disabilities to act as a forum that advises the Partnership on how services can better relate to and address the needs of people with learning disabilities.

New purpose built mental health unit for young people in Leeds

The Partnership is building a new unit in the grounds of St Mary's Hospital in Leeds. The unit will have 22 bedrooms, a range of therapy and activity spaces, educational facilities and welcome areas in which families can visit, including a number of safe, outdoor spaces.

'West Yorkshire Positive Vibes' campaign

This campaign was created to help people to concentrate on the positives by looking at actions and activities we can all do, however small, to improve our physical and mental health and wellbeing in the current climate, whilst also recognising that many

people are struggling at the moment. The campaign focuses on four areas – exercising, having some ‘me’ time, keeping in touch and connecting with the outdoors.

Reducing the carbon footprint from inhaler use

The Partnership has been spearheading a campaign to reduce the carbon footprint from inhaler use. Inhalers are a major priority on the climate change agenda as they represent 3 % of the health and care carbon footprint. Specifically, Metered Dose Inhalers (MDI) have a much higher carbon equivalent than Dry Powder Inhalers (DPI). There are national NHS targets for decarbonisation and also the legally binding target of 2050 in the Climate Change Act. Our medicines optimisation team has written guidance and shared with our practices to promote the change.

Production of resources

The Partnership has produced a range of resources for its organisations including:

- ‘Think Delirium’ - a range of materials including e-learning, films, posters, etc. to alert professionals to the signs of delirium, a common but under-diagnosed condition
- Films in community languages delivered by clinicians to raise awareness among pregnant women from ethnic minority communities about risk factors, signs and symptoms of COVID-19 and how to protect themselves
- DadPad, an information pack in digital form developed by dads to help fathers of all ages prepare for family life at a time when access to parent education classes and midwife appointments has been curtailed due to COVID-19. Its aim is to provide new fathers with guidance on how to develop the mindset, confidence and practical skills needed to meet their babies’ physical and emotional needs
- A phone app for young carers, co-produced with young carers, which provides a one-stop shop for young carers with advice and information on relationships, education, health and more. The app includes a facility for virtual anonymous support, which was identified as being of key importance

- A film and resource pack designed for patients, carers and families and professionals to help them to have conversations about their future wishes and record them in some form of an advance care plan
- 'My Pregnancy Journal' – a digital tool to help women make choices about their care in pregnancy, in labour and following the birth of their baby

Production of Reports

The Partnership has produced reports on a number of subjects, including tackling inequalities for ethnic minority communities, housing for health and best practice around health of women before, during and after pregnancy. These can be accessed at West Yorkshire and Harrogate Health and Care Partnership publications

Recognition of previous work undertaken

Previous work undertaken by the Partnership was acknowledged through awards won by the Healthy Hearts Improvement Project and the 'Looking After our Neighbours' campaign (both described in the CCG's annual report last year) and the Partnership's ambition to increase leadership diversity. The Partnership's work on developing a working carer's passport was also highly commended.

Managing finances effectively

Overview

During 2020/21 the normal financial planning cycle was changed significantly due to the impact of COVID-19. The original financial planning cycle for the year was suspended and extraordinary measures were put in place and the CCG allocations for the year 2020/21 were rebased, based on 2019/20 out-turn with a number of specific adjustments to both budgets and activity.

The normal contracting regime for NHS contracts was changed significantly meaning that CCGs now had block contracts with the main NHS providers and that NHS non contracted billing between NHS providers and commissioners was suspended. In addition, contracting responsibility for independent sector acute capacity was moved onto a national contract and was no longer the responsibility of CCGs.

NHS England established mechanisms for CCGs to be able to claim additional resources to cover any COVID-19 related expenditure during the year.

As a result of these extraordinary changes to the NHS finance regime the CCG's budgets and expenditure profile was significantly different to the pre COVID financial plan.

A summary of the CCG allocations and expenditure is shown in the table below:

Description	**Allocation £'000**	**Expenditure £'000**	**Variance £'000**
Accumulated surplus brought forward	-5,569	0	-5,569
Programme allocation	-302,460	306,100	3,640
Primary medical services allocation	-32,277	33,067	790
Running cost allocation	-4,029	4,294	265
Additional Covid related allocations	-4,742	0	-4,742
Total allocation	-349,077	343,461	-5,616
Change in accumulated surplus	0	0	-47

Under this regime the CCG was required to deliver a balanced financial plan and deliver the statutory financial duties and targets against which the CCGs performance is monitored. Although the CCG has experienced significant challenges, we are pleased to be able to report that the CCG has met all its statutory financial duties.

The table below shows a summary of the CCG's performance against these duties in 2020/21.

Financial duty	**Achieved/Not Achieved**	**Performance in 2020/21**
Achieve operational financial balance	Achieved	Delivered and increase in year surplus of £47k
Revenue administration resource use does not exceed the amount	Achieved	The CCG had a notified running cost allocation of

Financial duty	Achieved/Not Achieved	Performance in 2020/21
specified in Directions		£4,295k with expenditure of £4,294k
Maintain capital expenditure within Capital	Achieved	No capital expenditure this financial year
Manage cash within the CCG's Cash Limit	Achieved	Cash balance of £105k
Public Sector Payment Policy – payment of 95% of invoices within 3 days of the invoice date or goods received if this is later (non-statutory duty	Achieved	97.8%

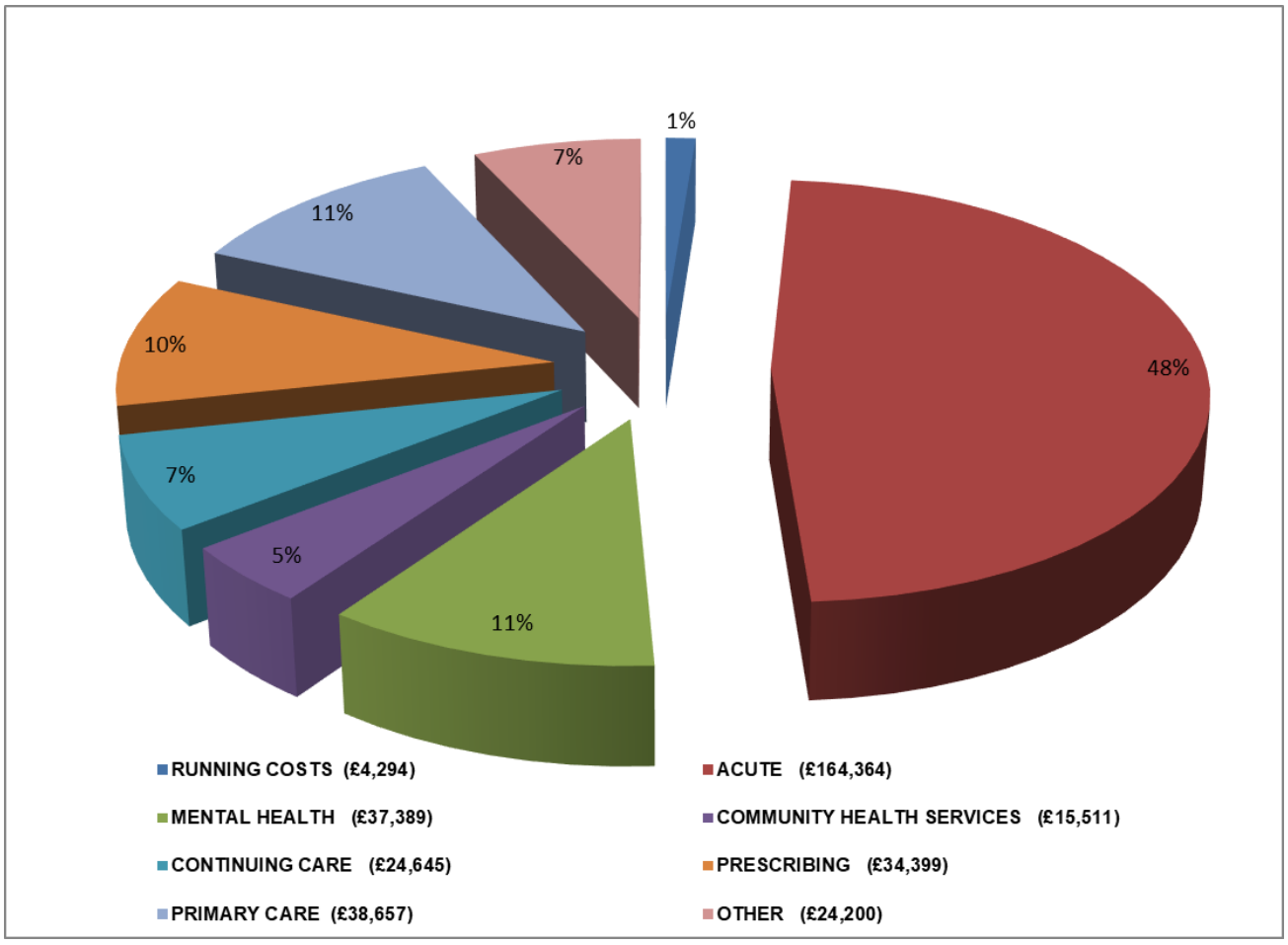
The CCG started the year with an accumulated surplus of £5.569m and had in year allocations of £338.766m including £4.742m of COVID related allocations, giving total allocations of £349.077m. In year expenditure was £343.461m, giving an accumulated surplus of £5.616m which is an in-year increase of £0.047m.

During 2020/21 we invested over £343.5m to improve the health and care of local people through the commissioning of high-quality services. The CCG was able to invest in specific priority areas which included:

- Investments into Primary Medical Services to support the delivery of the GP Forward View
- Delivery of the Mental Health Investment Standard and investments to support the delivery of the Five Year Forward View for Mental Health
- Investing £4.7m on specific COVID related expenditure

The actual expenditure in the different sectors as well as the proportion of spend against the CCG's management cost allowance is set out in the diagram below:

Actual expenditure by the CCG in 2020/21 (£'000)



Financial planning guidance has been issued for the period April to September 2021. At the time of writing this report the financial plan is draft and forms part of the overall West Yorkshire & Harrogate Integrated Care System plan.

The draft financial plan for that six-month period was considered by the CCGs Governing Body in its meeting in April 2021 and approved.

There is expected to be further planning guidance issued for the period October 2021 to March 2022.

Accountability Report

ROBIN TUDDENHAM

Accountable Officer

14 June 2021

Corporate Governance Report

Members' report

Member profiles

The CCG is a membership organisation. It consists of the 21 GP practices that are based in Calderdale. The practices have formed themselves into five groups known as Primary Care Networks (PCNs).

Calderdale Primary Care Networks

Primary Care Network	Practices	Clinical Director	Number of patients
Calder & Ryburn	Bankfield Surgery, Brig Royd Surgery, Stainland Road Medical Centre and Station Road Surgery	Dr F Azam	42,700
Central Halifax	Boulevard Medical Practice, King Cross Practice, Rosegarth Practice and Spring Hall Group Practice	Dr N Akhtar	53,900
Lower Valley	Church Lane Surgery, Longroyde Surgery, Northolme Practice, Rastrick Health Centre and Rydings Hall Surgery	Dr A Ross	44,700
North Halifax	Beechwood Medical Centre, Caritas Group Practice, Keighley Road Surgery, Lister Lane Surgery and Plane Trees Group Practice	Dr G Chandrasekaran	45,800
Upper Valley	Calder Community Practice, Hebden Bridge Group Practice and Todmorden Group Practice	Dr N Taylor	35,100

Since the CCG's establishment, strong clinical engagement of the member practices has been enabled through Practice Commissioning Leads meetings, locality meetings, the Medicines Advisory Group and the Practice Managers Action Group.

This year, to respond to the challenges presented by the pandemic, the Practice Commissioning Leads meetings were paused, and regular virtual meetings with the Local Medical Committee Executive and the Clinical Directors of the Primary Care Networks were established. The Practice Managers Action Group increased the frequency of its virtual meetings and the Medicines Advisory Group continued to meet virtually.

More about the work of the practices and PCNs during the year can be found on pages 17 to 18.

CCG Chair and Accountable Officer

Dr Steven Cleasby is the CCG's Chair. The CCG's Accountable Officer at the beginning of 2020/21 was Dr Matt Walsh. Dr Walsh left the CCG on 15th April 2020, and Neil Smurthwaite covered the role on an interim basis until 16th October 2020, when Robin Tuddenham was confirmed as Accountable Officer.

The Governing Body and its Committees

The CCG's membership has delegated authority to the Governing Body to oversee the work of the organisation and make decisions on its behalf as set out in the Scheme of Reservation and Delegation incorporated in the CCG's Constitution. The composition of the Governing Body as set out in the CCG's Constitution can be found below.

Composition of the Governing Body 2020/21 and up to the signing of the Annual Reports and Accounts on 14 June 2021

Membership type	Name	Role
GP as elected by the member practices	Dr Steven Cleasby	Clinical Chair
GP as elected by the member practices	Dr Caroline Taylor	Clinical Vice Chair
GP as elected by the member practices	Dr James Gray	
GP as elected by the Member practices	Dr Farrukh Javid	
Lay member	Professor Peter Roberts	Lay Member (Audit) / Conflict of Interest Guardian and Freedom to Speak Up Guardian
Lay member	John Mallalieu	Deputy Chair/Lay Member (Finance and Performance)/ Chair of Commissioning Primary Medical Services Committee
Lay member	Alison Macdonald	Lay Member (Patient and Public Involvement)
Lay Advisor to the Governing Body	Denise Cheng-Carter	
Secondary Care Specialist	Dr Robert Atkinson	Secondary Care Specialist
Registered Nurse	Professor Rob McSherry	Registered Nurse
Accountable Officer	Dr Matt Walsh Robin Tuddenham	(Until 15th April 2020) (From 16th October 2020)
Interim Accountable Officer	Neil Smurthwaite	(From 16th April to 15th October 2020)

Membership type	Name	Role
Chief Finance Officer/ Deputy Chief Officer	Neil Smurthwaite	(From 16th April to 15th October 2020)
Chief Operating Officer	Neil Smurthwaite	(From 16th October 2020)
Interim Chief Finance Officer	Lesley Stokey	(From 16th April 2020 to 15th October 2020)
Director of Finance	Lesley Stokey	(From 16th October 2020)
Chief Quality and Nursing Officer	Penny Woodhead	

Invitations to assist the Governing Body

Role	Name	Job title
Director of Adult Services or another Director that holds a health and social care portfolio (Calderdale Council)	Iain Baines	Director of Adult Services
Director of Public Health (Calderdale Council)	Debra Harkins	Director of Public Health

Committees, including Audit Committee

Details of the Governing Body and Committee membership (including the composition of the Audit Committee), terms of reference and attendance during the reporting year can be found in the Governance Statement and in the Remuneration and Staff Report (Remuneration and Nomination Committee).

Register of interests

CCGs are required to make arrangements to manage actual or potential conflicts of interest so that decisions by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest. The CCG

has a number of systems and processes in place to manage conflicts of interests. These are set out in the CCG's Constitution, our Policy on the Management of Conflicts of Interest and our Standards of Business Conduct.

The registers of interest for our Governing Body and Committees, Associates and Subject Specialists, Senior Management Team and CCG members can be found on our website.

Further information on the internal audit of our arrangements for the management of conflicts of interest is contained within the Governance Statement.

Personal data-related incidents

During 2020/21, there was one personal data-related incident that met the required threshold for notification to the Information Commissioner's Office. Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject).

Date of Incident	Nature of Incident	Number of patients affected	How the patients were informed	Lessons learned
19 March 2021	Disclosure of personal information to a third party. This information was pasted into an e-mail and sent to a third party in error.	One member of the public (not a patient)	Our member of staff realised the error immediately so tried to recall it. However, unfortunately this was not successful. Our colleague then quickly made contact by e-mail (telephone was not an option for the recipient in this incident)	Details of this specific breach (suitably redacted) will be used as training to help staff understand the impact of not taking appropriate measures to ensure the security of the personal information they process and store

In compiling this report, we have considered breach incidents for data for which we were the data controller, as defined by the General Data Protection Regulation and the Data Protection Act (2018).

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Calderdale CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Home Office research in 2018 revealed the devastating impact of modern slavery. The data estimates that the economic and social costs to the UK are up to £4.3 billion each year. Each instance of the crime is estimated to cost around £330,000, including the cost of support, lost earnings and law enforcement but most significantly the physical and emotional harms suffered by individuals, who are often exploited over months and sometimes years. This places each modern slavery crime as second only to homicide in terms of harm to its victims and society.

The main focus for health partners is to continue to improve the skills and knowledge of all frontline health professionals who have face to face contact with victims. A new focus may also be on the development of a Modern Slavery statement in relation to

the supply chains of a public body if this is made a legal process in 2021 for all public bodies with a budget of over £36 million.

The CCG's safeguarding team plays an integral leadership role on Modern Slavery across the health community. It ensures that providers are highly trained and responsive in order to appropriately identify potential victims of modern slavery and ensure that the right support is offered at the right time. The Quality, Finance and Performance Committee has oversight of this work and it is included in the CCG's Safeguarding Annual Report.

Statement of Accounting/Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Accountable Officer of NHS Calderdale CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Calderdale CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

ROBIN TUDDENHAM
Accountable Officer
14 June 2021

Governance statement

NHS Calderdale CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2021, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out

under the National Health Service Act 2006 (as amended) and in the Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the Group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The Governance Framework for the CCG is set out in our Constitution. It covers:

- Statutory duties and responsibilities of the CCG
- Details of how we are configured, our governance structure and decision-making processes
- The roles and responsibilities of the Governing Body and committees
- The vision and values of the organisation, and adherence to the Nolan principles on Standards in Public Life and the NHS Constitution

The provisions of the CCG's Constitution are supported by our Standing Financial Instructions and Standing Orders as well as a suite of policies and procedures.

Responsibilities of the CCG membership body

The CCG is a membership body which consists of the 21 general practices in Calderdale. The member practices are responsible for agreeing the vision and values and overall strategic direction of the CCG. A number of decisions are reserved to the membership and these are set out in the Calderdale CCG Scheme of Reservation and Delegation.

These include approval of:

- Applications to NHS England on any matter concerning changes to the CCG's Constitution;
- The overarching Scheme of Reservation and Delegation;
- The arrangements for appointing GPs or Nurse Practitioners to represent the membership on the Governing Body; and for the recruitment, appointment and removal of non-practice representatives;
- The establishment of committees of the CCG, delegating to them the exercise of any CCG functions as appropriate.

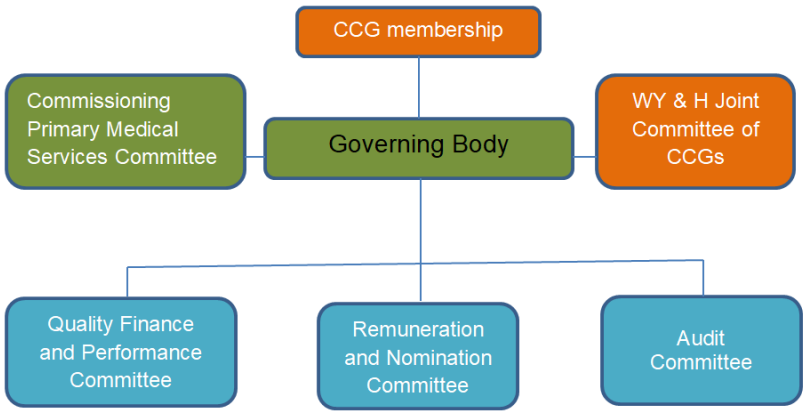
Further detail on the key responsibilities, membership, attendance and highlights of the membership's work over the year is contained within the Members' Report on pages 82 to 90, Appendix 1 (pages 111 to 156) and page 136.

The CCG's Scheme of Reservation and Delegation sets out those decisions that are delegated by the membership to the Governing Body and its committees. These include approval of:

- The arrangements for discharging the CCG's statutory duties associated with its commissioning functions;
- The CCG's commissioning plan following engagement with member practices;
- The CCG's operating structure, corporate budgets and risk management arrangements;
- The arrangements for co-ordinating the commissioning of services with other CCGs and/ or with the Calderdale Council, where appropriate;
- Arrangements for any risk sharing or pooled budgets;
- Process for the appointment of the CCG's external auditors.

The diagram below shows how the different governance elements relate to each other.

Governance Structure of the CCG



The membership of the Governing Body and its committees and sub-committees, together with the attendance records is set out in Appendix 1 at the end of the Governance Statement (pages 111 to 115). Attendance at the Remuneration and Nomination Committee is set out in the Remuneration and Staff Report on page 136.

Work of the Governing Body

The role and responsibility of the Governing Body is to ensure that the CCG has appropriate arrangements in place so that it can exercise its functions effectively, efficiently and economically and with openness, transparency and candour. In practical terms this means that the role of the Governing Body is to formulate and hold the organisation to account for the delivery of its strategy, to provide leadership in terms of shaping a healthy culture across the CCG and to seek assurance that our systems of internal control are robust and reliable.

Governing Body key activities in 2020/21

The Governing Body is actively involved in the formulation of the CCG's strategic priorities and ensuring their delivery. Supported by the management team, this activity is taken forward by the Governing Body's clinical leads, through our Clinical Development Forum and the Governing Body Development workshops and through the business of our formal Governing Body meetings held in public.

Key areas of activity this year have been:

- Working with partners and the local population to respond to the challenges of the COVID-19 pandemic
- Assuring themselves of robustness of the CCG's response and its participation in the local, regional and national efforts to tackle the pandemic.
- Continuing to work with the Health and Wellbeing Board and its partners:
  - On the delivery of the Single Plan for Calderdale through the mechanism of Calderdale Cares;
  - On the delivery of the Wellbeing Strategy for Calderdale which will support the delivery of Calderdale Cares and Vision 2024.
- Developing primary and community care
- Working with Calderdale Council and the CCG membership to support the delivery of Active Calderdale and the ambition that everyone in Calderdale is able to live a larger life, for longer through physical activity
- Continuing to transform mental health services across Calderdale for children, young people, adults and older adults and for young people with autism
- Right Care, Right Time, Right Place – hospital service change
- The CCG's response to the Climate Emergency
- Oversight of Calderdale Collaborative Care Partnership and the support of Primary Care Networks
- Performance management and compliance with statutory and regulatory duties

Throughout the year the Governing Body and its committees have continued to maintain a strong focus on the CCG's performance and performance across the system. It has sought and received assurance in five key areas:

- Quality, Safety and Equalities
- Finance, Contracting and Recovery
- Performance
- Risk Management and Information Governance
- Workforce

The Governing Body has received the Annual Statement of Public and Patient Involvement, the Joint Safeguarding Annual Report and the Annual Report on our Emergency Preparedness, Resilience and Recovery (EPRR).

The Governing Body has also had a strong focus on partnership working with its member practices, across Calderdale and with the wider West Yorkshire and Harrogate Health Care Partnership.

Further information on the CCG's key activities during the year, including our partnership working can be found in the Performance Report on pages 9 to 69.

Governing Body Performance

Under the leadership and oversight of the Governing Body, the CCG has delivered its financial plan and has met all its statutory financial duties. Whilst there have continued to be real challenges in terms of performance on some of the NHS Constitution standards and national targets, the level of performance in the Calderdale system remains strong when benchmarked with others nationally.

The committees have demonstrated the right level of focus and grip, enabling them to provide the Governing Body and NHS England with the assurance needed on the quality of services being commissioned, the financial position, system-wide performance and compliance with statutory and regulatory duties.

The focus of the Quality, Finance and Performance Committee this year has been on the quality and financial aspects of the response of the CCG and partners to the COVID-19 pandemic. The Committee has continued with its usual business, receiving regular reports on quality and safety and finance and performance, as well as annual reports on joint safeguarding adults and children, complaints, children looked after and care leavers health, Learning Disabilities mortality reviews and the Public Sector Equality Duty.

The Commissioning Primary Medical Services Committee has made a number of important decisions about GP practice contracts/premises demonstrating a high level of scrutiny and commitment to ensure that patients are receiving good quality care and that mitigating actions are in place to support those affected including the vulnerable.

The Audit Committee has continued to provide important assurance to the Governing Body about the robust risk management arrangements and systems of internal control that are in place. This assurance is supported by the independent audit reports produced by Audit Yorkshire.

Finally, the Remuneration and Nomination Committee has considered and made recommendations to the Governing Body on remuneration and made good progress on discharging its responsibilities for Nominations matters under its wider remit.

There has been excellent attendance at meetings by Governing Body members, advisors and officers, providing the right level of scrutiny and discussion in the meetings.

Further detail on the performance and activities of the CCG can be found in the Performance Report on pages 9 to 69.

Governing Body and Committee effectiveness

The Governing Body has reviewed and considered its effectiveness during the year, considering its Governing Body's composition, culture and priorities.

The Governing Body committees carried out their annual self-assessment between January and March 2021. Compliance with committee terms of reference was reviewed as well as committee membership, culture and effectiveness. The results of these self-assessments were reviewed at a workshop in April 2021.

Work of the Governing Body committees

Quality Finance and Performance Committee (QFPC)

The role of the Quality, Finance and Performance Committee is to advise and support the Governing Body:

- on the assurance of the CCG's plans and programmes for financial and performance management including reporting
- in challenging, scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's Strategic and Operational Plans
- by providing assurance that effective quality arrangements underpin all services provided and commissioned on behalf of the CCG
- by providing assurance that regulatory requirements are met and patient safety is continually improved to deliver a better patient experience and safeguarding
- by providing direction to the development of systems and processes for managing quality, finance and performance governance

Work of the Quality, Finance and Performance Committee: Highlights

- Approved a service description for the Enhanced Health in Care Homes and a pathway for Long Covid
- Approved a Mental Capacity Act and Deprivation of Liberty Safeguards policy
- Agreed the focus of the CCG's Public Sector Equality Duty work in 2021/22
- Continued to seek and receive assurance in relation to the quality of services we commission, and financial and performance matters
- Provided advice and a steer on quality, finance and performance issues relating to the CCG's local response to COVID-19

Commissioning Primary Medical Services Committee

The Commissioning Primary Medical Services Committee (CPMSC) has responsibility for the management of the functions and powers delegated to the CCG by NHS England. The Committee makes decisions on the review, planning and procurement of primary medical care services in Calderdale. In order to support this, the Committee receives regular financial reports on the delegated and non-delegated budgets; as part of the primary care assurance report and tool, and on work supporting the delivery of the General Practice Forward View and the CCG's strategic intent for primary care. The Committee continues to make sound decisions whilst ensuring that conflicts of interest are managed appropriately.

Work of the Commissioning Personal Medical Services Committee: Highlights

- Approved arrangements for the investment of Primary Medical Services premium funding
- Use of the Primary Care Assurance Report (PCAR) to consider metrics at a Practice and Locality Level
- Agreed the suspension of face to face services at two branch surgeries, requiring mitigating actions to ensure that people who would normally use those surgeries are able to access care elsewhere.
- Approved a set of Golden Rules that all submissions for premises development proposals in Calderdale must meet before being considered for investment support.
- Agreed the establishment of a time-limited estates sub-group to move forward work relating to premises investments

Remuneration and Nomination Committee

The Remuneration and Nomination Committee has the following key functions:

- To advise the Governing Body on determinations about the appropriate remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it
- To advise the Governing Body on provisions for other benefits and allowances under any pension scheme established by the CCG
- To advise the Governing Body on any arrangements for termination of employment of the Chief Officer or the Chief Finance Officer/Deputy Chief Officer
- To review and approve Human Resources' Policies on behalf of the Governing Body in accordance with the CCG's scheme of reservation and delegation
- To ensure that the Governing Body and its committees have the appropriate balance of skills, experience, knowledge, perspectives and independence to enable them to discharge their respective duties and responsibilities effectively

Work of the Remuneration and Nomination Committee: Highlights

- Undertook the annual review of Non Agenda for Change pay awards for Very Senior Managers (VSMs), Governing Body and Associates, managing conflicts of interest appropriately and making recommendations to the Governing Body
- Made recommendations to the Governing Body concerning changes to the membership of the Quality, Finance and Performance Committee
- Made recommendations to the Governing Body concerning changes to the membership and quoracy of the Commissioning Primary Medical Services Committee
- Oversaw and made recommendations to the Governing Body on roles and remuneration for interim and permanent VSM posts

Audit Committee

The role of the Audit Committee is to provide the CCG's Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions directing the CCG in so far as they relate to finance. The Governing Body has approved and keeps under review the terms of reference of the Audit Committee.

In addition, the Governing Body has delegated scrutiny of the following functions to the Audit Committee – audit, governance, risk management and internal control and Emergency Preparedness and Business Continuity.

Work of the Audit Committee: Highlights

Sought and received assurance on:

- the progress towards achieving compliance with the Data Security and Protection Toolkit
- the systems of internal control in place, as part of the internal audit programme of work
- the Annual Report and Financial Statements 2019/20, approving these on behalf of the Governing Body

West Yorkshire and Harrogate (WY&H) Joint Committee of CCGs

The Committee has delegated authority from the West Yorkshire CCGs to take joint decisions on agreed priorities. The Committee also makes recommendations when a collaborative approach across WY&H will help to achieve better outcomes. The Committee has an independent lay chair, three CCG lay members and two representatives from each West Yorkshire CCG. North Yorkshire CCG is an associate member. As a result of COVID-19, all meetings were held virtually in 2020/21 and were live streamed.

The Committee has a Public and Patient Involvement Assurance Group made up of lay members from each CCG. The Group provides assurance that public and patient voice informs the Committee's decisions.

Information about the meetings of the Joint Committee can be found on the WY&H Health and Care Partnership website.

Work of the Joint Committee of CCGs: Highlights

- Supported a proposal to develop a new care model for people with complex learning disabilities
- Supported a national programme which built on the learning from COVID-19, which encouraged people to phone 111 as an alternative to attending an Emergency Department unheralded
- Agreed to extend the contract for primary medical services provided by Local Care Direct for another three years, taking into account the response to COVID-19, changes in national policy and potential changes to the commissioner landscape
- Supported changes to the Improving Planned Care programme which focused on restarting planned care following the first wave of COVID-19, including improving access to diagnostic testing services and more shared decision-making between primary and secondary care
- Approved an amendment to the policy for flash glucose monitors – small sensors worn on the skin for monitoring the glucose levels of people with diabetes. The amendment enables people with learning disabilities with Type 2 diabetes to have a monitor to promote independence and reduce health inequalities

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, as the UK Code is based on the underlying principles of good governance (accountability, transparency, probity and sustainability of the organisation over the longer term) the CCG has ongoing regard for the code and takes the principles relevant to the CCG into account when reviewing its systems, processes and governance arrangements.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Further information on how the CCG has fulfilled its statutory duties can be found in the Performance Report. This includes compliance with the duty to consult the Health and Wellbeing Board when reviewing the extent to which the CCG has contributed to the delivery of the joint Wellbeing Strategy.

Risk management arrangements and effectiveness

The CCG's Integrated Risk Management Framework (IRMF) describes its approach to managing risk.

The CCG manages and reports on risk in two ways:

- The Governing Body Assurance Framework (GBAF), which focusses on principal risks to the delivery of the CCG's strategic objectives. The GBAF is seen as a 'live' document but is formally reviewed and updated twice a year. More detail regarding the GBAF is provided in the Internal Control Framework section of this report on pages 101 to 102.
- The Corporate Risk Register focusses on operational risks that may rise and fall within relatively short time periods. The CCG now operates four risk review and reporting cycles per annum.

The process that we use to identify, evaluate and control risks is set out below.

Risk Identification

A risk can only be managed if it is identified. Bringing together information from different sources provides assurance that all significant risks have been captured. The key sources of information used by the CCG to check completeness of risk capture are:

- Performance indicators reporting variance from plan within commissioning performance contracts and related reports;
- The results of planned reviews of compliance with statutory and regulatory requirements e.g., Care Quality Commission (CQC) standards and reviews, Ofsted reviews, fire and health and safety regulations, information governance systems including the Data Security and Protection Toolkit;
- Routine review of serious incidents and complaints to identify emerging risks, themes or specific concerns;
- Use of intelligence through partners and stakeholders;
- Ensuring contact with regional and national professional associations that provide early warning of serious adverse events;
- Review of the West Yorkshire Community Risk Register;
- Risk review and discussion through operational meetings (Senior Management Team, project or programme management or contract management meetings), and the formal governance arrangements, i.e. Governing Body and its Committees, which highlight risks that need to be reflected in the Risk Register, assessing the mitigating/management actions and risk rating.

Risk assessment and risk rating

A 5x5 (Likelihood x Impact) matrix is used to arrive at the risk rating. The target score is identified by assessing the additional controls that can be put in place together with level at which the risk can be accepted (risk tolerance) - taking into account the CCG's risk appetite.

Risk rating matrix

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

Risk Recording, Reviewing and Monitoring

The CCG has an integrated approach to risk, supported by the on-line risk register. This system consists of an auditable review process and supports the monitoring and updating of risks within review deadlines.

Once every risk cycle, the Senior Management Team (SMT) reviews all the risks on the register, identifies any new risks and assesses the actions to manage/mitigate the risk and the risk rating. Any risks rated 15 or above are reported to SMT by exception only outside this quarterly review. The Quality, Finance and Performance Committee reviews the risks relating to its remit. Risks rated as 'Serious' i.e. at 15 or above are submitted to each of the Governing Body meetings. All Commissioning Primary Medical Services risks are reported into the CPMS Committee. A 'Critical Risk' report, with an associated action plan is produced for risks rated 20 or above.

Although a comprehensive review of risks by their respective risk owners and senior managers for risk cycle 1 of 2020/21 took place during late spring, the risk register was not presented at Committees or to the Governing Body at their meetings during this period. Due to COVID-19 the focus of these specific meetings evolved to primarily decision making rather than routine assurance or discussion items. This

was to ensure that CCG staff were able to focus on the COVID-19 response and supporting the NHS frontline.

Risk Appetite

The CCG's aim is to minimise the risk of harm wherever possible to service users, the public, staff, members and other stakeholders. However, the CCG also recognises the need to take considered risks in some areas (for example, transformation / re-design of services) and that an overly risk averse approach can be a threat to the achievement of some strategic objectives.

All risks on the CCG Risk Register specify the target risk rating (i.e. the level at which the risk can be tolerated). The acceptability of the target risk score is subject to review by the Senior Management Team and relevant Committee as part of the normal review and reporting process for the Risk Register. Our risk appetite informs our approach to decision making

Embedding risk management in the CCG's activity

Our risk management system is complemented by other control mechanisms which are designed to deliver assurance on the identification, mitigation and/or management of risks. These control systems include our systematic approach to completing impact assessments in equality, quality and data privacy as part of our service improvement processes and recovery plans.

The risk management of potential fraud, bribery and corruption, data security and conflicts of interest are all supported with appropriate policies, mandatory training, briefings as well as compliance audits. These systems are audited on an annual basis by our internal auditors (Audit Yorkshire), External Audit (Grant Thornton) and NHS Counter Fraud Authority.

All these mechanisms, together with the use of the intelligence provided by performance, quality and safety and primary care assurance dashboards as well as partner and stakeholder engagement put us in a stronger position to prevent/manage risks to the CCG.

Incident reporting

An indicator of good staff and patient safety management is the incident reporting culture. One of the key complementary systems is the CCG's incident reporting system.

The CCG uses the DATIX online reporting system and encourages all staff to report incidents or near misses in order to provide learning and enable the CCG to reduce the likelihood of the incident re-occurring. Feedback on the learning is provided to staff in an anonymised form through the CCG's communication channels including the monthly staff workshop where appropriate.

GP Practices are actively encouraged to report all incidents on DATIX. The more incidents that are reported the more information the CCG has to act upon in order to learn from incidents and consequently prevent recurrence.

Involving partners and other stakeholders

The CCG has close working relationships with a number of stakeholders and has a strategic risk management objective to develop risk management arrangements for key partnerships and for major programmes of work.

The CCG has adopted a programme management approach for all major transformation activities. Risk and issues logs are produced for all programmes and are reported to the relevant Programme Board and through to the corporate risk register as required.

Key partnerships for the CCG include a number of NHS providers, Pennine GP Alliance, Calderdale Council and the third sector, voluntary and community groups, patient and service user groups. In addition to having robust internal scrutiny arrangements, partnership organisations are required to contribute to relevant joint programme / project risk registers and frameworks.

The CCG endeavours to manage risk across organisational boundaries and involve partners in aspects of risk management as appropriate to support the delivery of system-wide objectives.

This is achieved by the following:

- Maintaining a corporate record of the key partnerships for the organisation.
- Prioritised implementation of programme / project risk registers for those areas categorised as high risk. The Risk Registers are reviewed through appropriate opinion and external governance frameworks.

Risks relating to the provision of commissioning support services are managed through contract management meetings.

The CCG has a robust and systematic approach to risk management. Leadership is provided by the Governing Body and Accountable Officer to ensure that the CCG has a positive and open approach to the identification and management of risk. The Integrated Risk Management Framework (IRMF) sets out the governance structures and responsibilities for risk management.

Effectiveness of Governance Structures

The Governing Body receives assurance on the effectiveness of the governance and risk management structures, systems and processes through its internal assurance processes.

The Governing Body is responsible for approving the Governing Body Assurance Framework (GBAF) and for receiving reports on 'serious' risks (i.e. those rated 15 or above) at each of its formal meetings as well as a separate report on 'Critical' risks (i.e. those risks rated 20 or above).

The Commissioning Primary Medical Services Committee receives reports on all its risks at each of its meetings in public and an update on all relevant risks on a quarterly basis.

Responsibilities of the Senior Management Team and Committees

The roles and responsibilities of staff as risk owners, and Senior Management Team as reviewers are clearly set out in the IRMF. This ensures that there is clarity about the levels of accountability for the management and monitoring of risks. The Senior Management Team ensures that there are robust control measures in place and that the appropriate assurances are generated. This risk review process includes an assessment as to whether the risk should be incorporated into the GBAF or the corporate risk register – depending upon the strategic or operational nature of the risk.

Reporting lines and accountabilities between the Governing Body, its Committees and the Senior Management Team

The Senior Management Team undertakes the first formal review of all risks at the beginning of each reporting cycle and identifies any new risks or changes to risk score as they arise.

This is followed by a review in the Quality, Finance and Performance Committee. The Committee has clear responsibility for the monitoring of existing risks and identification of further risks as set out in its terms of reference. The same approach is used for the GBAF, with senior managers and Governing Body leads reviewing the principal risks prior to review by this Committee and Governing Body.

The Audit Committee has the responsibility for providing assurance to the Governing Body on the effectiveness of the CCG's governance and risk management systems and processes.

It is supported in fulfilling its responsibilities by our internal audit providers (Audit Yorkshire) who report on the findings of the annual mandated audit of governance and risk management.

Timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's statutory obligations

The assessment of risks is a continuous process informed by:

- Senior Management Team identifying new risks or changes to risk profile;
- Financial, contracting, recovery, performance, quality and safety reports, which are submitted to the Quality, Finance and Performance Committee;
- Finance, contracting and primary care assurance reports submitted to each Commissioning Primary Medical Services Committee meeting in public.
- Scrutiny of the Risk Register and the Governing Body Assurance Framework at the Committees and Governing Body

Degree and rigour of oversight of CCG performance by the Governing Body

The Governing Body provides challenge and scrutiny of the suite of performance reports referred to above. These reports focus on the delivery of the key performance targets, quality and safety, financial and contractual requirements.

This level of oversight, which has been supported by the detailed work of the Committees, enables the Governing Body to maintain a clear grip on our performance, quality and financial targets.

Staff and Governing Body training

All risk owners, senior reviewers and Heads of Service are trained and equipped to manage risks in a way that is appropriate to their authority and duties. Bespoke training is provided to individuals and teams as required.

The Governing Body continues to assess its risk appetite in response to the ongoing shifts in our operating environment.

Learning from good practice

Our CCG is committed to the principles of creating a positive learning environment which is open and honest and which seeks to improve our systems and processes - keeping local people and staff safe. Whilst we work hard to put systems and

processes in place that prevent incidents, we recognise that on occasion things go wrong. When that happens, we want to learn from those incidents, improving the way that we do things.

We also seek to learn from good practice elsewhere. Valuable learning information is provided to staff and our member practices through a variety of systems and activities:

- Incident and post-incident reporting;
- Complaints received;
- Issues raised via Patient Advice and Liaison Services (PALS);
- Feedback from Independent Contractors and their associated bodies.

Risk Assessment

Risk assessments in relation to governance, risk management and internal control are carried out through a number of mechanisms including:

- Through internal governance arrangements taking account of self-assessment activity, the review of the CCG Constitution and standing financial instructions, new national guidance or regulations and the findings from external inquiries;
- Through the annual internal audit and anti-crime audit plans carried out by Audit Yorkshire. These include the annual mandated reviews of the CCG's risk management and governance arrangements as well as audits in specified areas as identified following a risk assessment of all areas of the CCG's activities;
- Audit Yorkshire also attends the Audit Committee and meets with the Audit Committee members twice a year to discuss any concerns without the officers being present;
- Through external audit activity carried out by Grant Thornton which includes attendance at the Audit Committee, meeting with Audit Committee members twice a year to discuss any concerns without the officers being present and focused pieces of external audit work as set out in the auditors annual work plan, culminating in the risk review undertaken prior to annual reporting and accounts.

The outputs and recommendations from each of these reviews are presented to the Audit Committee.

Major Risks to Governance, Risk Management and Internal Control

The risks classed as ‘serious’ ‘major’ or above on the Corporate Risk Register, (i.e. those with a score of 15 or above), that have been managed during the reporting year are summarised in Appendix 2 of this Governance Statement on pages 116 to 124.

Appendix 2 not only includes more serious risks where risk mitigation meant that they were able to be closed this year but also the three critical risks that are currently on the CCG’s risk register. It should be pointed out that none of these risks are unique to Calderdale and they also impact on other stakeholders. These risks have not always been categorised as critical and will regularly fluctuate in risk scoring.

The CCG continues to take a rigorous approach to the management of the risks across the system. The pressures on the system and progress being made in managing or reducing those pressures are discussed at the weekly Senior Management Team (SMT) meetings, the financial recovery meetings and work taken forward through the different teams within the organisation including primary care, service improvement, continuing healthcare, quality, finance, corporate and contracting/procurement.

The pressures, together with the actions being taken to address these whilst staying true to the values of the CCG in providing high quality, effective and safe care, are discussed on a regular basis with staff, the Governing Body and the member practices through the Practice Commissioning Leads’ meetings.

The Quality Finance and Performance Committee maintains a robust oversight on the relevant risks through regular finance, performance and contract, quality and safety, primary medical commissioning reports and the review of the risk register.

The CCG is also proactive in working with partners across the system to discuss and find effective solutions to the pressures. The mechanisms for these performance management discussions include the Accident and Emergency Delivery Board, The

Partnership Board, the System Recovery Group and Contract Management meetings.

Other sources of assurance

Internal Control Framework

The system of internal control is the set of processes and procedures in place that ensures that the CCG delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the potential impact, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Governing Body Assurance Framework (GBAF)

The GBAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the CCG. The GBAF deals with strategic and long-term risks / threats whereas the Risk Register is used to identify and manage performance based (operational) risks that may rise and fall within relatively short-term periods. A summary of the principal risks to the CCG's licence and delivery of its strategic objectives is set out in Appendix 3 to this governance statement on pages 125 to 129.

The GBAF makes reference to relevant operational risks if they relate to the ability of the organisation to deliver on one or more of its strategic objectives.

All risks on the GBAF have a named Senior Manager Lead, Governing Body Lead and responsible Committee. The GBAF also details:

- The key controls in place to manage the risk;
- Mechanisms to provide assurance on controls (i.e. specific evidence that controls are effective and the risk is being managed);

- Any actions being taken to address gaps or the need to strengthen controls or assurance.

The GBAF is considered by the relevant Governing Body Committees twice a year prior to submission to the Governing Body for approval. This enables a detailed review of the strategic objectives, to ensure that these sufficiently reflect, for example, the increasing focus of our work with partners on the Health and Wellbeing Board to deliver the Single Plan for Calderdale, work with the West Yorkshire and Harrogate Health and Care Partnership and system financial recovery. An online GBAF was developed and launched in August.

During the autumn of 2020 a full review of the GBAF was commenced with discussions at SMT and with Internal Audit including a review of the strategic objectives of the CCG. However as a consequence of the potential impact of the White Paper Integration and Innovation: Working together to improve health and care for all, the CCG has focused on reviewing key risks during the year.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

We have received an overall internal audit opinion of '**high assurance**' about the systems and processes in place to manage conflicts of interest.

Data Quality

The Data Quality Team is responsible for developing and improving quality, consistency and assurance in relation to primary care records and their management. It ensures the implementation of consistent approaches to data recording including the use of templates and structured data sets. The team supports the information requirements of clinicians and commissioners, supporting quality, consistency and assurance through summarising and SNOMED coding training.

Working with the three local CCGs (Calderdale, Kirklees and Wakefield) and their member practices the team also works closely with West Yorkshire Research and Development and the West Yorkshire and Harrogate Healthy Hearts Project developing GP reports, resources and data extracts for these projects. The team has provided specialist support to the West Yorkshire and Harrogate Health and Care Partnership in meeting the data requirements of the NHS Diabetes Prevention Programme.

As a shared service team across three CCGs, the team has also provided advice and support to the GP practices involved in mergers and system migrations.

Information Governance

The NHS Information Governance Framework sets out the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect personal and corporate information.

The final submission date for the 2019/20 DSPT was moved by NHS Digital from 31 March 2020 to 30 September 2020 to help ease the pressure on organisations responding to the COVID-19 pandemic. We are pleased to be able to report that the CCG has self-assessed as meeting all of the DSPT mandatory standards with an overall published grade of 'Standards met'. This position is supported by the independent audit (Audit Yorkshire) of the evidence submitted as part of our self-assessment.

NHS Digital has moved the final submission deadline for the 2020/21 assessment of the Data Security & Protection Toolkit from 31 March 2021 to 30 June 2021. We are working towards achievement of all mandatory assertions.

We have an information governance management framework in place and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have a robust annual Information Governance work programme and work to ensure that all staff and Governing Body members complete the Data Security Awareness training.

The information governance handbook is available to all staff so that they are aware of their information governance roles and responsibilities. All staff are required to complete Data Security Awareness training annually and this is monitored by the Senior Management Team and Audit Committee. As referred to earlier in this report, there are processes in place for incident reporting and investigation of serious incidents. We have information risk assessment and management processes in place to fully embed the information risk culture throughout the organisation against identified risks. Assurance is provided through the Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those involving personal data security) on a routine basis, together with any learning points.

Business Critical Models

In line with best practice recommendations of the 2013 Macpherson review into the Quality Assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

For functions that are carried out on behalf of the CCG by third parties, we receive assurance from the organisation or their auditors that appropriate systems and internal control are in operation. We receive services from the following organisations and details of assurances received for 2020/21 are provided below:

- NHS Shared Business Services (provision of financial and accounting services and primary care payments services) – service auditor's report: reasonable assurance with the exception of a qualified opinion in relation to one control objective set out in the report. This was in relation to raising of sales order credit request above allowed client limits. The CCG has internal audit of our financial systems and processes has provided us with a high level assurance and believe the identified control weakness does not pose a significant risk to the CCG.
- NHS Business Services Authority (prescription pricing services) – service auditors report: reasonable assurance with the exception of qualified opinion in relation to three control objectives set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified. This combined with the CCG's monthly management accounts processes and medicines management team review of prescription cost and activity gives assurance that we believe that the identified control weaknesses do not pose a significant risk to the CCG.
- Capita (payments to GP contractors) – service auditors report reasonable assurance with the exception of qualified opinion in relation to three control objectives set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified. This combined with the CCG's monthly management accounts processes and internal audit review of delegated primary care gives assurance that we believe that the identified control weaknesses do not pose a significant risk to the CCG.
- Electronic Staff Record (ESR) – service auditors report reasonable assurance with the exception of qualified opinion in relation to two control objectives set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified and we believe that the identified control weaknesses do not pose a significant risk to the CCG.
- Leeds Teaching Hospitals NHS Foundation Trust (provision of payroll services) – assurance on payroll services provided the CCG via contract management arrangements and internal audit testing.
- North East Commissioning Service (provision of human resources support services) – assurance provided via contract management arrangements.

Control Issues

During the year no significant internal control issues or gaps in control have been raised.

Review of economy, efficiency & effectiveness of the use of resources

The Director of Finance has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Governing Body receives regular reports from the Quality, Finance and Performance Committee regarding finance, contracting, performance and system recovery. In order to provide the necessary level of rigour and governance in support of the CCG's financial plan, an update is also submitted to the Quality, Finance and Performance Committee.

These processes, with the opinions available from the work of the CCG's internal and external auditors and the assurances from the Audit Committee, enable the Governing Body to make a determination on the economic, efficient and effective use of resources by the Clinical Commissioning Group.

Further information on our financial planning, in-year performance monitoring, central management costs and efficiency controls is included in the Performance Report.

We maintain efficiency controls through our recovery and resilience processes and through the role of the Quality Finance and Performance Committee.

Delegation of functions

The CCG has delegated some of its functions to the West Yorkshire and Harrogate Joint Committee of CCGs (part of the West Yorkshire and Harrogate Health and Care Partnership). The extent of the delegated authority and responsibilities are set out in the Memorandum of Understanding and Terms of Reference. The Chair and Accountable Officer represent Calderdale CCG on that committee.

The minutes and reports of key decisions taken by the committee and its annual report are received by the Governing Body for scrutiny and assurance. The CCG's Accountable Officer and Chair report back to the Governing Body on these at each public meeting. No issues of concern were identified from this feedback in-year.

Further information on the role of the Joint Committee and highlights of its work during 2020/21 can be found on pages 89 to 90.

Counter fraud arrangements

The CCG has a team of accredited Local Counter Fraud Specialists (LCFS) that are contracted to undertake counter fraud work proportionate to identified risks.

In January 2020 the NHS Counter Fraud Authority (NHSCFA) issued Standards for commissioners – fraud, bribery and corruption to LCFSs and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In May 2020, the LCFS produced an annual counter fraud plan aligned to the standards.

The CCG's Audit Committee reviews and approves the annual counter fraud plan identifying the actions to be undertaken to promote an anti-fraud culture, prevent and deter fraud, and investigate suspicions of fraud. The LCFS also produces an annual report and regular progress reports for the review and consideration of the Chief Finance Officer and the Audit Committee.

The Director of Finance for the CCG is proactively and demonstrably responsible for tackling fraud, bribery and corruption and the LCFS regularly attends the Audit Committee. The CCG has also appointed an officer at the CCG as a Counter Fraud Champion to assist and support the work of the LCFS.

The CCG's counter fraud arrangements are currently in compliance with NHSCFA's Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the appointment of the LCFSs, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Director of Finance

as the executive lead for counter fraud. However, it should be noted that these standards have subsequently been superseded by the Government Functional Standard GovS 013: Counter Fraud (Functional Standard), which was formally introduced in February 2021.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's Standards for commissioners: fraud, bribery and corruption, on behalf of the CCG. This assessment is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA. The 2019/20 assessment for Calderdale CCG was completed and submitted in May 2020 with an overall assessment of green.

In January 2021 the NHS Counter Fraud Authority published the new NHS Requirements which replaced the Standards for Commissioners. The self-assessment for 2020/21 was completed with reference to the new requirements with an overall assessment of amber. The draft submission was presented to the Audit Committee on the 20th May 2021 and is also summarised within the Annual Counter Fraud Report 2020/21.

Head of Internal Audit Opinion

The overall opinion for the period 1st April 2020 to 31st March 2021 provides Significant Assurance, that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

During the year Internal Audit issued the following audit reports:

Audit Area	Assurance Level
Governance and Risk Management Arrangements	High
Financial Systems and Management	Significant
Conflicts of Interest	High
Data Security and Protection Toolkit	High
Primary Care Co-Commissioning Framework	Significant
CHC BroadCare review – CIA Stage 2	Significant

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed. I have been advised on the implications of the results of this review by:

- The Governing Body which keeps under review the systems of internal control through reports on risk management and the review of the Governing Body Assurance Framework (GBAF). It also receives performance, contracting, finance, quality and safety reports at each of its meetings in public. The GBAF is formally reviewed by the Governing Body twice a year. The GBAF provides me with evidence that the effectiveness of controls that manage principal risks to the CCG achieving its strategic objectives have been reviewed.

- The Audit Committee which has oversight of the CCG's financial systems, financial information, risk management and systems of internal control, audit, information governance and business continuity. It is supported in its role by independent audit reports produced by Audit Yorkshire and regular meetings with the internal and external auditors.

- The Quality, Finance & Performance and Commissioning Primary Medical Services Committees, which are responsible for keeping under review the governance arrangements relating to their remit. This includes review of all relevant operational risks and review of the principal risks as set out in the GBAF.

- The external and internal auditors provide independent assurance through the delivery of their annual work plans, as well as recommendations for further development of the system of internal control.

- Self-assessment of the risk management system and Committee governance arrangements is undertaken on an annual basis. An external review of different aspects of our governance arrangements is commissioned every three years.

- Third Party Assurance. Together with the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as NHS Shared Business Services, Primary Care Support England (Primary Medical Services Payments), and Leeds Teaching NHS Foundation Trust (provider of payroll services). Further details can be found on pages 104 to 105.

It is my conclusion, based on the information submitted and my belief about the effectiveness of the systems and processes within the CCG that no significant control issues have been experienced during the year.

ROBIN TUDDENHAM
Accountable Officer
14 June 2021

Governance Statement – Appendix 1: CCG Governing Body and Committee Membership and Attendance

The table below provides the composition of the Governing Body and its committees throughout the financial year and up to the signing of the Annual Report and Accounts on 14 June 2021 and attendance for the 2020/21 financial year.

Name	Role	Attendance
Dr Steven Cleasby	CCG Chair and GP Member	4/4
Dr Majid Azeb	CCG Clinical Vice Chair (until 24th April 2020) and GP Member	0/0
Dr Caroline Taylor	CCG Clinical Vice Chair (from 24th April 2020) and GP Member	2/2
John Mallalieu	Deputy Chair / Lay Member (Finance and Performance) / Chair of Primary Medical Services Committee	4/4
Robin Tuddenham	Accountable Officer (from 16th October 2020)	2/2
Neil Smurthwaite	Chief Finance Officer / Deputy Chief Officer (Interim Accountable Officer between 16th April and 15th October 2020) Chief Operating Officer (from 16th October 2020)	4/4
Dr Matt Walsh	Chief Officer / Accountable Officer (until 15th April 2020)	0/0
Lesley Stokey	Interim Chief Finance Officer (between 16th April and 15th October 2020) Director of Finance (from 16th October 2020)	1/1
Penny Woodhead	Chief Quality and Nursing Officer	4/4
Prof. Peter Roberts	Lay Member (Audit)	4/4
Dr Rob Atkinson	Secondary Care Specialist	3/3
Dr James Gray	GP Member	2/2
Dr Farrukh Javid	GP Member	2/2
Alison Macdonald	Lay Member (Patient and Public Involvement)	4/4

Name	Role	Attendance
Prof. Rob McSherry	Registered Nurse	3/4

Note: Drs Cleasby and Azeb were not required to attend the meeting in April due to a conflict of interest. For them, this meeting has been excluded from the attendance column.
Note: Drs Gray and Javid were not required to attend the meetings in April and July 2020 due to the suspension of standing orders so as to prioritise frontline response to COVID 19. For them this meeting has been excluded from the attendance column.
Note: Dr Atkinson was not required to attend the meeting in April 2020 due to the suspension of standing orders so as to prioritise frontline response to COVID 19. For him, this meeting has been excluded from the attendance column.

Advisors to the Governing Body and attendance

Name	Role	Attendance
Denise Cheng-Carter	Lay Advisor	4/4
Debra Harkins	Director of Public Health (Calderdale Council)	1/4
Iain Baines	Director of Adult Services (Calderdale Council)	3/4

Quality, Finance and Performance Committee

Name	Role	Attendance
Dr Farrukh Javid	Committee Chair and GP Member	3/4
John Mallalieu	Deputy Committee Chair / Lay Member (Finance and Performance)	4/4
Neil Smurthwaite	Chief Financial Officer / Deputy Chief Officer (until 15th October 2020) Chief Operating Officer (from 16th October 2020)	4/4
Penny Woodhead	Chief Quality and Nursing Officer	4/4

Name	Role	Attendance
Dr Caroline Taylor	GP Member	4/4
Alison Macdonald	Lay Member (Patient and Public Involvement)	4/4
Prof. Rob McSherry	Registered Nurse	3/4
Lesley Stokey	Interim Chief Finance Officer (between 16th April and 15th October 2020) Director of Finance (from 16th October 2020)	4/4

Commissioning Primary Medical Services Committee

Name	Role	Attendance
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	5/5
Alison Macdonald	Committee Vice Chair and Lay Member (Patient and Public Involvement)	5/5
Neil Smurthwaite	Chief Finance Officer / Deputy Chief Officer	5/5
Dr Steven Cleasby	GP Member	4/4
Dr James Gray	GP Member	3/3
Dr Rob Atkinson	Secondary Care Specialist	5/5
Prof. Rob McSherry	Registered Nurse	1/3
Lesley Stokey	Interim Chief Finance Officer (between 16th April and 15th October)	2/2

Notes

Dr Cleasby was not required to attend the meeting in April as it had a single agenda item in relation to which he had a conflict of interest. For him, this meeting has been excluded from the attendance column.

Dr Gray was not required to attend the meetings in April and July 2020 due to the suspension of standing orders so as to prioritise frontline response to COVID 19. For him, this meeting has been excluded from the attendance column.

Prof. McSherry was not required to attend the meetings in July 2020 and March 2021. For him, these meetings have been excluded from the attendance column.

Audit Committee

Name	Role	Attendance
Prof. Peter Roberts	Committee Chair / Lay Member (Audit)	3/3
John Mallalieu	Deputy Committee Chair / Lay Member (Finance and Performance)	3/3
Neil Smurthwaite	Chief Finance Officer / Deputy Chief Officer (until 15th October 2020) Chief Operating Officer (from 16th October 2020)	2/2
Denise Cheng-Carter	Lay Advisor	3/3
Dr Farrukh Javid	GP Member	3/3
Alison Macdonald	Lay Member (Patient and Public Involvement)	3/3
Prof. Rob McSherry	Registered Nurse	2/2
Dr Rob Atkinson	Secondary Care Specialist (deputising for Prof. McSherry)	1/1
Lesley Stokey	Interim Chief Financial Officer (from 16th April to 15th October 2020) Director of Finance (from 16th October 2020)	1/1

West Yorkshire and Harrogate Joint Committee of CCGs

Name	CCG role	Attendance
Dr Steven Cleasby	Governing Body Chair	2/3
Neil Smurthwaite	Chief Finance Officer / Deputy Chief Officer Interim Accountable Officer (from 16th April to 15th October 2020)	2/2

Name	CCG role	Attendance
Robin Tuddenham	Accountable Officer (from 16th October 2020)	1/1

Note. The meeting in April 2020 was cancelled due to the COVID-19 pandemic, so this has not been included in the attendance column.

Governance statement – Appendix 2: Summary of major risks to CCG governance, risk management and internal control

Risk no	Risk summary	Action to manage risk	Means to assess outcomes
Critical risk (scoring 20) movement during 2021-22			
1493 (new risk at beginning of 2020-21)	Patients being discharged from hospital are subject to delays in their transfer of care (TOC) due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on acute post-COVID19 bed plans which require minimum delayed patients. The need to optimise discharge has become more acute during the pandemic, ensuring patients leave hospital as soon as possible to reduce their risk of hospital acquired infection and releasing beds for poorly patients, whilst ensuring the quality of the discharge with the context of the COVID19 pandemic.	- Accident and Emergency Delivery Board (A&EDB) review performance as a standing item monthly - Weekly discharge touchpoint in place across Calderdale and Greater Huddersfield - Optimum range for number of people on TOC list for Calderdale confirmed as 13-21 (same as Kirklees) - System call in place weekly to review risks and mitigating actions - continued through COVID19 period - Multiple weekly integrated home first huddles to continue to support flow - Surge and Escalation processes documented and agreed by A&EDB	- A&EDB highlight report considered by Quality, Finance and Performance Committee (QF&P) as a standing item - Performance updated to QF&P includes TOC performance - TOC list reviewed daily during weekdays - Implementation of new guidance is in final stages. - Process now in place for reviewing patients on the Reason to Reside list - CCG has funded GP input into CHFT virtual ward rounds to optimise discharge

62 (this was already a critical risk at the end of 2019-20)	The system will return to the pre-COVID19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised. There is also a risk of significant harm associated with patients spending extended time on a trolley in A&E awaiting a bed within the context of COVID19 -related bed pressures.	- Surge and Escalation processes triggered to mitigate performance risk in line with agreed plan (daily or weekly) through winter - A&EDB focus work on understanding and mitigating performance risk at each meeting (monthly) - QF&P consider F&FT response rate and satisfaction included in Quality Dashboard reviewed monthly - QF&P receives quarterly reports on any serious incidents - including A&E	- Performance reviewed at QF&P and Governing Body - Quality Team have oversight of any learning from 12-hour breaches - Winter reset action plan agreed, with focus on reducing A&E attendances, including comms work
187 (became a critical risk during the last risk cycle of 2020-21 (from a score	Under-achievement of 18 weeks performance (Incomplete referral to treatment (RTT)) at specialty level due to pressures caused by the pandemic resulting in breaches of patients' constitutional right to access certain	- Joint Calderdale and Greater Huddersfield CCG approach to the safe restart of elective services, being clinically led by the Elective Improvement Group, which reports to Outpatient Transformation Board	- System have agreed joint principles and priorities to underpin reset work - CCG Reset plan held by SMT and progress shared with QF&P

of 16))	services within maximum waiting times and potential harm to patients	- Joint (GP, Consultant) clinical reviews of patients waiting over 16 weeks - Joint work between CCGs, CHFT and Independent sector to ensure we maximise all available capacity - A key element of the CCG Reset Plan and CHFT's Incident Management Plan - Joint approach to gathering thematic views of patient harm via agreed clinical assurance routes. f) Closer working with the Integrated System (IS) to ensure we maximise their available capacity	- 18 weeks' performance is reported to QF&P - Notes of Outpatient Transformation Board to be considered at QF&P
In year serious risks (scoring 15 or 16) that have a reduced risk rating at the end of March 2021			
1373 (reduced from 16 to 4)	Access rates for IAPT (Improving Access to Psychological Therapies) in Calderdale will fall significantly due to the withdrawal of the Insight Healthcare, which provides around 70% of the	- The provider has been asked to provide a detailed exit plan, setting out the arrangements for responsible withdrawal from the provision of the service	- Meetings held with Insight leads (both face to face and via telephone) February; minutes taken for these meetings

	activity within that service. People will not be able to access help and support at the time they need it, waiting times will increase (with Calderdale failing to meet the waiting times targets and access rates mandated in the NHS Long Term Plan).	- The provider has provided an overview of the risks relating to the withdrawal process - The provider is discussing its withdrawal confidentially with the other current provider (SWYPFT – South West Yorkshire Partnership NHS Foundation Trust) to see whether there are opportunities for SWYPFT to take on staff, and to discuss managing transition of any patients whose treatment has not concluded by the date of withdrawal of service - The Head of Contracting has given agreement for the provider appointed under the AQP (Any Qualified Provider) process to be advised in advance of the formal appointment process that they have reached the required standard, and to be informed	

		of the situation around Insight, so that if they wish to have discussions with Insight around the possibility of taking on staff/premises, they can do so at an early stage	
1557 (reduced from 16 to 4)	The CCG fails to manage running cost spend within the ring fenced allocation of £4.1m which means it will not achieve the key NHS England planning requirements and this will affect the regulators assurance of the CCG. In addition NHSE/I have made some further deductions to running costs under the COVID19 temporary financial arrangements. There are a number of risks within the principal risk which contribute to the overall score which include the increased risk of annual pay award.	- The CCG had initially developed a financial plan for 2020/21 which was set to deliver the required running cost reductions with the requirement to make only some small savings in year which we anticipate can be managed through vacancies and recruitment slippage. The CCG was able to do this as it planned for and delivered significant recurrent savings of £0.6m in 2019/20 - The plan for 2020/21 was presented and agreed by Quality, Finance and Performance Committee in December 2019 demonstrating how savings had been delivered in 2019/20 and further	- Monthly Financial Reporting systems - Internal Audit reviews on financial systems and processes - Regular budget holder meetings to review running cost budgets - Discussion of risk and position in monthly Finance and Performance paper - Detailed review of impact of pay review scenarios - work undertaken to mitigate impacts - Heads of Service are reviewing budgets in light of

	The CCG has a target to reduce running costs by 20% in real terms by 2020/21. This is an absolute reduction of 11.8% in cash terms on 2019/20 allocation.	savings plans agreed to be implemented. These plans had been agreed with budget holders	savings target, work to be completed on reviewing vacant posts
1556 (reduced from 16 to 8)	The CCG will fail to deliver our 2020/21 planned in year breakeven and therefore fail to deliver a planned £5.5m cumulative surplus. The 20/21 financial plan submitted to NHSE included a number of pressures/risks which have been articulated in the plan approval process. These risks include activity pressures on acute contracts, prescribing and under-delivery of QIPP. In addition, due to the impact of COVID19, the CCG has been put under a temporary financial regime for the period April 2020 to July 2020. This has overwritten the CCGs' initial financial plan. The CCG has had its allocation	- The 2020/21 initial financial plan has been approved by Quality, Finance and Performance Committee. In April 2020 it was noted at Governing Body that a new financial regime was likely to be implemented which would supersede our initial plan and the CCG was awaiting further guidance to be issued - The CCG has implemented robust procedures to capture COVID19 related expenditure. - The CCG is planning to upload budgets based on the temporary financial guidance - The CCG will report through to Quality, Finance and Performance	- Internal and external audit reports - Role of Audit Committee Quarterly Area Team Assurance Process where the CCG financial position is assessed - Monthly reporting to Quality, Finance and Performance Committee and Governing Body

	reduced by £4.3m over the four month period. The CCG is still working through the implications of this.	Committee and Governing Body - A Quality Innovation Productivity and Prevention (QIPP) plan will have to be revised in light of guidance. - There is a monthly budget monitoring process in place which reviews all expenditure against budgets and is shared with budget holders. In addition reports are produced monthly to the Quality, Finance and Performance Committee and Governing Body and also to NHS England - The financial plan includes a £1.6m contingency budget to manage in year risk. The CCG has entered into an Aligned Incentive Contract with CHFT. This should mitigate against swings in cost due to activity variation	

202 (reduced from 15 to 12)	Key performance targets will continue to be adversely affected due to continued high demand for West Yorkshire Urgent Care (WYUC) and capacity of Local Care Direct to meet the demand in respect of the required response to the COVID19 pandemic. This could lead to a deterioration of service and patient experience and possible reputational damage to the CCG.	- Robust WYUC Contract and Quality Governance arrangements in place where regular monitoring of the service takes place - Daily routine SITREP reports received and where required escalation process in place (and teleconferences, where required) where WYUC performance is reviewed - High level of local involvement from Greater Huddersfield CCG as Lead Commissioner - Greater Huddersfield CCG hosting contract management on behalf of the West Yorkshire CCGs - Contract performance reviewed at Finance and Performance Committee; quality reviewed by Quality and Safety and Performance of WYUC/Local Care Direct service	- Contract Management Board receive regular updates - led by Greater Huddersfield CCG - Sub-Regional WYUC Contract Management and Clinical Governance arrangements in place - Local contingency plan held by the A&E Delivery Board for times of increased pressure e.g. Bank Holidays - Escalation in relation to service through GH & C CCG On-Call arrangements then to NHS England - Issues are identified and worked through as they arise

		managed and monitored via a WY Sub Regional Group; mitigating actions taken to support improvement but issues continue - WYUC Network leading focused piece of work on current issues - mitigations, risks, etc.	

Governance Statement – Appendix 3: Governing Body Assurance Framework (GBAF)

Governing Body Assurance Framework: principal risks to the achievement of the strategic objectives and compliance with the CCG's licence and actions identified to mitigate these risks in 2020/21

Strategic Objective		Summary of Principal Risks	Mitigation
1.	**Achieving the agreed strategic direction for Calderdale**	We do not deliver our strategic outcomes because we have not integrated our commissioning activities with Calderdale Council.	▪ Chief Operating Officer, Chair and Vice Clinical Chair members of the Health and Wellbeing Board supporting effective partnership working. ▪ Single Plan for Calderdale (SPFC) - a single strategic direction.
		We do not deliver our strategic outcomes because we have not tackled the wider determinants of health.	▪ Partnership working via Calderdale Council senior staff including Directors of Public Health and Adult Health and Social Care. ▪ SPFC provides single strategic direction for Calderdale Council and CCG.
		We do not deliver our strategic outcomes because we have not implemented new models of primary care and community services	▪ Wellbeing Strategy sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. ▪ CCG one year operational plan sets the strategic direction aligned to the Wellbeing Strategy and Calderdale Cares.

Strategic Objective		Summary of Principal Risks	Mitigation
			▪ Partnership working through the Health and Wellbeing Board to develop an integrated model of primary and community services, physical and mental health.
		We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint.	▪ Work plan agreed by the West Yorkshire & Harrogate Joint Committee and approved by CCG member practices.
		We do not deliver our strategic outcomes because we have not delivered the proposed clinical model of hospital and community services as set out in the response to the Secretary of State in August 2018.	▪ Process developed between CCG and CHFT in regards to managing interim service changes. ▪ We completed consultation on 21st June 2016 on proposed future arrangements for hospital and community health services. ▪ Interim service changes to cardiology, respiratory and frail elderly services have been put in place. ▪ Regular reporting to the Secretary of State for Health & Social Care ▪ Regular reporting through the Clinical Quality Board to Quality Finance and Performance Committee.
		We do not deliver our strategic outcomes because we have not fully developed and	▪ **Workforce:** System forum to understand and develop workforce plans to deliver new models of care.

Strategic Objective		Summary of Principal Risks	Mitigation
		optimised system working on enabling functions, such as workforce, estates, digitisation and communications.	▪ **Estates:** System forum to understand and develop plans to digitise in order to deliver new models of care, recognise one public estate strategy and Calderdale development plans. ▪ **Digitisation:** System forum to understand and develop Estate plans to deliver new models of care. ▪ **Communications:** Clear integrated plans to ensure high quality communications in order to share the CCG narrative with stakeholders and the public.
		We are unable to deliver our strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.	▪ Engagement of practices through the Commissioning Engagement Scheme. ▪ Practice Managers' Action Group inputs to clinical commissioning and shares information with member practices on behalf of the CCG.
2.	**Improving Quality**	We do not improve patient experience in line with our plans due to a failure to use appropriate patient and public engagement intelligence to support service improvement and plans to change service models	▪ Patient and Public Engagement and Experience Strategy (2013-20) and annual improvement plan (2020-21) in place. ▪ Patient and Public Experience and Engagement Steering Group (including partners) and Patient Experience Group.

Strategic Objective		Summary of Principal Risks	Mitigation
		We are unable to commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans – thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire & Harrogate Partnership Plan	▪ Patient and Public Engagement and Experience Group and terms of reference. ▪ Engagement and Equality and Diversity Assurance Process.
		We do not maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients	▪ Quality outcome standards, quality schedule, patient safety and relevant targets within service specifications ▪ Quality and Safety Dashboard (information at CCG level and by main providers).
		We are unable to provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding arrangements, resulting in harm to children and adults.	▪ Safeguarding policies and procedures in place. ▪ Annual section 11 audits scrutinise provider safeguarding arrangements. ▪ Collaborative working through provider safeguarding committees.

Strategic Objective		Summary of Principal Risks	Mitigation
3.	**Improving value**	We do not deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable.	▪ Annual review of financial controls arrangements by Internal/External audit. ▪ 5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting planned community services, reducing financial risk. ▪ Development of Care Closer to Home model to reduce increasing demand on acute services (CC2H).
4	**Improving governance**	We don't comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.	▪ Compliance with the provisions of the CCG's Constitution which has been approved by the membership and NHS England. ▪ Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework
		We don't release capacity and enable the development of new integrated commissioning, Primary Care Networks and provider alliance arrangements due to low risk appetite and not having the right CCG Governance form and membership.	▪ Robust governance structure, integrated risk management framework and systems of internal control in place. ▪ Annual Governing Body and committee performance assessment – identifying development needs and action plans.

Governance Statement - Appendix 4: Head of Internal Audit Opinion

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS CALDERDALE CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 2021

1. Introduction

The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Governing Body in the completion of its Annual Governance Statement, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS have faced unprecedented challenges due to COVID-19.

2. Executive Summary

This Head of Internal Audit Opinion forms part of the Annual Report for NHS Calderdale Clinical Commissioning Group in which the planned internal audit coverage and outputs during 2020/21 and Audit Yorkshire's Key Performance Indicators (KPIs) are detailed.

Key Area	Summary
Head of Internal Audit Opinion & the Role of Internal Audit During the Pandemic	The overall opinion for the period 1st April 2020 to 31st March 2021 provides Significant Assurance, that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. The Internal Audit Standards Advisory Board (IASAB) issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020). All our work has continued to be delivered in full compliance with the PSIAS. Audit Yorkshire adopted a pragmatic approach to the delivery of your Internal Audit Service during 20/21, with the focus on the delivery of your Head of Internal Audit Opinion. This again, was in line with the IASAB guidance. We supported you through the provision of a wide range of briefings, updates and benchmarking materials focused on helping you manage the challenges of COVID-19. We also supported the wider NHS systems across Audit Yorkshire's client base / geographies through the redeployment of our staff to maintain the effective delivery of services.

Key Area	Summary
Planned Audit Coverage and Outputs	The 2020/21 Internal Audit Plan has been delivered with the focus on completion of high priority or 'must do' audits to support the provision of a meaningful Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. The impact on the organisation of COVID-19 required us to review your internal audit risk assessment and plan for 2020/21 on a regular basis, in liaison with yourselves. As part of this assessment we took account of the following: • How the organisation has implemented NHSE/I guidance, issued to support them in responding to COVID-19, whilst still discharging their stewardship responsibilities; • Any revisions to the organisation's strategic priorities as well as liaising with you to review areas for internal audit focus; • Independent assurance requirements on how COVID-19 costs are captured and claimed across a range of areas; and • Mandated review requirements and audits which from a professional internal audit perspective are pre-requisite to ensuring sufficient coverage for a robust Head of Internal Audit Opinion. Therefore review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; and • A range of individual risk based assurance reviews. Due to the impact of the pandemic, there was limited coverage of the Quality and Business Development reviews originally included in the plan for 2021/21. These areas have been considered as part of the 2021/22 risk assessment and planning process.
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

3. Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accounting Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accounting Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its Annual Governance Statement.

4. The Opinion

My opinion is set out as follows:

1. Basis for the opinion;
2. Overall opinion;
3. Opinion Definitions
4. Commentary.
5. Considerations for your Annual Governance Statement
6. Looking Ahead

1. The **basis** for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
- An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Unless explicitly detailed within our reports, third party assurances have not been relied upon.

2. Overall Opinion

Our **overall opinion** for the period 1st April 2020 to 31st March 2021 is:

Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

3. Opinion Definitions

The following potential opinion levels are available when determining the overall Head of Internal Opinion. These levels link closely with our standard definitions for report opinions:

Opinion Level	HOIA Opinion Definition
High (Strong)	High assurance can be given that there is a strong system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are being applied consistently in all areas reviewed.
Significant (Good)	Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.
Limited (Improvement Required)	Limited assurance can be given as there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and internal control that could result in failure to achieve the organisation's objectives.
Low (Weak)	Low assurance can be given as there is a weak system of internal control and/or significant weaknesses in the application of controls that will result in failure to achieve the organisation's objectives.

Where limited or low assurance is given the management of the Governing Body must consider the impact of this upon their overall Governing Body Assurance Framework and their Annual Governance Statement.

4. The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

<u>The design and operation of the Assurance Framework and associated processes.</u>

An audit of the operation of the Assurance Framework and associated Risk Management processes has been undertaken in 2020/21. The audit has confirmed that the Assurance Framework is fit for purpose and is designed to provide the Governing Body with sufficient and timely assurances on its system of internal controls to manage its strategic risks. Arrangements are in place to provide sufficient oversight of the Assurance Framework. The Assurance Framework as designed in accordance with NHS requirements and meets all the elements required. The Assurance Framework covers the organisation's key risks.

The Governing Body and supporting committees have been provided regular COVID-19 updates and continued to review the Risk Register and Governing Body Assurance Framework in line with the requirements of the Integrated Risk Management Framework.

The audit has confirmed that the Clinical Commissioning Group has appropriate and effective controls in place to ensure that risks are recorded, reviewed, updated and reported on, with escalation where appropriate and has established clear processes for reviewing risk registers and for tracking progress on addressing risks.

An audit of the risk management framework was also conducted in 2020/21 for which a High Assurance opinion was awarded.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

Core & Risk Based Reviews Issued

We issued:

3 **high** assurance opinions:	Governance and Risk Management Arrangements Conflicts of Interest Data Security and Protection Toolkit
3 **significant** assurance opinions:	Financial Systems and Management Primary Care Co-Commissioning Framework Continuing Healthcare BroadCare Control Improvement Audit (Stage 2)
0 **limited** assurance opinions:	
0 **low** assurance opinions:	
1 reviews without an assurance rating	Accountable Officer Role

Follow Up

23 Internal Audit recommendations have been live during 2020/21 (this includes recommendations from previous years' reports that were still live at 1 April 2020).

During the course of the year we have undertaken work to track the implementation of Internal Audit Recommendations. The Recommendation clear up summary 2020/21 was as follows:

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
0	3	11	9	23	13%

We can conclude that the organisation has made good progress with regards to the implementation of recommendations. The vast majority of recommendations are implemented on a timely basis. There is a small core of recommendations that are overdue in comparison to their original agreed action date. We can confirm that have received appropriate support from the Executive Directors in relation to these and these recommendations have been regularly reviewed by the Audit Committee throughout the year.

5. Consideration for your Annual Governance Statement

The Head of Internal Audit Opinion is one source of assurance that the organisation has in providing its Annual Governance Statement and other third party assurances should also be considered. In addition the organisation should take account of other independent assurances that are considered relevant. We recommend that the Executive Summary above (page 10) is used in your Annual Governance Statement.

A significant overall opinion has been provided. Attention is drawn to the fact that three "high" and three "significant" assurance reports have been issued. In addition, no final reports have been issued in 2020/21 with a "limited" or "low" assurance opinion:

6. Looking Ahead

This opinion is provided in the context that NHS Calderdale Clinical Commissioning Group like other organisations across the NHS continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and COVID-19 recovery. The COVID-19 pandemic led to changes to the NHS financial framework, the establishment of the control and command structures both regionally and within individual organisations and an ongoing focus on the emergency response. This has required NHS organisations to operate in a different way to previous 'business as usual' practice. Guidance was clear that financial constraints must not stand in the way of taking immediate and necessary action but that there was no relaxation in fiduciary duties.

Bold decision making will continue to be needed as organisations recover from COVID-19 whilst at the same time maintaining due focus on governance, probity and internal control. The maintenance of robust financial and organisational control is at the heart of the Head of Internal Audit Opinion and we will continue to work with the organisations we serve to provide timely advice and insight throughout 2021/22.

During the COVID-19 response, there has been an increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This focus on collaboration will continue as the NHS progresses on its journey towards integrated care systems.

Audit Yorkshire has refreshed its planning approach for 2021/22 to take account of the impact of COVID-19 and the moves towards integrating care. Our plans for 2021/22 therefore focus on post-COVID recovery, on how our work can make a real difference on Patient Care and on maximising opportunities for sharing knowledge and learning. In particular, the strategy we have adopted has ring fenced provision in plans to carry out co-ordinated audits across all Audit Yorkshire Members and clients, or at Place, ICS or Sector level. Our plans for 2021/22 leave us very well placed to support organisations in their delivery of the six key priority areas listed in the NHS Operational Planning Guidance issued on 25 March 2021.

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
3 June 2021

Remuneration and Staff Report

Remuneration report

This section of the Annual Report sets out the CCG's remuneration policy for Governing Body and Very Senior Managers and reports on how that policy has been implemented. It also sets out information about staff numbers and costs, policies, activities, relations and the CCG's approaches to engagement.

Remuneration and Nomination Committee

The table below shows the composition of the Remuneration and Nomination Committee throughout the financial year and up to the signing of the ARA on 14 June 2021 and attendance for 2020/21 financial year.

Name	Role	Attendance
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	5/5
Alison Macdonald	Committee Vice Chair and Lay Member (Patient and Public Involvement)	5/5
Dr Rob Atkinson	Secondary Care Specialist	3/4
Prof. Rob McSherry	Registered Nurse (deputising for Dr Atkinson)	1/1
Dr Steven Cleasby	GP Member	3/5
Dr Farrukh Javid	GP Member	4/4

Notes:
Dr Javid and Dr Atkinson were not required to attend the meeting in June 2020 due to the suspension of standing orders so as to prioritise frontline response to COVID 19. For them this meeting has been excluded from the attendance column.

The Remuneration and Nomination Committee is supported in its considerations by Human Resources Managers and Business Partners. The CCG's HR, Learning and Development and OD service is commissioned from the North of England Commissioning Support unit (NECS) which commenced as the CCG provider from 1 August 2019. The committee was supported by the Chief Finance Officer/Deputy Chief Officer until 15th October 2020 and has been supported by the Director of Finance since then.

Policy on the remuneration of senior managers

For the purpose of this report, the senior managers of Calderdale CCG are defined as:

- Very Senior Managers (VSMs) i.e. the Accountable Officer, the Chief Finance Officer/Deputy Chief Officer (now Chief Operating Officer) and Director of Finance;
- GPs on the Governing Body – including the Chair of the CCG;
- Registered Nurse and Secondary Care Specialist;
- Lay Members;
- Chief Quality and Nursing Officer

The post of Chief Quality and Nursing Officer is shared with Greater Huddersfield and North Kirklees CCGs, and the post-holder is engaged by Greater Huddersfield CCG under a contract of employment. The arrangement is governed by a Memorandum of Understanding between the CCGs.

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above, with the exception of the Chief Quality and Nursing Officer, who is engaged under the Agenda for Change framework.

There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement. These, together with a review of comparative data across CCGs, any recommended rates of remuneration for Very Senior Managers and legal advice,

are used to inform the determinations of the Remuneration and Nomination Committee.

Hutton Review Fair Pay Principles (2011):

- Remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;
- Remuneration must be set through a process that is based on a consistent framework and independent decision making based on accurate assessments of the weight of roles and individuals' performance in them;
- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay are being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay;
- Remuneration must be based on the principle of equal pay for work of equal value.

GP Members of the Governing Body

For GP Governing Body members (including the Chair of the Governing Body) remuneration should be either:

- At a reasonable rate, in line with practice earnings; or
- At a rate commensurate with allowing backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary;
- In line with any local sessional rate.

Registered Nurse and Secondary Care Specialist

For the Registered Nurse and Secondary Care Specialist posts on the Governing Body, remuneration should be:

- If still in NHS employment, at a rate commensurate with their salary or as needed for replacement costs; or at a rate commensurate with the average rate for their profession and level of seniority;

- If retired/not working, at the same rate as lay members;
- If self-employed, in line with earnings.

Lay Members

For Lay Members, remuneration is based on benchmarking with other CCGs.

Remuneration of Very Senior Managers (VSMs)

No senior managers are paid more than £150,000 per annum pro rata. The posts which are subject to VSM terms and conditions at Calderdale CCG are the Accountable Officer, Chief Finance Officer/Deputy Chief Officer (now Chief Operating Officer) and the Director of Finance. In considering the remuneration for these posts the committee takes account of the following factors:

- Pay guidance provided by NHS England and Improvement;
- Benchmarking with other CCGs
- Complexity factors;
- Availability of guidance on recruitment and retention premiums;
- Prevailing economic climate and local market conditions;
- Any joint management arrangements;
- Public and internal perception to others in the CCG;
- Performance of the individuals and the CCG.

This approach has been applied for 2020/21 and will also be applied for future years.

Senior manager remuneration (including salary and pension entitlements)

The senior manager remuneration for 2020/21 is set out in the table below.

Name & Title	2020/21					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total
Dr Steven Cleasby, Chair	55-60	0	0	0	0	55-60
Dr Caroline Taylor, GP Member	35-40	0	0	0	0	35-40
Dr Farrukh Javid, GP Member	35-40	0	0	0	0	35-40
Dr James Gray, GP Member	30-35	0	0	0	0	30-35
Dr Rob Atkinson, Secondary Care Clinician	20-25	0	0	0	0	20-25
Prof Rob McSherry, Registered Nurse	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member and Deputy Chair	15-20	0	0	0	0	15-20
Prof Peter Roberts, Lay Member	5-10	0	0	0	0	5-10
Alison Macdonald, Lay Member	5-10	0	0	0	0	5-10
Denise Cheng Carter, Lay Advisor	5-10	0	0	0	0	5-10
Robin Tuddenham - Accountable Officer	30-35	0	0	0	0	30.35
Dr Matt Walsh - Accountable Officer	60-65	0	0	0	0	60-65
Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	130-135	0	0	0	72.5-75	200-205
Lesley Stokey - Director of Finance	100-105	0	0	0	82.5 - 85	185-190
Penny Woodhead - Chief Quality and Nursing Officer	30-35	0	0	0	25-27.5	55-60

Note 1: The information in the table above is subject to audit by our external auditors, Grant Thornton

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k; however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 3: Robin Tuddenham joined the Governing Body on 16th October 2020.

Note 4: Neil Smurthwaite was Interim Chief Officer for the period 16th April 2020 to 15th October 2020 and Chief Operating Officer and Chief Finance Officer from 16th October 2020.

Note 5: Matt Walsh left the Governing Body on 15th April 2020

Note 6: Lesley Stokey was Interim Chief Finance Officer from 16th April 2020 to 15th October 2020 and Director of Finance from 16th October 2020.

The senior management remuneration for 2019/20 is set out in the table below.

Name & Title	2019/20					
	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total
Dr Steven Cleasby, Chair	55-60	0	0	0	0	55-60
Dr Majid Azeb	40-45	0	0	0	0	40-45
Dr Nigel Taylor	10-15	0	0	0	0	10-15
Dr Caroline Taylor	45-50	0	0	0	0	45-50
Dr Farrukh Javid	30-35	0	0	0	0	30-35
Helen Davies	45-50	0	0	0	0	45-50
Dr Rob Atkinson, Secondary Care Clinician	15-20	0	0	0	0	15-20
Dr James Gray	35-40	0	0	0	0	35-40
Prof Rob McSherry, Registered Nurse	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	5-10	0	0	0	0	5-10
Denise Cheng Carter, Lay Advisor	0-5	0	0	0	0	0-5
Prof Peter Roberts, Lay Member	0-5	0	0	0	0	0-5
Alison Macdonald, Lay Member	0-5	0	0	0	0	0-5
Penny Woodhead Chief Quality and Nursing Officer	30-35	0	0	0	22.5-25	55-60
Dr Matt Walsh - Accountable Officer	135-140	0	0	0	0	135-140
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	105-110	0	0	0	30.0 - 32.5	140-145

Note 1: The information in this table was subject to audit by our external auditors, KPMG

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k; however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 3: David Longstaff left the Governing Body on 29th February 2020

Note 4: Peter Roberts joined the Governing Body on 1st December 2019

Note 5: Denise Cheng Carter joined the Governing Body on 1st December 2019

Note 6: Alison Macdonald joined the Governing Body on 1st December 2019

Note 7: Dr Nigel Taylor left the Governing Body on 30th June 2019

Pension benefits as at 31 March 2021

Name & Title	Real increase in pension at pension age 60. (Bands of £2,500) £000's	Real increase in lump sum at age 60. (Bands of £2,500) £000's	Total accrued pension at age 60 as at 31/03/21. (Bands of £5,000) £000's	Lump sum at age 60 related to accrued pension as at 31/03/21. (Bands of £5,000) £000's	CETV at 1 April 2020 £000's	CETV at 31 March 2021 £000's	Real Increase in CETV £000's	Employers Contribution to Stakeholders Pension
Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	2.5-5	0-2.5	25-30	0-5	249	311	58	0
Lesley Stokey - Director of Finance	2.5-5	5-7.5	25-30	45-50	334	406	66	0
Penny Woodhead - Chief Quality & Nursing Officer	0 - 2.5	0 - 2.5	5 - 10	0 - 5	60	88	13	0

Note 1: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore not included in the table.

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k, however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.
The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Remuneration of Very Senior Managers

This is covered in pages 137 to 143.

Compensation on early retirement or for loss of office

No payment has been made in compensation for loss of office or early retirement during 2020/21.

Payments to past members

No payment has been made to past senior managers during 2020/21.

Pay multiples

Note1: The information in this section is subject to audit by our external auditors, Grant Thornton.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director/Member in their organisation and the median remuneration of the organisation's workforce. The rationale for the remuneration of Governing Body members including the clinical Chair is set out on pages 137 to 139.

The banded remuneration of the highest paid Director/Member in NHS Calderdale CCG in the financial year 2020/21 was £160-165K (2019/20: £155-160k) this is after pro rata'ing part time employees. This was 4.25 times (2019/20: 4.24) the median remuneration of the workforce, which was £37,890 (2019/20: £37,598).

In 2020/21, 0 (2019/20, 0) employees received remuneration in excess of the highest-paid Director/Member. Remuneration ranged from £20k - £161k (2019/20: £17k to £160k).

Total remuneration includes salary, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The CCG does not offer any performance-related pay, including non-consolidated performance-related pay.

Staff report

The CCG's workforce profile is shown below. The information is based on the directly employed staff of the CCG as at 31st March 2021. Information relating to the Governing Body is reported separately.

Number of senior managers

Information relating to individuals classed as senior managers for the purposes of this annual report can be found on pages 137 to 143.

Staff numbers and costs

The average number of people employed and engaged by the CCG is shown in the table below.

2020/21

Permanent employees	Other	Total
84	2	86

2019/20

Permanent employees	Other	Total
61	16	77

Staff costs and employee benefits

The staff costs and employee benefits as at 31st March 2021 are set out below.

2020-2021 Staff Costs & Employee Benefits	2020-2021								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,951	3,543	409	2,224	65	2,289	1,319	344	1,663
Social security costs	377	377	0	244	0	244	133	0	133
Employer contributions to the NHS Pension Scheme	616	616	0	449	0	449	167	0	167
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	3	3	0	3	0	3	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**4,948**	**4,539**	**409**	**2,920**	**65**	**2,985**	**1,619**	**344**	**1,963**
Less: Recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure including capitalised costs	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**4,948**	**4,539**	**409**	**2,920**	**65**	**2,985**	**1,619**	**344**	**1,963**

The staff costs and employee benefits as at 31st March 2020 are set out below.

2019-2020 Staff Costs & Employee Benefits	2019-2020								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	3,566	3,330	236	2,233	2,187	46	1,333	1,143	190
Social security costs	351	351	0	235	235	0	117	117	0
Employer contributions to the NHS Pension Scheme	569	569	0	431	431	0	138	138	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	3	3	0	3	3	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**4,490**	**4,254**	**236**	**2,902**	**2,856**	**46**	**1,588**	**1,398**	**190**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(26)	(26)	0	(26)	(26)	0	0	0	0
Net employee benefits expenditure including capitalised costs	**(26)**	**(26)**	**0**	**(26)**	**(26)**	**0**	**0**	**0**	**0**
Less: Employee costs capitalised				0	0	0		0	0
Net employee benefits expenditure excluding capitalised costs	**4,464**	**4,228**	**236**	**2,876**	**2,830**	**46**	**1,588**	**1,398**	**190**

Staff composition

As at 31st March 2021, the CCG directly employed 86 staff (excluding Governing Body, but including the Very Senior Managers (VSMs)). This equates to 78.45 whole time equivalent (WTE).

Gender profile of the organisation

The following table sets out the gender profile of the organisation as at 31st March 2021.

	Governing Body (excl. Very Senior Managers)	Very Senior Managers (VSM)	Staff Excl. Governing Body and VSMs	Total
Female	3	1	69	73
Male	7	2	17	26
Total	10	3	86	99

Note 1: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay report.

Sickness absence data

The yearly average sickness figures for the CCG between 1st April 2020 and 31st March 2021 are shown in the table below.

Total FTE Days lost:	745.97
Total FTE Staff	27,732.56
Rolling 12 month period average	2.69%

The CCG recognises the importance of balancing the health needs of employees with the needs of the CCG, and it is the considered view of the management team of the CCG that the pertinent overarching strategic priority is to create the kind of organisational culture within which people can be the best that they can possibly be.

As such the CCG has policies and procedures in place to support employees with sickness absence and continues to develop a positive and pro-active approach in supporting employees through sickness absence or difficult periods in their lives. This has recently been evidenced by reviewing the Managing Sickness Absence Policy in not only aiming to reduce the levels of sickness through improvement plans but providing supporting mechanisms to employees during periods of short and long term sickness.

The CCG commissions an Employee Assistance Programme (EAP) to further support the needs of the workforce and this service has been recently renewed for a further year. The aim of EAP is to help employees deal with personal problems that might adversely impact their work performance, health and well-being. This service provides confidential advice and counselling support to employees which makes available an early source of practical and emotional support for employees facing issues in their home or work life. This is viewed by the CCG as being important in supporting the health and wellbeing of employees.

The CCG is committed to the health and wellbeing of its staff and works hard to promote a healthy working environment.

During the COVID-19 pandemic, the CCG has continued to focus on staff wellbeing. The Virtual Kitchen, Wall of Wellbeing and Staff Forum meetings help staff stay connected with each other and the senior management team. Staff regularly share advice and support, such as hints and tips about working virtually, practical and financial support, activities for children being home-schooled, and how to stay physically well. This has remained a strong focus as individuals support each other during the pandemic. Staff have also joined virtual films (including Netflix film reviews), concerts and theatre events.

Staff turnover percentage

Information about the CCG's staff turnover can be found on the NHS workforce statistics website.

Staff engagement

The CCG engages with its staff through a variety of mechanisms, including an active staff forum, weekly updates with the Chief Operating Officer and Accountable Officer, monthly staff workshops, and through a staff intranet, which includes discussion forums and regular news. The CCG also participates annually in the national NHS Staff Survey in order to gain staff feedback and understand how the CCG benchmarks against other NHS organisations. 77.1% of staff responded to the survey in 2020. Overall, the CCG's results were positive, with the engagement index score being higher than average when benchmarked against other CCGs.

Particular highlights related to the organisation taking positive action on health and wellbeing, communication between senior managers and staff, clarity of responsibilities, and a focus on organisational values in appraisal conversations. The results will be discussed with staff in order to build on the CCG's ongoing staff engagement plan, focusing on strengths and areas for improvement.

Staff policies

The CCG has a suite of 25 staff policies providing clarity on the CCG's vision, values and expectations. These include policies on health and safety, trade union recognition and time off for representation, whistleblowing and flexible working. All the CCG's policies can be found on our website at the link below.
Calderdale CCG - key documents

The CCG's commitment to recruitment, continuing employment, training and career development of disabled people is set out in a number of policies and procedures. These include:

Requirement	Policy or procedure
Giving full and fair consideration to applications for employment by the CCG made by disabled persons, having regard to their particular aptitudes and abilities.	• Equality and Diversity in Employment Policy; • Recruitment and Selection Policy.
Continuing the employment of, and arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company.	• Equality and Diversity in Employment Policy; • Managing Sickness Absence Policy; • Flexible Working Policy; • Learning and Development Policy.
Training, career development and promotion of disabled people employed by the company.	• Equality and Diversity in Employment Policy; • Recruitment and Selection Policy; • Learning and Development Policy; • Pay Progression Policy; • Appraisal Paperwork.

Policy review

The CCG has a rolling programme of policy review and awareness-raising, as well as the appraisal procedure to further improve the focus on the quality of conversations taking place. The implementation of these policies together with occupational health input supports the continuation of employment and provision of appropriate training to any employee who becomes disabled and ensures access for all CCG employees, including disabled staff members to training, career development and promotion opportunities.

Equality impact assessments have been carried out on all the above policies. Over the past 12 months monitoring has taken place to ensure there has been no detrimental effect with regard to implementation of these workforce policies on CCG staff and to ensure that the CCG has proactively identified and addressed any inequalities.

Disability Confident Employer

In 2016, the government made a commitment to halve the employment gap for disabled people and in order to achieve this it introduced a new Disability Confident scheme. We are extremely proud to say that our CCG was awarded the level 2 Disability Confident Employer badge for 2 years from August 2019. The award is based on us being able to demonstrate that we:

- Have undertaken and successfully completed the Disability Confident self-assessment;
- Are taking all of the core actions to be a Disability Confident employer;
- Are offering at least one activity to get the right people for the business, and at least one activity to keeping and developing employees.

As a Disability Confident Employer, we are able to use the logo which lets people know that we have made a commitment regarding recruitment, training, and

retention of people with disabilities and the promotion of disability awareness across the organisation. We will continue to work to make this a welcoming and accessible place for people with a disability.

Trade Union relations and representation

Having good working relationships with trade union representatives is important to us. HR representatives and CCG senior managers from Calderdale and Kirklees CCGs meet with the relevant trade union representatives at the Joint Partnership Forum to discuss any staff issues or test proposals that might have a direct impact on staff.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974.

During 2020/21, there were two members of staff, who were accredited Trade Union representatives. These representatives provided a service across the two CCGs – Calderdale and Kirklees. One of these representatives is employed by Calderdale CCG.

Relevant union officials during 2020/21

Total number of employees who were relevant union officials during the period of 1st April 2020 to 31st March 2021 (note1) (FTE)	2

Note 1: One of the representatives is employed by NHS Calderdale CCG

The table below contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Percentage time spent on facility time

Percentage of time spent	No. of Employees
0%	
1-50%	2
51-99%	
100%	

Percentage of pay bill spent on facility time

	£
Total cost of facility time (note1)	1,494
Total pay bill (note2)	15,169,636
% of total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.01%

Note1: This is based on actual salary of the two trade union representatives

Note 2: This is the combined total pay bill for Calderdale and Kirklees CCGs.

Paid Trade Union Activities

The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2020/21, on paid trade union activities.

Paid Trade Union Activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100	100%

Other employee matters

The CCG works closely with partners in health and social care and is a leader in a number of initiatives to develop the current and future workforce of Calderdale and beyond.

The CCG is also instrumental in leading other pieces of system-wide work. For instance, providing leadership to work which will support the development of relationships across multi-disciplinary teams, and forming part of a group to bring stakeholders to discuss and agree actions in relation to workforce.

The CCG's approach to human capital management is supported by a robust set of policies and procedures, which underpin the full employee cycle. This includes a fair and transparent approach to recruitment and learning, and a well-embedded appraisal process, to assist individuals and teams with career management in support of the strategic aims of the CCG and the health and care system.

The CCG is an active participant in a Calderdale-wide Future Leaders programme. This is a new venture in partnership with public and private sector employers across Calderdale. It provides existing managers with the opportunity to develop leadership skills and gain a qualification, and contributes to human capital management and employability across the CCG's local area.

The CCG's approach to pay is included in the remuneration report. With the exception of Very Senior Managers, all staff are engaged under Agenda for Change terms and conditions. There is a clear pay progression policy, ensuring that employees are performing to the standards required in their role, in order to progress up the pay scale.

Employee consultation

The CCG recognises the benefits of joint partnership working through the Social Partnership Forum across Calderdale and Kirklees CCGs. The purpose of this forum is to allow a mechanism to formally consult and negotiate on a range of CCG business that directly impact on staff.

Expenditure on consultancy

Expenditure on consultancy (2020/21)

Description	Costs(£)
Expenditure on consultancy in 2020/21	0
TOTAL	0

External Audit

NHS Calderdale CCG appointed Grant Thornton as their external auditor from 1st April 2020. The cost of the work performed by the auditor in respect of the reporting period 2020-21 is £71,400 (including VAT).

Services from Grant Thornton (2020/21)

Audit Services: Statutory audit and services carried out in relation to the statutory audit, e.g. reports to the Secretary of State	£59,400
Further assurance services - Compliance with the requirements of the Mental Health Investment Standard	£12,000
Other Services	£0
Total	£71,400

Before agreeing to carry out any non-audit work, Grant Thornton's risk and quality policies require all independence issues to be considered and reviewed by senior partner to ensure that the non-audit work is in line with ethical standards/AGN01.

Off payroll engagements

All off-payroll engagements

For all off-payroll engagements as of 31st March 2021, for more than £245 per day and that last longer than six months:

Description	Number
Number of existing engagements as of 31st March 2021	4
Of which the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	1
For between three and four years at the time of reporting	2
For four or more years at the time of reporting	0

We can confirm that all existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary that assurance has been sought.

New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1st April 2020 and 31st March 2021, for more than £245 per day and that last for longer than six months

Type	Number
Number of new engagements, or those that reached six months in duration between 1st April 2020 and 31st March 2021	1
Of which	
Number assessed as caught by IR35	1
Number not assessed as caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0

Type	Number
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll Governing Body member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2020 and 31st March 2021

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	2
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure must include both on payroll and off-payroll engagements.	14

Note:

1) There are two senior off payroll engagements in place. The first relates to the Secondary Care Specialist on the CCG Governing Body, Dr Rob Atkinson, who is employed by Barnsley Hospital NHS Foundation Trust and his costs are recharged to the CCG under a secondment agreement and as such he does not sit on the CCG payroll. The second relates to Robin Tuddenham who was appointed as Accountable Officer on 16th October 2020, for the period until 31st March 2021 his primary salary was paid by Calderdale Council and recharged to the CCG.

Exit packages, including special (non-contractual) payments

There has been one exit package or other departure, requiring exit packages or severance payments during 2020/21.

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	1	73,581	1	73,581	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	1	73,581	1	73,581	0	0

There were no exit packages or other departures, requiring exit packages or severance payments during 2019/20.

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where NHS Calderdale CCG has agreed early retirements, the additional costs are met by NHS Calderdale CCG and not by the NHS Pensions Scheme. Ill- health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

	Agreements 2020/21 Number	Total Value of agreements 2020/21 £000s
Voluntary redundancies including early retirement contractual costs	0	Not applicable
Mutually agreed resignations (MARS) contractual costs	0	Not applicable
Early retirements in the efficiency of the service contractual costs	0	Not applicable
Contractual payments in lieu of notice	1	74
Exit payments following Employment Tribunals or court orders	0	Not applicable
Non-contractual payments requiring HMT approval	0	Not applicable
Total	1	74

ROBIN TUDDENHAM

Accountable Officer

14 June 2021

Parliamentary Accountability and Audit Report

NHS Calderdale CCG is not required to produce a Parliamentary Accountability and Audit Report. The CCG has no remote contingent liabilities and for losses and special payments, gifts, and fees and charges see Financial Statements note 19. An audit report is also included in this Annual Report at pages 186 to 191.

ROBIN TUDDENHAM
Accountable Officer
14 June 2021

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2021 have been prepared by
Calderdale CCG under the Health and Social Care Act 2012
in the form which the Secretary of State has, with the approval of the Treasury, directed.

Calderdale Clinical Commissioning Group - Annual Accounts 2020-21

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(857)	(2,360)
Total operating income		**(857)**	**(2,360)**
Staff costs	4	4,948	4,490
Purchase of goods and services	5	339,173	334,716
Depreciation and impairment charges	5	15	1
Other Operating Expenditure	5	182	392
Total operating expenditure		**344,318**	**339,599**
Net Operating Expenditure		**343,461**	**337,239**
Comprehensive Expenditure for the year		**343,461**	**337,239**

The notes on pages 166 to 185 form part of this statement

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	8	29	44
Total non-current assets		29	44
Current assets:			
Trade and other receivables	9	1,233	310
Cash and cash equivalents	10	105	5
Total current assets		**1,338**	315
Total assets		**1,367**	359
Current liabilities			
Trade and other payables	11	(20,827)	(27,065)
Borrowings	12	(3,524)	-
Total current liabilities		**(24,351)**	(27,065)
Total Assets less Net Current Liabilities		**(22,984)**	(26,706)
Assets less Liabilities		**(22,984)**	(26,706)
Financed by Taxpayers' Equity			
General fund		(22,984)	(26,705)
Total taxpayers' equity:		**(22,984)**	(26,705)

The notes on pages 166 to 185 form part of this statement

The financial statements on pages 162 to 165 were approved by the Audit Committee on the 10th June 2021 under delegated authority from the Governing Body and signed on its behalf by:

Accountable Officer
Robin Tuddenham

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(26,705)	**(26,705)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(26,705)**	**(26,705)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(343,461)	**(343,461)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(343,461)**	**(343,461)**
Net funding	347,182	**347,182**
Balance at 31 March 2021	**(22,984)**	**(22,984)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20		
Balance at 01 April 2019	(27,104)	**(27,104)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(27,104)**	**(27,104)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20		
Net operating costs for the financial year	(337,239)	(337,239)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(337,239)**	**(337,239)**
Net funding	337,637	337,637
Balance at 31 March 2020	**(26,705)**	**(26,705)**

The notes on pages 166 to 185 form part of this statement

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(343,461)	(337,239)
Depreciation and amortisation	5	15	1
(Increase)/decrease in trade & other receivables	9	(923)	286
Increase/(decrease) in trade & other payables	11	(6,238)	(635)
Net Cash Inflow (Outflow) from Operating Activities		**(350,606)**	(337,587)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(46)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(46)
Net Cash Inflow (Outflow) before Financing		**(350,606)**	(337,633)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		347,182	337,637
Net Cash Inflow (Outflow) from Financing Activities		**347,182**	337,637
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(3,424)**	4
Cash & Cash Equivalents at the Beginning of the Financial Year		**5**	1
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(3,419)**	5

The notes on pages 166 to 185 form part of this statement

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. DHSC guidance confirms that it is reasonable to assume funding will continue to flow on the same basis for 2021/22.
Based on this position, the CCG believes that it remains appropriate to prepare the accounts on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities. The accounts for 2020-21 have been calculated under a net accounting basis.

1.3 Joint arrangements

The clinical commissioning group has no joint arrangements other than one pooled budget see note 1.4.

1.4 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Calderdale Council under Section 75 of the National Health Service Act 2006.

The pooled budget is jointly controlled between the CCG and Calderdale Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.60 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of
• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.14 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.16 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
· Financial assets at amortised cost;
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **Other Financial Liabilities at Amortised cost**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. Management does not consider that there are any critical accounting judgements or material sources of estimation uncertainty.

1.21 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted early adoption is not therefore permitted.

2 Other Operating Revenue

	2020-21 Total	2019-20 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**760**	2,148
Other Contract income	**97**	186
Recoveries in respect of employee benefits	**-**	26
Total Income from sale of goods and services	**857**	**2,360**
Total Operating Income	**857**	**2,360**

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Other Contract income	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	2020-21	2020-21	2019-20	2019-20	2019-20
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	103	-	1,674	113	26
Non NHS	657	97	474	73	0
Total	**760**	**97**	2,148	186	26

	Non-patient care services to other bodies	Other Contract income	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	2020-21	2020-21	2019-20	2019-20	2019-20
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	760	97	2,148	186	26
Over time	-	-	-	-	-
Total	**760**	**97**	2,148	186	26

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,543**	**409**	**3,951**
Social security costs	**377**	**-**	**377**
Employer Contributions to NHS Pension scheme	**616**	**-**	**616**
Apprenticeship Levy	**3**	**-**	**3**
Gross employee benefits expenditure	4,539	409	4,948
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	4,539	409	4,948
Net employee benefits excluding capitalised costs	4,539	409	4,948

4.1.1 Employee benefits

	Total		2019-20
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,330**	**236**	**3,566**
Social security costs	**352**	**-**	**352**
Employer Contributions to NHS Pension scheme	**569**	**-**	**569**
Apprenticeship Levy	**3**	**-**	**3**
Gross employee benefits expenditure	4,254	236	4,490
Less recoveries in respect of employee benefits (note 4.1.2)	**(26)**	**-**	**(26)**
Total - Net admin employee benefits including capitalised costs	4,228	236	4,464
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,228	236	4,464

4.1.2 Recoveries in respect of employee benefits

	2020-21 Total £'000	2019-20 Total £'000
Employee Benefits - Revenue		
Salaries and wages	**-**	**(21)**
Social security costs	**-**	**(2)**
Employer contributions to the NHS Pension Scheme	**-**	**(3)**
Total recoveries in respect of employee benefits	-	(26)

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**60.59**	**19.03**	**79.62**	**61.29**	**16.39**	**77.68**

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	73,581	1	73,581
Total	**-**	**-**	**1**	**73,581**	**1**	**73,581**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	1	73,581	-	-
Total	**1**	**73,581**	**-**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs are accounted for in accordance with relevant accounting standards in full in the year of departure. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Admin £'000	2020-21 Programme £'000	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	110	254	364	602
Services from foundation trusts *(1)	0	182,913	182,913	180,739
Services from other NHS trusts	-	21,741	21,741	21,445
Purchase of healthcare from non-NHS bodies	-	63,005	63,005	58,866
Prescribing costs	-	34,393	34,393	37,584
General Ophthalmic services	-	171	171	206
GPMS/APMS and PCTMS *(2)	-	32,300	32,300	30,750
Supplies and services – clinical	-	14	14	17
Supplies and services – general	222	999	1,221	676
Consultancy services	-	-	-	-
Establishment	258	746	1,004	1,020
Transport	0	9	9	3
Premises	390	1,432	1,822	2,496
Audit fees *(4)	59	-	59	49
Other non statutory audit expenditure				
· Internal audit services	-	-	-	-
· Other services *(3)	12	-	12	10
Other professional fees	40	71	111	198
Legal fees	6	-	6	45
Education, training and conferences	14	14	28	10
Total Purchase of goods and services	**1,111**	**338,062**	**339,173**	**334,716**
Depreciation and impairment charges				
Depreciation	15	-	15	1
Impairments and reversals of investment properties	-	-	-	-
Total Depreciation and impairment charges	**15**	**-**	**15**	**1**
Other Operating Expenditure				
Chair and Non Executive Members	182	-	182	392
Total Other Operating Expenditure	**182**	**-**	**182**	**392**
Total operating expenditure excluding staff costs	**1,308**	**338,062**	**339,370**	**335,109**

Admin Expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or

***1** Internal Audit Fees of £33k 2020-21 (2019-20 £35k) are included in Services from Foundation Trusts.

***2** GPMS/APMS and PCTMS included £31.650m for delegated responsibility for commissioning Primary Medical Services for 2020/21 (£29.558m in 2019/20).

***3** Fee relates to compliance work in relation to the Mental Health Investment Standard.

***4** Audit fees stated are inclusive of irrecoverable VAT.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the CCG's contract with its auditors provides for a limitation of the auditor's liability of £2m.

6.1 Better Payment Practice Code

Measure of compliance	2020-21 Number	2020-21 £'000	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,351	99,555	9,782	94,751
Total Non-NHS Trade Invoices paid within target	9,132	92,904	9,586	92,228
Percentage of Non-NHS Trade invoices paid within target	**97.66%**	**93.32%**	98.00%	97.34%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,087	210,073	2,888	207,431
Total NHS Trade Invoices Paid within target	1,049	209,927	2,792	206,389
Percentage of NHS Trade Invoices paid within target	**96.50%**	**99.93%**	96.68%	99.50%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2020-21 £'000	2019-20 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2020-21 Buildings £'000	2020-21 Total £'000	2019-20 Buildings £'000	2019-20 Total £'000
Payments recognised as an expense				
Minimum lease payments	904	**904**	1,071	1,071
Contingent rents	-	**-**	-	-
Sub-lease payments	-	**-**	-	-
Total	**904**	**904**	1,071	1,071

7.1.2 Future minimum lease payments

	2020-21 Buildings £'000	2020-21 Total £'000	2019-20 Buildings £'000	2019-20 Total £'000
Payable:				
No later than one year	870	**870**	963	963
Between one and five years	3,096	**3,096**	3,191	3,191
After five years	2,841	**2,841**	3,615	3,615
Total	**6,807**	**6,807**	7,769	7,769

The CCG occupies property owned and managed by NHS Property Services. The two most significant leases are in relation to Dean Clough and to Todmorden Health Centre.

8.1 Property, plant and equipment

2020-21	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	184	700	884
Cost/Valuation at 31 March 2021	**184**	**700**	**884**
Depreciation 01 April 2020	140	700	840
Charged during the year	15	-	15
Depreciation at 31 March 2021	**155**	**700**	**855**
Net Book Value at 31 March 2021	**29**	**-**	**29**
Purchased	29	-	29
Total at 31 March 2021	**29**	**-**	**29**
Asset financing:			
Owned	29	-	29
Total at 31 March 2021	**29**	**-**	**29**

2019-20	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	138	700	838
Additions purchased	46	-	46
Cost/Valuation at 31 March 2020	**184**	**700**	**884**
Depreciation 01 April 2019	139	700	838
Charged during the year	1	-	1
Depreciation at 31 March 2020	**140**	**700**	**840**
Net Book Value at 31 March 2020	**44**	**-**	**44**
Purchased	44	-	44
Total at 31 March 2020	**44**	**-**	**44**
Asset financing:			
Owned	44	-	44
Total at 31 March 2020	**44**	**-**	**44**

8.2 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2020-21	2019-20
	£'000	£'000
Information technology	139	139
Furniture & fittings	700	700
Total	**839**	**839**

8.3 Economic lives

	Minimum Life	**Maximum Life**
Information technology	1	3
Furniture & fittings	3	15

9.1 Trade and other receivables	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	1,209	-	3	-
Non-NHS and Other WGA receivables: Revenue	16	-	152	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	-	-	115	-
VAT	8	-	40	-
Total Trade & other receivables	**1,233**	**-**	**310**	**-**
Total current and non current	**1,233**		**310**	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

9.2 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	14	-	94	12
By three to six months	3	12	-	-
By more than six months	-	-	-	-
Total	**17**	**12**	**94**	**12**

£28k of the amount above has subsequently been recovered post the statement of financial position as at 9 June 2021.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2021.

10 Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	5	1
Net change in year	(3,424)	4
Balance at 31 March 2021	**(3,419)**	**5**
Made up of:		
Cash with the Government Banking Service	105	5
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**105**	**5**
Bank overdraft: Government Banking Service	(3,524)	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2021	**(3,419)**	**5**
Patients' money held by the clinical commissioning group, not included above	-	-

11 Trade and other payables	**Current 2020-21 £'000**	Current 2019-20 £'000
NHS payables: Revenue	232	1,651
NHS accruals	117	1,368
Non-NHS and Other WGA payables: Revenue	7,382	13,751
Non-NHS and Other WGA accruals	12,697	9,563
Social security costs	56	56
Tax	46	45
Other payables and accruals	297	631
Total Trade & Other Payables	**20,827**	**27,065**
Total current and non-current	**20,827**	**27,065**

The CCG has no liabilities for early retirement.

Other payables include £292k outstanding pension contributions at 31 March 2021 (2019-20 £67k).

12 Borrowings

The Clinical Commissioning Group has a bank overdraft as at 31 March 2021 (£3,524K) which are the payments made on the 31st March 2021. The payments were made to meet contractual commitments which are included in the cash book and ledger but will not clear until after the 1 April 2021. This has resulted in the CCG having a credit ledger cash position which is acceptable and only reflects a timing difference in the drawdown process and cash being made available in the bank. This is acceptable within NHSE guidance.

13 Provisions

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2021 is nil. (2019/20 £51,001).

14 Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

14.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

14.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

14.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	1,208	1,208
Trade and other receivables with external bodies	16	16
Cash and cash equivalents	105	105
Total at 31 March 2021	**1,329**	**1,329**

	Financial Assets measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	3	3
Trade and other receivables with external bodies	151	151
Cash and cash equivalents	5	5
Total at 31 March 2020	**159**	**159**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Bank overdraft	3,524	**3,524**
Trade and other payables with NHSE bodies	349	**349**
Trade and other payables with other DHSC group bodies	10,345	**10,345**
Trade and other payables with external bodies	10,031	**10,031**
Total at 31 March 2021	**24,249**	**24,249**

	Financial Liabilities measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Bank overdraft	-	-
Trade and other payables with NHSE bodies	528	528
Trade and other payables with other DHSC group bodies	11,253	11,253
Trade and other payables with external bodies	15,183	15,183
Total at 31 March 2020	26,964	26,964

15 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

16 Joint arrangements - interests in joint operations

Better Care Fund – The CCG entered into a partnership agreement with Calderdale Council in April 2015 to manage the Better Care Fund (BCF) as a pooled budget arrangement from 2015/16 onwards. A joint assessment was conducted with the Council on how the arrangement should be accounted for by reference to the Department of Health Group Manual for Accounts 2015/16 (Chapter 3 Annex 1) and the guidance on "Pooled budgets and the Better Care Fund" produced in October 2014 by HFMA/CIPFA. In accordance with this guidance, the CCG recognises this as a joint operation under joint arrangements in accordance with IFRS11 in respect of accounting for the income and expenditure and assets and liabilities proportionate to the risks and rewards it enjoys. The total available BCF funding for the year was £18.5m (2019/20 £17.4m), of which the CCG was allocated and recognised in its accounts £4.9m of income and £4.9m of expenditure (2019/20 £4.8m) (Calderdale Council £13.6m (2019/20 £12.6m). NHS Calderdale CCG's participating cash contribution is £15.5m (2019/20 £14.7m).

16.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in CCG's books ONLY 2020-21 Expenditure	Amounts recognised in CCG's books ONLY 2019-20 Expenditure
			£'000	£'000
Better Care Fund	NHS Calderdale CCG & Calderdale Council	Reduction of DTOC and Emergency Readmissions	4,914	4,832

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Council in relation to the Better Care Fund.

The Better Care Fund (BCF) is a mandatory policy to facilitate integration of service provision between Health and Social Care.

The schemes managed through the BCF include: Disabled Facilities Grants, carers services, supporting social care, reablement and recovery services. Under the policy we have to report on a number of metrics which include delayed discharges from hospital and levels of emergency admissions.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budget is jointly controlled between the CCG and Calderdale Council.

16.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The CCG has no interests not accounted for under IFRS 10 or IFRS 11.

17 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health.

During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practice for which Governing Body members have a relationship have been disclosed below. In 2020/21 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

	2020/21 £'000	2019/20 £'000
Spring Hall Group Practice (Dr Steven Cleasby)	2,528	1,310
Beechwood Medical Centre (Dr Caroline Taylor)	1,297	1,126
Rastrick Health Centre (Dr F Javid)	667	646
Bankfield Surgery (Dr J Gray)	1,207	1,230
Rosegarth (Dr H Davies moved from Hebden Bridge Practice 2019-20)	1,266	1,283

CCG Accountable Officer (from 16 October 2020) is Chief Executive of Calderdale Council.

Robin Tuddenham is employed as the CCG's Accountable Officer. This is a joint appointment with Calderdale Council. The two parties pay 50% of the Accountable Officer's salary

In addition the executive Governing Body and Senior Management Team members have relatives or interests with the following organisations :
North Halifax Community Wellbeing Partnership
Rosegarth Surgery
Calderdale and Huddersfield NHS FT,
Leeds United Foundation
Calderdale MBC
West Yorkshire & Harrogate Health and Care Partnership.
Rycroft Health Associates
Pennine GP Alliance
Caring for Health Ltd
Moorside Pharma Developments Ltd
Optimal Healthcare Ltd
Beechwood Medical Centre
Rastrick Health Centre
Bankfield Surgery
Elland Pharmacy
Calderdale Group Practice Ltd
TCV Employment and Training Services Limited
Spring Hall Group Practice
Spring Hall Group Properties Ltd
Bank Workers Charity
Thornton Medical Centre
NHS Greater Huddersfield CCG
NHS North Kirklees CCG

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

Calderdale and Huddersfield NHSFT
South West Yorkshire Partnership NHSFT
Yorkshire Ambulance NHS Trust
Leeds Teachings Hospitals NHST
Bradford Teachings Hospitals NHSFT

In addition the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies:

Calderdale Council

18 Events after the end of the reporting period

The Clinical Commissioning Group is expecting to cease operations as an individual entity after the 31st March 2022 and is expecting to merge into an Integrated Care System from 1st April 2022.
The Clinical Commissioning Group has no other post balance sheet events which will have a material effect on the financial statements.

19 Losses and special payments

Losses
The CCG has had no losses during the period.

Special payments
The CCG has had no special payments during the period.

20 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2020-21 Target £'000	**2020-21 Performance £'000**	**2020-21 Duty Achieved**	2019-20 Target £'000	2019-20 Performance £'000	2019-20 Duty Achieved
Expenditure not to exceed income	344,365	344,318	Yes	340,616	339,599	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes	50	45	Yes
Revenue resource use does not exceed the amount specified in Directions	343,508	343,462	Yes	338,256	337,239	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	50	45	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,295	4,294	Yes	4,850	4,138	Yes

The CCG received total revenue resource allocation of £343,508k and had net expenditure of £343,462k delivering an in year surplus of £46k.

Independent auditor's report to the members of the Governing Body of NHS Calderdale Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journals, management estimates and transactions outside the course of business.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud
  - journal entry testing, with a focus on manual journals, pooled budget transactions, journals posted post year end, closing entry journals and large value journals
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

As explained in the Annual Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Calderdale CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Gareth D Mills

Gareth Mills, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Leeds

15 June 2021