NHS
Calderdale
Clinical Commissioning Group

MINUTES OF THE PUBLIC SECTION OF THE MEETING OF NHS CALDERDALE CCG GOVERNING BODY HELD ON THURSDAY 29 JULY 2021 AT 2PM VIA VIDEO CONFERENCE

Due to the COVID 19 public health emergency this meeting was live streamed.

PRESENT

Dr Steven Cleasby (SC) CCG Chair
Robin Tuddenham (RT) Accountable Officer
Lesley Stokey (LS) Director of Finance
Penny Woodhead (PW) Chief Quality and Nursing Officer
Dr Farrukh Javid (FJ) GP Member
Dr James Gray (JG) GP Member
John Mallalieu (JM) Deputy CCG Chair, Lay Member (Finance and Performance)
Alison MacDonald (AM) Lay Member (Patient and Public Engagement)
Prof Peter Roberts (PR) Lay Member (Audit)
Dr Rob Atkinson (RA) Secondary Care Specialist
Prof Rob McSherry (RM) Registered Nurse
Denise Cheng-Carter (DCC) Lay Advisor

IN ATTENDANCE

Zoe Akesson (ZA) Corporate Governance Officer (Minutes)
Rhona Radley (RR) Deputy Head of Service Improvement (for item 6, minute 40/21)
Jenna McGuinness (JMcG) HR Manager (for item 10, Item 44/21)
Debbie Graham (DG) Head of Integration and Partnerships (for item 11, minute 45/21)
Tim Shields (TS) Performance Manager (for item 11, minute 45/21)

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35/21 APOLOGIES FOR ABSENCE

Apologies were received from Neil Smurthwaite, Dr Caroline Taylor, Iain Baines and Deborah Harkins.

36/21 DECLARATIONS OF INTEREST

Governing Body members were invited to declare any interests relevant to items on the agenda. There were no declarations of interest. The Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests.

37/21 MINUTES OF THE LAST MEETING

The minutes of the public section of the Governing Body meeting held on 29 April 2021 were **RECEIVED** and **ACCEPTED** as a correct record.

Matters Arising

The actions from the previous meeting were complete apart from 25/21, around developing a patient story on the long COVID-19 pathway, which would be actioned in due course.

38/21 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

39/21 PATIENT STORY - FEEDBACK FROM THE ST AUGUSTINE'S CENTRE COVID CLINIC

The story about 4 people's experiences who accessed the pop-up vaccination centre at the St Augustine's Centre was played out in a short film to the Governing Body. The purpose of the pop-up site was to ensure equity of the vaccine across all communities, recognising the centre was in contact with people from ethnic communities, refugees and those seeking asylum. Over 100 people had their first dose in April and 65 attended for a second dose in June. PW explained the programme team worked with staff at the centre on clear messaging and the best time to maximise the opportunity to allow people to get the vaccine. The learning taken from this is that going into communities, and using trusted people and venues allows for a more successful uptake by people who wouldn't have routinely accessed the

service through regular channels. Although bespoke services often require extra time and money, it was recognised a universal service doesn't reach everybody and this learning can be taken into not only the extension of the vaccination programme but other areas of health screening. RT confirmed this learning would be built upon and the model would be replicated for the booster and flu campaign in the Autumn.

The Governing Body **RECEIVED** the Patient Story.

40/21 ACCOUNTABLE OFFICER'S REPORT

The report provided an overview of the last quarter and thanked everybody in the system for their efforts in managing the current pressures. Attention was drawn to the following matters:

There will be an Autumn vaccination campaign that will include flu, which will be a matter of importance going forwards due the reduce level of immunity in the population.

An update on the percentage of vaccine uptake was provided to the meeting. Those in the in the JCVI cohorts 1-9 (50+, CEV and those with an Underlying Health Condition) who have received their vaccination had risen to: 1st dose - 92,565 (91%) and 2nd dose - 89,462 (88%). Those in JCVI cohorts 10-12 (aged 18-49) had risen to : 1st dose - 62,249 (71%) and 2nd dose - 40,715 (46%).

A proposal has been agreed by the Government for mandatory vaccines for staff who work in and routinely visit social care settings. The mandatory vaccination date for the second dose is 11 November 2021 and work has started to ensure staff are fully vaccinated before this date. It was also recognised this decision will have an impact on the social care sector's workforce, which is currently running with a large number of vacancies. There are currently no plans for vaccines to be mandatory for all NHS staff, it is only indirectly for those who go into social care settings.

Urgent and emergency care is currently running at unprecedented levels. The volume of people presenting is high including those who have delayed

seeking treatment and those presenting with long term conditions. Primary Care and community pharmacies are also under a great amount of pressure and combined with workforce absence issues, it is leading to capacity issues amongst providers. PW assured the meeting that the CCG is working with Calderdale and Huddersfield NHS Foundation Trust (CHFT) to ensure safe staffing levels and through put within the Emergency Department (ED).

Good performance has been reported in Elective Care recovery. The CCG continues to work with CHFT on backlogs, supporting unblocking and targeting specific referral pathways such as Ears, Nose and Throat (ENT) where providers are opening-up more appointment slots.

The report provided an update on the process around the Integrated Care Partnership (ICP) and Calderdale Cares. The Health and Care Bill had a second reading on 14 July 2021, and it is likely to become law in the Autumn to enact the transition to the Integrated Care System (ICS) from 1st April 2022. Rob Webster was appointed Interim Chair of the ICS on 1st July 2021 and further executive appointments will follow in the Autumn.
In relation to governance, Place is currently working towards a preferred model of a joint committee. Rachel Bevan, from North East Commissioning Support Unit, has been appointed as Programme Manager for ICP development in Calderdale and is supporting the CCG on a full-time basis. The team is on track with this work and a more **substantial proposal will be presented at October's Governing Body meeting**.

RT acknowledged the CCG's Annual Assessment 2020-21 letter received from NHSE, which was based on rigorous place assurance processes. The letter reflected the good leadership work over the last 12 months across place and **the Chair asked for this to be published on the CCG's website and thanks be given to the workforce and wider system for their support.**

The Governing Body **RECEIVED** and **NOTED** for assurance the Accountable Officer's Report.

41/21 BURNT BRIDGES REPORT: LEARNING AND ACTIONS

The report provided an overview of the key learning from a Safeguarding Adults Review (SAR) that was undertaken by the Calderdale Safeguarding Adults Board, into the deaths of 5 people who lived street-based lives in Calderdale. The report set out 3 key areas for health to address: training and education, integration and collaboration and timely and modified access. Work relating to all three areas had already started with some outreach work being undertaken with homeless people and a multi-agency group working together to address the issues.

Governance arrangements were in place and the CCG produced its own action plan. The Quality Finance and Performance Committee (QFPC) formally approved this in June and would monitor the progress and delivery of the actions on a quarterly basis.

The following comments were made:

- PR offered RR connections into the live national debate on homelessness.
- PW acknowledged the work of the Safeguarding Adult Board's leadership for commissioning this non-statutory review.
- Learning taken from the review is that place lead healthcare and a wraparound trauma informed service is the way forward for people who live street-based lives. The learning has been shared both regionally and nationally.

In conclusion, the Governing Body supported the approach, governance arrangements, and action plan. A recommendation was made for the Senior Management Team to help with any system blocks encountered and as the CCG transitions next year, this work would be embedded into system working.

DECISION: The Governing Body **AGREED** the CCG's action plan.
The Governing Body **NOTED** the learning and specific actions assigned to the CCG and **NOTED** the governance approach to address the actions and monitoring of the action plan

42/21 COMPLAINTS ANNUAL REPORT 2020 - 2021

The annual report detailed the performance around the CCG's complaint handling process and support provided to complainants during the pause period. The meeting was reminded that the CCG complaints process restarted in July 2020. The number of complaints received from people around vaccinations and access into Primary Care peaked around December 2020 and January 2021. The report also informed Governing Body about the changes to the ombudsman arrangements and the expected publication of the changes to the NHS complaints standards. No complaints were received by the CCG last year that involved the National Guardian's Office. PW thanked the complaints team for all their hard work and day to day support around complaints.

A short discussion followed on access to primary care and how some still perceive as closed. The position for Calderdale is that everything is open. The team and primary care colleagues are listening to individuals and working with member practices on these cases. JS also provided a generic question and answer sheet to Member of Parliament offices to help support them with issues or queries they receive. The Governing Body were assured with the processes in place to manage complaints. The Chair commented it was a very challenging area to deal with and the team do an excellent job.

The Governing Body **NOTED** the complaint activity regarding services commissioned by NHS Calderdale CCG during 2020 and 2021.

43/21 JOINT SAFEGUARDING ADULTS AND CHILDREN ANNUAL REPORT 2020 – 2021

The report provided a review of the safeguarding adults and children's work undertaken this year. It described how the CCG discharged and met its statutory and legislative duties for safeguarding adults and children at risk of abuse or neglect as well as the impact and achievements for the team. The report evidenced how the scope of the work and its diversity is constantly growing. It was noted that the team has a full complement of safeguarding roles, either directly employed by the CCG or in commissioned roles.

A key theme of the team's work this year was on the impact of austerity and poverty inequalities on safeguarding. A master's student was asked to write a dissertation on this topic. The Safeguarding Adults Board (SAB) ran a workshop in December 2021, which led to several actions including the collection of data on safeguarding referrals and deprivation in Calderdale. The SAB also published the Burnt Bridges report, which has helped focus the system on closing the inequalities gap.

From an ICS perspective, work is taking place to ensure robust safeguarding systems are in place both in Calderdale and across the system. PW pointed out the CCG team had driven the work in relation to the regional designated professionals' network, working on embedding a common set of principles across West Yorkshire.

The organisational risk around the Liberty Protection Safeguards was raised. The team is unable to fully describe the implications for the CCG until the guidance and code of practice are received but this will be a key feature in the quality and safety conversations at QFPC in the future.

The Governing Body **RECEVEID** and were **ASSURED** that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity.

44/21 PATIENT AND PUBLIC ENGAGEMENT ANNUAL STATEMENT OF INVOLVEMENT APRIL 2020 – MARCH 2021

The report provided an annual account of the CCG involvement activity along with examples from partners. The report described the vast amount of engagement activity, delivered during a difficult year, with individuals, communities, and special interest groups. It also reflected how voice has impacted on the CCG's work and how the organisation values and focusses on people's opinions.

PW reminded members, the Governing Body approved the Involving People's Strategy in 2020, which supports the direction of travel in relation to Calderdale Cares and the integration journey. The CCG received a green

star for the NHSE involvement assessment in 2020. PW thanked the people of Calderdale who shared their views and opinions, which has helped the CCG make better decisions, that can be built upon in the future.

DECISION: The Governing Body **APPROVED** the annual statement of involvement as an accurate account of the CCG's engagement activity during the period of April 2020 - March 2021 and **AGREED** for the report to be published.

45/21 WORKFORCE REPORT

The report provided an overview of the CCG's workforce data for the reporting period 1 January to 30 June 2021. It also provided the Governing Body with detailed information and assurance on matters relating to the CCG's workforce.

Staff turnover was relatively consistent. There had been 8 leavers but no significant concerns to report in relation to reason for leaving. Exit interviews were offered but uptake was low. A suggestion was made for SMT to encourage uptake. There are currently no formal disciplinary, grievance or performance cases.

Sickness absence rates fluctuated with peaks in long term sickness. The top reason was due to stress, anxiety, and depression due to a combination of personal and work situations. All return-to-work meetings had taken place for staff returning to work.

Considering the difficult year, staff mandatory training performance was good with close to 95% compliance in most cases. JMc was asked to revisit the age profile table and extend to 75years. There was also a request for an explanatory note to be added to the mandatory training graphs on how many in the population would be expected to complete the modules, as this differs for different levels.

Equality and diversity work continues. Action plans around the WRES and WDES data for 2020-21 would be presented to SMT in the Autumn.

HR colleagues have been involved in key pieces of work including supporting carers in the workplace, arranging for a wellbeing gift to be sent to all staff early August to say thank you for their hard work during the pandemic, the recent completion of the base change procedure for the accommodation review and conversations have commenced with Accountable Officers around the HR changes to be made through the Health and Care Bill and employment commitment and how staff will be informed.

The Governing Body **RECEIVED** and **NOTED** the content of the CCG workforce report.

46/21 UPDATE ON 2021-2022 PLANNING ROUND

An overview paper and a copy of the narrative planning submission for 2021-22 was received by Governing Body. The submission covered H1 (first 6 months of the year) with the expectation of another planning submission request for H2. The approach was place based, with all partners working together on the submission, an excellent example of collaborative work. It was presented in 2 formal checkpoint meetings to NHSE and at the ICS World Café event for assurance. The submission also included risks, which if material were included on the CCG's risk register.

An observation was made that the plan may identify opportunities for organisations to pool resources, benefiting from economies of scale, such as the workforce initiatives and to take this into account when planning for H2.

There was a concern around the amount of work involved. DG assured members that a prioritisation process is being worked through to ensure core actions/key priorities are met. The aim is to develop an easy framework that will support staff to work through this next period, keeping in line with the CCG's strategic direction and focussed on its priorities as a place. The CCG is using the ICS development framework to guide its approach.

A comment was received on the low percentage of employed people with autism and learning difficulties and if post-diagnosis could be considered at the planning stage in the future.

The Governing Body **CONSIDERED** the update on the process, which has taken place for the completion of a place-based planning submission for 2021/22 and the full version of the narrative. Members would **SEEK** further updates on progress, particularly in relation to the development and delivery of operational priorities for 2021/22.

47/21 DIRECTOR OF FINANCE'S REPORT

In relation to Finance, the CCG submitted its audited annual accounts to NHSE on 15 July 2021, it delivered its financial plan, and the CCG accounts were signed off 'unqualified' by the external auditors Grant Thornton.

The CCG received £176m of the ICS allocation for H1 (April 2021 to September 2021). It is expected to breakeven against this allocation, making a QIPP saving of £2m. Currently the CCG is forecasting an over overspend of £0.9m relating to expenditure outside the baseline however an additional allocation is expected to cover this. The QIPP forecast is showing an under delivery of £0.8m due to the unidentified plan at the beginning of the year. The team is working on identifying potential savings opportunities to mitigate this and is currently utilising its contingency to deliver a balanced plan.

The confirmed planning allocation for H2 is not yet known and is due September. It is expected there will be an additional 'waste reduction' savings target. The Governing Body acknowledged the risk and to be mindful around future spending until this has been received.

The update provided key messages relating to contracting activity. It was highlighted there are significant pressures on 999/111 and urgent care services, as activity waiting times deteriorate. However good performance was reported on the wheelchair and posture mobility service with the CCG being nominated for a national award for their work and engagement in the procurement of the service.

With regards to Performance, there is considerable pressure on emergency services, with activity levels in the A&E department 18% higher than pre-covid levels. CHFT are performing well despite the increased activity levels and

remain in the upper quartile nationally for performance. To manage the pressures, the Urgent and Emergency Care Board is focussing on priority areas such as the new urgent community response work and working collaboratively with ED on developing integrated pathways and revisiting the modelling.

Recovery is being seen in elective care and outpatients, which is a positive message, and the Elective Care Improvement Group continues to focus on specialities, to address the back log and improve pathways. Good performance is consistently reported for Cancer waiting times and there are specific pieces of work happening in mental health for children and young people with an eating disorder, perinatal access rates and learning disability health checks. It was also pointed out the IAPT is still consistently meeting targets. PW added that a more focussed conversation on mental health, around lessons learned from the learning disability health checks and people with serious mental illness, would be taken into Commissioning Primary Medical Service Committee.

In relation to a question around LOS and maintaining performance in DTOC, this area remains very pressured due to issues in community and challenges around transfers and workforce. Work is ongoing to alleviate these pathways through resourcing additional providers and opening new pathways to keep the flow moving.

In conclusion, Governing Body felt overall system performance was strong considering the current challenges and was assured by the report.

The Governing Body **NOTED** the content of the finance and contracting updates, the progress made towards achieving the standards set out in the NHS Constitution and the impact Covid 19 is having on the restoration of access levels to NHS services.

48/21 QUALITY AND SAFETY REPORT AND QUALITY DASHBOARD

The report and appended dashboard were received by the Committee, attention was brought to the following points:

- The Learning Disabilities Mortality Review (LeDeR) Programme's annual report was considered in detail at QFP Committee. The challenging but timely completeness of the reviews was acknowledged. A shift in the balance of the report from previous years was also highlighted, in that it was less about the processes and more about the learning and transformation, evidenced in the moving stories within the paper.
- It was pointed out that the publication of the National Quality Board Position Statement - Managing Risks and Improving Quality through Integrated Care Systems will be useful for the place-based discussions with quality leads. Further guidance is expected from the National Quality Board, including a dashboard and guidance how to conduct risk summits and quality surveillance arrangements.

The GB were assured with the high-quality report and dashboard. There were no further questions.

The Governing Body **RECEIVED** and **NOTED** the update on Quality and Safety information providing assurance regarding its main providers.

49/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 2 2021-22 (17 MAY - 2 JUNE 2021)

The high-level risk report for the end of the second risk review cycle for 2021-22 was presented to the meeting. There were 37 risks, with 4 marked for closure and 5 serious risks. Critical risk templates for risks 187, 1493 and 62 were appended to the report. The register was reviewed at June's QFP Committee and there were no challenges made. The critical risks around urgent and emergency care, transfer and elective recovery were covered in items on the agenda. Governing Body felt it was a fair reflection but noted the changing position and acknowledged there was no room for complacency.

The Governing Body **CONFIRMED** that it was assured that the high-level Risk Register represents a fair reflection of the risks experienced by the CCG at the end of risk cycle 2 2021-22.

50/21 COMMITTEES

a) **AUDIT COMMITTEE ANNUAL REPORT**

The Audit Committee Annual Report was presented to the Governing Body for its assurance. The following points were highlighted:

- there was a regular review and updating of policies
- the good ability to adapt by the internal audit facility, during challenging times
- although a good outcome from external audit there were certain transitional aberrations during the process where the Committee did have to track, monitor, and urge compliance.

The Governing Body **RECEIVED** the Audit Committee's Annual Report.

b) **MINUTES**

The Governing Body **RECEIVED** and **ACCEPTED** the following minutes:

- **Audit Committee held on 20 May 2021 and 10 June 2021**
  PR confirmed the Committee received the updated Conflict of Interest policy, the CCG and the sub-committees' annual reports and the updated Counter Fraud Guidance, which was subsequently sent out to member practices.
- **Quality, Finance and Performance Committee held on 24 June 2021**
  FJ invited the Governing Body to read the annual research report, which was an example of the good work happening regionally, despite Covid.

- **Commissioning Primary Medical Services Committee held on 27 May 2021**
  Attention was drawn to the devolvement to SMT of the process for approving the PCN delivery plans, clarity around direction of travel on the Estates Strategy which will take place in development session, the return of the quality dashboard and MH metrics and the balanced CPMSC budgets for 2021.

51/21 EXTERNAL MEETINGS

- The Governing Body **RECEIVED** and **ACCEPTED** the minutes of the West Yorkshire and Harrogate Joint Committee of CCGs meeting held on 6 April 2021
- The Governing Body **RECEIVED** and **ACCEPTED** the West Yorkshire and Harrogate Joint Committee of CCGs Annual Report 2020-21- summary version

52/21 KEY MESSAGES FOR MEMBER PRACTICES

The Governing Body **AGREED** the following messages:

- To share the Burnt Bridges 7-minute briefing produced by the Safeguarding Board with any further additions and recirculate to practices.
- To share a note about the CCGs Annual Assessment and outcome
- To share the open letter currently being developed by the ICS communications team on system pressures.

53/21 DATE AND TIME OF THE NEXT MEETING IN PUBLIC

Thursday 28 October 2021, 2.00pm, via video conference

The Governing Body Meeting 29 July 2021 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments / Completion Date
Patient Story	05/21	To develop a patient story as part of the Learning Disability Mortality Review	PW/SR	**Closed**	Work has taken place. Shared at HWBB, staff workshop / briefings.
Workforce Report	09/21	To review the process for recording and for the workforce report to be commented on and supported by Remuneration & Nomination Committee in advance of presenting to GB.	NS/JM	**Closed**	The process is in place and the report was shared with Rem & Nom ahead of July's GB meeting.
Patient Story	25/21	To develop a patient story on the long COVID-19 pathway	PW/FJ	C/fwd	Colleagues have been asked to share stories, once received will consider bringing into the GB meeting. Action remains open.

RECORD OF URGENT DECISION

1. **COMMITTEE/BODY ON BEHALF OF WHICH DECISION MADE**:
   Calderdale Governing Body

2. **DECISION MAKERS**

Robin Tuddenham	Accountable Officer
Dr Steven Cleasby	CCG Chair
Neil Smurthwaite	Chief Finance Officer / Chief Operating Officer
Lesley Stokey	Director of Finance

3. **CONSULTEE**

Dr James Gray	GB GP Member
John Mallalieu	Lay Member (Finance & Performance), CCG Deputy Chair

4. **CLINICAL/GB LEAD**

Dr James Gray	GB GP Member

5. **LEAD OFFICER**

Debbie Graham	Head of Strategic Planning, Performance & Delivery

6. **SUBJECT**
   Management of the CHFT elective joint replacement backlog at 'The Nuffield'

7. **DECISION**
   The Governing Body **APPROVED** the proposal to implement a contract waiver to fund and utilise the available capacity within The Nuffield.

8. **DETAILS AND RATIONALE**
   There is a challenge with elective recovery. A proposal was put forward for additional capacity within the Nuffield to support waiting lists for joint

replacements. Due to the urgency to progress this work, it was agreed that this would be made through the Urgent Decision (chair's actions) arrangements.

Patients will benefit from this proposal and it is affordable to the CCG however it was recognised this is extra spend and the CCG would be paying additionality, due the activity already being paid for under the CHFT contract.

Responses from Governing Body members have been saved down electronically providing a relevant audit trail.

9. **ANY RELEVANT IMPLICATIONS (Quality/Safety, Engagement/Equality, Resources/Finance, Data Protection, Risk, Legal/Constitutional, Conflicts of Interest etc):** Detailed in report

10. **REPORT ATTACHED?** Yes

11. **PUBLIC/PRIVATE?** Public

12. **If private, give reason(s):**

13. **TIME AND DATE OF DECISION:** 27 September 2021 at 14.41

14. **DECISION RECORDED BY**: Zoe Akesson, Corporate Governance Officer

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Accountable Officer's Report**	**Agenda Item No.**	6
Report Author	Robin Tuddenham, Accountable Officer, Neil Smurthwaite Chief Operating Officer	**Public / Private Item**	Public
Clinical Lead	-	**Responsible Officer**	Robin Tuddenham, Accountable Officer

Executive Summary
This report updates the Governing Body on current issues. This report provides assurance on the breadth of depth of work being undertaken by the CCG in a challenging operating context for the local health and care system.

Previous Considerations

Name of meeting	NA	**Meeting Date**	
Name of meeting	NA	**Meeting Date**	

Recommendations
It is recommended that the Governing Body: 1. **NOTES** the content of the report and 2. **RATIFIES** the joint Individual Funding Request policies detailed in point 10 of the report.

Decision ☒	**Assurance ☒**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified.

Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The CCG is committed to working with public, staff, patients, partners, and other stakeholders to improve health care services.
Resources / Financial Implications (including Staffing/Workforce considerations)	None identified.
Sustainability Implications	None identified.

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	• Achieving the agreed strategic direction for Calderdale • Improving quality • Improving value • Improving governance	**Risk (include risk number and a brief description of the risk)**	None identified.
Legal / CCG Constitutional Implications	• None identified.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest will be managed in line with the CCG's Conflict of Interest Policy.

1.0 Introduction

My report to the Governing Body provides an update on the wide-ranging work of the CCG as we approach the winter months. Since the last meeting there have been several developments regarding the COVID-10 vaccination programme, which plays a pivotal role in mitigating the risk and impact of the pandemic in Calderdale. We have seen a fantastic response so far as we move into the booster and school age programme before Christmas.

Our overarching priorities continue to be the vaccination programme, elective recovery, resumption of full cancer services, health inequalities, and primary care. We engage in all of these issues cognisant of the fundamental challenge of workforce capacity and resilience needed to sustain and deliver health and social care services. Our most recent assurance meeting with the ICS Team highlighted this challenge, also reflected in our own team, which is seeking to ensure maximum impact for our place within the West Yorkshire system, but is extremely stretched in doing so. I would like to thank all our staff for their tenacity, and professionalism in meeting these demands on a daily basis.

We enter one of the trickiest periods for health care providers remembering our Vision 2024 for Calderdale, and the core values of kindness, and resilience. As well as responding to these pressures, the report highlights impact in key areas of health and care such as children's mental health through our THRIVE model and provision of wheelchairs.

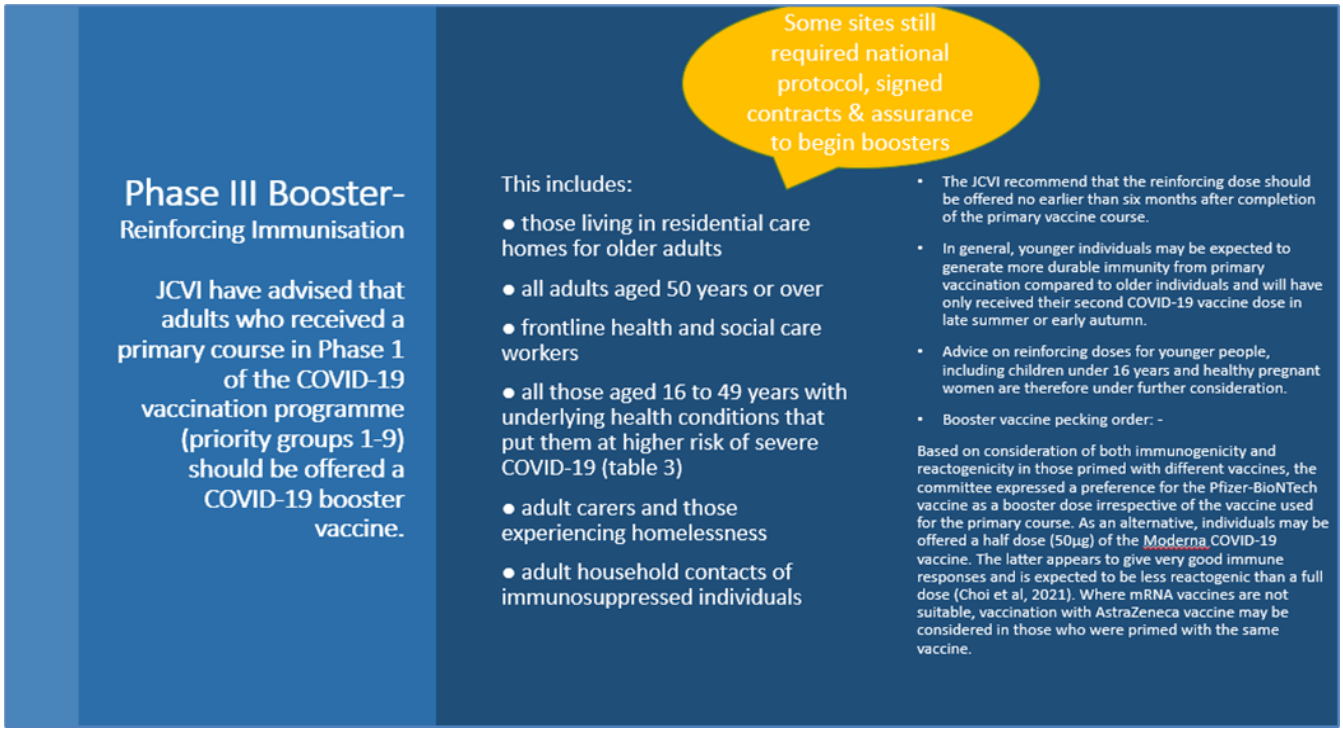
2.0 Covid-19 Update

2.1 COVID-19 Vaccination Programme

2.1.1 It's almost a year since the first COVID-19 vaccination was given in England.
Since that day we've seen an army of people come together across Calderdale to support the roll out of the programme here. And I know that includes you. As the vaccination programme now moves into the next phase, delivering boosters this winter, the programme team just wanted to take a moment to say a very big 'thank you'. Click on the link to receive your thank you:-
https://drive.google.com/drive/folders/1dS8Fe4s9bW97kwsbRO75EpWAvl3TE7gG?usp=sharing
(We're asking that everyone shares the video far and wide to ensure we reach out to everyone involved, so please do share this amongst your colleagues and friends).

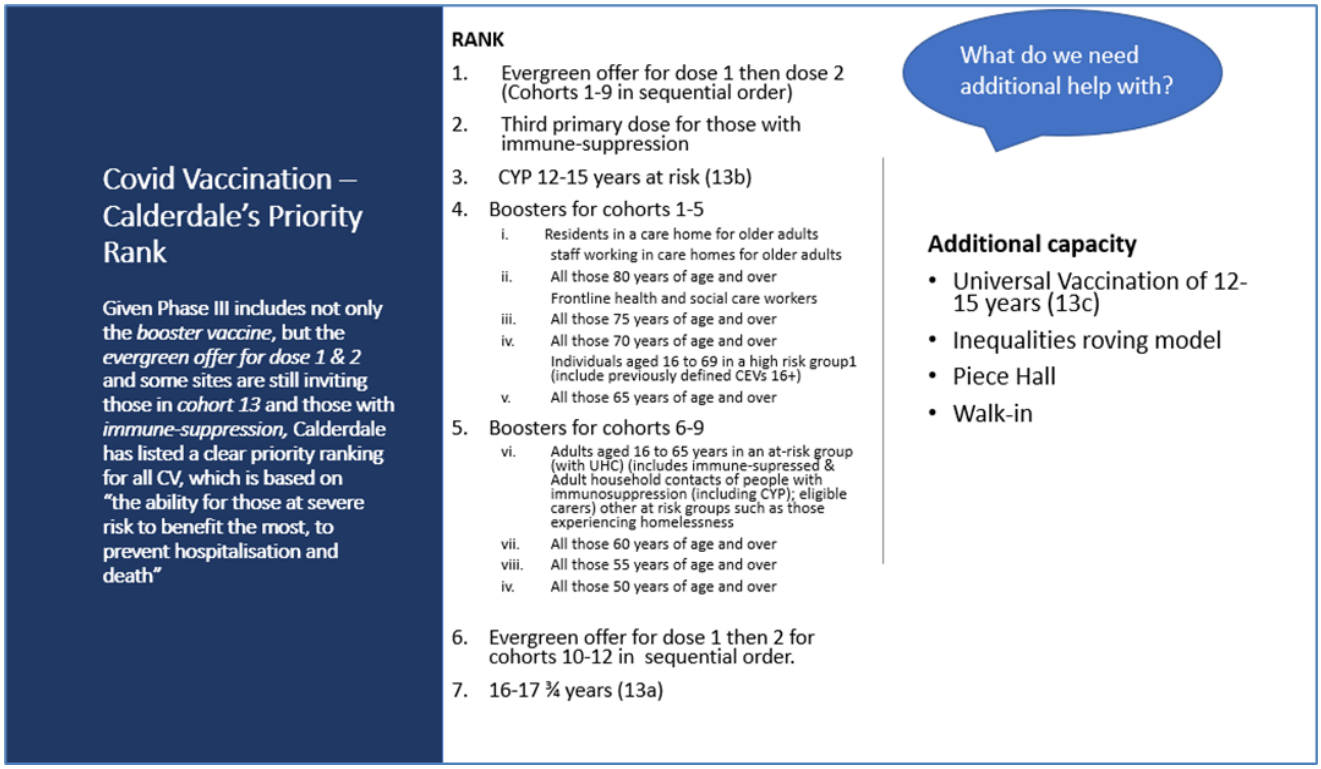
Because of your help, in Calderdale as of the 7th October 310, 261 vaccines have been administered to residents. Approximately 161, 000 of these are 1st doses. Out of those eligible (aged 12 years plus) 72% of people are fully vaccinated and 90% of those in cohorts 1-9 (over 50 years and with under lying health conditions) who are at risk of the worse outcomes of Covid have also received both doses.

2.1.2 On 14th September, the JCVI advised that adults who received a primary course in Phase 1 of the COVID-19 vaccination programme, should be offered a COVID-19 booster vaccine. The slide below covers the guidance.

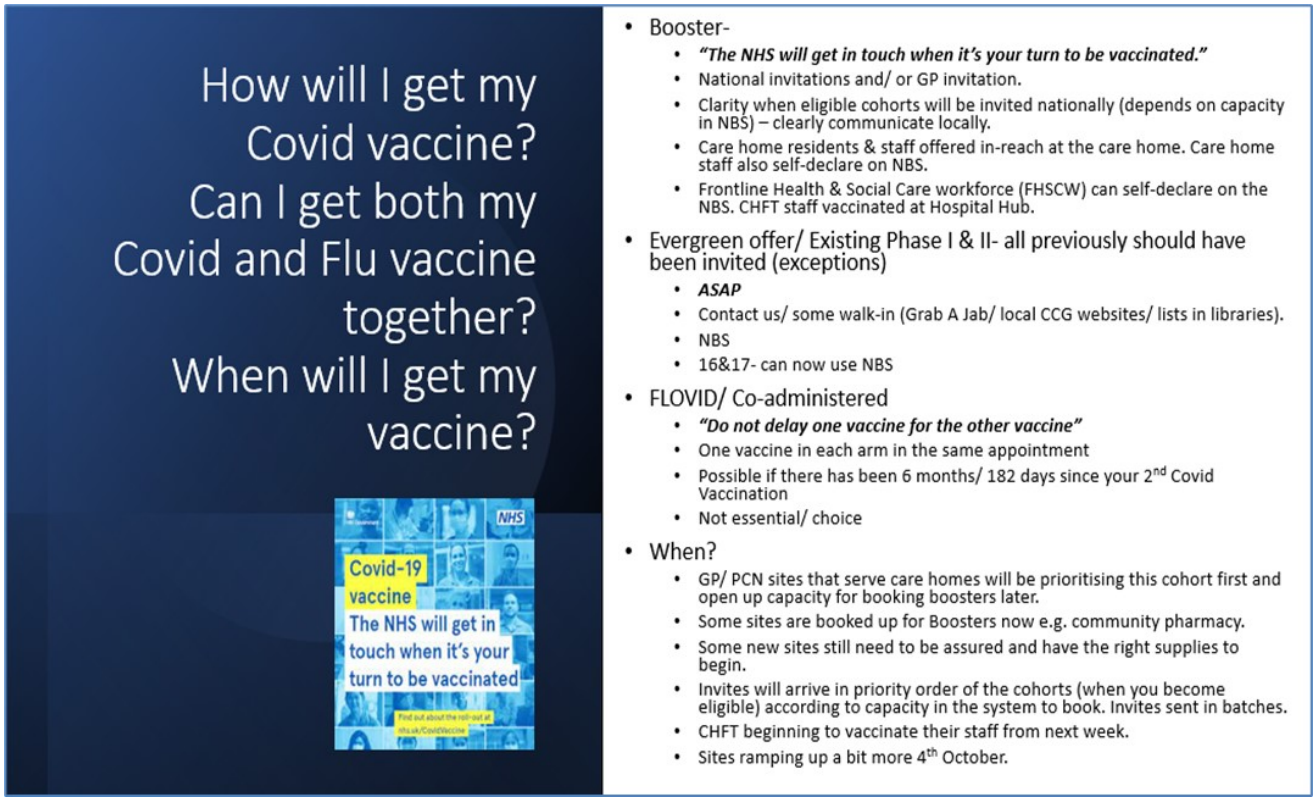


2.1.3 Booster vaccinations started at the beginning of October in Calderdale and are expected to escalate over coming months, as individuals become eligible (182 days since dose 2) and new sites continue to be onboarded. At the time of writing, over two thirds of older adult CQC registered care homes in Calderdale have already received their initial visit for booster vaccinations. We expect further progress by today's meeting date.

2.1.4 Out of those eligible in Phase I, approximately 95, 000 received both doses of the vaccine in cohorts 1-9. It is hoped that we will see at least this number of people come forward for their booster dose. These doses will be administered in addition to the continuation of the evergreen offer throughout Phase III. Calderdale JCVI group met on 27th September and agreed the ranking of all doses for Phase III. See below slide.



2.1.5 Based on this ranking the public facing communications was agreed in the following slide, which is in-line with most national communications. However, Calderdale will not yet be promoting walk-ins for boosters to ensure those people in the priority rankings (at the highest risk from the worse outcomes of Covid) can access their vaccine in order and priority evergreen doses can be protected. The following slide details the main Covid vaccination messages and access.



2.1.6 Operational Delivery

PCNs during phase I & II conducted nearly all vaccinations from their designated site, with some temporary pop-up vaccination sites at practices to improve uptake. Each PCN has administered between 53,000 to 70,000 Covid Vaccines since the programme began.

2.1.7 A roving model was set-up to address health inequalities, improve access and maximise uptake, to improve coverage across Calderdale, with Calder & Ryburn PCN acting as lead provider. The PCN lead worked in conjunction with other PCN designated leads operating under the National Standard Operating Procedure: 'Roving and Mobile Models'. The model has a steering group to ensure provision is targeted according to need where; geographical uptake is low; uptake is low amongst a specific demographic or to take vaccines to groups for whatever reason find it difficult to access through mainstream provision. Examples of these pop-up have been held at; our local Mosques, drug and alcohol service, the shelter and taken to our Asylum Seekers. To date Team Calderdale have administered approximately 5000 vaccines in Calderdale under this model.

2.1.8 During Phase I & II PCNs/ Practices had their own roving teams and a Calderdale roving model was also established (between PCNs and CHFT) to help vaccinate the housebound and in care homes. Approximately 1000 residents and 1000 staff were vaccinated in care homes for older people, ensuring 97% of residents and 76% of staff were protected and approx. 1500 housebound patients received both doses of the vaccine. These teams worked in line with the SOP https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/06/C1432-Standard-Operating-Procedure-Roving-and-mobile-models-v2.pdf and the PCN/ Practices roving teams will continue to operate under this model for Phase III.

2.1.9 By the end of Phase II, Calderdale had four Community Pharmacies (CP) administering vaccines. Boots in Halifax the largest CP provider, administering over 2000 vaccines per week at full capacity.

2.1.10 Plans and assurance for Phase III

The CVP in Phase III will continue to have five designated PCN hub sites, along with four existing CP sites (dark blue pins on the map), with six additional CP (light blue or white pins on the map) being onboarded (2 of which have already begun vaccinating), two in the process of being onboarded and two still to complete assurances. These sites will have

direct supply of Covid Vaccines through the national supply chain. CRH hub (red pin on the map) started vaccinating CHFT staff on 27th September.

2.1.11 Calderdale Covid Vaccination Proposed Sites- Phase III

2.1.12 Currently two PCNs (Upper Valley and Calderdale & Ryburn) will continue to administer the majority of vaccinations at the designated hub and at other practices, as pop-ups (orange pins on the map). Three PCNs wish to regularly conduct vaccination sessions at practices within the grouping (yellow pins on the map, indicated with a line from the designated hub).

2.1.13 On this basis Calderdale CCG have conducted assurance conversations with all 5 PCN Clinical Directors for the temporary and routine use of the non-designated sites for vaccination. The roving models will continue.

2.1.14 Universal Vaccination of 12-15 years

On 13th September the CMOs recommended universal vaccination of those 12-15 years. CHFT are lead provider for the School Aged Immunisation Service for Calderdale. The Vaccine programme team along with CMBC have been working hard to prepare for the role out. Pharmacy 2U have been sub-contracted to administer the vaccines with CHFT began vaccinating in schools from week commencing 11th Oct. Assurances have been conducted with NHSE and CHFT over Pharmacy 2U. We will work to support schools and the provider on take up, and address any issues which may arise. The expected uptake is 50%; based on current uptake for 16 &17 year olds, and Kirklees average uptake for 12-15 years in

schools to date is 42%. Plans are in place to ensure vaccination of those not in school on the day of vaccinations.

3.0 Wheelchairs Services

3.1 Calderdale CCG and Kirklees CCG were finalists in the 2020-2021 UK National Go Awards, the 'Oscars' for UK Public Procurement, held in September. The Awards recognise the achievements of public and private sector organisations from each of the devolved nations in the UK.

3.2 As joint entrants, NHS Calderdale CCG and NHS Kirklees CCG were one of 8 nominees in the 'Best Procurement Delivery - Health and Social Care' category, for the procurement of the Calderdale and Kirklees Posture & Mobility (Wheelchair) Service. Other nominees in this category included: Public Health England, NHS England & Improvement, the Department of Health and Social Care and NHS Supply Chain. Although we weren't winners on the night (the winner was NHS Supply Chain), we were delighted to be nominated. It shows our CCGs have much to be proud of, punching above our weight yet again. This achievement was even more significant this year because many of the finalists were nominated because of their contribution during COVID-19.

3.3 The Wheelchairs procurement exercise and the positive outcome it reached were only possible due to the excellent support and advice from our Procurement Team, and the passion and involvement of local people who use wheelchairs, and those who work with and support them.

4.0 Diabetes Recovery Fund

4.1 The CCG have successfully received funding via the Diabetes Recovery Fund. The proposal is a dedicated project which will see system support given to Calderdale by working in partnership to support GPs in the achievement of the nine care processes for diabetes paying particular attention to the three NICE treatment Targets. The impact of Covid has seen an increase in patients not being able to attend for their annual review, the result of which significantly increases further the real possibility of patients deteriorating further.

4.2 This project will support GP practices with dedicated support provided by the Diabetes Quality Improvement Team, which will include educational support to practice clinicians and support staff.

4.3 This will include the delivery of dedicated specialist diabetes clinics run by the ICS diabetes clinical lead to offer reviews for more complex patients or those identified as high risk of further developing complications. The clinics run as "joint clinics" with the Health Care Professional from where the patient is registered attending thereby providing an opportunity for upskilling primary care colleagues. Virtual education sessions will also be open to all the ICS thereby reaching a wider audience for confidence and upskilling the workforce.

5.0 Elective Recovery

5.1 The elective recovery programme is working to effectively increase capacity in CHFT. So far over 400 additional outpatients have been seen, and additional operating lists have been taking place every weekend since the beginning of September. On 2 October, capacity for a further 150 patients a weekend in ENT starts and Virtual Clinics for Neurology took place.

5.2 In order to maximise the existing capacity in our system, we continue to support CHFT by facilitating the transfer of patient to providers who have capacity to see them sooner. Current work is focusing on in sourcing of theatre teams to increase resilience in the weekday operating, working innovatively with Primary Care to increase capacity in the Rheumatology service and getting the in sourced Ophthalmology Outpatients and Operating weekend services up and running from October 15th.

6.0 Pre-School ASD Assessments Waiting List Initiative

6.1 The pre-school ASD assessment service provided by Calderdale and Huddersfield NHS Trust (CHFT) is no longer provided. This service change has taken place at the request of CHFT and with the agreement and involvement of CHFT and NHS Calderdale Clinical Commissioning Group.

6.2 ASD assessments for pre-school aged children who are currently on the CHFT Children's Services waiting list will be provided by the Oakdale Centre Community Interest Company from September 2021. A process to appoint an experienced provider of high-quality pre-school ASD assessments is underway, led by NHS Calderdale CCG, with the involvement of CHFT. Having the Waiting List Initiative in place means no child/family has to wait for an assessment while the CCG process to appoint providers of the core Pre-School ASD Assessment service is completed. Further information will be provided when this process is complete.

7.0 Children and Young People Open Minds CAMHS – Thriving

7.1 Calderdale Children and Young People's Scrutiny received a paper and presentation on the interventions, support and services available for CYP Open Minds CAMHS THRIVE. Councillors met some young people who represent three of the young people's forums (1 - SEND Reference Group, 2 - Commissioning Group and 3 - Tough Times Group).
These young people ensure the voice of young people are heard and listened to on a range of different topics. The young people provided Scrutiny Panel with updates on some of the work they have influenced and co-produced. They described their experience as being positive with the outcome meaning changes being made to areas based on their suggestions. One young person stated:
"..throughout my experience of this group, I have felt listened to and taken seriously, like my and the rest of the groups opinions had value and respect. It's also really great to know that this survey is now being used, and that the work we've done will have a meaningful impact".
The Chair, Councillor Collin Raistrick thanked and praised the young people for their fantastic inspiring work and delivery of their presentation to members.

7.2 The Scrutiny Board then took the report, submitted to Scrutiny Board Members by the Calderdale Open Minds Partnership (OMP) in advance of the meeting. The focus for the report was to provide members with assurance on:

- Progress of transformation in delivering the 'Thrive' model of care for emotional wellbeing and mental health model adopted in Calderdale (a video was shared where some of our Young People describe their own 'Thrive' journey and aims to illustrate how 'Thrive' works in practice).
- How the COVID-19 Pandemic is affecting CYP, how the OMP is responding and our system's learning about COVID-19.

Although the impacts of the Pandemic are still being felt, Scrutiny Board were provided with an overview of our system's learning about Covid, progress in other areas of emotional wellbeing and mental health, and our future direction of travel.

7.3 Open Minds Partners attended and presented to Scrutiny Board some of the interventions, support and services available to Covid in Calderdale as part of Open Minds CAMHS. The report and presentation were well received by the Scrutiny Board with a few areas highlighted by members where further attention and focus were required.

7.4 Dr Caroline Taylor summed up to members the work of Calderdale OMP by saying "in her experience from the work she is involved in on a national perspective, it still surprises her how far behind other services are to Calderdale on emotional health and well-being". She shared with members the uniqueness of the Open Mind Partnership, in the form of its common aim to support children and young people to improve their lives, to talk collectively in true partnership approach and set high standards of each other. She said she is "genuinely amazed at the interest from other areas across the country to learn from the journey undertaken in Calderdale that we are now seeing the benefits"

7.5 The Chair, Cllr Colin Raistrick– echoed Dr Taylor's comments and said "I've been on this panel a long time, CAMHS as it was then was a major thorn and I am much more encouraged now, and I thought the report was excellent/outstanding. I sense a sense of purpose not seen before and I am pleased with that and it gives us (Scrutiny Board) more confidence. I am very encouraged by the trajectory of improvement and think we are making significant progress".

8.0 Further Developing Calderdale Cares

8.1 As we work towards transitioning to the new ICS arrangements, health and care partners in Calderdale continue to work collaboratively to further the development of our place-based partnership – or integrated care partnership (ICP) – Calderdale Cares. Since it's inception in the summer, the Calderdale ICP Development Programme has been a vehicle for driving forward progress across a number of areas:

8.2 Calderdale Cares Partnership Agreement: Partners have worked together to draft a framework which sets out how the organisations within the Calderdale Cares Partnership

will work together for the benefit of Calderdale's population, based on a shared vision underpinned by a common set of principles, values and behaviours. The Agreement will be shared across the Calderdale system throughout November and December, before being finalised and brought to partners' formal boards and equivalent for endorsement. The Agreement will be brought to the CCG's Governing Body on 27th January 2022 for endorsement.

8.3 Calderdale Cares Partnership Board and supporting arrangements: Upon the establishment of the Integrated Care Board (ICB), the functions of CCGs will be absorbed by that Board, Calderdale Cares Partnership Board will be a committee of the ICB, and the majority of those functions will be delegated back to the place – Calderdale – level. It is planned that in ensuring Calderdale is able to receive those functions the Calderdale Cares Partnership Board will be established, to operate in shadow form until it may formally be constituted as a committee of the Integrated Care Board. Arrangements for the membership and operation of the board have been drafted, and work is continuing to ensure that the board is supported by the right arrangements to ensure the Partnership continues to deliver positive outcomes for communities.

8.4 System development plan: A first draft of Calderdale's system development plan has been submitted to the ICS based on both locally identified development priorities and the West Yorkshire and Harrogate ICS's place development framework. The draft plan provided an opportunity to reflect on Calderdale's current position, sharing areas of excellence and identifying where further work may be of value. The draft plan also provided a platform to demonstrate the breadth of development work underway across Calderdale, both through the ICP Development Programme but also more widely, e.g. through the refresh of the Health and Wellbeing Strategy.

9.0 CCG Assurance

9.1 The CCG doesn't receive assurance on the organisations and this year, we have transition to NHS England providing assurance on the Calderdale system, and its key stakeholders. Calderdale held its multi-organisational Quarter 2 assurance meeting with NHS England on the 8th October, whilst we haven't received the official feedback, I am pleased to report the positive discussions held with our NHS England and West Yorkshire colleagues. A detailed presentation was share, with the focus being particularly on the risks associated with

delivery over the coming months, recognising the current pressures in health and social care. The integrated ways of working and ongoing focus on the determinants of health in place were evident. The need to attend to prevention and early intervention remains imperative to us in ensuring a sustainable health and care system.

10.0 Kirklees and Calderdale CCG Policies

Due to the merger of Greater Huddersfield and North Kirklees CCGs in May 2021 forming Kirklees CCG, all Kirklees CCG policies were reviewed to reflect this merger process. The review included approval of policies by Kirklees CCG's Governing Body. There are a number of these Kirklees CCG policies which are joint policies with Calderdale CCG and are only being reviewed due to the merger. Any amendments are minor, but do require further ratification by Calderdale CCG's Governing Body. The policies below are appended to the report:

- Operating Framework for Managing Individual Funding Requests (Appendix 4)
- Commissioning Policy for Individual Funding Requests (Appendix 5)

11.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

11.1 I have appended a summary of the discussions and decisions reached at the Joint Committee of CCGs, which took place on 5th October.

12.0 Recommendations

12.1 It is recommended that the Governing Body **NOTES** the contents of the report and **RATIFIES** the joint Individual Funding Request policies detailed in point 10 of the report.

13.0 Appendices

13.1 Appendix 1 CYP Scrutiny Board Open Minds
13.2 Appendix 2 CTP Report to Scrutiny 29/09/21
13.3 Appendix 3 WY&H Joint Committee Key Decisions - 5 October
13.4 Appendix 4 Operating Framework for Managing Individual Funding Requests
13.5 Appendix 5 Commissioning Policy for Individual Funding Requests

Calderdale Open Minds Partnership

Children and Young People Scrutiny Board

29th September 2021

Introduction

- This Open Minds (CAMHS) presentation is supplementary to
  - the paper submitted to Scrutiny Board in advance of today;
  - and the informal session between the Board and children and young people.
- Aims to provide more detail of
  - outcomes achieved for children and young people;
  - improvements made by services.
- And illustrate 'Thrive' in practice
  - Also described in the YouTube video produced by our young people: *My Thrive Journey*

Thrive in practice

School, MHST, Kooth, Samaritans, Childline, Neurodevelopmental Waiting List support

Services and resources

FPoC, Identity, Kooth, Which Way Up Open Minds CAMHS Neuro-developental Assessment

Multi Agency Support inc. Open Minds CAMHS, Social Care etc

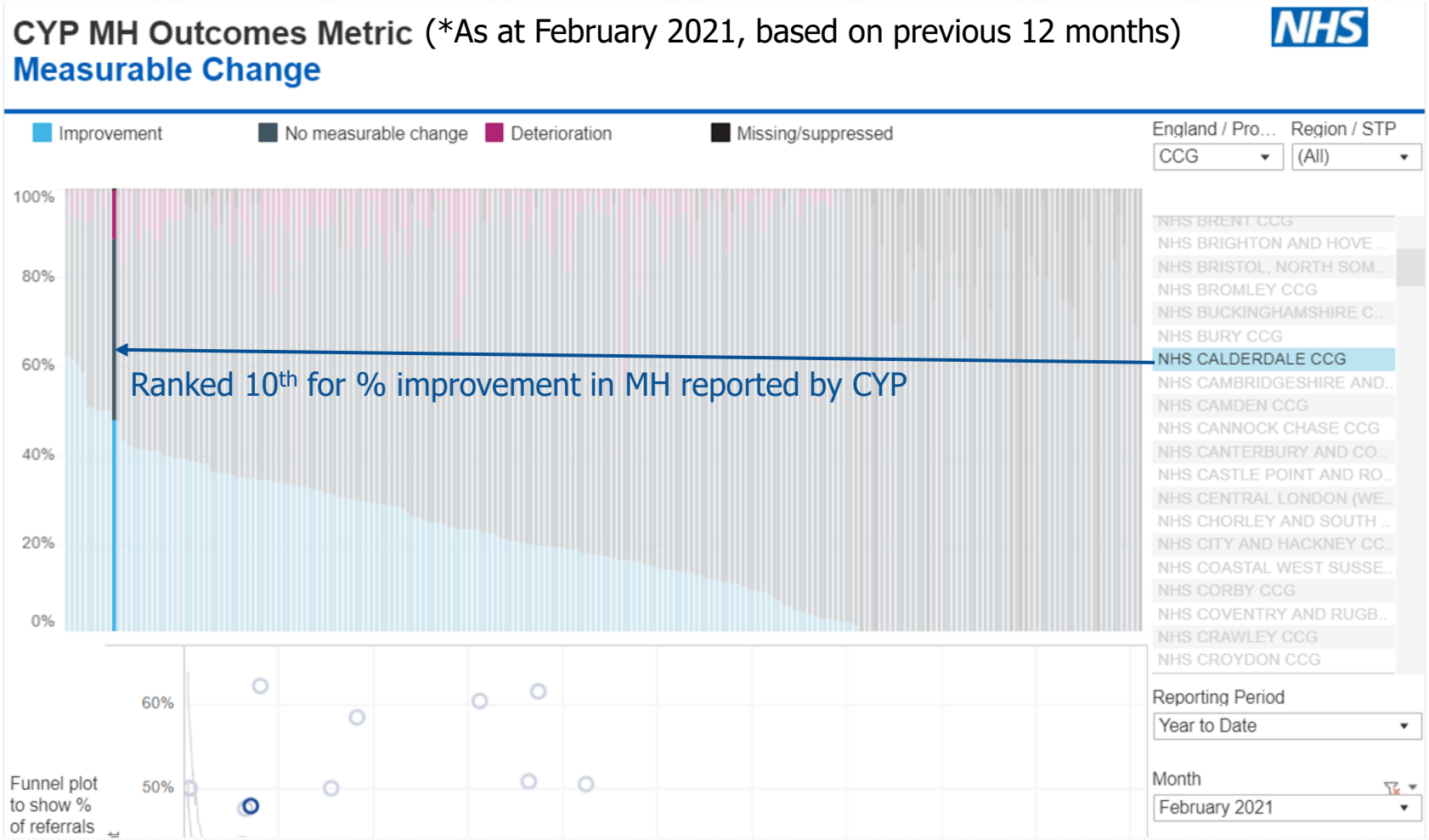
Early Intervention and Prevention: advice & signposting

- FREE resources and support for children and young people
- **Kooth**: free, safe anonymous online counselling & support service, self-help resources, peer to peer forums, articles written by young people for young people.
- **BREW Project** (Invictus Wellbeing) bespoke support sessions for CYP with personal, social, emotional concerns.
- **Time Out** (Healthy Minds) helps CYP 'find their thing' via arts, crafts, sports, singing and drama sessions. Also has a Listening Line: support and advice for students
- **Open Minds (CAMHS)** emotional wellbeing workshops for CYP - Mental Health Awareness, Resilience, Anxiety, Transition, Friendship, Kindness and Social Media and Diversity, gender identity, relationships.
- **Therapeutic Interventions in Secondary Schools (THISS)** 11 secondary schools - enables access to EHWB support for KS3 students from Noah's Ark
- **Calderdale School Nursing Team** identify health needs and help manage long and short-term conditions in education settings for CYP. Chat Health is a text messaging service for young people aged 11 – 19; parents can also contact School Nursing Team

First Point of Contact (FPoC)

- Single point of access for mental health referrals
- Gateway into Open Minds (CAMHS) including neurodevelopmental (ASD/ADHD) assessments
- Focus on signposting and advice in line with the Anna Freud 'Thrive' model: Getting Help, Getting More Help
- Helping people to access online and digital resources
- Improved accessibility to services: over ⅓ referrals are made by parents/carers/CYP
- Increased emphasis on partnership working (per 'Thrive')
  - e.g. School nurses based in FPoC one day per week
- Significant increase in demand

Outcomes



- The extent to which children and young people report there's been a measurable change (improvement) in their emotional wellbeing/mental health

Calderdale Mental Health Support Teams (MHST) for education settings

3 nationally mandated core functions

- Deliver evidence based interventions for mild to moderate mental health (MH) issues (anxiety, low mood, friendship, self-harm, behaviour)
- Support senior education MH leads to develop whole school/college approach
- Give timely advice to staff, liaise with specialist services, help CYP get the right support & stay in education

Additional Calderdale priorities:

- SEND school support
- At risk of exclusion
- Young carers
- Edge of care
- Those who identify as "Gender: other" in eHNA
- Families affected by flooding
- COVID-19 MH issues: likely to be our most vulnerable families
- Health Inequalities, including BAME pupils

Outcomes

Delivering evidence-based interventions for mild-to-moderate mental health issues		Whole School Approach (Apr – June 21 only)		Advice & Liaison (Apr – June 21 only)	
Accepted Individual Requests for Support	100	**Number of staff** **Number of Pupils**	415 1192	**Number of staff**	43
Most Common Types of Need	Anxiety (52%) & Depression (34%)	**Most Common Types of Support**	- Pupil Workshops (group) 34% - Relationship Building with Staff 21% - Supporting the coordination of MH Support 16%	**Most Common Type of Advice**	Suitability (for pupil support) discussion 78%
CYP with Measured Improvements	**75%**	**Did it Help? Yes/ Somewhat**	**91%**	**Did it Help? Yes/ Somewhat**	**81%**
Most Common Age	11- 16 yrs (80%)	**Most Common Topic**	- Pupil Wellbeing 36% - Mental Health Understanding 28%	**Most Common Staff**	MHST School Senior Mental Health Lead

Calderdale Neurodevelopmental Assessment Service: The family's journey

Open Minds
For Children and Young People in Calderdale

Referral

Professionals/families refer to FPOC to ask for an assessment.

Initial screening

A practitioner telephones the family and school to gather further information about support needs and presence of neuro traits.

Clinical screening

Screening Questionnaires sent to family & school - Unique Ways can support families complete. Qs reviewed weekly by FPOC & SWYFT SALT/Psychologist. Families may be invited to one-off screening assessment if unclear.

Case not accepted if insufficient information and/or signposted as appropriate

Support for families waiting

Accepted to waiting list. Families can & should access support whilst on the waiting list. Northpoint offer consultation and advice to families/schools.

ND Assessment

Full Neurodevelopmental Assessment: Neurodevelopmental history interview with parents/carers **+** Structured neurodevelopmental observation with child **+** School questionnaire to gather up-to-date information

Professional review & discussion

MDT Discussion to confirm diagnostic outcome

Further Assessments Needed

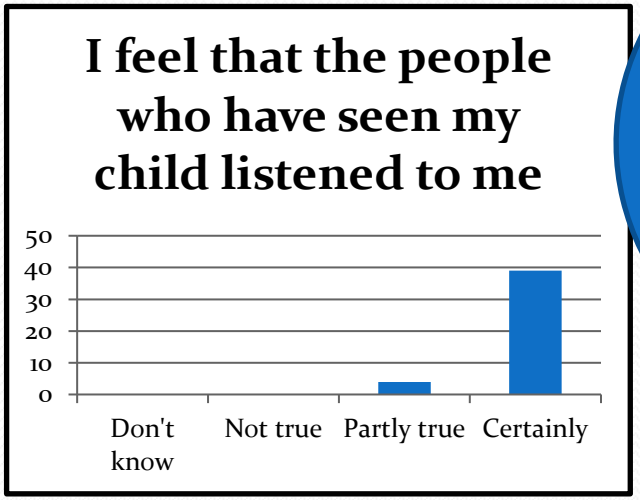
- QB Assessment (measure of attention, hyperactivity, and impulsivity)
- ADOS Assessment (further exploration of social communication)
- WISC Assessment (to pick apart specific cognitive difficulties from neuro traits)
- School Observation
- Other (e.g., home observation)

Outcome; feedback to family

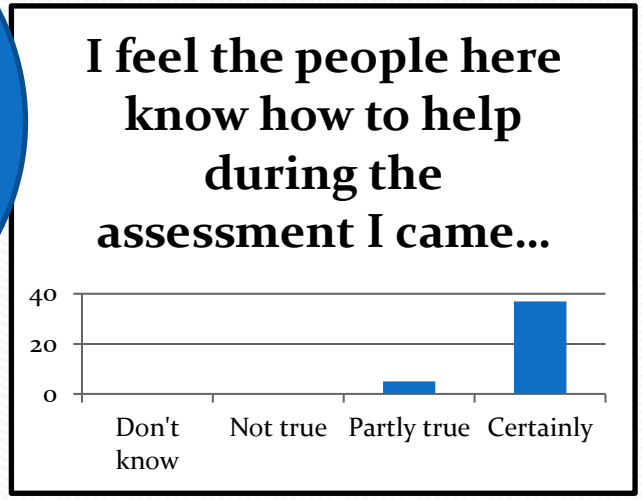
Feedback Appointment + Neurodevelopmental Assessment Report

Discharge

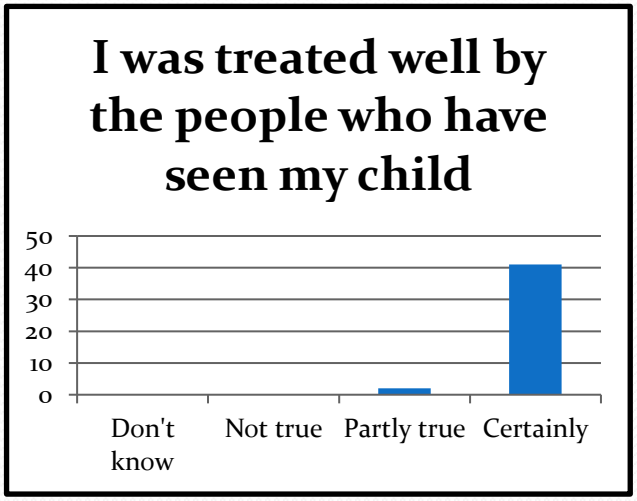
Neuro outcomes: family feedback



I suffer with anxiety and left both times with huge relief. A massive job well done. My child being assessed said herself it was awesome, and I totally agree"



The extensive report that I received was very detailed, very sufficient and will be very helpful in supporting our child's long term needs



The whole process was very quick and easy (not waiting list)!

Crisis, self-harm and suicide

- Despite increased demand, the SWYPFT Crisis team are consistently meeting the 4 hour target to assess a child/young person in crisis
- There is 24 hour Crisis cover: in A&E and via the new overnight WY 'Night Owls' telephone/text/webchat service (pilot)
- Disordered Eating and Eating Disorder:
  - Notable increased demand & severity of CYP in crisis due to eating disorder due to/during COVID-19 Pandemic – consistent with WY/National picture
  - Pathway is being reviewed to ensure high quality care; focus on Partnership working re early intervention – to prevent high acuity cases requiring hospitalisation.
  - National issues with shortage in specialist beds
  - Substantive staff remained stable; Agency staff used to meet increased demand.

Conclusion

- Feedback from children, young people, families and partners agree that the 'Thrive' model of care is the right approach.
  - Achieved by dedicated (multi-agency) professionals listening to and working with cyp and families and each other.
- 'Thrive' will be reviewed by the Open Minds Partnership in 2021, 2022 to inform the future offer. We will maintain our focus on
  - Early preventative, 'medical' and 'non-medical', holistic support: signposting to services who can best meet the needs of children and young people.
  - Partnership working among the VCS/Third sector, local authority, health, social care, CYP and families.
  - Outcomes as well as demand and activity.

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Report to Scrutiny Board

Name of Scrutiny Board	Calderdale Children and Young People's Scrutiny Board
Meeting Date	29 September 2021
Subject	Update on the progress of transformation by the Open Minds Partnership, 'Thrive' and response to the COVID-19 Pandemic
Wards Affected	All
Report of	Rhona Radley, Deputy Director of Improvement (Acute and Community), NHS Calderdale CCG on behalf of the Open Minds Partnership

Why is it coming here?

This report is an update for Scrutiny Board since June 2020. It describes:

- The progress of transformation by the Open Minds Partnership (OMP) in delivering 'Thrive'– the children and young people's (CYP) model of care for emotional wellbeing and mental health model adopted in Calderdale. Some of our Young People describe their own 'Thrive' journey in a video which will be shared at the Scrutiny Board meeting. It aims to illustrate to Elected Members how 'Thrive' works in practice.
- How the COVID-19 Pandemic is affecting children and young people, and how the Open Minds Partnership – which includes children and young people (CYP) – is responding. Although the impacts of the Pandemic are still being felt, Scrutiny Board are provided with an overview of our system's learning about COVID-19, progress in other areas of emotional wellbeing and mental health, and our future direction of travel.

What are the key points?

This report provides an update to Scrutiny Board on:

- celebrating the involvement of Calderdale's children and young people in the delivery of THRIVE and the work by our system to better meet their needs
- the work of the Open Minds Partnership (OMP) in delivering 'Thrive': a person-centred, whole system approach, where responsibility for meeting the emotional wellbeing and mental health needs of children and young people is everyone's business;
- the impact of the COVID-19 Pandemic on children and young people across the UK and in Calderdale;
- how the OMP has responded to the Pandemic, including resources developed by children and young people for their peers, and learning;
- challenges and priorities as part of the future direction of travel.

Possible courses of action

Members of the Calderdale Children and Young People's Scrutiny Board are asked to **note**:

- the contribution made by our Young People in supporting Calderdale's response to the COVID-19 Pandemic;
- the key points made in the report;
- and support the progress of the transformation programme.

Contact Officer
Rhona Radley, Deputy Director of Improvement (Acute and Community), NHS Calderdale Clinical Commissioning Group, 5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX. Rhona.radley@nhs.net

Should this report be exempt?
No

Report to Scrutiny Board

1. Background

1.1 An update to Scrutiny Board was provided in June 2020 about the work of the Open Minds Partnership (OMP), delivering 'Thrive' – the children and young people's model of care for emotional wellbeing and mental health model adopted in Calderdale.

1.2 This report gives an update on the actions arising from the 2020 paper, describes the COVID-19 Pandemic impacts on children and young people across the country and how the Open Minds Partnership has responded. Although the impacts of the Pandemic are still being felt, Scrutiny Board are provided with a summary of our system's learning about COVID-19, the impact and our direction of travel.

2. Main issues for Scrutiny

2.1 **Open Minds Partnership and 'Thrive' – a brief reminder**

2.2 In Calderdale, emotional wellbeing and mental health resources and services are provided by the Open Minds Partnership. The Open Minds Partnership includes local authority, NHS, education, voluntary and third sector partners, parent carers, children & young people, and other stakeholders. Together we work as a cooperative to ensure Calderdale's children and young people have access to the support and services they need. The name of this group is based on the name created by young people from the Tough Times campaign, back in 2015. An illustration about the Partnership can be found in Appendix 1.

2.3 Calderdale no longer delivers emotional wellbeing and mental health under the old 'tiered' CAMHS model, but via the 'Thrive' model, developed by the Anna Freud Centre. This is a person-centred, whole system approach, where responsibility for meeting the emotional wellbeing and mental health needs of needs of children and young people is everyone's business**.** The core principles underpinning 'Thrive' are provided in Appendix 2 and will be described in the video shared at the Scrutiny Board meeting.

2.4 At the heart of the THRIVE approach is prevention and early intervention, ensuring that the child or young person receives support at any time from the most appropriate services and resources that meet their needs rather than them fitting into a specific service, or driven by a specific diagnosis or severity of the issues.

2.5 Under 'Thrive', the Open Minds Partnership provides emotional wellbeing and mental health resources and services with and for children and young people. This is aligned to *Vision 2024*, *Calderdale Cares*, West Yorkshire and Harrogate Integrated Care System's (WYH ICS) '*10 big ambitions*' and the aims of the *NHS Long Term Plan*.

2.6 The achievements of our system over 2020-2021 are being captured in the *Calderdale Children and Young People's Mental Health Strategic Plan*. This will be shared with the Calderdale Health and Wellbeing Board and subsequently to the WYH ICS and NHS England & Improvement in October 2021. (The Strategic Plan is the successor to the Local Transformation Plan.)

2.7 **What difference is 'Thrive' making to the children and young people of Calderdale?**

Compared to the traditional 'tiered' CAMHS model, 'Thrive' is transforming the experiences and outcomes for children, young people (plus families and services). Several examples will be shared by partners during the Scrutiny meeting. However, some key differences include:

2.7.1. **Services working better together:** Open Minds partners believe that responsibility for meeting the emotional wellbeing and mental health needs of needs of children and young people **is everyone's business**. The 'Thrive' approach means partners don't operate in a silo, they work and communicate with each other much more effectively, for the benefit of children and young people.

2.7.2. **A greater focus on prevention:** Under 'Thrive', Open Minds partners are working towards (despite COVID-19) shifting their focus from being mainly reactive to mental health problems and crises, towards prevention: helping children and young people take care of themselves, build on their own strengths and bolster their resilience in the face of life's ups and downs.

2.7.3. **Recognising that not everyone needs a 'mental health' intervention from Open Minds (CAMHS):** in simple terms, the 'Thrive' approach is based on the concept that:

80% of children and young people at any one time experience the normal ups and downs of life but do not need 'mental health' interventions. They are 'Thriving'.

20% do need help and support for their emotional wellbeing and mental health. They receive this support **from the most appropriate service or services** that meets their needs at that time or over time, not solely provided by statutory mental health providers, Northpoint and SWYPFT (which is the old, tiered CAMHS approach).

We are proud that many people and organisations in Calderdale, including in the VCS, education, and health and social care, offer a rich diversity of support and evidence-based treatment that meet the diverse needs of our young population and their families.

2.8 **The result?**

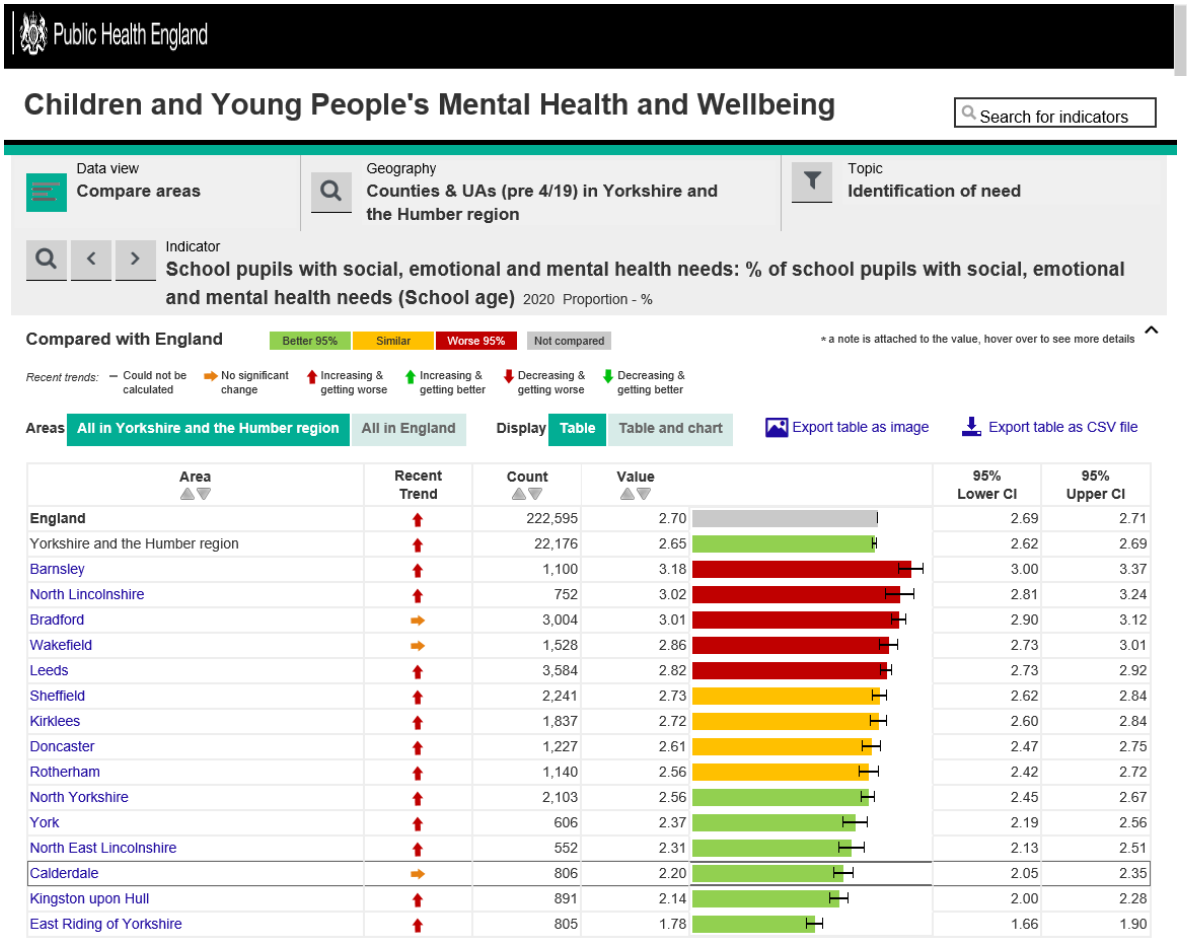
Under the 'Thrive', rather than the old CAMHS model, our children and young people are more likely to

- get the support they need when they need it – they don't have to 'fit' into a service to get help;

- access more than one service at the same time, or over time;
- live healthy and independent lives, secure in the knowledge that, if they need them, services will be there to keep them safe, supported and cared for.

2.8.1. Chart 1 below shows how Calderdale compares in the percentage of school-age pupils with social, emotional and mental health needs. This shows Calderdale is performing **better** compared to most Yorkshire and Humber Regions.

Chart 1 [1]

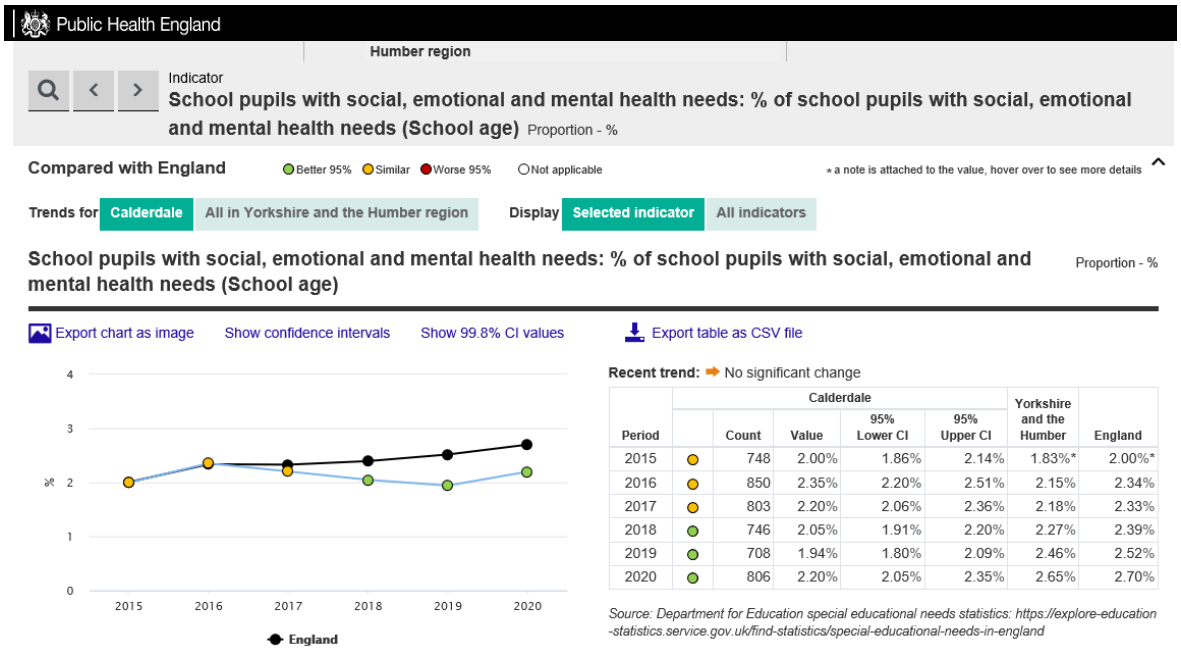


Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	222,595	2.70	2.69	2.71
Yorkshire and the Humber region	↑	22,176	2.65	2.62	2.69
Barnsley	↑	1,100	3.18	3.00	3.37
North Lincolnshire	↑	752	3.02	2.81	3.24
Bradford	→	3,004	3.01	2.90	3.12
Wakefield	→	1,528	2.86	2.73	3.01
Leeds	↑	3,584	2.82	2.73	2.92
Sheffield	↑	2,241	2.73	2.62	2.84
Kirklees	↑	1,837	2.72	2.60	2.84
Doncaster	↑	1,227	2.61	2.47	2.75
Rotherham	↑	1,140	2.56	2.42	2.72
North Yorkshire	↑	2,103	2.56	2.45	2.67
York	↑	606	2.37	2.19	2.56
North East Lincolnshire	↑	552	2.31	2.13	2.51
Calderdale	→	806	2.20	2.05	2.35
Kingston upon Hull	↑	891	2.14	2.00	2.28
East Riding of Yorkshire	↑	805	1.78	1.66	1.90

[1] Source: Department for Education special educational needs statistics: https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england

2.8.2. Chart 2 below illustrates the Calderdale trends in the percentage of school-age pupils with social, emotional and mental health needs from 2016 (12 months following the implementation of THRIVE) to 2019 (pre-Pandemic).

Chart 2



Period		Calderdale Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2015		748	2.00%	1.86%	2.14%	1.83%*	2.00%*
2016		850	2.35%	2.20%	2.51%	2.15%	2.34%
2017		803	2.20%	2.06%	2.36%	2.18%	2.33%
2018		746	2.05%	1.91%	2.20%	2.27%	2.39%
2019		708	1.94%	1.80%	2.09%	2.46%	2.52%
2020		806	2.20%	2.05%	2.35%	2.65%	2.70%

Source: Department for Education special educational needs statistics: https://explore-education-statistics.service.gov.uk/find-statistics/special-educational-needs-in-england

Section 3.24 below provides the most recent data on the impact of the Pandemic on school-age pupils, shown in the Electronic Health Needs Assessment (eHNA) undertaken by Public Health.

3. COVID-19 Pandemic – impact and response

3.1 Initial response to the COVID-19 Pandemic in Calderdale

3.2 Scrutiny Board received the last Open Minds Partnership report mid-Pandemic. At that point[2], Open Minds (CAMHS) and other services were in the midst of lockdown and implementing business contingency plans. Face to face appointments with children and young people were not permitted under UK Government social distancing requirements, except in exceptional circumstances (such as crisis or eating disorder), to minimise risks to them and members of staff.

3.3 Some Calderdale services were able to adapt their ways of working at pace: developing new or enhanced digital offers and/or services, operating at different times and locations. Others closed to new referrals, had staff on furlough or operated a skeleton service, depending on the staffing and capacity of each service. The Open Minds (CAMHS) First Point of Contact continued to open, accepting referrals over the telephone, email or via the web site.

[2] June 2020

3.4 At that point, partners were only able to predict possible outcomes for children and young people, based on experience and emerging information. Since then, local and national intelligence has emerged to further inform our understanding of how the COVID-19 Pandemic is affecting children and young people, and how we respond as a place.

3.5 **Impact of the Pandemic on children and young people in the UK**

3.6 The Pandemic has presented challenges for everyone in different ways.

3.7 **The UK picture**

3.8 Public Health England maintain a live *COVID-19 mental health and wellbeing surveillance: report*[3]. This presents an analysis of, "emerging findings from UK studies of the mental health and wellbeing of children and young people (CYP) in relation to the coronavirus (COVID-19) Pandemic". In brief, as of July 2021, it states that,

3.8.1 "Between March and September 2020, some CYP coped well…and happiness was relatively stable. It was females and those with pre-existing mental health issues who experienced more negative impacts, compared to pre-Pandemic data."

3.8.2 "Between September 2020 and January 2021, there was a decline in wellbeing and increased anxiety was a key impact."

3.8.3 "[Although] the volume of published new intelligence covering January to June 2021 has reduced, the evidence…showed an increase in behavioural, emotional, and restless/attentional difficulties in January, that had subsequently decreased by March 2021. Children also appeared to have experienced a reduction in mental health symptoms as restrictions eased in March 2021, as seen in both parents/carers reporting and child self-reporting data."

3.8.4 "Some children and young people's mental health and wellbeing has been substantially impacted due to and during the Pandemic." The report references children who are financially disadvantaged, had pre-existing mental health needs, some children with Special Educational Needs (SEN)

[3] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/7-children-and-young-people

and children who identify as LGBTQ+. Evidence regarding children from Black, Asian and Minority Ethnic backgrounds is currently inconclusive.

3.9 **The impact on Calderdale children and young people**

3.10 The Pandemic and lockdown periods have highlighted the stark realities of the health inequalities faced by different groups, and has affected every child, adult, family and community in Calderdale. These impacts mirror the national picture and are clearly affecting children and young people now. And some will need mental health support in the months and years to come.

3.11 The Calderdale eHNA Pupil Survey asks young people a number of questions about their emotional wellbeing. The latest overarching data are shown below in Table 1, revealing a significant decrease in wellbeing between 2019 and 2021 across almost all associated measures. A more detailed analysis is provided in Appendix 3.

Table 1

	Primary			Secondary		
	2019	**2021**	**Difference**	**2019**	**2021**	**Difference**
Feel sad more than once a week (10e)	18%	27%	10%	29%	37%	8%
Feel irritable more than once a week (10f)	19%	29%	9%	33%	40%	7%
Has trouble sleeping more than once a week (10h)	25%	36%	11%	29%	36%	8%
Low life satisfaction (52)	8%	9%	1%	15%	18%	3%
Low Personal wellbeing (53)	8%	10%	2%	18%	22%	4%
Low self-esteem (55)	22%	31%	10%	38%	45%	7%
Worry all the time about…? (56)	44%	49%	5%	47%	52%	4%
Ever self harmed (62)		38%	na		35%	

By grouping together the responses to some questions, robust indicators of **life satisfaction**, **personal wellbeing** and **self-esteem** can be derived. For each of these, the percentage of pupils with a low score was significantly higher in 2021 than in 2019. This is true for both primary and secondary pupils, with the most marked downturn being in self-esteem. The percentage of pupils reporting feeling sad or irritable or having trouble sleeping more than once a week is also significantly higher in 2021 than in 2019 for both primary and secondary pupils.

The percentage of primary pupils who worry all the time about anything is significantly higher in 2021 than in 2019, as is the percentage of secondary pupils who have ever self-harmed.

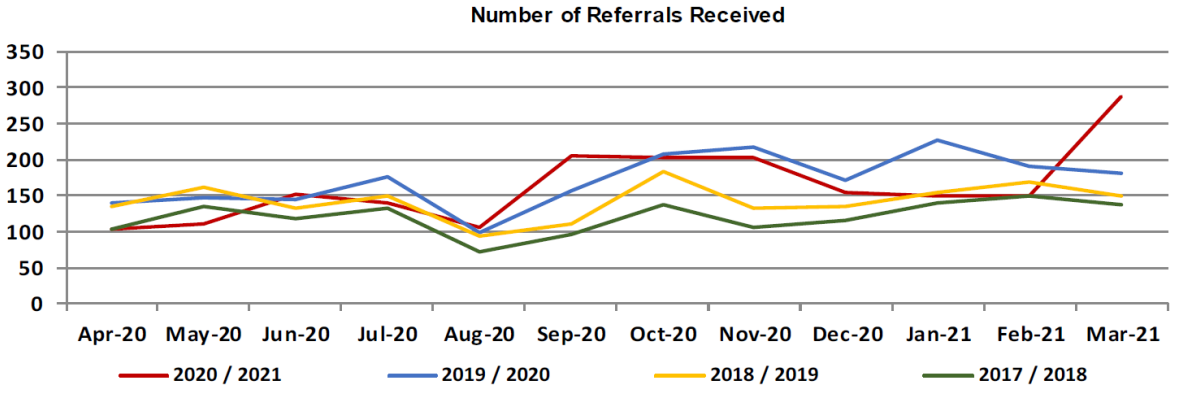
Public Health plan to undertake in-depth analysis to better understand how these indicators play out across year groups, and consider other factors, including young people's self-reported experiences of the COVID-19 Pandemic.

3.12 The impact of the decrease in wellbeing reported by CYP is being seen in data from the Open Minds (CAMHS) First Point of Contact (FPoC). This illustrates that, unlike the trend in previous years, demand for these services initially decreased between December 2020 – February 2021.

Partners believe that this represents a 'COVID-supressed group': children and young people who didn't access emotional wellbeing and mental health resources or services but would have, had the Pandemic not occurred.

Since February 2021, there has been a sharp increase in demand, which has continued during 2021 – not only in FPoC as illustrated in Chart 3 below but reported by other Calderdale partners, this trend is mirrored across the region and nationally.

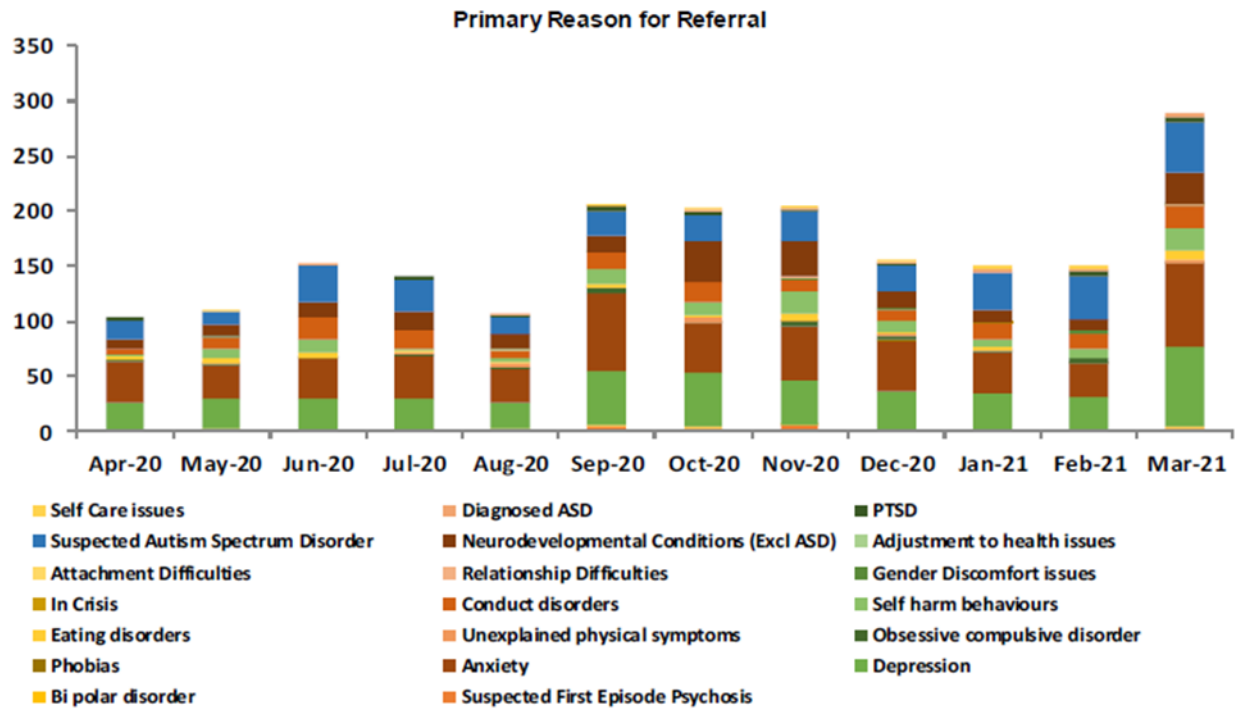
Chart 3



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
2020 / 2021	103	111	152	140	107	206	202	204	155	150	150	289
2019 / 2020	139	146	145	177	98	158	208	217	171	228	190	182
2018 / 2019	134	162	133	150	94	112	183	133	136	154	168	149
2017 / 2018	103	135	118	132	73	97	138	105	116	140	149	137

3.13 The primary reason referrals were made over this period (either by children, young people, families, schools or other referrers), is provided below in Chart 4.

Chart 4



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Suspected First Episode Psychosis	1	2	1	1	1	5	3	6	0	2	2	3
Bi polar disorder	0	1	0	1	2	1	1	1	0	0	0	1
Depression	26	27	29	27	24	49	49	39	37	33	30	73
Anxiety	37	30	36	40	29	71	45	50	45	36	29	75
Phobias	0	0	0	0	0	0	0	0	2	0	1	0
Obsessive compulsive disorder	1	1	1	1	3	4	1	4	3	2	5	1
Unexplained physical symptoms	0	1	0	1	2	1	4	1	1	1	0	3
Eating disorders	3	4	5	2	2	3	3	6	3	3	0	8
Self harm behaviours	2	10	11	3	4	14	11	20	10	7	8	20
Conduct disorders	5	9	21	16	6	14	18	11	10	14	14	20
In Crisis	0	0	0	0	0	0	0	0	0	1	0	0
Gender Discomfort issues	0	2	0	0	0	0	0	1	1	0	3	1
Relationship Difficulties	0	0	0	0	1	0	0	1	0	0	0	1
Attachment Difficulties	0	0	0	0	0	0	0	0	0	0	0	0
Adjustment to health issues	0	0	0	0	2	1	0	0	0	0	0	1
Neurodevelopmental Conditions (Excl ASD)	9	10	13	16	12	15	37	33	16	12	10	28
Suspected Autism Spectrum Disorder	17	11	34	30	15	21	25	27	23	33	38	45
PTSD	2	0	0	2	3	5	2	1	2	0	6	5
Diagnosed ASD	0	0	1	0	1	1	2	2	1	3	1	4
Self Care issues	0	3	0	0	0	1	1	1	1	3	3	0
	103	111	152	140	107	206	202	204	155	150	150	**289**

3.14 While the reasons for referral have always been mixed, Chart 4 data shows the proportion of referrals related to depression, anxiety, self-harm and neurodevelopment (including ASD and ADHD) increased since April 2020. Subsequent, thorough screening assessments with children, young people, parent carers, schools and health professionals as part of the neurodevelopmental pathway identified that the underlying cause of concern for many children was not a neurodevelopmental need, but in fact anxiety.

FPoC continues to see high numbers of children and young people referred, whose needs can best be met by a non-medical/clinical intervention provided by, for example, Public Health/the School Nursing Team, and VCS services.

3.15 **Crisis, Self-Harm and Suicides**

Crisis

3.16 As discussed at Adults, Health & Social Care Scrutiny Board on 19th August 2021, concerns about crisis/self-harm and suicide were prevalent in high schools pre-COVID-19, however, social media interaction has played a part in all these cases and there is a hidden danger of online bullying and enticement into forums children and young people would not have normally engaged with.

3.17 Education colleagues report that the Pandemic has affected a cohort of children who would normally be resilient in the face of life's ups and downs. These tend to be the high achievers with previous good attendance, significantly affected by isolation and lack of routine over the last year. Open Minds (CAMHS) and others in the Open Minds Partnership, along with school staff, youth workers and the Mental Health Support Teams are providing considerable support for children and young people experiencing mild/moderate symptoms such as: anxiety disorders and depression.

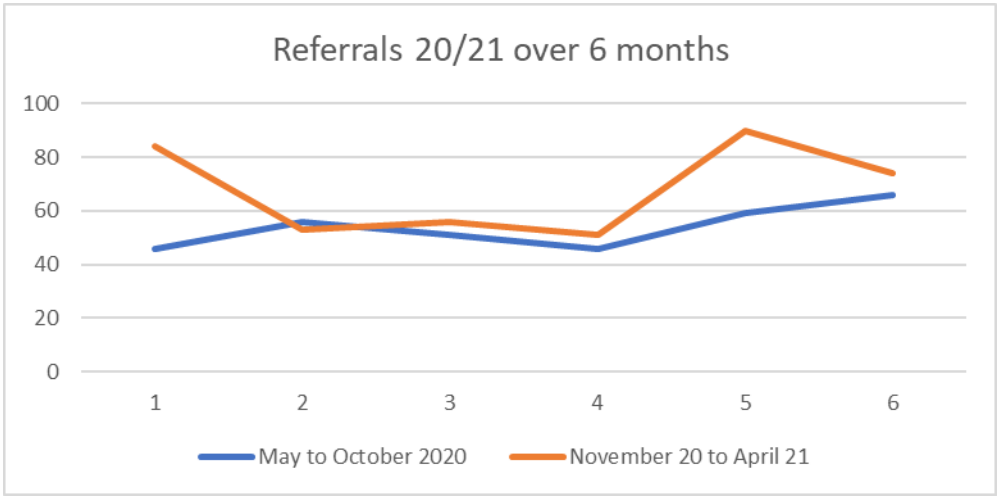
3.18 Services have seen an increase in the number of referrals of CYP in crisis since the pandemic. One quoted:

"It is unbelievable the risk coming through at such a high volume. Largely suicidal ideation."

The CYP Crisis Service provided by South West Yorkshire Partnership Foundation Trust (SWYPFT) report an increase in the number of referrals into the service, see Chart 5 below. For example:

- April 2020 = 41 referrals
- March 2021 = 90 referrals and;
- April 2021 = 74 referrals.

Chart 5



Evidence also shows that children and young people are presenting with higher acuity and often require more intensive interventions.

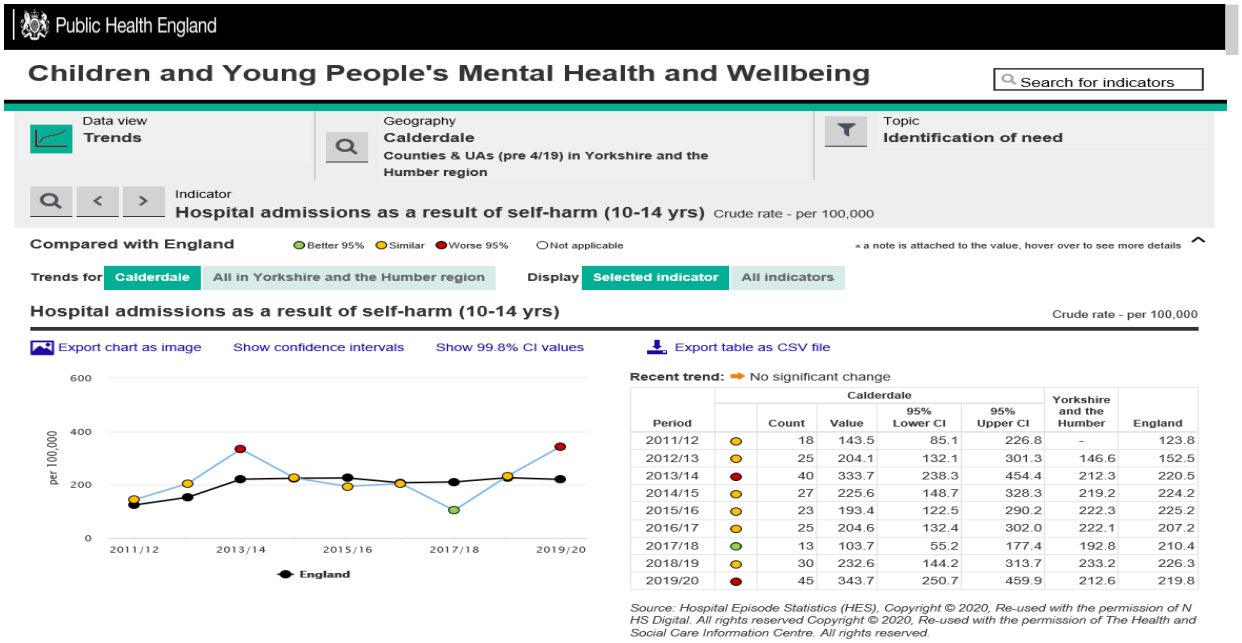
3.19 Calderdale and Kirklees CCGs have jointly invested additional funding to support the impact of this increase into the SWYPFT Crisis Service. Calderdale CCG has invested £35,000 recurrently plus £50,000 non-recurrently. This is to enable the service to manage long waits for CYP in crisis, manage the complexity and high acuity being presented, ensure timely access to diagnosis and treatment where appropriate, and reduce the number of children and young people with escalating needs (e.g, self-harming, or being admitted to hospital.

In addition, short-term counselling commissioned for CYP with mild/moderate needs has been extended due to the increase in demand and acuity.

3.20 **Self-Harm and Suicides**

3.21 Self-Harm is becoming a 'common issue', with school staff reporting they feel somewhat desensitised to the issue. Charts 6 & 7 below illustrate how hospital admissions due to self-harm in Calderdale compare to other areas in Yorkshire and Humber, and England.

Chart 6

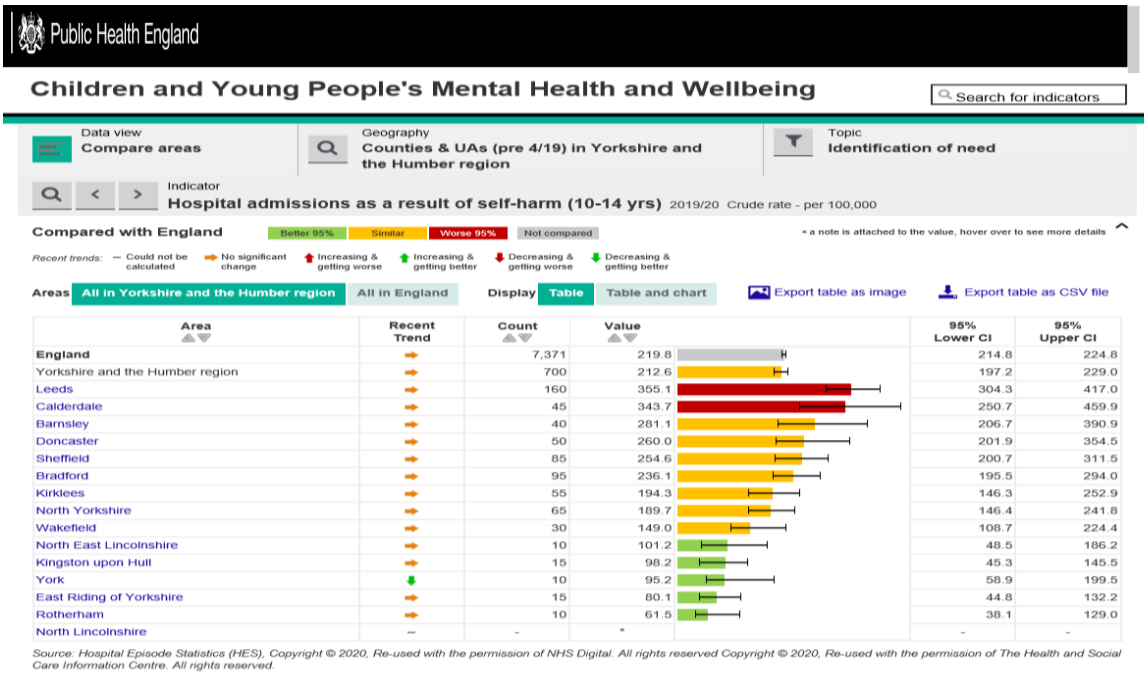


Period		Calderdale Count	Value	95% Lower CI	95% Upper CI	Yorkshire and the Humber	England
2011/12		18	143.5	85.1	226.8	-	123.8
2012/13		25	204.1	132.1	301.3	146.6	152.5
2013/14		40	333.7	238.3	454.4	212.3	220.5
2014/15		27	225.6	148.7	328.3	219.2	224.2
2015/16		23	193.4	122.5	290.2	222.3	225.2
2016/17		25	204.6	132.4	302.0	222.1	207.2
2017/18		13	103.7	55.2	177.4	192.8	210.4
2018/19		30	232.6	144.2	313.7	233.2	226.3
2019/20		45	343.7	250.7	459.9	212.6	219.8

Adult and Children's Scrutiny Boards received a paper in August 2021 on the Calderdale Self-Harm and suicide position.

3.22 We know that in Calderdale, disproportionately negative impacts resulting from the Pandemic are being experienced by certain cohorts of CYP, for example, those living in the most socio-economically disadvantaged areas; those from BAME communities, children and young people who identify as LGBTQ+, and Young Carers.

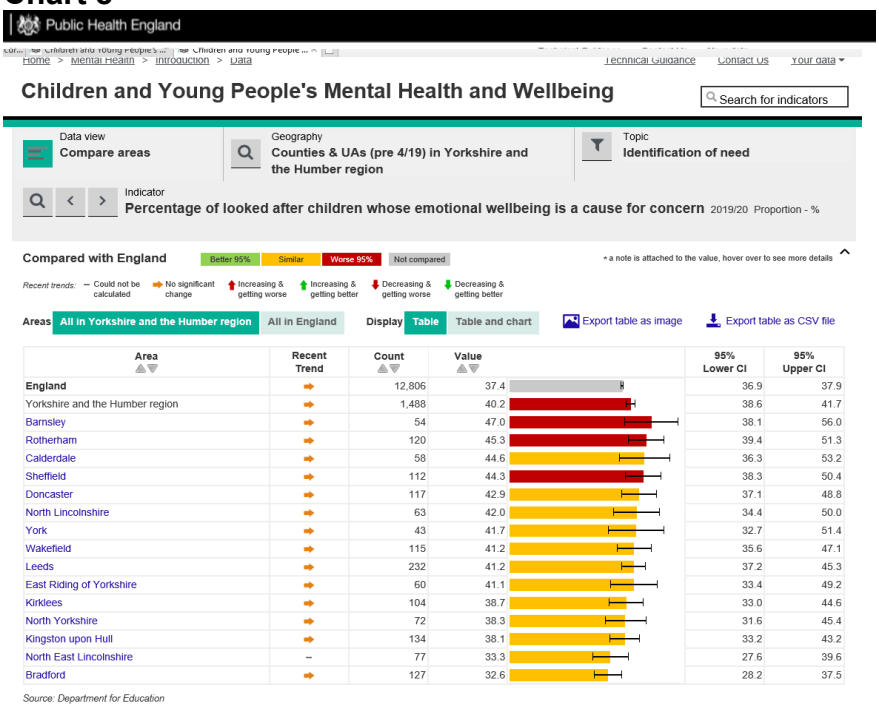
Chart 7



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	7,371	219.8	214.8	224.8
Yorkshire and the Humber region	→	700	212.6	197.2	229.0
Leeds	→	160	355.1	304.3	417.0
Calderdale	→	45	343.7	250.7	459.9
Barnsley	→	40	281.1	206.7	390.9
Doncaster	→	50	260.0	201.9	354.5
Sheffield	→	85	254.6	200.7	311.5
Bradford	→	95	236.1	195.5	294.0
Kirklees	→	55	194.3	146.3	252.9
North Yorkshire	→	65	189.7	146.4	241.8
Wakefield	→	30	149.0	108.7	224.4
North East Lincolnshire	→	10	101.2	48.5	186.2
Kingston upon Hull	→	15	98.2	45.3	145.5
York	↓	10	95.2	58.9	199.5
East Riding of Yorkshire	→	15	80.1	44.8	132.2
Rotherham	→	10	61.5	38.1	129.0
North Lincolnshire	–	-	*	-	-

3.23 We are also aware that as lockdown measures begin to ease, it is even more critical we as a system understand what Children Looked After have been experiencing during Pandemic, as well as how they can be best supported over the coming months and years. The trends in emotional wellbeing for this cohort have fluctuated since 2015/16. Nevertheless, this understanding will inform responses to recovery implemented at a policy level and by those working directly with CYP. Charts 8 & 9 illustrates pre-Pandemic data on the extent to which the emotional wellbeing of children looked after is a cause for concern in Calderdale compared to Yorkshire and Humber, and England as a whole.

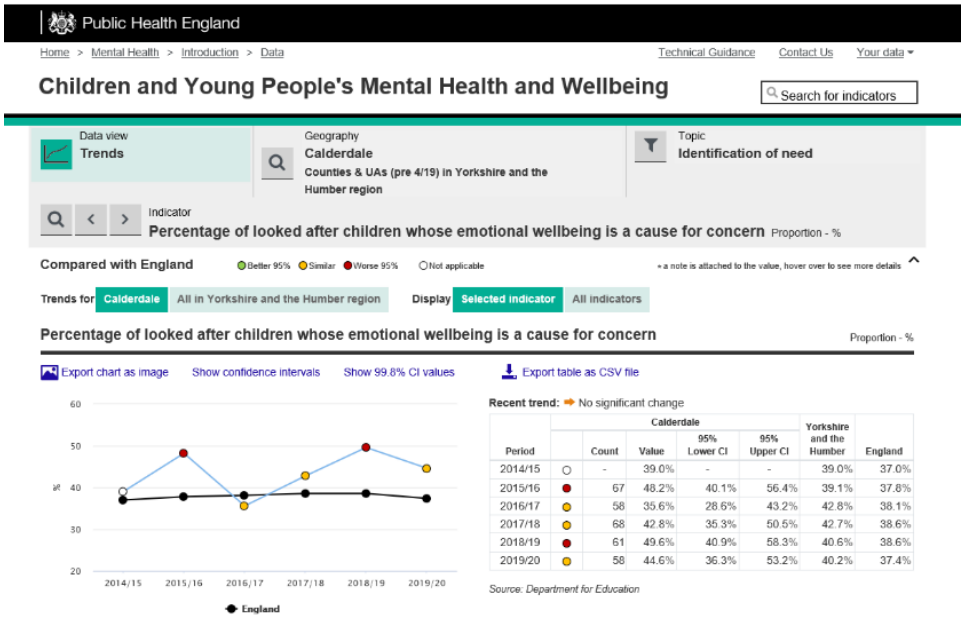
Chart 8



Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	12,806	37.4	36.9	37.9
Yorkshire and the Humber region	→	1,488	40.2	38.6	41.7
Barnsley	→	54	47.0	38.1	56.0
Rotherham	→	120	45.3	39.4	51.3
Calderdale	→	58	44.6	36.3	53.2
Sheffield	→	112	44.3	38.3	50.4
Doncaster	→	117	42.9	37.1	48.8
North Lincolnshire	→	63	42.0	34.4	50.0
York	→	43	41.7	32.7	51.4
Wakefield	→	115	41.2	35.6	47.1
Leeds	→	232	41.2	37.2	45.3
East Riding of Yorkshire	→	60	41.1	33.4	49.2
Kirklees	→	104	38.7	33.0	44.6
North Yorkshire	→	72	38.3	31.6	45.4
Kingston upon Hull	→	134	38.1	33.2	43.2
North East Lincolnshire	–	77	33.3	27.6	39.6
Bradford	→	127	32.6	28.2	37.5

Source: Department for Education

Chart 9



3.24 **The impact of COVID-19 on the Calderdale emotional wellbeing & mental health workforce**

Our approach has been to work together to address need on a number of levels ensuring that emotional mental health and wellbeing remains a high priority across our partnership.

3.25 A system-wide discussion about COVID-19 impacts took place at the April 2021 Calderdale Open Minds Partnership meeting. Partners described the flexible response of their workforce in adjusting to the needs of children, young people and their families during the Pandemic. Members of the Calderdale Voluntary Community and Social Enterprise (VCSE) sector confirmed that pressure has increased in their organisations, as the emotional toll of providing support on the workforce is high.

4. The Open Minds Partnership response to the Pandemic

4.1 Individuals and organisations across Calderdale deserve recognition for how they responded to the needs of children and young people over the last 18 months. They embody *Calderdale Vision 2024*: showing great kindness towards each other, enabling children, young people and families to have their voices heard, and working hard to help each other (children, young people and provider staff) be resilient and recover from the impact of COVID-19.

4.2 We are proud that children, young people and families have continued to be involved in shaping our response to the COVID-19 Pandemic, despite the restrictions. Their feedback on which services and resources they find most relevant and useful has been and continues to be vital.

4.3 Examples of what has been delivered at pace **for children and young people** by the Open Minds Partnership are provided below[4].

4.3.1 **Promotion of existing resources and support:** Kooth and other digital services were promoted widely and regularly, including the Open Minds Calderdale site.

4.3.2 **Partners supporting vulnerable/at risk children:** the Voluntary and Community Sector has provided children living in the most deprived areas of Calderdale with food parcels and vouchers; supported children and families of children with chaotic lives at home with trips to the local park; offered support to Young Carers who've been particularly vulnerable during the Pandemic and lockdowns; offered regular check-ins, blended approaches, such as online/remote support groups, doorstop wellbeing packs and socially distant/COVID-secure face-to-face visits; providing support at different times of the day, including evenings, promoting self-care to adults caring for children and young people (including foster carers); and offering peer-led support.

4.3.3 **New resources: young people** worked with the Open Minds Partnership to produce new emotional health and wellbeing resources via the Open Minds Calderdale web site http://www.openmindscalderdale.org.uk/[5]. These include how to manage concerns and anxieties about coronavirus[6], and *Worry Cards*[7] to support students concerned about returning to education after lockdowns. Tough Times created a poster[8] to promote services available for children and young people, widely promoted widely by partners.

4.3.4 **Service developments:** Open Minds (CAMHS) have taken steps to increase capacity and gain efficiencies, such as:

- Introducing additional roles – a Care Navigator, providing targeted support to young people, a second triage worker (for 12 months), a Neurodevelopmental triage worker, a Signposting & Advice Worker to champion Silvercloud and digital resources, a Senior Clinician to support triage and assessment of complex cases.
- Strengthening links with partner organisations, including those in the wider Open Minds Partnership.
- Enhanced signposting support to parent carers/families to proactively help them access support from family services etc.

4.3.5 **Return to education resources and support:** Partners, including Healthy Futures, School Nurses and the third sector, have supported students, families and staff throughout the Pandemic. Bespoke *return-to-school guides*[9] were developed with, and for Calderdale's students, parents, and school staff. New resources for parent carers, on anxiety, low mood, anger, routines,

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[4] Further details will be available in the *Calderdale Children and Young People's Mental Health Strategic Plan 2020-2021*.

[5] http://www.openmindscalderdale.org.uk/

[6] http://www.openmindscalderdale.org.uk/category/help-and-support-coronavirus/

[7] http://www.openmindscalderdale.org.uk/i-am-worried-about/

[8] http://www.openmindscalderdale.org.uk/wp-content/uploads/2020/09/EHWB-for-CYP-2020-09-08_FINAL.pdf

[9] http://www.openmindscalderdale.org.uk/wp-content/uploads/2021/03/Primary-school-staff-guideV2-Supporting-EHWB-of-students-returning-to-school.pdf and http://www.openmindscalderdale.org.uk/wp-content/uploads/2021/03/Secondary-school-staff-guideV2-Supporting-EHWB-of-students-returning-to-school.pdf

self-harm and suicidal thoughts[10]. Using a small DfE grant, a *'Wellbeing for Education Return*' training project was delivered by Calderdale MBC and the Open Minds Partnership in Autumn 2020. It was designed to give school staff the tools to support students returning to education. Led by Calderdale MBC, an *Education Recovery Plan* is being developed which has a strand focussing on Wellbeing for students and staff.

4.3.6 **Silvercloud[11], a digital anxiety guided self-help programme** introduced by Open Minds (CAMHS) and developed with input from the Tough Times Reference Group. This provides instantly accessible online Cognitive Behavioural Therapy (CBT) informed support for young people and parents/carers in addition to other digital tools available to young people in Calderdale.

4.3.7 **Mental Health helplines:** new services went live during the Pandemic, including a confidential 24/7 helpline offering support and guidance to people aged 16 years and above in Calderdale, Kirklees, Wakefield and Barnsley, and a pilot 'Night Owls' overnight service for children and young people across West Yorkshire.

4.4 **The workforce** also implemented initiatives to safeguard their own wellbeing and ensure they were able to continue supporting children and young people. They have highlighted the importance of effective communication amongst partner organisations, as well as with children and young people and their parent carers.

Working patterns have changed significantly and staff have needed to be flexible to meet the needs of children. They also have helped each other navigate changes to COVID-19 rules and guidance. For example,

4.4.1 **Unique Ways** "organised regular Team KIT meetings over the duration of Covid-19 to have a space to talk about non-work things. The chief officer involved her staff in producing the risk-assessments when returning to work to ensure they felt safe when returning to the office"

4.4.2 **Women's Centre** "Trying to remain as flexible as possible and take staff views into consideration i.e., enabling staff to work in the office if they want to whilst staying safe (providing proper sanitisation, social distancing, proper ventilation etc.), whilst managing the contractual requirements, workload and impact on the workforce capacity during Covid-19".

4.4.3 **Northpoint Wellbeing (Open Minds CAMHS)** "During lockdown practitioners were quickly provided with training, equipment, and support to equip them with the skills and confidence to provide remote therapy to children & young people while working from home. An external facilitator was also brought in to provide specialist support and training."

4.4.4 In addition, **a new West Yorkshire & Harrogate Mental Health Hub[12]** was launched mid-Pandemic to support people who work in health, social care services and the voluntary community social enterprise sector (VCSE) as they deal with the impact of COVID-19.

Staffed by a dedicated team, the hub is a confidential, free of charge service funded by NHS England/Improvement that builds on existing wellbeing

[10] http://www.openmindscalderdale.org.uk/emotional-health-support-parents/
[11] https://openmindscamhs.org.uk/silvercloud/
[12] https://workforce.wyhpartnership.co.uk/

support that is available in hospital Trusts, councils and the many voluntary services organisations that make up the WYH ICS. The hub offers 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.

5. Progress in other (non-COVID-19) areas

5.1 Despite the Pandemic, we continue to make every effort to maintain the momentum in delivering 'Thrive' and making improvements in the emotional wellbeing and mental health offer for children and young people.

5.2 Children's emotional health and wellbeing is one of Calderdale's main priorities, monitored strategically at senior level through our *Starting Well Partnership Board* (0-25 years). This group is chaired by the Director of Children's Services (DCS) with the Director of Public Health as vice-chair. Under this, governance in Calderdale is led by multi-agency groups which have continued to operate fully during the Pandemic and have supported this programme of work.

There is a named experienced GP clinical lead for children and young people in Calderdale and the CCG has prioritised funding for this post to ensure the GP has ringfenced time to support this work. The GP clinical lead is the chair for the core Open Minds Core Group and Co-chair of the Open Minds Partnership Group.

5.3 Examples of other areas of progress include:

5.3.1 **Open Minds Partnership:** This group takes a partnership approach to delivering improvements in emotional health and wellbeing services for children and young people. It has been meeting quarterly online throughout the Pandemic and includes young people who help shape and deliver the group's work. Members of Scrutiny Board are involved in an observer capacity. Key areas of focus have included: how the Group works together, the impact of the Pandemic, and disordered eating. A dedicated web space has been created to support collaboration among the Partnership, available on the national *NHS Futures* platform[13]

5.3.2 **Thrive Communications:** After a soft launch in 2019, 'Thrive' was promoted further during 2020 and 2021, with resources provided for the Open Minds Partnership on the NHS Futures platform.

5.3.3 **Mental Health Support Teams:** MHSTs provide early intervention on some mental health and emotional wellbeing issues in line with the 'Thrive' model. The teams act as a link with the OMP and prioritise disadvantaged areas and vulnerable groups. Further information on progress and outcomes achieved to date will be provided in the presentation which will be made to Scrutiny Board.

5.3.4 **Neurodevelopment (Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)):** Inspired by the experiences of our young people shared at the February 2020 '*Find Your Brave'* Summit, partners developed a new action plan, aligned to the THRIVE principles. It focuses on providing and promoting early intervention services and support

[13] https://future.nhs.uk/CCYPS/grouphome

for children, young people and their families, regardless of whether they have diagnosis of ASD or ADHD. Further information on progress and outcomes achieved to date will be provided in the presentation which will be made to Scrutiny Board.

5.4 The children's ASD diagnostic assessment service in Calderdale has been a priority over the past few years. Pre-Pandemic, Calderdale CCG funded a waiting list initiative to reduce the numbers of pre-school and school age CYP waiting for an ASD diagnostic assessment. The waiting list initiative was proving successful, with waiting list expected to be at 12 months by the end of April 2020.

5.5 Due to COVID-19 and the introduction of lockdowns starting in March 2020, services were required by the UK Government to pause all assessments until July 2020. Furthermore, when services did resume, additional measures where needed to protect children, families and staff, resulting in a reduced number of assessments being available. Through subsequent lockdowns, the pre-school ASD and school-age neurodiversity services continued to provide assessments in a safe and effective way.

5.6 Waiting Times: across West Yorkshire there are different approaches to recording waiting times. Most providers 'stop the clock' at the first appointment. However, Bradford 'stop the clock' once a diagnosis outcome has been reached. Table 3 below illustrates the waiting times and lists across West Yorkshire.

Table 3

CCG	Pre-COVID waiting times	September 2020		No of CYP waiting up to July 2021
		Waiting times	No. CYP waiting	
Bradford	24 months	36 months	1,433	
Calderdale	12 months (school-age)	18 months (pre-school) 24 months (school-age)	Pre-school: 109 School-age: 187 ASD 247 Neuro* (*A single ASD/ADHD pathway began in September 2020)	Preschool: 120 (N.B: all will be cleared by early 2022 via a waiting list initiative). School Age: Neuro (ASD/ADHD) approx. 380
Kirklees	6 months	12 months	700	
Leeds	*Not provided*	5 ½ months	510	
Wakefield	26 weeks (for assessment)	12 months	*Not provided*	

5.6.1 In August 2021 Calderdale CCG invested an additional £150,000 recurrently into the School-age Neurodiversity service. This investment will reduce the number of CYP waiting, with the waiting time to be reduced to 18 months by September 2022 (based on 19 referrals per month). The waiting list may be further reduced as a result of people exercising Choice in referral.

This means CYP currently on the SWYPFT waiting list can ask to choose a different provider to carry out their assessment and therefore be removed from the SWYPFT waiting list. As the arrangements around Choice are still in their infancy, we are unable to predict the impact on the current waiting lists.

5.6.2 In addition, a waiting list initiative has been commissioned by the CCG to reduce the Pre-School ASD wating list to 3 months. An 'Any Qualified Provider' procurement took place, with one provider being successful (Oakdale Centre, located in Halifax). The CCG has committed approximately £150,000k to this.

6. Learning

6.1 Learning, our ongoing response and recovery from the Pandemic, system transformation continues to be informed by feedback from children, young people, parents and families.

6.2 Our ambition is for children and young people of Calderdale to have good mental health and we believe that promoting and supporting positive emotional health and wellbeing **is everyone's business**. Through the implementation of our partnership vision we have been moving away from a system defined by services and organisations to one built around the needs of children, young people and their families, offering increased choice and control, intervening early and building long term resilience.

6.3 From 2015 to 2020 there has been progress through the delivery of the Local Transformation Plan priorities. Services are now more joined up and are working in partnership towards the implementation of the Thrive framework rather than in a tiered model: ensuring that support for children and young people is more holistic and focused on their needs rather than being service driven.

6.4 A summary of our learning as a system is provided below:

6.4.1 **Thrive is absolutely the right approach**: providing services for children and young people when and where they need them, aligned to the 'Thrive' model of care, continues to be the correct and most effective approach for Calderdale children and young people.

6.4.2 **The importance of leadership**: to transform services and shift culture in a way that is inspiring, approachable, and supportive.

6.4.3 **The role of the VCS/third sector:** who are best placed to effectively engage with communities experiencing poorest health outcomes/inequalities, understand their experiences of the health and care system pre-COVID, and identify how their needs may have changed.

6.4.4 **Partnership working:** the VCS, local authority, health, and social care working in key collaboration with each other and children and young people to engage with communities, co-produce and deliver more integrated care, and transform and address gaps, inequalities and improve wellbeing.

6.4.5 **Provider collaboration:** the benefits of improved collaboration, provider to provider, for example in case management (particular for those individuals at

risk, who require a co-ordinated approach), mutual aid, communication and take a non-traditional, creative approach to problem solving.

6.4.6 **The need to focus on early preventative, 'medical and 'non-medical', holistic support:** signposting to services who can best meet the needs of children and young people, enabling priorities to be met, make effective progress in improving health and reduce the demand on statutory services.

6.4.7 **Appropriate use of digital** and on-line support to increase access to support and resources: but being mindful that this needs to form part of a blended, flexible offer to minimise inequalities.

6.4.8 **The workforce:** Organisations and individuals across Calderdale have, and continue to work extremely hard to ensure that advice and services are still available to children and young people. Our system, particularly system leaders, have a responsibility to ensure we have a well-resourced, diverse, healthy, motivated workforce that can adapt to changing demands and circumstances.

7. Challenges and opportunities

7.1 There is no doubt that COVID-19 has and continues to present many challenges to Calderdale children and young people, and the organisations and individuals providing them with emotional wellbeing and mental health support. The Pandemic has also provided us with opportunities: to listen and learn from children, young people and each other as partners; for greater collaboration and mutual aid; to overcome barriers, innovate and implement improvements; and to utilise digital tools when no other offer was possible.

7.2 As a system, we are using the intelligence arising from the Pandemic, and will maximise future changes to the commissioning landscape and the West Yorkshire & Harrogate ICS, outlined in the *Health and Care Bill* currently before the UK Parliament[14], to shape our ongoing response and future direction of travel.

7.2.1 **'Thrive':** the Pandemic has reinforced what we already believed, that continuing implementing the 'Thrive' model of care (providing services for children and young people when and where they need them), is the correct and most effective approach. 'Thrive' is aligned to Vision 2024, Calderdale Cares, West Yorkshire and Harrogate Integrated Care System's (WYH IC) '10 big ambitions' and the aims of the NHS Long Term Plan.

7.2.2 **Inequalities:** We recognise the importance of identifying and addressing health inequalities in our current models of care for children and young people. We are building capacity and capability to ensure we fully understand the health inequality agenda, accurately analyse data, interpret feedback in a meaningful way, and make truly informed decisions. Our actions are informed by the Calderdale *COVID-19 BAME Inequalities Action Plan* and WYH ICS *BAME Inequalities Action Plan*. It is our aim to:

- understand why inequalities exist and solutions of how these can be addressed – working at place with communities to reflect the diverse ethnicity of local areas, through population planning processes.

[14] https://bills.parliament.uk/bills/3022

- ensure all settings have 100% ethnicity recording and visible data across all models;
- ensure services meet local need to reduce inequalities for specific ethnic groups;
- increase the focus on specific groups (for example, refugees, asylum seekers, Roma, Gypsy and Travellers), with better understanding of the relationship between ethnicity and poverty.

7.2.3 **Holistic approach to children and young people's wellbeing:** as described the Calderdale Health and Wellbeing Strategy[15], partners recognise there are significant opportunities to improve the overall wellbeing of children and young people by forging greater connections between physical and mental wellbeing in our system, processes, pathways and organisations. The Open Minds Partnership will focus on this with Public Health, primary and secondary care partners.

7.2.4 **Integrated ways of working between children's and adult services:** there are benefits to be gained for the whole of Calderdale by keeping moving towards an all-age approach, as described in the Calderdale Health and Wellbeing Strategy[16]. By improving the links and partnership working between CYP and adult services to ensure support is offered for parent carers/family members who may have their own emotional wellbeing and mental health challenges, this will have a positive impact on the wellbeing of CYP in their family unit.

7.2.5 **Crisis:** As reported in section 3.16, additional funding has been identified to support the increase in referrals to the crisis service. A Population Health Management approach is also being taken to look at 'the rising risk in demand for crisis, self-harm and suicides'. This work will commence in October 2021.

7.2.6 **Disordered Eating:** There has been a large increase in referrals to secondary care mental health (South West Yorkshire Partnership Foundation Trust – SWYPFT) during and due to the Pandemic, particularly in recent months. The level of illness in children and young people being referred is generally quite severe. The OMP is establishing a task and finish group, including young people, to review the current offer and the outcomes it achieves, where the gaps are and options to address these. This includes understanding what early support is and can be provided.

7.2.7 **Demand:** As shown earlier in this Report, some services have noted an impact of the Pandemic on their ability to meet demand. In some cases (such as the FPoC), services are 'victims of their own success'. We are working in partnership with Public Health to help manage demand and review the role and expectations of FPoC, particular in relation to the role of school nurses in providing the Health Needs Assessment for CYP contacting FPoC.

7.2.8 **Preparing for adulthood:** the 'Thrive' service specification and NICE guidance[17] states that, "Transition arrangements into adult services must be in place", that transition should be, "…a purposeful and planned process of supporting young people…" and that "Without proper support, young people [moving from children's services] may not engage with [adults'] services…" not least because "…making this move can be difficult or provoke anxiety in

[15] https://www.calderdale.gov.uk/nweb/COUNCIL.minutes_pkg.view_doc?p_Type=AR&p_ID=66736
[16] https://www.calderdale.gov.uk/nweb/COUNCIL.minutes_pkg.view_doc?p_Type=AR&p_ID=66736
[17] https://www.nice.org.uk/guidance/ng43

young people and their carers…" This requires further focus by Open Minds Partners and has been captured in the Calderdale Children and Young People's Mental Health Strategic Plan.

7.2.9 **Waiting times:** The impact of lockdowns and operating services under COVID-secure guidelines means that waiting times for some services have increased. This has been compounded by increased demand from children and young people coming forward now, who held off accessing OMP services when they normally would have, during the Pandemic. Population health management population segmentation (through defined tools) are being used to support the system to define the demand and capacity required.

7.2.10 **Digital:** Due to the Pandemic, services rapidly switched to digital and remote models to deliver care and ensure continuity of support for children and young people. Many children, young people and services have found value in the new approach, resulting in plans to increase the blended service offer in the future. The OMP recognises that choice is important and where we can, services should offer choice of digital and face-to-face support. The Open Minds Partnership also needs to how we support those children and young people who do not have access to a device, or the Internet.

7.2.11 **Choice in Mental Health:** Following updated advice from NHS England/Improvement, people have the right to choose a mental health service provider in England, under certain circumstances. Calderdale Commissioners will continue to work with local stakeholders, the West Yorkshire & Harrogate ICS and NHS England/Improvement to enable the right to choose.

7.2.12 **Workforce:** By developing a Calderdale Emotional Wellbeing & Mental Health *Workforce Strategy*, our system will set out its ambitions for workforce recruitment, retention and development to deliver change. In particular, recruiting a diverse workforce, understanding skills and roles, motivating staff to act as change leaders, and harnessing the determination of staff to move from traditional roles to multi-disciplinary team working, building empowerment and encouraging innovation. This will be underpinned by the annual Workforce Surveys and action plans which were already in place before the Pandemic.

8. Conclusions

8.1 The Pandemic is testing the resilience of children and young people, their parent carers, and organisations who meet their emotional wellbeing and mental health needs. Although services have been very flexible, adapting during a time of great pressure, the Pandemic has exacerbated systemic weaknesses at place, regionally and nationally, and created new challenges.

8.2 It has made the Open Minds Partnership even more determined to work together to support children and young people, because the emotional wellbeing and mental health of children and young people is everyone's business.

8.3 Calderdale CCG has made additional investment and service changes, many of which have focused on connections between mental health services, community and voluntary care. This has been very positive and has overcome some of the traditional organisational boundary issues which can impede joint working.

8.4 Partnership working has been strengthened during this difficult time, creating a stronger infrastructure on which to build further improvements and to work towards a future where all children and young people are supported to thrive and make the most of their potential. Partners, including Public Health will continue to work together to help manage demand.

8.5 The next step in our journey is to develop a strategic plan and programme of work setting out the direction of travel for Children and Young People's Emotional Well-Being over the next three to five years. This will be informed by:

- a refresh of the impact of 'Thrive' over the past four to five years,
- learning gathered from COVID-19 pandemic,
- experiences from Children and Young People,
- information collected from professionals and services,
- the Calderdale Emotional Wellbeing & Mental Health *Workforce Strategy*,
- opportunities arising from changes to commissioning and our commitment to deliver *Calderdale Cares*.

8.6 Although this paper focuses in on children and young people's emotional health and wellbeing, the strategic plan and work programme will overlap, support and complement all other children and young people's work carried out in Calderdale.

9. Additional information and presentation

9.1 Further information on the outcomes achieved by partners will be available in a presentation which will be made to Scrutiny Board. Officers and Commissioners will be available to answer any questions and provide additional detail.

10. Appendices

10.1 **Appendix 1:** Illustration of the Open Minds Partnership – who's who and how we're connected

10.2 **Appendix 2:** 'Thrive' Principles

10.3 **Appendix 3:** eNHA Pupil Survey

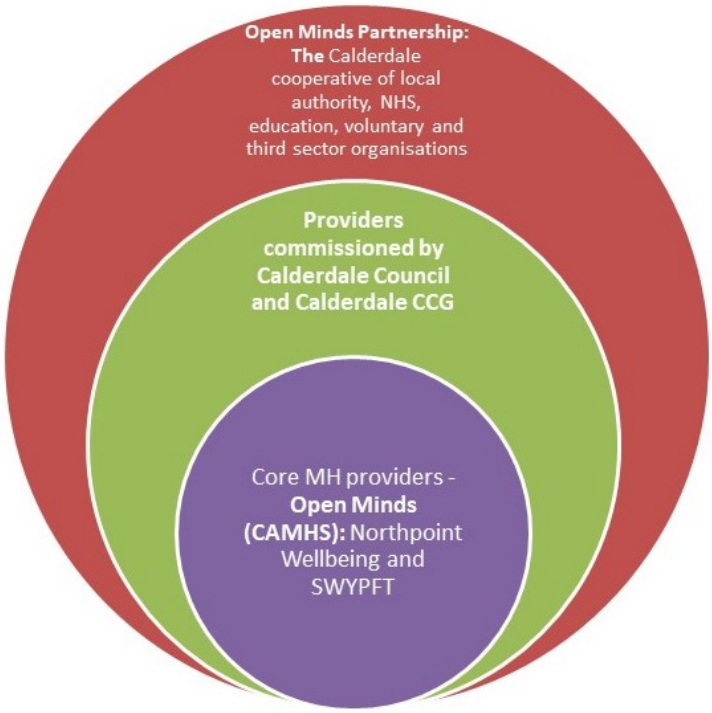
11. Background documents

11.1 *Update to Scrutiny Board on the Open Minds Partnership and 'Thrive'* (June 2020)

11.2 Minutes from Adults, Health & Social Care Scrutiny Board (19th August 2021)

12. Documents available for inspection at

Appendix 1: Open Minds Partnership – who's who, and how we're connected



Appendix 2: Thrive principles

a) ‘Thrive’ is a person-centred, whole system approach, where responsibility for meeting the emotional wellbeing and mental health needs of needs of children and young people is everyone’s business.

b) The focus is on prevention: helping children, young people and their communities build on their own strengths and bolster their resilience.

c) Services work closely together in partnership and share knowledge so a young person should only tell their story once.

d) The child or young person receives support at any time from the most appropriate services and resources that meet their needs rather than them fitting into a specific service, or driven by a specific diagnosis or severity of the issues (which is how the old CAMHS model operated).

   In addition, their needs shouldn’t and aren’t always solely provided by statutory mental health providers, Northpoint and SWYPFT (which is the old CAMHS model). Other agencies, including the third sector, offer a rich diversity of support that can meet the different needs of our young population and their families.

e) Children, young people and their families have a central role in deciding what success would look like for them, knowing that there will be ‘no decisions about me, without me’.

f) The support and help provided is based on focused, evidence-based treatment, provided to achieve the goals of children and young people, and measuring progress towards these.

Appendix 3: eHNA Pupil Survey – analysis of emotional wellbeing

	Primary			Secondary		
Secondary	2019	2021	difference	2019	2021	difference
Feel sad more than once a week (10e)	18%	27%	10%	29%	37%	8%
Feel irritable more than once a week (10f)	19%	29%	9%	33%	40%	7%
Has trouble sleeping more than once a week (10	25%	36%	11%	29%	36%	8%
Low life satisfaction (52)	8%	9%	1%	15%	18%	3%
Low Personal wellbeing (53)	8%	10%	2%	18%	22%	4%
Low self-esteem (55)	22%	31%	10%	38%	45%	7%
Worry all the time about...? (56)	44%	49%	5%	47%	52%	4%
Ever self harmed (62)		38%	na		35%	

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Feel sad more than once a week	2019	690	3911	18	16.48	18.87	1.16	1.23	1130	3942	29	27.28	30.10	1.39	1.43
	2021	1139	4154	27	26.08	28.80	1.34	1.38	1341	3617	37	35.52	38.66	1.56	1.59

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Feel irritable more than once a week	2019	752	3892	19	18.11	20.59	1.21	1.27	1295	3942	33	31.40	34.33	1.45	1.48
	2021	1167	4075	29	27.27	30.05	1.37	1.41	1424	3593	40	38.05	41.24	1.59	1.61

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Has trouble sleeping more than once a week	2019	995	3925	25	24.01	26.73	1.34	1.38	1128	3950	29	27.17	29.99	1.39	1.43
	2021	1503	4152	36	34.75	37.67	1.45	1.47	1307	3606	36	34.69	37.83	1.55	1.58

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Low life satisfaction	2019	274	4130	7	5.91	7.43	0.72	0.80	612	4058	15	14.01	16.22	1.07	1.13
	2021	392	4484	9	7.95	9.60	0.79	0.86	684	3703	18	17.25	19.75	1.22	1.28

		Primary						Secondary						
		Number	Total respon	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	Total respon	Percentage	LCI	UCI	Dif LCI	Dif UCI
Low personal well-being	2019	296	3918	8	6.77	8.42	0.79	0.87	722	3912	18	17.27	19.70	1.18	1.25
	2021	402	4164	10	8.79	10.59	0.86	0.93	786	3552	22	20.79	23.52	1.33	1.39

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Low self-esteem	2019	811	3752	22	20.33	22.96	1.29	1.35	1387	3676	38	36.18	39.31	1.55	1.58
	2021	1291	4126	31	29.89	32.72	1.40	1.43	1524	3417	45	42.94	46.27	1.66	1.67

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Worry all the time about...?	2019	1836	4128	44	42.97	46.00	1.51	1.52	1993	3983	50	48.49	51.59	1.55	1.55
	2021	2181	4442	49	47.63	50.57	1.47	1.47	1878	3621	52	50.24	53.49	1.63	1.62

		Primary						Secondary						
		Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI	Number	responses	Percentage	LCI	UCI	Dif LCI	Dif UCI
Ever hurt yourself on purpose	2019	na	na						1035	3943	26	24.90	27.65	1.35	1.40
	2021	1698	4452	38	36.72	39.58	1.42	1.44	1273	3603	35	33.79	36.91	1.54	1.58

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate (WY&H) Joint Committee of Clinical Commissioning Groups

Summary of key decisions - Meeting in public, Tuesday 5th October 2021

Lidocaine plasters for the treatment of pain in children
The Committee considered a policy which would enable primary care clinicians to prescribe lidocaine plasters for the treatment of pain in children who were already receiving specialist tertiary care. The policy would affect a very small number of children but would improve their quality of life by reducing the need for them to attend the paediatric pain specialist centre in Leeds to receive repeat prescriptions. The policy would bring us in line with clinical practice in other specialist centres nationally. Evidence suggested that the treatment was safe and effective. The Joint Committee was keen to ensure that primary care clinicians had the necessary support to enable them to prescribe effectively and minimise any risk to patients. The Committee was assured that advice and support would be available from the specialist paediatric team in Leeds. Explanatory information would be provided and the shared care guidance would be revised to set out the need for a direct conversation between the specialist initiating the treatment and the primary care clinician who would continue it.
The Committee: **Agreed** the commissioning statement for adoption as policy across the WY CCGs.
Hydroxychloroquine & Chloroquine Retinopathy Monitoring - Pathway and Policy Amendment
The Committee presented revisions to the policy which had been agreed by the Joint Committee in November 2019. It removed a baseline assessment, as the Royal College of Ophthalmologists had decided that it was not necessary. The amendment would ensure that patients who are prescribed hydroxychloroquine or chloroquine have the correct monitoring and follow the same pathway, in line with the updated guidelines. This would ensure safe, evidence-based interventions with follow-up at the appropriate time.
The Committee: Agreed the amendment to the WY&H Hydroxychloroquine and Chloroquine Pathway and Policy to reflect updated clinical guidance.
Integrated Care Board constitution – development and stakeholder involvement
The Committee noted that whilst the Health and Care Bill required CCGs to propose the ICB constitution and carry out involvement on it, NHS England guidance was that the process should be led by the designate ICB chair and Chief Executive, with system partners engaged throughout. This supported our 'whole Partnership' approach, building on the work of the ICS Governance Working Group, which included partners from across our places and sectors. The involvement process would be 'designed once' and delivered five times across our local places, involving all relevant and interested stakeholders via our local communication and engagement leads. Final agreement of the constitution would be through the Partnership Board and the shadow ICB Board.
The Committee: Recommended that each CCG agree that the Partnership would co-ordinate the development of the draft integrated care board (ICB) constitution and stakeholder involvement on the constitution.

The Joint Committee has delegated powers from the WY CCGs to make collective decisions on specific, agreed WY&H work programmes. It can also make recommendations. The Committee supports the Partnership, but does not represent all partners. Further information is available here: https://www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs or from Stephen Gregg, stephen.gregg@nhs.net.

Operating Framework for Managing Individual Funding Requests

Version / Status: 8.0

Responsible Clinical Commissioning Group (CCG):

Kirklees CCG and Calderdale CCG

Responsible Committee:

Kirklees CCG Governing Body and Calderdale CCG Governing Body

Date Approved: 14.04.21 Kirklees CCG Governing Body

Author: Assistant Manager, Individual Funding Requests

Review Date: June 2022

Version Control:

The table below provides an audit trail for all amendments to this document. The table provides the following information, the version, date amended, author of the amendment, the status of the document and additional comments as to what amendments were made.

Version	Date	Author	Document Status	Comment
6.0	Apr 2014	Claire Gordon – Project Officer GHCCG	FINAL	Approved by Greater Huddersfield and North Kirklees CCG Governing Bodies.
6.1	Sept 2016	Claire Wood – Assistant Manager IFR	Draft	Revised and circulated to the GHCCG, NKCCG and CCCGs SMT and the Joint Exceptional Cases Committee –
6.2	Oct 2016	Claire Wood – Assistant Manager IFR GHCCG	Draft	Revised with comments from GHCCG and NKCCG SMT. Approved by GHCCG and NKCCG Governing Bodies – October 2016. Circulated to staff and public via website
6.3	Apr 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft	The Operating Framework updated to incorporate comments from Calderdale CCG SMT Meeting - April 2017 Presented to Calderdale CCG Governing Body for approval – June 2018
7.0	Jun 2018	Claire Wood – Assistant Manager IFR GHCCG	FINAL	Approved by Calderdale CCG Governing Body – 14 June 2018 Circulated to staff and public via website.

8.0	April 2021	Claire Wood – Assistant Manager IFR KCCG	Final	Updated to reflect policy being adopted by new organization, Kirklees CCG.

Contents

Operating Framework Statement

NHS Kirklees Clinical Commissioning Group (KCCG) and NHS Calderdale Clinical Commissioning Group (CCCG) throughout this document will be known as 'the CCGs'. KCCG is the host commissioner for the implementation of the Individual Funding Requests (IFR) operating framework, on behalf of KCCG and CCCG as covered within the Memorandum of Understanding dated January 2016.

The CCGs have a systematic and documented process for considering all Individual Funding Requests that will take into account national, regional and local guidance to support decision making.
All Individual Funding Requests will be considered via this documented process.

This will ensure decisions are consistent and based on the best available evidence and enable the most appropriate care to be delivered within the context of individual clinical need.
The operating framework will be made publically available on each CCGs website with links to clinical guidance documents where these are available.

Introduction

This document sets out the CCGs procedures for managing requests for an individual to receive a health care intervention that is not routinely funded by the CCGs. The vast majority of health care commissioned by the CCGs is covered by NHS Service Level Agreements or other Contracts. However, there are a small number of requests for treatment by individual patients each year that are not covered by either of these.

For the purpose of this document, and in common with the Secretary of State's Directions to CCGs and NHS Trusts concerning decisions about drugs and other treatments 2009, the term "health care intervention" includes use of a medicine or medical device, diagnostic technique, surgical procedure and other therapeutic intervention.

Scope of this Operating Framework

This operating framework applies to all employees of the CCGs, any staff who are seconded to the CCGs, contract and agency staff and any other individual working on the CCGs premises or on behalf of the CCGs who are involved in the administration processes for IFRs.

Clinicians making an IFR request on behalf of their patient are expected to adhere to the procedure outlined in this document. Advice and support is available from the IFR Team based at Broad Lea House.

The scope is to have a clear operating framework to:

- Manage Individual Funding Requests
- Consider the legal aspects of priority setting
- Have a systemic and consistent approach to the management of Individual Funding Requests This will be achieved by the following objectives:
- To be compliant with the NHS Confederation guidelines on interpretation of legislation
- To have systems in place that enable a consistent approach to decision making within appropriate timescales
- To ensure decisions made are based on the best available evidence at the time of consideration

The process for managing new treatments will not be considered as part of this because it is a separate process within the CCGs. This operating framework will aim to provide a robust process of decision making by which all Individual Funding Requests can be considered.

In responding to an Individual Funding Request the CCGs accept no clinical responsibility for the health care intervention or its use, or for the consequences of not using the intervention

Legal Context

The CCGs have a duty:

- To allocate healthcare resources, utilising a consistent framework for decision making
- To promote and provide a comprehensive healthcare service within its allocations and consider how this is best done
- To be aware of differences in neighbouring CCGs and be able to justify them if necessary

(NHS Confederation, 2008a)

The CCGs need to be satisfied that any decision follows the procedures and processes described in this document and in doing so ensure requests are considered on their own merits.

The courts have established that a CCG is not under an absolute obligation to provide every treatment that a patient demands, although they must be able to clearly demonstrate why a treatment has been refused (NHS Confederation, 2008a). A CCG can develop a policy which prioritises treatment to take account of the resources available to it and the competing demands on those resources. Patients with rare or unusual medical conditions have as much right to care as anyone else and have the right to have their requests considered properly, on their own merits and against the CCGs policy in each individual case.

The need for priority setting processes to be central to CCGs corporate governance in relation to Individual Funding Requests and commissioning decisions cannot be underestimated because the potential for Judicial Review is increasing. Judicial Review is the process by which the lawfulness of decision making can be challenged and can occur as a result of major service change or refusal to fund treatments for individual patients. There are grounds for a review if:

- Decisions may be unlawful – acting outside statutory power (e.g. not following direction of the Secretary of State)
- Decisions may be irrational – considering irrelevant/excluding relevant factor
- Decisions are procedurally improper – (e.g. failure to comply with the CCGs policy or the CCGs policy itself being unlawful or irrational) (NHS confederation, 2008a)

Commissioning Principles

The CCGs have a statutory duty to provide health care for their population and in doing so have to take account of the resources available, usually a fixed budget from central government to commission health care and services. The CCGs commissioning principles are used to make decisions in a consistent, fair and transparent way, given that funds are not endless and choices inevitably need to be made. The criteria for commissioning treatments are:

- Clinical Needs – Consideration should be given to understanding the need and whether we are likely to achieve the greatest possible health outcome for the patient. Health care interventions which produce the greatest benefit in terms of clinical improvement and/or improvements in quality of life should be prioritised.
- Lawful – As previously discussed in this document as part of the legal responsibilities of the CCGs. In addition, as part of this process a Clinician makes a request on behalf of the patient and therefore must be aware of the need to obtain informed consent for the referral as well as ensuring the patient is aware of both the potential benefits and risks of any treatment being requested.
- Clinically Effective – Commissioning decisions should be based on evidence of effectiveness wherever possible. For example, this could come from sources such as NICE, Cochrane reviews, meta-analysis or randomised control trials.
- Cost-effective – Given limited resources, the CCGs must receive optimum value from available resources and recognises that QALY (Quality Adjusted Life Years) would help judge this, with NICE using a maximum value of £30,000 per QALY. However it is important to note that cost alone will not be a reason for refusing an Individual Funding Request. The Exceptional Cases Committee shall have a broad discretion to determine whether the proposed treatment is a justifiable expenditure for the CCGs. The CCGs are however required to bear in mind that the allocation of any resources to support any individual patient will reduce the availability of resources for investments in previously agreed care and treatments.
- Equitable – In this context equity means that if an Individual Funding Request is agreed for a new treatment/drug trial then it could lead to service development which could benefit the wider population. In addition, once a precedent has been

set, it is likely that future requests for the same treatment would also qualify for funding, subject to the clinical presentation of the patient.

- Accessible – While accessibility implies utilisation of local services the CCGs also need to take into account patient choice. The CCGs would expect referrals to be made to the NHS services wherever possible but a choice list will be provided to highlight where the CCGs will fund treatment outside the local NHS if available and where requested by the patient.
- Good quality of care and patient experience – Decisions should be based on the potential to deliver good and safe care, improve health outcomes and enhance patient experiences. Individual Funding Requests should be agreed if it meets this criteria and will achieve or has the potential to achieve explicit measures of quality, including:

    1. Patient feedback through local and national surveys, PALS and complaints
    2. Local and national standards, targets and quality indicators

Associated Policies and Procedures

This operating framework and the procedures outlined within it are related to:

- Policy and procedure for commissioning treatments not covered by existing service level agreements
- Medicines (and technologies) commissioning policy

Accountability and Responsibilities

The Chief Officer and Governing Body of the CCGs are accountable for the discharge of CCG statutory duties and have a scheme of delegation in place that is set out in the CCGs Standing Orders and Standing Financial Instructions.

CCG Leads

The Lead Manager with overall responsibility for this operating framework and the procedures within it is the Head of Strategic Planning, Service Transformation and Integration for KCCG.

Committee Accountability

Overall responsibility for the development and implementation of this operating framework and its procedures remain with each CCGs Governing Body. The annual report will be made available to the Finance & Performance and Quality and Safety Committees and reported formally to the Governing Bodies of each CCG to enable them to:

- Ensure the systems in place are sufficient to meet patient's needs
- Ensure that decisions made throughout the process are consistent and appropriate
- Ensure positive health outcomes are being achieved as a result of the decisions made

Delegated Responsibilities

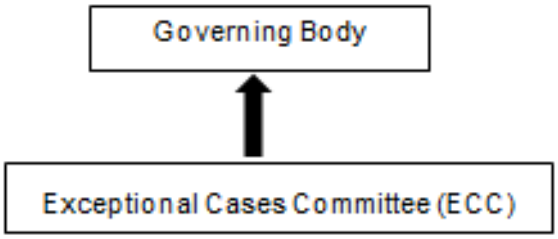
Responsibility for making decisions regarding Individual Funding Requests on behalf of the CCGs has been delegated by the Governing Bodies of each CCG to:

- The Exceptional Cases Committee (ECC)

The membership, roles and responsibilities of each of these bodies is set out in the procedures section of this document.

Structure of Reporting

The ECC reports directly to the KCCG Governing Body Meeting. The diagram below shows the flow of reporting information and accountability from the ECC to the KCCG Governing Body.



Responsibility for Operating Framework Review

Where a need to change any aspect of the structure or process of decision making is identified, the IFR Team will co-ordinate a review of this policy. A review may also be required in response to new local, regional and national guidelines as they become available.

Changes to other policies within the CCGs may occur as part of this process. This could occur following the introduction of new national guidelines or where a significant number of people are applying for funding for the same treatment or intervention,

leading to a review of routinely commissioned treatments / services. When a policy decision needs to be made recommendations will go to:

- Senior Management Team – for decisions involving policy changes that impact on the management of the CCGs
- Quality & Safety Committee – for clinical decisions
- Finance & Performance Committee – for financial impacts
- Governing Body

Screening and Decision Making Principles

The Screening Panel will assess each individual request taking into account:

- Appropriateness.
- Comprehensiveness.
- Effectiveness (including that of safety).
- Size of intended benefit (outcomes).
- Alternative interventions.
- Consequences of not having the treatment/intervention.

Individuals requesting funding are screened for:

- Whether the CCG or NHS England are the responsible commissioner.
- Treatment or drugs not covered by existing Service Level Agreements or are specifically identified as exceptions within the Service Level Agreement
- Treatment availability locally but requested from another provider where additional costs will lead to uncertain extra clinical benefit
- Treatments or drugs that are not routinely commissioned
- Treatment or drugs that are new or experimental
- Complex or unusual cases

The following guidance should also be taken into account when considering appropriateness of a request:

High Cost Drugs

IFRs for high cost drugs. On receiving a request for high cost drug treatment the Screening Panel will consider available evidence based reviews to inform the decision making process. The request will also be reviewed by a Medicines Management Representative to provide key information that should be considered. A representative from Medicines Management will attend the Screening Panel to present any information and discuss these cases as required.

Introduction of New Drugs or Treatments

Consideration of new drugs/treatments should be referred into established planning frameworks but a decision should be made as to whether an interim commissioning policy is needed to enable the clinician/patient to access treatment.

Restricted Treatments

Treatments not included in existing pathways are not routinely funded but policy statements on restricted treatments are available. IFRs can be considered in relation to these restricted treatments to assess whether the request fits the criteria or if exceptional circumstances exists.

Rare Conditions

NHS England has the responsibility for commissioning treatments for many rare conditions as set out in their Specialised Services Manual and accompanying documents. The CCG will be the responsible commissioner where NHS England is not responsible for commissioning the service. These patients are unlikely to have treatment options covered by NICE guidance or commissioning policies and therefore, Individual Funding Requests should be considered against the commissioning principles.

Drug Trials

The CCGs will not usually provide funding for individuals coming off drug trials unless prior agreement has been obtained before commencement of the trial. In accordance with the Medicines Act (2004) responsibility for an exit strategy from a trial lies with those conducting it (NHS Confederation, 2008b).

Continuing Private Care

Funding for individuals to continue care purchased privately, where an individual has exhausted their own resources or chosen to terminate a private arrangement, will not routinely be funded by the CCGs. Applications for funding can be considered via the funding request process in the usual way.

Inheriting decisions from other PCTs / CCGs

Patients moving into either of the CCG areas and registering with a GP in that CCG area, become the responsibility of that CCG and therefore decisions for treatment already agreed by the previous PCT / CCG would normally be upheld as long as it is consistent with the principles in this framework and the Department of Health publication “Establishing a Responsible Commissioner”.

Retrospective Payment

The CCGs would not support applications for patients who have paid for private treatment and then asked for reimbursement of these costs from the CCG because prior approval for funding should have been sought through the processes outlined in this document.

Co-payment

Patients who pay for some aspects of treatment while being treated in the Public Sector. The NHS Act (2006) does not allow for recovery of charges for healthcare and the Code of Conduct for Private Practice: Guidance for NHS Medical Staff (2003) states that patients wishing to become private patients cannot be treated as both a private and NHS patient during the same visit to an NHS Organisation. The government’s current position is to rule out co-payment and it is recommended that CCGs follow this guidance because it would provide access to a treatment that the CCGs were not making available to others (NHS Confederation, 2008b).

Patient Safety

The CCGs have a responsibility for patient safety when being treated in healthcare settings. The Care Quality Commission (CQC) governs the suitability of providers of NHS services and therefore patients should only be referred to providers registered with the CQC.

Exceptionality

Exceptionality should be considered in the context of the CCGs general policy for a health care intervention and specified indication.

In general, the CCGs must justify the grounds upon which they are choosing to fund a health care intervention for a patient when that intervention is unavailable to others with the condition.

A patient may be considered exceptional to the general policy if:

- The patient has demonstrated exceptional clinical circumstances in comparison to the cohort of other patients in the same clinical condition1 (Patient is significantly different to the general population of patients with the condition in question who would normally be refused the health care intervention)
- There are good grounds to believe that the requested health care intervention will be clinically effective (there are good grounds to believe the patient is likely to gain significantly more benefit from the intervention than might be expected for the average patient with that particular condition. e.g. may not tolerate standard treatment options)
- It is likely that the requested health care intervention will be a cost effective use of NHS resources (David Lock 2011)

When considering Individual Funding Requests the CCGs will use the same ethical framework and guidelines for decision-making that underpin its general policies for health care interventions, see commissioning principles above. Where social, demographic or employment circumstances are not considered relevant to population based decisions, these factors will not be considered for Individual Funding Requests. Any assessment of exceptionally will therefore be based primarily on the consideration of clinical need.

When a patient has already been established on a health care intervention, for example as part of a clinical trial or following payment for additional private care, this

will be considered to neither advantage not disadvantage the patient. Response to an intervention will not be considered to be an exceptional factor.

Though this test may need some revision in the case of a patient with a rare condition where there is no policy.

Procedures

Making a Request

An Individual Funding Request (IFR) is a request to a CCG to fund a health care intervention for an individual who falls outside the range of services and treatments that the CCG has agreed to commission (NHS Confederation 2008b). The process should be both thorough and comprehensive taking into account the legal issues and commissioning principles outlined in the operating framework above. The process of decision making in all cases should therefore be:

- Consistent – in line with agreed policy
- Concise – often requests for funding are related to care which is required relatively urgently, but not so concise that key issues are marginalised
- Transparent and explicable
- Defensible – based on sound evidence from national or legal guidance The Individual Funding Request Procedure

The IFR procedure can only be initiated by a Clinician i.e. the General Practitioner, Consultant or Dentist making a request for funding for a treatment to the CCG. It is the responsibility of the individual seeking funding in conjunction with the referring Clinician to ensure that all relevant information is forwarded to the IFR Team. This should include:

- An outline of the patient's problem and the circumstances of the case, including any previous treatment
- A clear statement of the referral/treatment plan proposed
- Consideration of whether the patient's needs could be met within existing pathways
- If the care could be provided within existing pathways, a statement of why an alternative referral, which would not be offered to others with a similar clinical need, is a priority in this case
- If the case is not routinely funded by the CCG through existing care pathways, evidence to show why this patient is exceptional

An IFR referral form should be completed by the referring clinician in all cases in order to ensure all the above information is received. The only exception to this is when an alternative proforma is available from individual Trusts requesting high cost drugs for individual patients.

If a referral form is not completed the referral will not be considered until the CCG has received the information that they require to enable a decision to be made.

All requests for funding should be referred in writing, preferably typed, in the first instance to the IFR Team. All requests must be legible in order to avoid delays in consideration of the request. On receiving a request the IFR Team will:

- Enter the request onto a secure database which will automatically assign a unique IFR reference number
- Create a file within which to keep all correspondence and information relating to the request
- Log all correspondence onto the secure database

The IFR Team should collate the information supplied for each case and ensure it is passed on to the Screening Panel to enable them to consider each case. All decisions made by the Screening Panel are logged on the IFR database as comprehensively as possible.

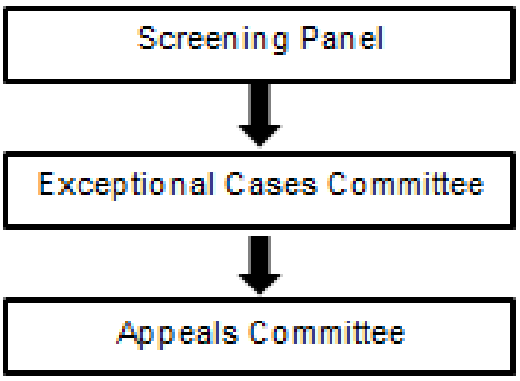
The role of the IFR Team is an administrative role tasked with co-ordinating the IFR process

Any queries relating to a specific case at any stage of the process should be communicated by the IFR Team, in writing via the GP or referring Clinician. This will enable accurate records of each case to be maintained and enquires to be answered by the most appropriate person.

The IFR Team can be contacted either by the patient or referring clinician if clarification is required regarding the IFR process.

Considering IFR Requests

There will be three stages for considering IFR requests, this three stages are Screening Panel, Exceptional Cases Committee and Appeals Committee. The diagram below shows the flow of information between the three stages within the request process. Further information for each stage is also provided below.



Stage One – Screening Process

Screening cases is recommended as good practice by the NHS Confederation (2008b). The role of screening is to review all applications in relation to current national, regional or local guidance and/or policies as well as identifying any previous precedents that have been set. The screening process will operate within principles set out in this operating framework.

Outcomes from the Screening Process[2]

Recommendations for Approval

IFRs can be recommended for approval to the Exceptional Cases Committee (ECC) as part of the screening process, if the referring Clinician is requesting approval for treatment on the restricted treatments list where the patient already meets agreed criteria. Requests can also be recommended for approval if the request clearly meets the criteria specified for that indication in NICE guidance. The referring Clinician and the patient will be informed in writing within 5-10 working days of the Screening Panel meeting.

Requests for high cost drugs can be recommended for approval by the Screening Panel if the request is supported by local, regional or national policy or guidance. The Screening Panel will also refer a request to the ECC for high cost drugs or rare conditions where there is no clear guidance or criteria available to enable them to make a recommendation. To aid the decision making process, the Screening Panel may request an evidence review to be carried out by the Public Health Team as per the Memorandum of Understanding dated April 2014.

The Chair of the Exceptional Cases Committee will take responsibility for signing off approved requests for KCCG. The Head of Finance at CCCG will take responsibility for signing off approved requests for CCCG.

Moratorium

It should be noted that in severe financial difficulties the following has occurred in 2006 by Huddersfield PCT's and thereafter by Kirklees PCT until early 2007:

In circumstances of severe financial constraint, consideration of Individual Funding Requests can be suspended by the CCGs. It is lawful and fair to restrict treatments on the basis of costs in extreme circumstances. However it will still be necessary to screen requests and continue to support those that the ECC agree meet the following criteria:

- The condition is immediately life threatening
- That undue delay would result in a real and imminent risk of harm, e.g. death, infirmity or handicap
- That the procedure needs to be carried out within a strict time frame as delay would result in it becoming ineffective

Refused

IFRs can be refused as part of the IFR process if:

- The individual does not meet the agreed criteria
- There is no clear evidence supporting the treatment

- Where the request does not clearly demonstrate exceptionality

In the event of refusal to fund a request, the referring Clinician and the patient will be informed in writing within 5-10 working days of the Screening Panel meeting. The reason and clear rationale will be documented within the letter along with the relevant appeals process to follow.

IFRs in the following circumstances will normally be refused:

- Where the patient does not take up treatment within one year of approval being granted, then the case will be closed and a new application for funding must be made
- Where an IFR is made by a non NHS clinician based in a private provider with whom the CCGs do not hold a contract
- Where an IFR is made for treatment within a non-contracted private provider, when equivalent NHS commissioned services are available

Urgent or Emergency Cases

It is recognised that there may be occasions when the Screening Panel receive cases for consideration that need a decision urgently. Given that there would be difficulties in convening the Exceptional Cases Committee at short notice in cases of extreme emergency (for example, someone's life is dependent on a decision being made) the Screening Panel will pass on its recommendations to the Chief Officer of the CCG or the Head of Strategic Planning, Service Transformation & Integration. The Clinical Lead or nominated deputy will also be involved in the decision making process of urgent or emergency requests.

The decision will be documented and formally reported to the Exceptional Cases Committee at the next meeting.

While the CCGs will endeavour to respond to such urgent requests as quickly as possible, this should not compromise the quality and validity of the decision making process.

At all times the provider is able to fund a health care intervention pending a decision from the CCGs and the CCGs accept no responsibility for the clinical consequences of any delay in responding to the request.

Membership of the Screening Panel

- Head of Service for KCCG (Chair)
- IFR Support Officer
- Senior Medicines Commissioning Pharmacist

This is the core membership of the Screening Panel and if for any reason a member of the Panel cannot attend then an agreed deputy will attend the meeting. The Panel will meet on a weekly basis.

Other officers from the CCGs or the Public Health Team can be invited to attend the Panel as necessary.

Stage Two – Exceptional Cases Committee

In making a decision the Committee will consider all available clinical history and examine the evidence base where necessary. The Committee will:

- Review each patient request on an individual basis
- Take into account relevant factors which are unique to the patient, e.g. current health status and existing co-morbidities
- Consider if the treatment is necessary and appropriate in relation to individual clinical need, with expected benefits outweighing any risks, and whether there are any exceptional needs or circumstances
- Consider the evidence base for safety and efficacy and if the request is drug related, its licensed indication
- Consider if the treatment is clinically and cost effective with equity of access and provision across the CCG, utilising clinical information (provided by patient's GP, Consultant or other appropriate clinical staff) and evidence base (regarding clinical and cost effectiveness of the intervention).

- Consider consistent with agreed guidance whether CCG, regional or national that may be available
- Consider other alternative options available for the patient including whether the request can be met by local or alternative providers or whether they are inappropriate for that individual
- Consider if this establishes a precedent or whether there is an existing precedent

The Panel will use the following information to make the decision as to whether the case referred is an exception:

- Information provided by the patient's GP/referring Clinician
- Clinical effectiveness reviews of the intervention requested
- Evidence that all alternative clinical strategies have been exhausted, e.g. conservative and primary care management of the patient's condition

Decision for Approval or Non Approval

Whether the request for funding is approved or not, the patient, the referring Clinician and the patients GP (where they are not the referring clinician) will be informed in writing of the decision within 5-10 working days of the Exceptional Cases Committee meeting.

Where the request was refused the Committee will set out their decision and the reasons for it to the referring Clinician and GP. The patient will be informed of the decision and encouraged to speak to their GP to discuss the reasons behind the decision. If the patient does not accept the outcome they can appeal via the referring clinical only to the Appeals Committee.

Membership of the Exceptional Cases Committee

Membership of the Exceptional Cases Committee is detailed below. It is the expectation that all of these people or their deputies will attend every Committee meeting.

- Chief Officer KCCG (Chair) or nominated deputy

- Chief Financial Officer KCCG or nominated deputy
- Lay member (KCCG)
- A maximum of 4 Clinical Leads (KCCG)

Each of the above nominated Committee members will have a deputy. The Committee is quorate with the presence of the following:

- Chief Officer KCCG (Chair) or nominated deputy
- Chief Financial Officer KCCG or nominated deputy
- Lay member (KCCG)
- Clinical Leads (KCCG)

The Committee will be chaired by the Chief Officer of KCCG or their Deputy. The Chair will be responsible for checking that the decisions made are accurately recorded and for signing any letters sent to patients and Clinicians reflecting those decisions. In case of disagreement, the Chair has the casting vote if necessary.

Stage Three - Appeals Process

Individuals wishing to appeal against a decision made by the Exceptional Cases Committee must notify the CCG of their intention in writing to the IFR Team, within 40 working days of the date of the initial decision via their GP or initial referring Clinician.

The GP or referring Clinician must demonstrate on what grounds they wish to appeal against the decision. An appeal can be made on the following grounds;

- Procedural irregularities (eg. due process has not been followed or that a Committee has not been quorate to make a decision) or all of the information has not been considered, or new / additional information is to be considered.
- The Clinician / patient is not happy with the outcome decision. In this case the appeal will be treated as a formal complaint and passed to the complaints department at the relevant CCG.

If the Clinician does not lodge an appeal within the allocated timescales the case will be closed and any further correspondence would start the process again.

Decision Making Process

The Appeals Committee considers and decides on appeal applications which challenge due process by reference to this operating framework.

The duties of the Appeals Committee are set out below:

- To consider and review the Exceptional Cases Committee's decision in relation to the funding of an individual's treatment by reference to fair and appropriate application of the process.
- To receive and review all documentation considered by the Exceptional Cases Committee and further submissions received from parties.
- To make a decision to uphold the original decision of the Exceptional Cases Committee or refer the case back to the Exceptional Cases Committee for reconsideration, if there is evidence that all of the relevant information was not considered or that due process has not been followed. In this instance this will be supported by a written recommendation from the Appeals Committee.

A failure in the process of handling an IFR does not necessarily mean that the decision that was made was incorrect (Guidelines from the NHS Confederation 2008b).

Decision for Approval or Non Approval

The IFR Team will write to the patient, referring Clinician and GP (where this is not the referring Clinician) within 5-10 working days with the Appeals Committee's decision and their reasons.

Patients who remain dissatisfied with the Appeal Committee decision will be given the information on potential courses of action as part of the letter detailing the Appeals Committee decision.

Membership of the Appeals Committee

It is the expectation that all of these people or their deputies will attend every Appeals Committee meeting. The Appeals Committee is quorate with the presence of the following:

- Clinical Lead (KCCG)
- Senior Manager (KCCG)
- Lay Member (KCCG)

Other representatives, for example from Public Health, can also be invited to be part of the Appeals Committee as required.

The chair of the Appeals Committee will be one of the Senior Managers detailed above.

The IFR Team will co-ordinate the meeting, circulate papers and minute and record the actions / recommendations from the meeting.

Precedence

At any point in the decision making process of the Exceptional Cases Committee or the Appeals Committee a precedent could be set. This means that any decision made can be used to inform future decisions for similar requests. If previous decisions are not taken into account this could form the basis for legally challenging the CCG and the decision made on an IFR. Given the significance of setting precedence and its potential impact on future decisions all decisions will be recorded on a secure database by the IFR Team. However a decision to allow or refuse funding will not be absolutely binding on the CCG but where the CCG departs from a previous decision, clear evidence must be available to justify and support this departure (examples of this might include a patient presenting with slightly different symptoms, or someone who due to age/weight/sex/other medication might not respond to treatment in the same way).

Where IFRs are to be referred to the Exceptional Cases Committee the Screening Panel will review all previous decisions for the same treatment and indication.

Any relevant decisions made about previous cases that could have an impact on the decision making process for an individual case will be made available to the Committee.

An IFR should not be seen as a mechanism to introduce a new treatment. The request should be seen as genuinely individual. The requesting clinician should also demonstrate that the request is an individual request to fund a treatment, and not about introducing a treatment to a group – however small.

Treatment outside the European Economic Area (EEA)

Requests for treatment outside the EEA will be considered in line with the Department of Health Guidelines.

Equality Impact Assessment (EIA)

The CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

This policy is not intended to discriminate against any group or individual on the grounds of ethnicity, gender, age, disability, sexual orientation or religion/belief. In order to meet these requirements, a single EIA is completed.

Training Needs Analysis

No specific training is required before this operating framework and the procedures outlined within it can be implemented.

Monitoring Compliance with this Operating Framework

The administration of this process continues beyond the stages described above in order to make informed commissioning decisions in the future. It will be the role of the IFR Team to track all agreed requests to enable the CCGs to collate information on patient flows and costs associated with IFRs.

Any information collected will be collated for an annual report in Q1 of each financial year. The report will include reporting the number of individual requests, those approved and declined by procedure at each stage of the process (Screening Panel, Exceptional Cases Committee and Appeals Committee). Information will also be collated in relation to numbers of IFR requests by GP Practice.

In certain circumstances it may be necessary to trial a treatment or high cost drug prior to a decision being made. Where this is the case the outcome of the trial will be obtained prior to any decision about further treatment being made.

References

Department of Health (2004) A Code of Conduct for private practice: Recommended Standards of Practice for Private Consultants

Lock, D 2011, What does the duty on PCT's to give reasons for an individual treatment decision mean in practice ; Barrister and Head of Public Law at No5 Chambers

NHS Constitution March 2013

NHS England, 'Defining the Boundaries between NHS and Private Healthcare'

National Prescribing Centre, 'Supporting rational local decision making about medicines (and treatments)'

North Yorkshire and York PCT, High Cost Healthcare Commissioning Policy. November 2007

The NHS Confederation (2008a) Priority Setting: Legal Considerations.

The NHS Confederation (2008b) Priority Setting: Managing Individual Funding Requests.

The National Health Service Bill (2006)

The Stationary Office (2004) 2004: The medicines for Human use (Clinical Trials) Regulations.

Yorkshire and the Humber Specialised Commissioning Group, ‘Policy for Individual Funding Requests’

NHS Kirklees and NHS Calderdale Clinical Commissioning Groups Commissioning Policy for Individual Funding Requests

Version / Status: 4.0 / Final

Responsible Clinical Commissioning Group (CCG):

Kirklees CCG, Calderdale CCG

Responsible Chief Officers:

Carol McKenna (KCCG), Robin Tuddenham (CCCG)

Responsible Committee:

Kirklees CCG Governing Body, Calderdale CCG Governing Body

Date Approved: 14.04.21 Kirklees CCG Governing Body

Executive Summary

This policy applies to all Individual Funding Requests (IFRs) for people registered with General Practitioners in the following Clinical Commissioning Groups (CCGs), where the CCG is the responsible commissioner for the treatment or service

- Kirklees CCG
- NHS Calderdale CCG

This policy does not apply where any one of the above CCGs is not the responsible commissioner.

This policy supersedes all previous policies and must (where appropriate) be read in association with the other relevant CCGs commissioning policies.

All IFR and associated policies will be publically available on the internet for each CCG.

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

1. Introduction

The Clinical Commissioning Groups (CCGs), NHS Kirklees CCG and NHS Calderdale CCG were established on 1st April 2013 under the Health & Social Care Act 2012 as the statutory bodies responsible for commissioning services for the patients for whom they are responsible in accordance with s3 National Health Service Act 2006.

As part of these duties, there is a need to commission services which are evidenced based, cost effective, improve health outcomes, reduce health inequalities and represent value for money for the taxpayer. The Clinical Commissioning Groups are accountable to their constituent populations and Member Practices for funding decisions.

The above Clinical Commissioning Groups throughout this policy will be referred to as the CCGs.

The policy identifies procedures / treatments which the CCGs consider to be primarily cosmetic in nature and which have relatively small health benefits compared to other competing priorities for NHS resources.

The policy will be applied in conjunction with the CCGs operating framework for decision making for Individual Funding Requests (IFRs) which is available on each CCGs website.

2. Scope of the Policy

The majority of service provision is commissioned through established service agreements with providers. However, there are instances when a treatment or procedure does not form part of the core commissioning arrangements.

Due consideration must be given to these procedures / treatments which do not form part of the core commissioning arrangements, or need to be assessed as exceptions to the CCGs commissioning policies.

Where a procedure or treatment is being requested that is not part of the core commissioning arrangements then an IFR must be submitted to the CCG in line with the IFR process detailed within the CCGs operating framework. The IFR process provides a mechanism to allow such requests to be considered for individuals in exceptional circumstances and all requests must strictly fulfil the criteria for exceptionality as defined within the CCGs current operating framework for considering IFRs.

Whilst this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. The CCGs reserve the right not to commission other procedures considered cosmetic and not medically necessary.

2.1 Exclusions to this Policy

The following are classed as exclusions to this policy:

- Specialist services that are commissioned by NHS England or Public Health England.
- Suspected cancer, diagnoses should be dealt with via a two week wait referral and not via an IFR request.
- Emergency or Urgent Care

2.2 Dissemination of the Policy

The policy will be disseminated via all the agreed communications and engagement channels internal and external to the CCGs.

The policy will be available to all stakeholders who are responsible for the broader dissemination of the policy within their individual organisations and services.

All members of staff responsible for commissioning services have a responsibility to familiarise themselves with the content of this policy.

A full copy of the policy will be available to the general public via each CCGs website.

2.3 Application of the Policy

The policy applies to all staff (clinical and non- clinical) who are involved in any way with the commissioning, authorising of treatments or proposed clinical interventions commissioned by the CCGs.

This policy must be followed by all staff who are employed by the CCGs including those on temporary, fixed-term or honorary contracts, secondments, pool staff and students. It must also be followed by any organisation contracted to commission, authorise or administer healthcare on behalf of the CCGs.

Both referrers (including GP practices) and provider organisations are expected to adhere to the principles, criteria and policies set out in this document. Any service requested or provided outside of the funding criteria set out in this policy will be undertaken at the organisations' own risk.

3. Aims and Objectives

The aim of this policy is to detail the eligibility criteria for procedures / treatments that the CCGs do not routinely commission.

The objectives of this policy are to;

- Reduce the variation in access to procedures / treatments that are not routinely commissioned by the CCGs.
- To ensure that the procedures / treatments detailed within the policy are commissioned where there is robust evidence of clinical benefit and cost-effectiveness.
- To have systems in place that enable a consistent approach to decision-making within appropriate timescales.
- To ensure decisions made are based on the best available evidence at the time of consideration.
- To give clarity to our local population on what procedures / treatments are funded by the CCGs and under what circumstances.

- To give clarity to referring clinicians and providers of commissioned services on what procedures / treatments are funded by the CCGs and under what circumstances.

4. Equality and Quality Impact Assessments

The CCGs aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

This policy is not intended to discriminate against any group or individual on the grounds of age, gender, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, the CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. Equality (EIA) and Quality Impact Assessments (QIA) have been carried out for this policy. The EIA is attached as Appendix 2 of this policy and the QIA is available on request.

5. Procedures and Treatments with Eligibility Criteria

The following section provides further detail on the eligibility criteria that is applicable to the procedures / treatments that are not routinely commissioned.

In this policy aesthetic or cosmetic surgery is defined as surgery undertaken to improve one's appearance or reshape normal body parts to improve appearance. This differs from reconstructive surgery that is undertaken to reshape abnormal structures of the body, from accidents, injuries, infections, cancers or other diseases, as well as congenital deformities.

Revisional procedures will only be considered electively for clinical reasons due to evidenced clinical complications. Any revisional procedures will require prior approval unless they are required on an urgent / emergency basis.

Psychological distress will rarely be considered as a reason for cosmetic surgery. Only in rare clinically exceptional circumstances in which severe and enduring psychological

dysfunction can be demonstrated, and for which all alternative psychotherapeutic interventions have been tried.

NOTE: Lifestyle Factors - Best Practice (This is not a restriction to this policy unless otherwise stated)

Patients who are current smokers should be referred or re-directed to a smoking cessation programme prior to surgical intervention.

In line with ‘Healthy Lives, Healthy People; a tobacco control plan for England', local authorities and health professionals are committed to encourage more smokers to quit. Smoking remains the leading cause of preventable morbidity and premature death in England. There is sufficient evidence to suggest that people who smoke have a considerably increased risk of intra- and post-operative complications such as chest infections, lung disorders, wound complications and impaired healing.

Patients with a BMI >30 should be encouraged by their clinician to lose weight prior to surgery and signposted to appropriate support to address lifestyle factors that would improve their fitness for surgery and recovery afterwards. There is a clinical balance between risk of surgical complications with obesity and the risk to delaying any surgery.

6. Procedures that require Individual Funding Approval:

All of the following procedures / treatments are criteria led and will require completion of an Individual Funding Request form by an appropriate clinician.

- Abdominoplasty / Apronectomy
- Breast Augmentation (Breast Enlargement)
- Mastopexy (Breast Lift)
- Revision of Breast Augmentation
- Breast Asymmetry
- Breast Reduction for Gynaecomastia (Male)
- Nipple Inversion
- Hair Replacement (Including Hair Transplant and Correction of Male Pattern Baldness)

- Hair Removal
- Acne Scarring
- Blepharoplasty
- Body Contouring Procedures (Buttock, Thigh & Arm Lift)
- Facial Procedures (Face Lift & Brow Lift)
- Pinnaplasty (Correction or Prominent Ears)
- Liposuction
- Labiaplasty
- Repair of External Ear Lobes (Lobules)
- Rhinophyma
- Scar Revision / Keloidectomy
- Skin Hypo-Pigmentation & Skin Resurfacing Techniques
- Rhinoplasty / Septo-rhinoplasty
- Circumcision (for Religious Reasons)
- Tattoo Removal
- Infertility Services & Surrogacy
- Reversal of Sterilisation (Male & Female)
- Complementary & Alternative Therapies
- Allergy Treatments
- Lycra Garments
- Functional Electrical Stimulation (FES) for Foot Drop
- Open / Upright MRI Scanning
- Botulinum Toxin for Axillary Hyperhidrosis
- Botulinum Toxin for Prophylaxis Migraine
- Spinal Cord Stimulation
- Sacral Neuromodulation
- Wig pathway
- Adult Snoring Surgery (in the absence of OSA)
- Dilatation and Curettage (D&C) for heavy menstrual bleeding in women
- Injections for nonspecific low back pain without sciatica
- Knee arthroscopy for patients with osteoarthritis

6.1 ABDOMINOPLASTY / APRONECTOMY ("Tummy Tuck")

Abdominoplasty / Apronectomy will not be routinely commissioned by the CCGs for requests made for:

- Cosmetic / aesthetic reasons, including stretch marks
- Psychological benefit without associated clinical need

Abdominoplasty / Apronectomy may rarely be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m^2 (stable is defined as within the acceptable range detailed above **AND** stable at the same measurement for **at least 2 years**) **AND** be suffering from severe functional problems:

- Those with complex scarring following trauma or previous abdominal surgery
- Those who have undergone treatment for morbid obesity and have excessive skin folds
- Previously obese patients who have achieved significant weight loss and have maintained their weight loss for at least two years. (significant is defined as moved down two levels of the BMI SIGN guidance as shown below)
- Where it is required as part of abdominal hernia correction or other abdominal wall surgery

Severe functional problems include:

- Chronic and persistent skin condition (for example, intertriginous dermatitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics
- Experiencing severe difficulties with daily living, i.e. ambulatory or urological restrictions
- Where previous post-trauma or surgical scarring (usually midline vertical or multiple) leads to very poor appearance and carries a risk of infection
- Problems associated with poorly fitting stoma bags

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- Confirmation that the panniculus hangs below the symphysis pubis when the patient is standing normally
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity

Body Mass Index is referred to as per SIGN guidance where:

- Less than 18.5 Underweight
- 18.5 -24.9 Normal BMI
- 25.0 - 29.9 Overweight
- 30.0 - 39.9 Obese
- 40 or above Extremely Obese

6.2 BREAST AUGMENTATION

Note: Breast augmentation which is part of reconstructive surgery after trauma or previous mastectomy or other excisional breast surgery does not go through the Individual Funding requests process as it is part of the treatment pathway for those conditions.

Breast augmentation will not be routinely commissioned by the CCGs for:

- Cosmetic reasons, for example for “small” but normal breasts or for breast tissue involution (including post-partum changes).
- Requests made for psychological benefit without associated clinical need.

Breast augmentation may rarely be considered on an exceptional basis, for example where the patient:

- Has congenital amastia (complete absence of bilateral breast tissue) or
- Has suffered trauma to the breast during or after development or
- Has endocrine abnormalities or

- Has developmental asymmetry (at least 3 cup sizes) or
- Has tubular breasts – type iii with severe breast constriction with minimal breast base and hypoplasia of all four quadrants (see Tuberous Breast: Clinical Evaluation and Surgical Treatment)
- Gender re-assignment – where requests for breast augmentation are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m2

6.3 MASTOPEXY (Breast Lift)

Mastopexy will not be routinely commissioned by the CCGs for cosmetic reasons, for example weight loss, post lactation or age related ptosis.

Mastopexy may be included as part of the treatment to correct breast asymmetry and reduction. In this instance, patients would be required to meet the established criteria to correct breast asymmetry or for breast reduction. Please see the relevant applicable criteria.

6.4 REVISION OF BREAST AUGMENTATION

Revision of breast augmentation will not be routinely commissioned by the CCGs.

Removal of implants (including implants inserted within the private sector) will be considered if at least one of the following criteria is met;

- Remnant breast cancer or cancer on the contralateral breast or
- Intra or extra capsular rupture of silicone gel filled implants or
- Implants complicated by recurrent infections or
- Extrusion of implant through the skin or
- Implants with Baker Class IV contracture associated with severe pain (classifications detailed below) or
- Implants with severe contracture that interferes with mammography

Implant replacement will **only** be considered if the NHS commissioned the original procedure and that the patient is still eligible for breast implant/s under the CCGs current commissioning criteria.

Note – Approval will be given for implant replacement/s for any patients whose original procedure was undertaken as part of the NHS commissioned cancer pathway.

Gender re-assignment – where requests for revisional breast surgery are submitted following gender re-assignment surgery, the same criteria outlined in this policy will be used to inform decision making.

In addition to the above, the following will also be required:

- Age over 19 years
- BMI within the range 18 – 27 kg/m2
- Ultrasound scan results to evidence implant rupture and / or capsular contracture
- Evidence to support the clinical need for revisional surgery
- Evidence to support that the patient meets the current criteria for augmentation

Baker Classification

Class I - Augmented breast feels soft as a normal breast.
Class II - Augmented breast is less soft and implant can be palpated, but is not visible.
Class III - Augmented breast is firm, palpable and the implant (or distortion) is visible.
Class IV - Augmented breast is hard, painful, cold, tender and distorted

National supporting evidence

NHS England Interim Commissioning Policy: Breast Implant removal and re-insertion November 2013

6.5 BREAST ASYMMETRY

Surgery to correct breast asymmetry will not routinely be commissioned by the CCGs for cosmetic reasons.

Breast Prosthesis or Implants often have a limited lifespan and are likely to require replacement or revision during the patient's lifetime. Therefore, where possible, breast reduction of the larger breast should be the preferred option for patients seeking to correct breast asymmetry.

Surgery may rarely be considered on an exceptional basis when there is no ability to maintain a normal breast shape using non-surgical methods, for example where the patient:

- Has developmental failure resulting in unilateral absence of breast tissue (unilateral congenital amastia) OR
- Patients with gross asymmetry (defined as a difference of 3 cup sizes) **AND** BMI in the range 18 – 27 kg/m2
- Has tried and failed with all other advice and treatment, including a padded bra and a professional bra fitting
- Age over 19 years to allow for completion of puberty

In addition to the above, the following will also be required:

- Written confirmation from a professional bra fitter evidencing a difference in breast size of at least 3 cup sizes difference.

Only the following cup sizes are recognised in the UK;

- AA
- A
- B
- C
- D
- DD
- E
- F
- FF
- G
- GG
- H
- HH
- J

- JJ
- K
- L

National supporting evidence

NHS England Interim Commissioning Policy: Breast Asymmetry November 2013;

6.6 BREAST REDUCTION FOR GYNAECOMASTIA – MALE

Surgery to correct benign gynaecomastia will not routinely be commissioned by the CCGs for cosmetic reasons. The CCG will not fund this procedure where the patient has previously used recreational drugs or anabolic steroids.

Surgery may be considered on an exceptional basis, for example where the patient:

- Has > 2cm palpable, firm, sub-areolar gland and ductal tissue (not fat) **AND**
- Has a BMI of 25 kg/m2 or less and stable for 12 months (stable is defined as within the acceptable range detailed above and stable at the same measurement for 12 months), unless a specific uncorrectable aetiological factor is identified such as androgen therapy for prostate cancer **AND**
- Has been screened prior to referral to exclude endocrinological and drug related causes or if drugs have been a factor then a period of one year since last use should have elapsed **AND**
- Has completed puberty - surgery is not routinely commissioned below the age of 19 years
- Has been monitored for at least 2 years to allow for natural resolution if aged 25 or younger

In addition to the above, the following will also be required:

- BMI to have been measured within 2 months of the request being submitted
- Evidence that screening for endocrine and drug-related causes has taken place and their results
- Documented additional information where circumstances include:
  - Pain
  - Gross Asymmetry
  - The Gynaecomastia is iatrogenic

National supporting evidence

NHS England Interim Commissioning Policy: Breast Reduction for Gynaecomastia (male) November 2013https

6.7 NIPPLE INVERSION

Surgical correction of benign nipple inversion will not be routinely commissioned by the CCGs for:

- Requests made for cosmetic/aesthetic reasons.
- Requests made for psychological benefit without associated clinical need.

Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded [1]

Surgical correction of nipple inversion may only be funded where it has been documented that there was an inability to breastfeed during a previous pregnancy and the patient is considering a subsequent pregnancy. In this instance all of the following criteria must be met in full:

- The nipple(s) must be non-retractable based on clinical examination **AND**
- The patient is post pubertal **AND**
- The inversion has not been corrected by correct use of a non-invasive suction device

National supporting evidence

NICE Guidance NG12 Recommendations organised by symptom and findings of primary care investigations lumps or masses

6.8 HAIR REPLACEMENT

Hair Transplantation

Hair transplantation will not be routinely commissioned by the CCGs for cosmetic reasons, regardless of gender.

Hair transplantation may be considered on an exceptional basis, for example when reconstruction of the eyebrow is required following cancer or trauma.

Correction of Male Pattern Baldness

Treatments to correct male pattern baldness will not be routinely commissioned by the CCGs for cosmetic reasons. This is excluded from treatment by the NHS.

6.9 HAIR REMOVAL

Hair removal will not be routinely commissioned by the CCGs for cosmetic reasons.

Patients concerned with the appearance of their body and facial hair should be advised about managing their condition through conservative methods including shaving, waxing, and depilatory creams although such treatments are also not routinely commissioned or funded by the CCGs.

Hair removal may be considered on an exceptional basis, for example where the patient:

- Has undergone reconstructive surgery resulting in abnormally located hair bearing skin to the face, neck or upper chest (areas not covered by normal clothing)
- Has a proven underlying endocrine disturbance resulting in hirsutism (e.g. Polycystic Ovary Syndrome)
- Are undergoing treatment for pilonidal sinuses to reduce recurrence

In addition to the above, the following will also be required:

- Evidence of the underlying endocrine disturbance eg. blood test results or ultrasound scan report

Where patients meet the above criteria, laser treatment for hair removal requested for hirsutism will only be approved for the removal of facial hair. In this instance three laser treatment sessions will be approved.

National supporting evidence

NHS England Interim Commissioning Policy: Hair removal (including Electrolysis and Laser Therapy) November 2013:

6.10 ACNE SCARRING

Procedures to treat facial acne scarring will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example when the patient has very severe facial scarring unresponsive to conventional medical treatments.

6.11 BLEPHAROPLASTY (Surgery for drooping or mis-shaped eyelid/s)

Blepharoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery on the upper lid/s maybe considered on an exceptional basis, for example:

- Impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields
- Clinical observation of poor eyelid function, discomfort, e.g. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow
- Significant ectropion or entropion that requires correction or for the removal of lesions of the eyelid skin or lid margin

In addition to the above, the following will also be required:

- Results from an appropriate visual fields test. Results from tests will be required with the eyelid/s both retracted and un-retracted to rule out any pathological causes.

6.12 BODY CONTOURING PROCEDURES (Skin Excision for Buttocks, Thighs & Arms)

Surgery to remove excess skin from the buttock, thighs and arms will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis for the following groups of patients who should have achieved a stable BMI between 18 and 27 Kg/m2 (stable is defined as within the acceptable range detailed above AND stable at the same measurement for at least 2 years) **AND** be suffering from severe functional problems:

- has an underlying skin condition, for example cutis laxa (rare inherited or acquired connective tissue disorder in which the skin becomes inelastic and hangs loosely in folds)

- has lost a considerable amount of weight resulting in severe mechanical problems affecting activities of daily living (ie. walking, dressing and ambulatory restrictions) which have been formally assessed

In addition to the above, the following will also be required:

- Age over 19 years
- Documented record of all BMI measurements over the previous 2 years
- Documented record of the number of repeat episodes of intertrigo and evidence to support what medical treatments have been prescribed to treat the infection
- For requests following bariatric surgery, the patient is at least 18 months post bariatric surgery, to minimise the risks of recurrent obesity
- If it is an adjunct to another surgical procedure, then patients would be required to meet the established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

6.13 FACELIFT / BROWLIFT

Facial procedures and Botulinum Toxin will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for treatment of:

- Congenital facial abnormalities
- Facial palsy (congenital or acquired paralysis)
- As part of the treatment of specific conditions affecting the facial skin, e.g. cuffs axa pseudoxanthoma elasticum, neurofibromatosis
- To correct the consequences of trauma
- To correct deformity following surgery

In addition to the above, for a Browlift procedure the following will also be required:

- Results from an appropriate visual fields test with eyelid un-retracted

6.14 PINNAPLASTY (Correction of Prominent Ears)

Surgical correction of prominent ears will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for example where the patient:

- Must be aged 5-19 at the time of referral and the child (not the parents alone) expresses concern **AND**
- has very significant ear deformity or asymmetry

Prominent ears may lead to significant psychosocial dysfunction for children and adolescents and impact on the education of young children as a result of teasing and truancy.

The National Service Framework for Children (National Service Framework for Children, Young People and Maternity Services (DH October 2004), defines childhood as ending at 19 years. Funding for this age group should only be considered if there is a problem likely to impair normal emotional development. Children under the age of five rarely experience teasing and referrals may reflect concerns expressed by the parents rather than the child, which should be taken into consideration prior to referral. Some patients are only able to seek correction surgery once they are in control of their own healthcare decisions and again this should be taken into consideration prior to referral.

National supporting evidence

NHS England Interim Commissioning Policy: Pinnaplasty / Otoplasty November 2013;

6.15 LIPOSUCTION

Liposuction will not be routinely commissioned by the CCGs for cosmetic reasons or to correct the distribution of fat.

Cases may be considered on an exceptional basis, for example when;

- It may be useful for contouring areas of localised fat atrophy or pathological hypertrophy (e.g. multiple lipomatosis, lipodystrophies)
- If it is an adjunct to other surgical procedures e.g. surgery for gynaecomastia. In this instance, patients would be required to meet the

established criteria (where applicable) for the defined surgical procedure being carried out. Please see the relevant applicable criteria.

6.16 LABIAPLASTY

Labiaplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Surgery may be considered on an exceptional basis, for example where the patient has;

- Congenital conditions **or**
- Recurrent disease or chronic irritation (with documented evidence of ulceration/severe excoriation over several months that has failed to respond to conservative treatment **or**
- Excess androgenic hormones

Note: Treatment for female genital mutilation is not considered cosmetic and does not require funding approval.

NHS England Interim Commissioning Policy: Labiaplasty/Vaginoplasty/Hymenorrhaphy

6.17 REPAIR OF EXTERNAL EAR LOBES (Lobules)

Repair of external ear lobes will not be routinely commissioned by the CCGs for cosmetic reasons.

This procedure is only commissioned by the CCGs for the repair of totally split earlobes as a result of direct trauma.

Repair of external ear lobes as a result of a gauge piercing is excluded from treatment by the CCGs.

6.18 RHINOPHYMA

Surgical / laser treatment of rhinophyma will not be routinely commissioned by the CCGs for cosmetic reasons.

The first-line treatment of this disfiguring condition of the nasal skin is medical. Severe cases or those that do not respond to medical treatment may be considered on an exceptional basis for surgery or laser treatment.

6.19 SCAR REVISION / KELOIDECTOMY

Revision surgery for scars including keloid scars will not be routinely commissioned by the CCGs for cosmetic reasons.

Cases may be considered on an exceptional basis, for example where the patient:

- Has significant deformity
- Has severe functional problems, or needs surgery to restore normal function
- Causes significant pain requiring chronic analgesic medication
- Bleeding
- Obstruction of orifice or vision
- Has a scar resulting in significant facial disfigurement

6.20 SKIN HYPO-PIGMENTATION & SKIN RESURFACING TECHNIQUES

Skin Hypo-Pigmentation

The recommended NHS suitable treatment for hypo-pigmentation is cosmetic camouflage. Access to a qualified camouflage beautician must be available on the NHS for this and other skin conditions requiring camouflage.

Skin Resurfacing Techniques

All resurfacing techniques including laser, dermabrasion and chemical peels may be considered for post-traumatic scarring (including post surgical) and severe acne scarring once the active disease is controlled.

Any requests for skin resurfacing techniques for scarring would be required to meet the established criteria for scar revision as shown above in section 6.19.

6.21 SEPTO-RHINOPLASTY / RHINOPLASTY

Septo-rhinoplasty and Rhinoplasty will not be routinely commissioned by the CCGs for cosmetic reasons.

Septo-rhinoplasty may be considered on an exceptional basis, for example in the presence of;

- Septal deviation causing continuous nasal airway obstruction resulting in nasal breathing difficulty associated with a bony deviation of the nose, where an operation on the nasal septum would not be effective in restoring the nasal airway without a simultaneous operation to straighten the nasal bones.
- Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy); or when done in association with cleft palate repair.

Rhinoplasty may be considered on an exceptional basis, for example;

- When it is being performed to correct a nasal deformity secondary to congenital cleft lip and / or palate
- To correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, disease, or congenital defect when all of the following criteria are met:

  - Nasal airway obstruction is causing significant symptoms (e.g., chronic rhinosinusitis, difficulty breathing), **AND**
  - Obstructive symptoms persist despite conservative management for three months or greater, which includes, where appropriate, nasal steroids; **AND**
  - Airway obstruction will not respond to septoplasty and turbinectomy alone.

In addition to the above, the following will also be required:

- Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity); **AND**
- Documentation of duration and degree of symptoms related to nasal obstruction, such as chronic rhinosinusitis, mouth breathing, etc.; **AND**
- Documentation of results of conservative management of symptoms

Note: For requests that meet the above criteria in relation to sporting / activity trauma, the CCGs reserve the right to decline funding where the request is for a repeat surgical procedure in relation to trauma where it is as a direct cause of the same sport / activity.

6.22 CIRCUMCISION (for religious reasons)

Circumcision for social, religious or cultural reasons will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example;

- When an underlying medical condition means that routine surgery in the usual setting may be unsafe

6.23 TATTOO REMOVAL

Tattoo removal will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example where the patient:

- Has suffered a significant allergic reaction to the dye and medical treatments have failed
- Where the tattoo is the result of trauma, inflicted against the patient's will ("rape tattoo")
- Exceptions may also be made for tattoos inflicted under duress during adolescence or disturbed periods where it is considered that psychological rehabilitation, break up of family units or prolonged unemployment could be avoided given the treatment opportunity. (Only considered in very exceptional circumstances where the tattoo causes marked limitations of psychosocial functioning.)

National supporting evidence

NHS England Interim Commissioning Policy: Tattoo Removal November 2013;

6.24 IVF – INFERTILITY TREATMENT and SURROGACY

Criteria has been agreed across the Yorkshire and Humber. See separate policy on each CCG website.

The CCGs arrangements are in line with the Yorkshire & Humber policy but the CCGs will only fund one full cycle of IVF where the eligibility criteria are met in full.

Surrogacy arrangements will not be funded, but the CCGs will fund treatment (IVF component and storage) in identified (fertile) surrogates, where this is the most suitable treatment for a couple's infertility problem and the eligibility criteria are met in full.

6.25 REVERSAL OF VASECTOMY AND FEMALE STERILISATION

Surgery for the reversal of a vasectomy or female sterilisation will not be routinely commissioned by the CCGs.

Cases may be considered on an exceptional basis, for example:

- the death of an existing child through accidents or illness
- There is clear evidence (over and above the patient's assertion) that the original operation had been performed under duress. E.g. Cases when the patient was very young when the procedure was carried out and evidence from the referring clinician shows that they did not receive any counselling

Funding is not agreed for these procedures for patients who are in a new relationship or who are not in contact with children from a previous relationship. The CCGs reserve the right to decline funding where either partner has living children (this includes adopted children but not fostered) from that or any previous relationship.

6.26 COMPLEMENTARY OR ALTERNATIVE THERAPIES

Complementary and alternative therapies are not routinely commissioned as stand-alone treatments by the CCGs.

See Appendix 1 for the list of therapies which are not routinely commissioned. The list is not exhaustive and other therapies not listed but that are considered 'alternative' therapies will be considered in the same way.

Those complementary and alternative therapies which are an integral part of an agreed care pathway within existing contracts (supported by a service specification) are excluded from this policy.

6.27 ALLERGY TREATMENTS AT A SPECIALIST ALLERGY CENTRE

The CCGs will support referrals being made to an NHS Specialist Allergy Centre when the condition has been thoroughly assessed and standard treatment given by a GP or Clinician has not improved the condition and that the condition is considered “resistant” to conventional treatment.

The CCGs will not support referrals made to non-NHS providers.

6.28 LYCRA GARMENTS

Lycra garments are not routinely commissioned by the CCGs. Cases may be considered on an exceptional basis for example;

- The patient should have cerebral palsy or similar condition with significantly abnormal postural muscle tone.
- There are no contraindications present (see below).
- Referral should identify the specific significant benefits offered by the therapy for this patient.
- Evidence provided that other therapies have been considered but were deemed to be insufficient.
- Evidence of the patient / carer’s willingness to comply with treatment (e.g. signed agreement or previous successful use).
- If the patient is over 18, successful previous use of Lycra garments and benefits evidenced.
- Requests for replacement garments should include a user or professional evaluation of benefits.

Contraindications

- Lycra garments are contraindicated when adequate monitoring and supervision are not available, there is deemed to be a lack of purposeful intent or, dependent on site of the garment, if severe epilepsy or chronic respiratory problems are present. Lycra splinting is not recommended if there is severe uncontrolled reflux or chronic skin conditions.
- Problems with comfort, reflux sickness and putting on / taking off the suit have been reported. Temperature can also be an issue, particularly in

summer. These factors may all impact on compliance and motivation of the patient.

- A study carried out with the support of Scope and Birmingham Community Health Trust from 1998 – 2000 also found that some people stop wearing the garments altogether because of:
- The level of support needed to get the garments on and off
- Toileting issues
- Garment took too long to dry after washing
- Unable to maintain the function gains achieved without continued use

Funding requests for replacement garments will be required to evidence on-going clinical benefit. Funding for a replacement garments will not normally be agreed within:-

- 12 months from last approval for children aged up to 18 or
- 18 months to 2 years from last approval for patients aged 18+

6.29 FUNCTIONAL ELECTRICAL STIMULATION (FES) (For Foot Drop of Central Neurological Origin)

The CCGs will routinely commission Functional Electrical Stimulation (FES) for drop foot, with the non-implantable wired device (skin surface FES - OPCS A70.7 application of transcutaneous electrical nerve stimulator), in line with NICE IPG278. Provisions for clinical, governance, consent, audit and research are fully expected to be in place for this service.

- The patient must be over 18 years of age and being treated for foot drop (deficit of dorsiflexion and / or eversion of the ankle) which must be of central neurological origin, due to an upper motor neurone lesion i.e. one that occurs in the brain or spinal cord at or above the level of T12.
- Upper motor neurone lesions resulting in dropped foot occur in conditions such as stroke, brain injury, multiple sclerosis, incomplete spinal cord injury at T12 or above, cerebral palsy, familial /hereditary spastic paraparesis and Parkinson's disease.

Exclusions

The following forms of FES are not commissioned by the CCGs:

- Other forms of electrical stimulation for conditions other than foot drop
- FES for upper limb
- Implanted FES
- Wireless FES

Funding will only be considered for wireless or implantable devices where there are exceptional clinical circumstances.

National supporting evidence

NICE Guidance IPG 278 - Functional Electrical Stimulation for drop foot of central neurological origin

6.30 OPEN / UPRIGHT MRI SCANNING

Open MRI

Referral to an NHS Open MRI scanner for an Open MRI scan as an alternative to a conventional MRI scan may be commissioned in the following circumstances as an exception where the following criteria are met:

- Patients who suffer from claustrophobia where an oral prescription sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). For the use for Spinal cord compression and neural axis tumours, the use of an Open MRI is recommended rather than the use of a general anaesthetic as there is a lesser risk to the patient.
- Patients who are obese and cannot fit comfortably in a conventional MRI scanner as determined by a Radiology department policy. (The issue re size is how the weight is distributed).

Upright MRI

Upright MRI scanning within the Private sector is not routinely commissioned by the CCGs.
Upright MRI scanning may be considered for cases on an exceptional basis where;

- Evidence supports that due to severe pain (having utilized appropriate pain medication) **AND**
- The patient cannot lie properly for the required scan time in a conventional MRI scanner due to the patient's condition

6.31 BOTULINUM TOXIN FOR AXILLARY HYPERHIDROSIS

Botulinum Toxin for axillary hyperhidrosis will not be routinely commissioned by the CCGs.

Treatment may be considered on an exceptional basis for intractable, disabling focal primary hyperhidrosis when all of the following criteria are met;

- Topical aluminium chloride or other extra-strength antiperspirants are ineffective or result in a severe rash **AND**
- Iontophoresis has been ineffective **AND**
- Unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics) if sweating is episodic **AND**
- Significant disruption of life has occurred because of excessive sweating

Exclusion

The CCGs will not commission Botulinum Toxin to treat hyperhidrosis in people with social anxiety disorder. – NICE CG159

NOTE - for approved requests the CCGs will fund a maximum of 2 treatments per year per patient, not to be repeated more frequently than every 16 weeks.

National supporting evidence

NICE CG159 - Social anxiety disorder: recognition, assessment and treatment;

6.32 BOTULINUM TOXIN FOR PROPHYLAXIS MIGRAINE

Botulinum Toxin for prophylaxis migraine will not be routinely commissioned by the CCGs.

Botulinum Toxin Type A is recommended as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine)

- that has not responded to at least three prior pharmacological prophylaxis therapies **AND**
- whose condition is appropriately managed for medication overuse.

Treatment with Botulinum Toxin Type A that is recommended according to the above should be stopped in people whose condition:

- is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) **or**
- has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months.

NOTE - for approved requests the CCGs will fund a maximum of 4 treatments per year per patient of Botulinum Toxin, not to be repeated more frequently than every 2 treatments without specialist review.

National supporting evidence

NICE Guidance TA260 - Botulinum toxin type A for the prevention of headaches in adults with chronic migraine

6.33 SPINAL CORD STIMULATION

Spinal Cord Stimulation (SCS) device and leads fall outside PbR tariff. Clinicians are responsible for deciding if the treatment is appropriate for individual patients. NICE Technology Appraisal Guidance 159 recommends SCS for adults with chronic neuropathic pain who:

- Continue to experience chronic pain (measuring at least 50mm on a 0-100mm visual analogue scale) for at least 6 months despite all other reasonable treatment alternatives having been tried with an unsatisfactory outcome **AND**

- Who have had a successful spinal cord stimulation trial (this determines suitability for permanent implantation by assessing tolerability and the degree of pain relief likely to be achieved by full implantation)

SCS is **NOT** commissioned for adults with chronic pain of ischaemic origin, except in the context of research as part of a clinical material (due to lack of evidence of clinical effectiveness).

SCS may only be commissioned after an assessment by a multidisciplinary team (MDT) experienced in chronic pain assessment and management of people with SCS devices, including experience in the provision of ongoing monitoring and support.

If different SCS systems are considered to be equally suitable for a person the least costly should be used. (Assessment of cost should take into account acquisition costs, the anticipated longevity of the system, the stimulation requirements of the person with chronic pain and the support package offered).

National supporting evidence

NICE Guidance TA159 - Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

6.34 SACRAL NEUROMODULATION

Sacral Neuromodulation in relation to urinary retention and constipation will be commissioned in line with NICE IPG 536. Individual funding must be sought prior to commencement of treatment.

Sacro Neuromodulation for faecal and urinary incontinence are currently commissioned by NHS England.

National supporting evidence

NICE IPG 536: Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention (published 25/11/15)

6.35 ADVICE & PATHWAY FOR THE SUPPLY OF NHS FUNDED WIGS

NHS wigs will be routinely funded outside of cancer pathways for the following indications:

1. Consultant Dermatologist request

   AND

2. Specialist diagnosis of

   a) Alopecia totalis

   OR

   b) Scarring alopecia including

   - Scleroderma
   - Lichen planus
   - Discoid lupus
   - Folliculitis decalvans
   - Frontal fibrosing alopecia

A Consultant Dermatologist will determine the patients' diagnosis and suitability for a wig and issue a prescription where appropriate.

Patients are entitled to either two stock modacrylic fibre wigs per year **or** one stock real hair wig every 2 years.

There are no nationally set limits on the number of wigs a patient can have from the NHS. However, this is a locally agreed own limit.

The patient will be expected to pay the current standard prescription charge for either of the above types of wig. This prescription charge is payable to either the hospital Trust or any NHS wig provider that accepts NHS prescriptions. The balance of the cost of the wig is paid by the NHS.

Some patients may be exempt from paying this prescription charge.

Many hospital Trusts will carry wigs as part of their appliance offering, however advice can be provided to patients on other NHS wig providers who will accept an NHS prescription.

Exclusions

Bespoke wigs including bespoke human hair wigs are not routinely prescribed. The patient's clinician would need to submit an Individual Funding Request to the Clinical Commissioning Group on behalf of the patient to request funding for a bespoke human hair wig or any other non-standard wig.

The funding request must evidence on what exceptional grounds that the patient should be prescribed a bespoke wig. Evidence of 'allergy' needs to be proven by patch testing prior to the clinician submitting an Individual Funding Request.

Should funding be successfully granted, patients would be expected to pay the current standard prescription charge (see more information on the NHS England link above for charges and exemptions).

The CCG will fund up to a maximum of one bespoke real hair wig every 2 years up to a maximum balance cost of £1,500.

Re-issue process in subsequent years

For bespoke wigs agreed through the Individual Funding Request process, once the initial request has been approved the patient can request subsequent years funding from the Clinical Commissioning Group when the wig is due for replacement.

The patient will be required to write to the IFR team informing them that the wig is due for replacement. The IFR team will process the request and confirm in writing to the patient that a replacement wig has been authorised.

6.36 ADULT SNORING SURGERY (IN THE ABSENCE OF OSA)

This guidance relates to surgical procedures in adults to remove, refashion or stiffen the tissues of the soft palate (Uvulopalatopharyngoplasty, Laser assisted Uvulopalatoplasty & Radiofrequency ablation of the palate) in an attempt to improve the symptom of snoring. Please note this guidance only relates to patients with snoring in the absence of Obstructive Sleep Apnoea (OSA) and should not be applied to the surgical treatment of

patients who snore and have proven OSA who may benefit from surgical intervention as part of the treatment of the OSA.

It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (e.g. nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to, this procedure should no longer be routinely commissioned in the management of simple snoring.

Alternative Treatments

There are a number of alternatives to surgery that can improve the symptom of snoring. These include:

- Weight loss
- Stopping smoking
- Reducing alcohol intake
- Medical treatment of nasal congestion (rhinitis)
- Mouth splints (to move jaw forward when sleeping)

6.37 DILATATION AND CURETTAGE (D&C) FOR HEAVY MENSTRUAL BLEEDING IN WOMEN

NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.

Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), can be used to investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) can treat heavy periods.

D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.

Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods.

Medication and intrauterine systems (IUS) can be used to treat heavy periods.

For further information, please see:

- NICE Guidance NG88: Heavy menstrual bleeding: assessment and management
- NHS website for England: Hysteroscopy and alternatives to hysteroscopy

6.38 INJECTIONS FOR NONSPECIFIC LOW BACK PAIN WITHOUT SCIATICA

NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work.

Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain.

For people with non-specific low back pain the following injections should not be offered:

- Facet joint injections
- Therapeutic medial branch blocks
- Intradiscal therapy
- Prolotherapy
- Trigger point injections with any agent, including botulinum toxin
- Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- Any other spinal injections not specifically covered above

Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.

Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic.

Alternative options are suggested in line with the National Back Pain Pathway.

Further information is provided in NICE Guidance NG59: Low back pain and sciatica in over 16s: assessment and management

6.39 KNEE ARTHROSCOPY FOR PATIENTS WITH OSTEOARTHRITIS

NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis, unless the knee locks (in which case it may be considered). More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and pain management.

If symptoms do not resolve, knee replacement or osteotomy are effective procedures that should be considered.

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking.

More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement or joint preserving surgery such as osteotomy is appropriate.

For further information, please see:

- NICE guidance IPG230 Interventional procedure overview of arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis

- NICE Guidance IPG 230 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis
- NICE Do not do recommendation for referral for arthroscopic lavage and debridement as part of treatment for osteoarthritis, unless the person has knee osteoarthritis with a clear history of mechanical locking

7. References

Department of Health (2013). The NHS Constitution the NHS belongs to us all.

Department of Health (2012). The Functions of Clinical Commissioning Groups

Department of Health (2010). Equity and Excellence: Liberating the NHS. Available

Scottish Intercollegiate Guidelines Network (2013). Information about SIGN.

The NHS Confederation (2008a) Priority Setting: Legal Considerations.

The NHS Confederation (2008b) Priority Setting: Managing Individual Funding Requests

NHS Modernisation Agency. Information for Commissioners of Plastic Surgery Services; Referrals and Guidelines in Plastic Surgery (2005)

NHS England - Evidence-Based Interventions: Response to the public consultation and next steps

Appendix 1 List of Complementary / Alternative Therapies

Active release technique
Acupressure
Acupuncture
Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries) technique Alexander technique
AMMA therapy
Antineoplaston Therapy and Sodium Phenylbutyrate
Apitherapy
Applied kinesiology
Aromatherapy
Art therapy
Aura healing
Autogenous lymphocytic factor
Auto urine therapy
Bioenergetic therapy
Biofield Cancell (Entelev) cancer therapy
Bioidentical hormones
Brain integration therapy
Carbon dioxide therapy
Cellular therapy
Chakra healing
Chelation therapy for Atherosclerosis
Chung Moo Doe therapy
Coley's toxin
Colonic irrigation
Colour therapy
Conceptual mind-body techniques
Craniosacral therapy
Crystal healing
Cupping
Dance/Movement therapy
Digital myography
Ear Candling

Egoscue method
Electrodermal stress analysis
Electrodiagnosis according to Voll (EAV)
Equestrian therapy - Hippotherapy
Essential Metabolics Analysis (EMA)
Essiac
Feldenkrais method of exercise therapy (also known as awareness through movement)
Flower essence
Fresh cell therapy
Functional intracellular analysis
Gemstone therapy
Gerson therapy
Glyconutrients
Graston technique
Greek cancer cure
Guided imagery
Hair analysis
Hako-Med machine (electromedical horizontal therapy)
Hellerwork
Hoxsey method
Human placental tissue
Hydrolysate injections
Humor therapy
Hydrazine sulfate
Hydrogen peroxide therapy
Hypnosis
Hyperoxygen therapy
Immunoaugmentive therapy
Infratronic Qi-Gong machine
Insulin potentiation therapy
Inversion therapy
Iridology
Iscador
Juvent platform for dynamic motion therapy

Kelley/Gonzales therapy
Laetrile
Live blood cell analysis
Macrobiotic diet
Magnet therapy
MEDEK therapy
Meditation/transcendentalmeditation
Megavitamin therapy (also known as orthomolecular medicine)
Meridian therapy
Mesotherapy
Moxibustion
MTH-68 vaccine
Music therapy
Myotherapy
Neural therapy
NUCCA procedure
Ozone therapy
Pfrimmer deep muscle therapy
Polarity therapy
(Poon's) Chinese blood cleaning
Primal therapy
Psychodrama
Purging
Qigong longevity exercises
Ream's testing
Reflexology (zone therapy)
Reflex Therapy
Reiki
Remedial massage
Revici's guided chemotherapy
Rife therapy/Rife machine
Rolfing (structural integration)
Rubenfeld synergy method (RSM)
Sarapin injections
Shark cartilage products

Telomere testing

Therapeutic Eurythmy-movement therapy

Therapeutic touch

Thought field therapy (TFT) (Callahan Techniques Training)

Trager approach

Traumeel preparation

Vascular endothelial cells (VECs) therapy

Vibrational essences

Visceral manipulation therapy

Whitcomb technique

Wurn technique/clear passage therapy

Yoga

Appendix 2 Equality Impact Assessment Checklist Tool

Title of Policy: Commissioning Policy for Individual Funding Requests

Names and roles of people completing the assessment:
Claire Wood – Assistant Manager Individual Funding Requests
Sarah MacKenzie - Cooper – Equality & Diversity Manager

Date assessment started: 01/07/2017

Date completed: 29/1/2018

1. Outline

Give a brief summary of the policy:
The purpose of the policy is to enable officers of the CCGs to exercise their responsibilities properly and transparently in relation to commissioned treatments including individual funding requests, and to provide advice to General Practitioners, clinicians, patients and members of the public about IFRs. Implementing the policy ensures that commissioning decisions are consistent and not taken in an ad-hoc manner without due regard to equitable access and good governance arrangements. Decisions are based on best evidence but made within the funding allocation of the CCGs.

What outcomes do you want to achieve?
That the CCGs commission services equitably, and only when clinically necessary and in line with current evidence on cost effectiveness.

2. Analysis of impact

This is the core of the assessment, using the information above detail the actual or likely impact on protected groups, with consideration of the general duty to; eliminate unlawful discrimination; advance equality of opportunity; foster good relations

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
General			Equality monitoring of IFR request has been introduced and will be continuously reviewed against outcomes. Where any trends are noticed further work will be undertaken to establish any areas for action.
Age	Yes. Some of the IFR criteria have age limitations. This is based on clinical evidence or considered a justifiable proxy for physical maturity. In the case of Pinnaplasty this is only considered for children up to the age of 19 due to the significant psychosocial dysfunction for children and adolescents and impact on education.	This could be negative for those people who fall outside the age related criteria.	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process. The IFR policy is published on the CCGs websites so clinicians and patients can access the criteria and be fully informed of any restrictions.
Carers	Not applicable	N/A	N/A
Disability	Yes. There is recognition that there may be	Potentially negative	This is addressed in the policy (section 5).

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
	psychological impacts of some of the conditions which present to IFR however clinical need must be evidenced.		Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Sex	Some procedures are likely to be sex related; e.g. Labiaplasty. Where this is the case the clinical thresholds will need to be met. Most procedures are gender neutral.		The IFR committee receives redacted patient information which should mitigate the impact for gender neutral processes. Equality monitoring of requests will be reviewed.
Race	No evidence to date – equality monitoring introduced and will be reviewed.	N/A	N/A
Religion or belief	There may be an expectation that circumcision for religious reasons should be approved however it is only undertaken for clinical reasons.	N/A	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
Sexual orientation	Not applicable	N/A	Not applicable
Gender reassignment	IFRs are considered in the patients affirmed gender and therefore subject to the clinical criteria within the policy. Other treatments may be available through the gender reassignment pathway, if not an IFR could be submitted.	N/A	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Pregnancy and maternity	Some IFRs could be impacted by pregnancy and maternity, e.g. breast procedures. There may be a delay to allow for full recovery after childbirth. Inverted nipple treatment is only available to support breast feeding in specific clinical circumstances.	N/A	Clinicians would still be able to submit an IFR on behalf of their patient. If they fall outside the criteria the request would be considered in line with the IFR process.
Marriage and civil partnership	Not applicable	N/A	Not applicable

Characteristics	Are there any likely impacts? Are any groups going to be affected differently? Please describe.	Are these negative or positive?	What action will be taken to address any negative impacts or enhance positive ones?
Other relevant group	No evidence	N/A	Not applicable

3. Monitoring, Review and Publication

How will you review/monitor the impact and effectiveness of your actions

We will review the basic equality monitoring data received. The number of IFR equality monitoring forms received is limited so we will report any issues that are noted across the CCGs. Following the introduction of this policy we will report annually to the constituent CCGs.

Lead officer: Claire Wood

Review date: June 2022

4. Sign off

Lead Officer: Vicky Dutchburn

Title: Head of Strategic Planning & Transformation

Date of Approval: 11/3/2019

Appendix 3 Version Control Sheet

The table below evidences the history of the steps in development of the document.

Version Control:

Version	Date	Author	Status	Comment
0.1	June 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.1	Initial starting draft
0.2	July 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.2	Updated using Joint Commissioning Policy from North Kirklees & Wakefield CCGs
0.3	August 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.3	Updated using NHS England commissioning policies & NICE Guidance
0.4	October 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.4	Updated after discussions with Dermatology and Plastics Departments at LTHT
0.5	December 2017	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.5	Updated after review of STP & other CCGs IFR policies
0.6	January 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.6	Updated after review of North East London CSU commissioning policy for complementary therapies
0.7	February 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.7	Updated after wig pathway included

Version	Date	Author	Status	Comment
0.8	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.8	Additional wording in relation to revisional procedures
0.9	May 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.9	Additional wording in relation to breast re-augmentation
0.10	June 2018	Claire Wood – Assistant Manager IFR GHCCG	Draft v0.10	Change to format of criteria in relation to breast reduction
1.0	June 2018	Claire Wood – Assistant Manager IFR GHCCG	FINAL V1.0	Approved by: Greater Huddersfield CCG - 13/06/2018 North Kirklees CCG - 13/06/2018 Calderdale CCG - 14/06/2018
2.0	March 2019	Claire Wood - Assistant Manager IFR GHCCG	FINAL V2.0	Criteria updated in light of national mandated policies published by NHSE.
3.0	July 2019	Claire Wood - Assistant Manager IFR GHCCG	FINAL V3.0	Criteria removed in line with the National mandated policies published by NHSE.
4.0	April 2021	Claire Wood - Assistant Manager IFR KCCG	FINAL V4.0	Updated to reflect policy being adopted by new organisation, Kirklees CCG

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Integrated Care Board – development and stakeholder involvement**	**Agenda Item No.**	7
Report Author	Rob Gibson	**Public / Private Item**	Public
Clinical Lead	Dr Steve Cleasby (Clinical Chair)	**Responsible Officer**	Neil Smurthwaite (Chief Operating Officer)

Executive Summary

- The Health and Care Bill published on 7July 2021, proposes the establishment of Integrated Care Boards (ICBs), which will take on the commissioning responsibilities of CCGs
- The Bill requires that the relevant Clinical Commissioning Group/s (CCGs) must "propose the constitution of the integrated care board and before making a proposal, consult any persons they consider it appropriate to consult". Subsequent guidance from NHSE states that "CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICS chair and CEO. System partners must be engaged in the development of the constitution"
- This report recommends that we take a 'whole Partnership' approach to developing the ICB constitution and involving stakeholders

Previous Considerations

Name of meeting	Joint Committee of the CCGs	**Meeting Date**	5 October 2021
Name of meeting		**Meeting Date**	

Recommendations

It is recommended that the Governing Body:

Takes a 'whole Partnership' approach and agrees that the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) co-ordinates:

- the development of the draft integrated care board (ICB) constitution
- stakeholder involvement on the constitution

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Equality impact assessment will be undertaken and health inequalities considered as part of the process
Resources / Financial Implications (including Staffing/Workforce considerations)	None identified
Sustainability Implications	None Identified

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	Improving Governance	**Risk (include risk number and a brief description of the risk)**	None identified
Legal / CCG Constitutional Implications	Changes to the status of CCGs from 1 April 2022 due to implementation of Health & Care Bill 2021	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None identified

1.0 Introduction

1.1 The Health and Care Bill, published on 7 July 2021, proposes the establishment of Integrated Care Boards (ICBs), which will take on the commissioning responsibilities of CCGs. The Bill requires that the relevant Clinical Commissioning Group/s (CCGs) must "propose the constitution of the integrated care board and before making a proposal, consult any persons they consider it appropriate to consult".

1.2 Subsequent guidance from NHS England states that "CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICB chair and Chief Executive Officer. System partners must be engaged in the development of the constitution".

1.3 This report recommends that we take a 'whole Partnership' approach to developing the ICB constitution and involving stakeholders. The Joint Committee of CCGs does not have specific delegated responsibility for agreeing the approach, so is asked to make a recommendation to each CCG for agreement through its own governance arrangements (see appendix 1 – WY&F Partnership paper on Integrated Care Board constitution – development and stakeholder involvement presented at their meeting on 5 October)

1.4 The Bill is currently proceeding through the Parliamentary process, and although changes are possible and opposition parties have strongly objected to some of its provisions, it is reasonable to assume that few significant amendments will be made.

2.0 Detail

2.1 A West Yorkshire & Harrogate Health and Care Partnership Governance Working Group, chaired by Tim Ryley, the Accountable Officer for Leeds CCG, is leading the co-production of the ICB constitution. The Group includes partners from across each place (Bradford district and Craven; Calderdale, Kirklees, Leeds and Wakefield) and sectors.

2.2 The draft constitution will be based on guidance produced by NHS England and NHS Improvement. It will set out how the ICB will operate. This will include how it intends to involve the public and carers in its work and how it will deliver transparency around decision making.

2.3 In relation to involvement, the proposal is to 'design once' and deliver five times across local places. A detailed communications and involvement plan is currently being drafted with input from Calderdale CCG's communications and engagement team. The team will lead the local implementation.

2.4 The aim of this involvement will be to ensure the constitution clearly describes the structure, function, and roles of the ICB and that relevant stakeholders have the opportunity to share their views.

2.5 To ensure transparency and reduce the risk of challenge, the draft constitution will be published to enable all interested parties to contribute.

3.0 Recommendations

3.1 It is recommended that the Governing Body:

Takes a ‘whole Partnership’ approach and agrees that the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) co-ordinates:

- the development of the draft integrated care board (ICB) constitution
- stakeholder involvement on the constitution

4.0 Appendices

Appendix 1: WY&H Partnership paper on Integrated Care Board Constitution – development and stakeholder involvement presented at meeting on 5 October 2021

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report			
Date of meeting: 5th October 2021		Agenda item: 38/21	
Report title:	**Integrated Care Board constitution – development and stakeholder involvement**		
Joint Committee sponsor:	Tim Ryley, Accountable Officer, Leeds CCG		
Clinical Lead:	N/A		
Author:	Stephen Gregg, Governance Lead Karen Coleman, Communications and Engagement Lead		
Presenter:	Stephen Gregg,		
Purpose of report: (why is this being brought to the Committee?)			
Decision	✓	Comment	✓
Assurance			

Executive summary

The Health and Care Bill, published on 7th July 2021, proposes the establishment of Integrated Care Boards (ICBs), which will take on the commissioning responsibilities of CCGs.

The Bill requires that the relevant Clinical Commissioning Group/s (CCGs) must "propose the constitution of the integrated care board and before making a proposal, consult any persons they consider it appropriate to consult". Subsequent guidance from NHSE states that "CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICS chair and CEO. System partners must be engaged in the development of the constitution"

This report recommends that we take a 'whole Partnership' approach to developing the ICB constitution and involving stakeholders. The Joint Committee of CCGs does not have specific delegated responsibility for agreeing the approach, so is asked to make a recommendation to each CCG for agreement through its own governance arrangements.

Recommendations and next steps

The Joint Committee is asked to recommend that each CCG agrees that the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) co-ordinates:

- the development of the draft integrated care board (ICB) constitution.
- stakeholder involvement on the constitution.

Delivering outcomes: describe how the report supports the delivery of outcomes (Health and wellbeing, care and quality, finance and efficiency)

The ICB constitution will support the delivery of priority outcomes.

Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	N/A
Public involvement:	The draft constitution will be published on the website and summary content will be made available in easy read form. The constitution will set out the ICB's arrangements for involving the public.
Finance:	N/A
Risk:	There are risks that the approach to developing and carrying out involvement on the constitution will be challenged. Stakeholders may feel they have not been involved or that their comments have not been taken into account. These risks will be mitigated by • Co-producing the constitution with partners. • Seeking legal advice on the content of the constitution • Agreeing a communications and involvement plan • Ensuring that the approach is agreed by the CCGs. • Involving a wide range of stakeholders. • Recording formal responses and producing a formal report for transparency.
Conflicts of interest:	The draft constitution will set out arrangements for managing conflicts of interest.

Background

1. The Health and Care Bill proposes the establishment of Integrated Care Boards (ICBs), which will take on the commissioning responsibilities of clinical commissioning groups (CCGs).

2. The Bill requires that the relevant CCG/s must "propose the constitution of the integrated care board and before making a proposal, consult any persons they consider it appropriate to consult". Subsequent guidance from NHS England (NHS E) states that "CCGs will be legally responsible for the development of ICB constitutions, but we expect this process to be led by the designate ICB chair and CEO. System partners must be engaged in the development of the constitution". Further guidance from NHS E is that extensive formal consultation on draft constitutions is not required and that engagement is to be determined locally (NHS England, 24 August 2021).

3. This report proposes that, on behalf of the West Yorkshire CCGs, the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) co-ordinates involvement with stakeholders on the draft ICB constitution. It is important to note that involvement activity will be about the content of the draft constitution, not about whether ICBs should be established.

4. The Bill is currently proceeding through the Parliamentary process, and although changes are possible, we are proceeding on the assumption that the proposal to dissolve CCGs and establish ICBs gains Royal Assent in March 2022.

Developing the ICB constitution

5. A WY&H HCP Governance Working Group, chaired by Tim Ryley, the Accountable Officer for Leeds CCG, is leading the co-production of the ICB constitution. The Group includes partners from across our places (Bradford district and Craven; Calderdale, Kirklees, Leeds and Wakefield) and sectors.

6. The draft constitution will be based on guidance produced by NHS England and NHS Improvement. The constitution will set out how the ICB will operate. This will include how we intend to involve the public and carers in our work and how we will deliver transparency around decision making. The latest national guidance about the constitution can be found here.

7. A key element of the constitution will be to set out arrangements for how resources and authority are delegated to each of our places. Each place is developing governance arrangements that meet their local circumstances, within a common framework of good governance. Stakeholder involvement on these local arrangements will be linked into involvement on the ICB constitution.

Approach to involvement

7. We propose that the involvement process is 'designed once' and delivered five times across our local places, involving all relevant and interested stakeholders, via our local communication and engagement leads. The aim of this involvement is to ensure the constitution clearly describes the structure, function, and roles of the ICB and that relevant stakeholders have the opportunity to share their views.

   Our objectives will be to:

   - communicate clearly and simply the proposed content of the draft constitution using various formats and approaches
   - listen and gather feedback on the draft constitution using a variety of mechanisms such as briefings, meetings etc as appropriate
   - ensure we have in mind organisations who represent protected groups, as defined by the Equality Act 2010in a meaningful way, adapting materials and approaches as appropriate
   - understand who the organisations most likely to be impacted by the plans are and how the draft constitution changes would impact them
   - analyse and collate the feedback from this involvement process and provide that information to decision makers
   - ensure enough time is given to conscientiously consider the feedback
   - further ensure we can demonstrate that the views expressed have been considered as part of the decision-making process
   - provide clear and meaningful feedback to organisations and citizens who have taken the time to be involved in the development of the constitution. This will be in the form of the final constitution which will be made public on the Partnership website, via partners and bulletins

8. The WY&H communications and engagement plan sets out our principles for communications, engagement, and our approach to working with local people. An easy read version is also available. WY&H HCP's Involvement framework sets out what the public can reasonably expect the Partnership to do as part of any involvement activity.

9. A detailed communications and involvement plan is currently being drafted. Delivery of the plan will be wholly dependent on input and support from our five local places - Bradford district and Craven, Calderdale, Kirklees, Leeds, and Wakefield. Structures for involving stakeholders and who those stakeholders are, will be different but similar in each of these places and it is important that each place feels comfortable with the approach taken to involve relevant stakeholders in this work.

10. We are proposing that involvement should include NHS organisations, local authorities, Healthwatch and other stakeholders such as voluntary, community and social enterprise (VCSE) partners and overview and scrutiny committees (OSCs) at place and West Yorkshire level. To ensure transparency and reduce the risk of challenge, we will publish our draft constitution to enable all interested parties to contribute.

11. The following groups have been initially identified for targeted activity:

- Local Healthwatch
- Overview and scrutiny committees
- Health and Wellbeing Boards
- Local authorities – commissioners
- Social services
- Primary care
- Trusts and Foundation Trusts
- Mental health and learning disability providers
- Community services providers
- Local voluntary, community, and social enterprise organisations
- Nursing and medical universities / faculties
- Local staff
- Unions

12. Our communication and involvement approach relies on the work taking place locally to ensure we reach organisations and citizens accordingly. We will be seeking support from Healthwatch and communication and engagement colleagues in each of the five local places Bradford District and Craven, Calderdale, Kirklees, Leeds, and Wakefield to reach their local stakeholders. Operating transparently by publishing the draft constitution, other interested parties will have the opportunity to contribute should they wish.

13. The ICB will be complemented by the Integrated Care Partnership (ICP) which will be the forum which includes a wide range of local stakeholders. The ICP will legally be a joint committee of the local authorities and the ICB, so cannot be technically formed until the ICB is established. However, our existing Partnership Board is essentially already operating as an ICP and will be a key forum for overseeing effective stakeholder involvement in the development of our constitution.

14. It is important to us that we feedback in a 'you said, we did' format and have an audit trail of comments and views recorded. This will involve looking at what needs to be communicated to whom and when, with a targeted tailored approach, using various communication methods.

Timelines

15. The ICS Design Framework published on 16 June 2021 sets out that "engagement" on local ICB Constitution and governance arrangements must be completed by the end of December 2021. However, at the time of writing this report, some key national guidance had yet to be published, which may impact this timeline.

16. Subject to publication of further national guidance, our intention is to have a working draft constitution, suitable for involvement activity with external stakeholders, by the end of October. The draft constitution will be presented to the Partnership Board held in public in December, with a near-final version presented to the Partnership Board and Shadow ICB Board in March. An outline timetable is set out below:

Action	Timeline
Draft communication and involvement plan coproduced with local place engagement leads with input from local place governance leads.	Sept / Oct 2021
Joint Committee recommends proposed approach to individual CCGs.	Oct 2021
CCGs agree partnership approach to involvement	Oct 2021
Preparation and planning for involvement	Sept / Oct 2021
Draft co-produced ICB constitution ready for involvement (subject to publication of national guidance)	End Oct 2021
Involvement with all key stakeholders 'goes live' To include presentation to local OSCs and JHOSC.	Nov to Jan 2022
Collation of comments and suggestions about the constitution	Nov to Jan 2022
Present draft constitution at WY&H HCP Partnership Board	7 Dec 2021
Draft constitution to NHS England for review and comment	December 2021
Suggestions incorporated into draft constitution	For Feb 2022
Final draft constitution presented to Partnership Board and Shadow ICB Board	Mar 2022
Final version to NHS England for comment and agreement	Mar 2022
Constitution comes into being with creation of ICB	1 April 2022

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Implementation of Urgent Community Response Service**	**Agenda Item No.**	8
Report Author	Rhona Radley	**Public / Private Item**	Public
Clinical Lead	Dr Helen Davies	**Responsible Officer**	Neil Smurthwaite

Executive Summary

As part of the NHS' Long Term Plan to support England's ageing population and those with complex needs, local health services and council teams are required to roll out Urgent Community Response teams (UCR), at pace, by December 2021.

The national minimum requirements for the UCR are to:

- Provide services at scale: to achieve full geographic coverage of two-hour crisis response care across systems
- Provide services from 08:00-20:00, 7 days a week at a minimum
- Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111
- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard

The UCR team will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs. People will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

NHS Calderdale CCG, Calderdale and Huddersfield NHS Foundation Trust (CHFT), Local Care Direct (LCD) and Calderdale Council are working together to implement the UCR across Calderdale, whilst taking learning from Kirklees who were an accelerator site. The local model uses this learning, but is based on what is right for Calderdale.

The CCG's Quality, Finance and Performance Committee agreed the Standard Operating Procedure at their September meeting, on the understanding that this is subject to change as the work progresses through implementation.

Funding is coming from NHS England based on a population formula. This does not cover the full costs of the service provision in the current year. The Calderdale Integrated Commissioning Executive has recommended the use of Better Care Funding to meet the shortfall for the recurrent model. A full description of the financial context is provided in the report. There remains a risk associated with the long-term funding of this model and the potential move to a 24/7 model.

Previous Considerations

Name of meeting	Senior Management Team	**Meeting Date**	September 2021
Name of meeting	Integrated Commissioning Executive	**Meeting Date**	September 2021
Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	September 2021

Recommendations
Members are asked to: (a) Note the recommendations and agreements made by the Integrated Commissioning Executive and Quality, Finance and Performance Committee relating to the Standard Operating Procedure. (b) Approve the full annual cost of £1.5m and the expected funding streams of NHSE funding £1m and Better Care Funding of £0.5m. (c) Recognition of financial risk associated with confirmation about recurrent funding allocations in the longer term, and the risk associated with a potential move to a 24/7 model, once mandated nationally as expected.

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	A Quality Impact Assessment has been completed and is attached. The Assessment has been used to support development of the Standard Operating Procedure

Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	An Equality Impact Assessment has been completed and is attached. The Assessment has been used to support development of the Standard Operating Procedure
Resources / Financial Implications (including Staffing/Workforce considerations)	Implementation of the Urgent Community Response Service requires use of an NHS England ring-fenced allocation. However, due to the nature of the population formula used, the funding does not cover the cost of the service. A recommendation has been made by the Calderdale Integrated Commission Executive to meet the shortfall through the Better Care Fund. Details are included within this paper.
Sustainability Implications	Our submission is underpinned by; the outcomes in the Calderdale Inclusive Economy Strategy, ambitions for Calderdale to tackle the climate emergency, and also, Calderdale's aims related to increasing social value.

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☒**	Work is ongoing to ensure Data Sharing Agreements are in place across the system to support this work

Strategic Objectives (which of the CCG objectives does this relate to?)	Implementation of the services touches on all of the organisations' strategic objectives	**Risk (include risk number and a brief description of the risk)**	There is no specific corporate risk, however the delivery programme

			has a risk register in place.
Legal / CCG Constitutional Implications	There are no legal or constitutional implications.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	There are no identified conflicts of interest – this service is being delivery through a collaboration of local providers.

1. Introduction

1.1 The strategic direction for the Calderdale health and care system is a clear focus on strengthening and integrating our community provision. This is a key element of our Calderdale Cares programme, and the refresh of our Wellbeing Strategy

1.2 NHS England and West Yorkshire and Harrogate Care Partnership Ageing Well programme have been established to support the implementation of the NHS Long Term Plan ambitions, with a key focus on community offers.

1.3 A key part of the National Ageing Well Programme is the establishment of urgent community response sites to support delivery against 0-2 hour and 2-day response targets. By March 2022, all systems in England must implement the two-hour community-based crisis response standard.

1.4 From a Calderdale perspective, there is recognition that this is the most significant change and investment into community services for many years, and, although mandated, is completely aligned to our integration approach and our approach to provider collaboration.

1.5 The Calderdale Urgent Community Response (UCR) offer has therefore been produced in line with the NHS England 'Urgent community response – two-hour and two-day response standards 2020/21: technical data guidance' (November 2020), whilst ensuring that it is fit for purpose for Calderdale, and supports service integration.

1.6 The service will be integrated into local pathways, particularly for urgent and planned care to ensure that there is clarity for; patients and their families, those working in the system, and referrers. It will seek to optimise pathways, and reduce movement of patients across multiple and complex pathways.

2. What is Urgent Community Response

2.1 As part of the NHS' Long Term Plan to support England's ageing population and those with complex needs, local health services and council teams will begin the roll out of Urgent Community Response teams.

2.2 The national minimum requirements of the UCR is to:

- Provide services at scale: to achieve full geographic coverage of two-hour crisis response care across systems
- Provide services from 08:00-20:00, 7 days a week at a minimum

- Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111
- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard

2.3 This guidance states the standard service definition as “a community response is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days”. Some providers offer a single, integrated service that covers all these types of care from crisis response to reablement. This is the preferred service delivery model.

2.4 Urgent community response services should be available following changes in an individual's health or circumstances. They provide a person-centred approach to optimise independence and confidence, enable recovery, and prevent a decline in functional ability. The service should also reduce demand on other urgent services within our system. Services should have a ‘no wrong door’ approach and work flexibly based on need, not diagnosis/condition.

2.5 Urgent Response teams will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs. Calderdale residents will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

2.6 Alongside this 0–2-hour response, a 2-day standard will also apply for teams to put in place tailored packages of intermediate tier care including reablement services for individuals where needed; to restore independence and confidence after a hospital stay.

2.7 These 0-2 hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people well at home and reduce pressure on other urgent care services.

3. Calderdale’s Approach

3.1 The aim for the Calderdale UCR is to rapidly respond to people, aged 18 years or older, who require a 0-2 hour response (and meet the UCR criteria), in order to prevent avoidable admissions and readmissions, by managing the person safely at home with appropriate ongoing community support.

3.2 A full Standard Operating Procedure (SOP) for the service is attached as Appendix A. However, as recognised in the Quality, Finance and Performance Committee discussions, the SOP remains organic as we learn from implementation. The organic nature of the SOP is also evidenced in the national pilot sites, who have continued to develop their SOPs as the services have been implemented.

3.3 Our aim is to bring the Calderdale service online by December 2021. This local acceleration of the national timescales has been supported by the Calderdale and Huddersfield Urgent and Emergency Care Board, and our Integrated Commissioning Executive.

3.4 There are four service elements that come together to form our new UCR service:

- Crisis response intermediate care service
- Reablement intermediate care service
- Home-based intermediate care service
- Community bed-based intermediate care service.

3.5 Whilst there is currently some level of community health and social care service urgent response in Calderdale, the Calderdale UCR service will enhance and align these services and processes to provide consistent service delivery in a fully integrated way.

3.6 A review of the geographical coverage of our current crisis response services has been undertaken across Calderdale and Kirklees. The aim is to avoid duplication in our planning. Data has been reviewed from across health and care services to inform the demand and capacity requirement of the UCR, including the workforce model required to deliver it.

3.7 Additionally, a review of existing pathways has been undertaken to understand; what currently works well, which services were also providing a crisis response within the 0-2 hour timescale, where there are opportunities, and the current gaps, in preparation for the expanded hours of provision from December 2021.

3.8 A demand modelling exercise was undertaken in June 2021 to understand the variation in need for a 2-hour response across different times of the day, night, and week.

3.9 The future model and pathways in the SOP have been designed based on this work. From December 2021 the UCR team will provide a 7-day, 8am-8pm service; and is expected to increase to a 24/7 service during 2022 (timescales to be agreed following review, learning from national pilots, and national expectations).

4. Who will use the Service

4.1. The service is for any Calderdale resident aged 18 years or over (including people who are homeless; vulnerably housed; or at risk of homelessness). The national criteria has been followed, with enhancements that align with the local needs of the Calderdale population (see Asterix below). The service criteria is as follows:

Inclusion criteria	Exclusion criteria
• Over 18 years of age • Living in their home or residential/care setting* • Is in a crisis and needs intervention, within 2 hours to stay safely at home/usual place of residence • Can be living with dementia- best practice is to share responsibility of older people's mental health teams**	• Is acutely unwell or injured and requiring emergency care intervention and admission to an acute hospital bed • Is experiencing mental health crisis and requires referral/assessment by a specialist mental health team • Needs acute/complex diagnostics and clinical intervention for patient safety in hospital

*Including individuals who are homeless; vulnerably housed; or at risk of homelessness.

**Patients with mental health conditions can access UCR if they have an unplanned physical health or social care need. Patients with deteriorating mental health needs must be referred to the mental health Single Point of Access

4.2 There are a number of common clinical conditions/needs that help describe the type of patients that may require a two-hour response in a crisis. However, this list is not exhaustive, and will not be used to exclude patients from the service;

Examples of common clinical conditions/needs that may require a two-hour response	
• Falls • Decompensation of frailty • Reduced function/ deconditioning/ reduced mobility • Rapid change in moving and handling needs • Palliative/end of life crisis support	• Urgent equipment provision • Confusion/ delirium • Urgent catheter care • Urgent support for diabetes • Unpaid carer breakdown • Injury and urgent wound care

5. What are the benefits of the Service

5.1 The following benefits are described from the national expectations and early learning from pilot sites, including our colleagues in Kirklees. They are consistent with our early thinking on Care Closer to Home, and strategic direction set out in Calderdale Cares

5.2 Alongside the mandated metrics that need to be collected for the service, we will use the benefits below to develop meaningful KPIs to monitor the impact of the service on our patients and other parts of the system

Benefits for Patients	Benefits for service providers, referrers and their teams
• Quicker access and treatment for people's urgent care needs as close to home as possible • Greater clarity on service offers, which are patient rather than organisational led • Increased choice to support a personalised approach • Only having to tell their "story" once • An improved patient experience • Reducing the risk of hospital acquired deconditioning and reduce risks of delirium • Maintaining people safely in their home for longer and reducing admission to a care home • Delivery of a high quality, consistent national offer • Available regardless of residence	• Clarity and consistency of offer and access • A streamlined offer with clear processes and access • Reducing confusion around multiple service offers and handoffs. • Providing clarity around common clinical needs that require a two-hour response and common crisis assessment tools and interventions • Enhancing and investing in community health services • Opportunity to understand the impact of different elements of the model, their links, and opportunities for change. • Opportunity for further learning and innovation • Value for money, reducing duplication of offers

6. Funding

6.1 The following table provides an overview of the annual costs of the service. Given the amount exceeds £0.5m, and in line with our Standing Financial Instructions, approval of the spend is being sought from Governing Body.

Urgent Community Response Financial Summary	2021/22 Part Year £'000	Full Year Model £'000
Funding		
- Allocation from NHSE	506	1,012
- Funding required from BCF pooled budget	109	533
Total Funding	615	1,545
Expenditure	615	1,545

6.2 Funding has been allocated nationally, and is coming down to Calderdale through the West Yorkshire Healthy Ageing Programme through a weighted capitation formular.

6.3 The Calderdale model commences in December 2021, and the allocation received for the first half of the financial year, 2021-22 is £0.506m.

6.4 Given the size of the Calderdale population, we have received the smallest allocation across West Yorkshire. However, the fixed and workforce costs of the model are significant, and the funding does not fully cover the costs in the first year.

6.5 Currently, the proposed model part year costs exceed the allocation by circa £101k. The full year costs of the model is estimated to be £1.513m and the national funding allocation is £1.012m giving a shortfall of £0.501m. Whist work is ongoing with CHFT and LCD to collectively reduce overheads and staffing models and mitigate the shortfall, we cannot assume at this point that we will be able to reduce the shortfall. Therefore, we are planning on the basis of needing an additional £0.1m in the first year, and £0.5m for a full year effect.

6.6 The Finance Sub-Group of the Calderdale Integrated Commissioning Executive therefore recommended to the Integrated Commissioning Executive (ICE) that the shortfall be identified from 2022/23 Better Care Fund pooled budget. ICE subsequently recommended this action to the Quality, Finance and Performance Committee and the Governing Body.

6.7 The annual expected allocation is £1,012m (from 2022-2023). The allocation will only be made if a plan is developed to spend the allocation in full in 2021/22.

6.8 The ICS Ageing Well Director at West Yorkshire has confirmed that these funds are likely to be in place for 3 years (until 2023-24). Whilst it is anticipated that this will be

made recurrent into future allocations, there remains a risk which has been escalated into the Ageing Well Programme.

6.9 It is expected that, following implementation, the full year cost envelope will be the budget set for future years. This is predicated on;

- Learning from the first 4 months of implementation
- The move to substantive posts, reducing backfill and other related staff costs
- Mitigation of some of the current fixed costs
- Potential to reduce provider costs through pathway changes in relation to the way in which the service is access

6.10 As stated in this report, there is an expectation that the UCR services nationally will move to a 24/7 model. We are yet to understand how this impact on allocations, and therefore there is a risk associated with this at the time of writing.

6.11 The ask from the Governing body relates to both the allocation of the ring-fenced funding from the West Yorkshire Healthy Ageing Programme, and allocation on non-recurrent Better Care Funding in the current financial year.

7. Recommendations

Members are asked to:

(a) Note the recommendations and agreements made by the Integrated Commissioning Executive and Quality, Finance and Performance Committee relating to the Standard Operating Procedure.

(b) Approve the full annual cost of £1.5m and the expected funding streams of NHSE funding £1m and Better Care Funding of £0.5m.

(c) Recognition of financial risk associated with confirmation about recurrent funding allocations in the longer term, and the risk associated with a potential move to a 24/7 model, once mandated nationally as expected.

Appendices

A – Standard Operating Procedure (Version 0.10)

B – Quality Impact Assessment

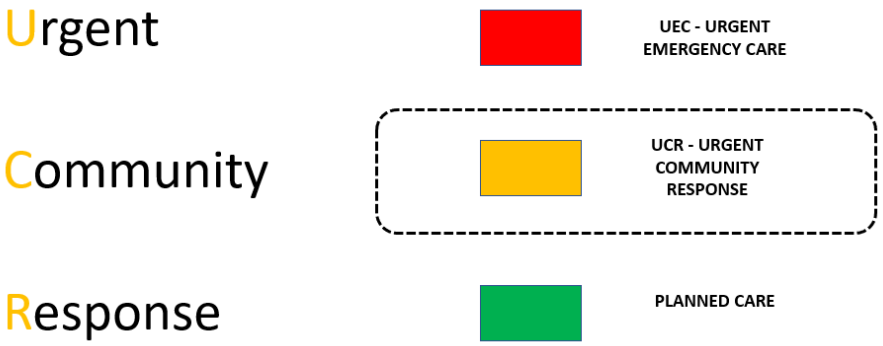
C - Equality Impact Assessment

Appendix A

Standard Operating Procedure

Calderdale Urgent Community Response

Standard Operating Procedure



Version	Date	Revision Author	Summary of Changes
0.1	27.08.21	Sarah Garforth	Draft version 0.1 developed
0.2	02.09.21	Rhona Radley	First review, amendments, and rewording
0.3	07.09.21	Sarah Garforth	Safeguarding sections updated (Luke Turnbull comments) & other updates from Helen Webster-Mair
0.4	09.09.21	Sarah Garforth	Updated following comments from Helen Wraith; and Rachel Russell (CMBC)
0.5	09.09.21	Sarah Garforth	Updated following comments from Claire Folan (CHFT)
0.6	10.09.21	Debbie Graham	Amendments throughout
0.7	10.09.21	Sarah Garforth	Updated following Medicines Management; and Safeguarding comments
0.8	13.09.21	Sarah Garforth	Updated following comments from Local Care Direct; Safeguarding; CCG Quality team
0.9	14.09.21	Helen Webster-Mair/Debbie Graham	Updated following SOG; and SMT meetings for QF&P
0.10	19.10.21	Sarah Garforth	Removal of GP email addresses for Governing Body

1. Background

NHS England and West Yorkshire and Harrogate Care Partnership Ageing Well programme have been established to support the implementation of the NHS Long Term Plan ambitions.

A key part of the National Ageing Well Programme is the establishment of urgent community response sites to support delivery against 0-2 hour and 2-day response targets. By March 2022, all systems in England must implement the two-hour crisis response standard.

This document provides details on the Calderdale Urgent Community Response ('UCR') offer and has been produced in line with the NHS England 'Urgent community response – two-hour and two-day response standards 2020/21: technical data guidance' (November 2020). This guidance states the standard service definition as "a community response is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days". Some providers offer a single, integrated service that covers all these types of care from crisis response to reablement. This is the preferred service delivery model.

Urgent community response services will be available following changes in an individual's health or circumstances. They provide a person-centred approach to optimise independence and confidence, enable recovery, and prevent a decline in functional ability. Services should have a 'no wrong door' approach and work flexibly based on need, not diagnosis/condition.

1.1 What is Urgent Community Response?

As part of the NHS' Long Term Plan to support England's ageing population and those with complex needs, local health services and council teams will begin the roll out of Urgent Community Response teams.

The national minimum requirements of the UCR is to:

- Provide services at scale: to achieve full geographic coverage of two-hour crisis response care across systems
- Provide services from 08:00-20:00, 7 days a week at a minimum
- Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111
- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard

These Urgent Response teams will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs.

Calderdale residents will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

Alongside this 0–2-hour response, a 2-day standard will also apply for teams to put in place tailored packages of intermediate tier care including reablement services for individuals where needed; to restore independence and confidence after a hospital stay.

These 0-2 hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people well at home and reduce pressure on hospital services.

1.2 Calderdale's Approach

The service aim for the Calderdale UCR is to rapidly respond to people aged 18 years or older who require a 0-2 hour response (and meet the UCR criteria) in order to prevent avoidable admissions and readmissions by managing the person safely at home with appropriate ongoing community support. Our aim is to bring this online by December 2021. This local acceleration of the national timescales has been supported by the C&GH UEC Board, and our Integrated Commissioning Executive.

There are four service elements that come together to form our new UCR service:
- Crisis response intermediate care service
- Reablement intermediate care service
- Home-based intermediate care service
- Community bed-based intermediate care service.

Whilst there is currently some level of community health and social care service urgent response in Calderdale, the Calderdale UCR service will enhance and align these services and processes to provide consistent service delivery in a fully integrated way.

A review of the geographical coverage of our current crisis response services has been undertaken across Calderdale and Kirklees. The aim is to avoid duplication in our planning. Data has been reviewed from across health and care services to inform the demand and capacity requirement of the UCR, including workforce model required to deliver it. Additionally, a review of existing pathways has been undertaken to understand; what currently works well, which services were also providing a crisis response within the 0-2 hour timescale, where there are opportunities, and the current gaps, in preparation for the expanded hours of provision from December 2021. A demand modelling exercise was undertaken in June 2021 to understand the variation in need for a 2-hour response across different times of the day, night, and week.

The future model and pathways in section 2 have been designed based on this work.

From December 2021 the UCR team will provide a 7-day, 8am-8pm service; and is expected to increase to a 24/7 service during 2022 *(timescales to be agreed following review, learning from national pilots, and national expectations).*

1.3 Who is the UCR Service for?

The service is for any Calderdale resident aged 18 years or over (including people who are homeless; vulnerably housed; or at risk of homelessness). The national criteria has been followed, with enhancements that align with the local needs of the Calderdale population (see Asterix below). The service criteria is as follows:

Inclusion criteria	Exclusion criteria
• Over 18 years of age* • Living in their home or residential/care setting** • Is in a crisis and needs intervention, within 2 hours to stay safely at home/usual place of residence • Can be living with dementia- best practice is to share responsibility of older people's mental health teams***	• Is acutely unwell or injured and requiring emergency care intervention and admission to an acute hospital bed • Is experiencing mental health crisis and requires referral/assessment by a specialist mental health team • Needs acute/complex diagnostics and clinical intervention for patient safety in hospital

*Services that provide assessment, treatment and support to patients in their home who are experiencing a health or social care crisis and who might otherwise be admitted to hospital.

** Including individuals who are homeless; vulnerably housed; or at risk of homelessness.

***Patients with mental health conditions can access UCR if they have an unplanned physical health or social care need. Patients with deteriorating mental health needs must be referred to mental health SPA.

There are a number of common clinical conditions/needs that help describe the type of patients that may require a two-hour response in a crisis. However, this list is not exhaustive, and will not be used to exclude patients from the service;

- Falls
- Decompensation of frailty
- Reduced function/ deconditioning/ reduced mobility
- Rapid change in moving and handling needs
- Palliative/end of life crisis support
- Urgent equipment provision
- Confusion/ delirium
- Urgent catheter care
- Urgent support for diabetes

- Unpaid carer breakdown
- Injury and urgent wound care

1.4 What are the benefits of Urgent Community Response?

The following benefits are described from the national expectations and early learning from pilot sites, including our colleagues in Kirklees. They are consistent with our early thinking on Care Closer to Home, and strategic direction set out in Calderdale Cares;

(a) Benefits for patients:

- Quicker access and treatment for people's urgent care needs as close to home as possible
- Greater clarity on service offers, which are patient rather than organisational led
- Increased choice to support a personalised approach
- Only having to tell their "story" once
- An improved patient experience
- Reducing the risk of hospital acquired deconditioning and reduce risks of delirium
- Maintaining people safely in their home for longer and reducing admission to a care home
- Delivery of a high quality, consistent national offer
- Available regardless of residence

(b) Benefits for service providers, referrers and their teams

- Clarity and consistency of offer and access
- A streamlined offer with clear processes and access
- Reducing confusion around multiple service offers and handoffs.
- Providing clarity around common clinical needs that require a two-hour response and common crisis assessment tools and interventions
- Enhancing and investing in community health services
- Opportunity to understand the impact of different elements of the model, their links, and opportunities for change.
- Opportunity for further learning and innovation
- Value for money, reducing duplication of offers

1.5 What is the workforce model?

(a) <u>Staffing</u>

The Calderdale UCR team will be initially available Monday-Sunday; 08:00-20:00; and is made up of:

- Advanced Clinical Practitioners (ACPs)
- Community Nurses
- Care Coordinator
- Team Leader
- Assessors (health)
- Independent Living Officers
- Rehabilitation Assistants
- Occupational Therapists

- Physiotherapists
- Pharmacists
- Handy-person(s)

(b) Access

Access into the UCR service is via Local Care Direct Hub. LCD staff comprise:

- Care Navigators (who are non-clinical) undertake the initial assessment
- ACPs who undertake the urgent clinical triage
- A Service Manager
- A Clinical Team Leader

(c) Role of LCD Care Navigators

- Receive calls from referrers
- Navigates through initial screening questions to ensure the patient fits the UCR criteria
- Add cases onto SystmOne
- Books a 0-2hr appointment to available visiting clinician using SystmOne

(d) Role of the LCD Advanced Nurse Practitioner and Physician Association

- Once the LCD hub receives the call, the referrer will be taken through a pathway by a hub clinician to determine if the patient meets the criteria for the UCR service. The questions differ dependent on the role/location of the referrer. This process will rule out any immediate life-threatening conditions and record details of the presenting condition.
- The clinician will perform a telephone/video consultation to clinically assess whether the person meets the criteria for a 0-2 hour response and/or to decide if the person requires a face to face appointment or can be completed via the phone/video assessment.
- If the person meets the referral criteria and requires a face-to-face appointment the person is remote booked into the next available appointment by creating a referral on SystmOne.
- If following remote clinical consultation by hub clinician the person does not meet the criteria for the service, the hub clinician will signpost to other services. Options include 999, GP and other community services.

(e) Role of the LCD GP

- Support clinical staff with complex triage
- Peer to peer discussions: with care homes, GPs, and community services (in longer term YAS, 111, and self-referrers)
- Assess all patient safety issues
- Available for deployed staff out in community via telephone and video to support medical optimisation and/or referral (either into hospital or onward service)
- Support governance of triage process

Referral into the service may prompt onward referral to community/social care support services as well as a requirement for a structured medication review/long-term condition review and/or care planning review, post assessment.

The UCR team made up of ACPs and appropriate qualified and trained clinicians who make face to face rapid response visits and can support the medical optimisation of people in their residence to avoid an unnecessary admission using their own autonomous clinical judgement.

For people meeting the UCR 0 to 2-hour service criteria the UCR Hub is clinically responsible for the person up to the point that the receiving provider contacts the person.

1.6 Referral into UCR

Referrals are made through LCD as shown in Appendix 4, and can be made by;

- Health and care professionals (including home care providers)
- YAS
- 111
- Self-referral

Consent for access to records will be obtained on the first phone call into the hub. This will apply for all UCR specific services. If the patient does not consent, referrer to be notified.

The service will develop a business continuity plan to describe the scenarios and actions which will take place should demand exceed capacity.

1.7 Service operating hours

Calls can be received into LCD hub between Monday – Sunday; 08:00 - 20:00. Face to face appointments are likely to take place between 10:00-19:00. Last referral time to be 17:30 to enable the team to visit if required. If no visit is necessary, the hub is open for telephone advice until 20:00.

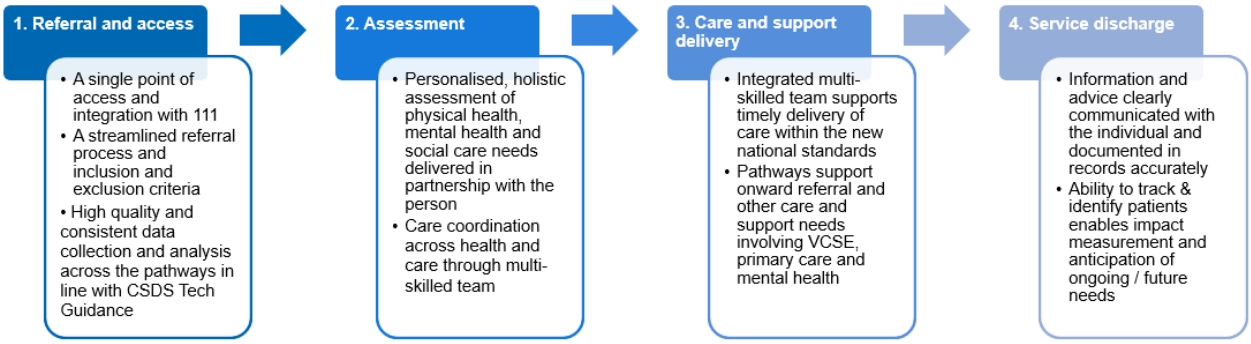
1.8 Calderdale UCR Care Pathway, Model and Referral Process

The key principle behind the model is the integration of services and ways of working, with services wrapped around the needs of the individual. The optimum delivery model will include MDT working and a single care plan, with clarity about how the service effectively steps down the individual after their episode of UCR care, back into the care of other services.

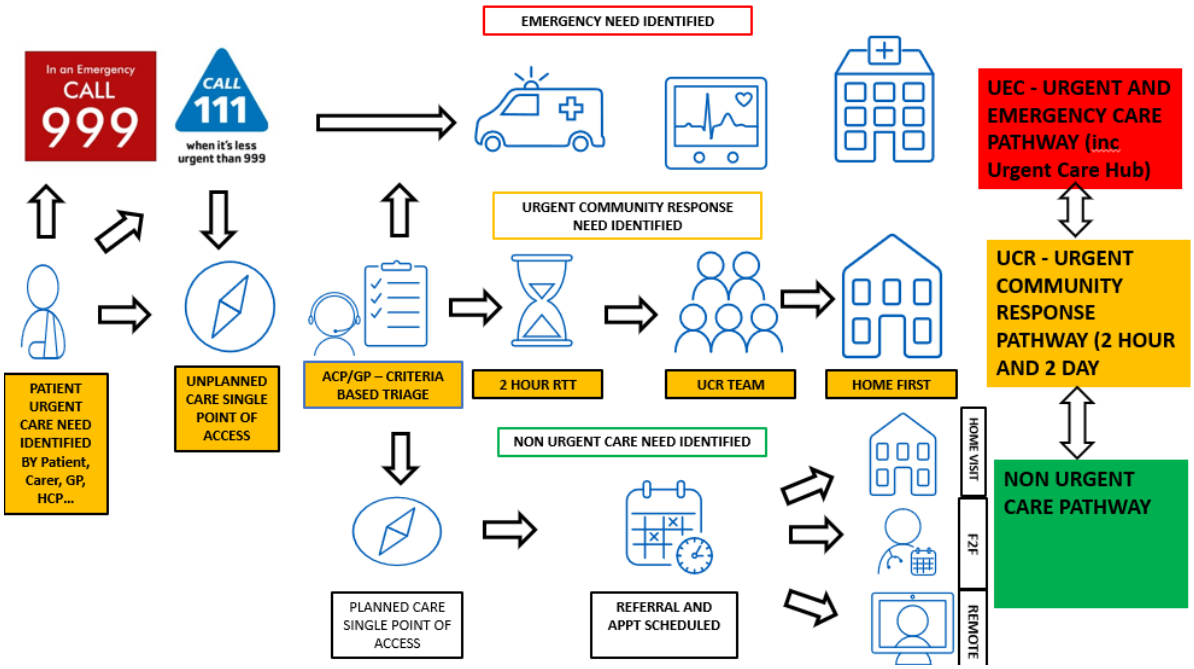
There are 3 minimum requirements for this service:

1. Provide services at scale; to achieve full geographic coverage of 2-hour crisis response care across system
2. Provide services from 8am-8pm, 7-days a week
3. Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111

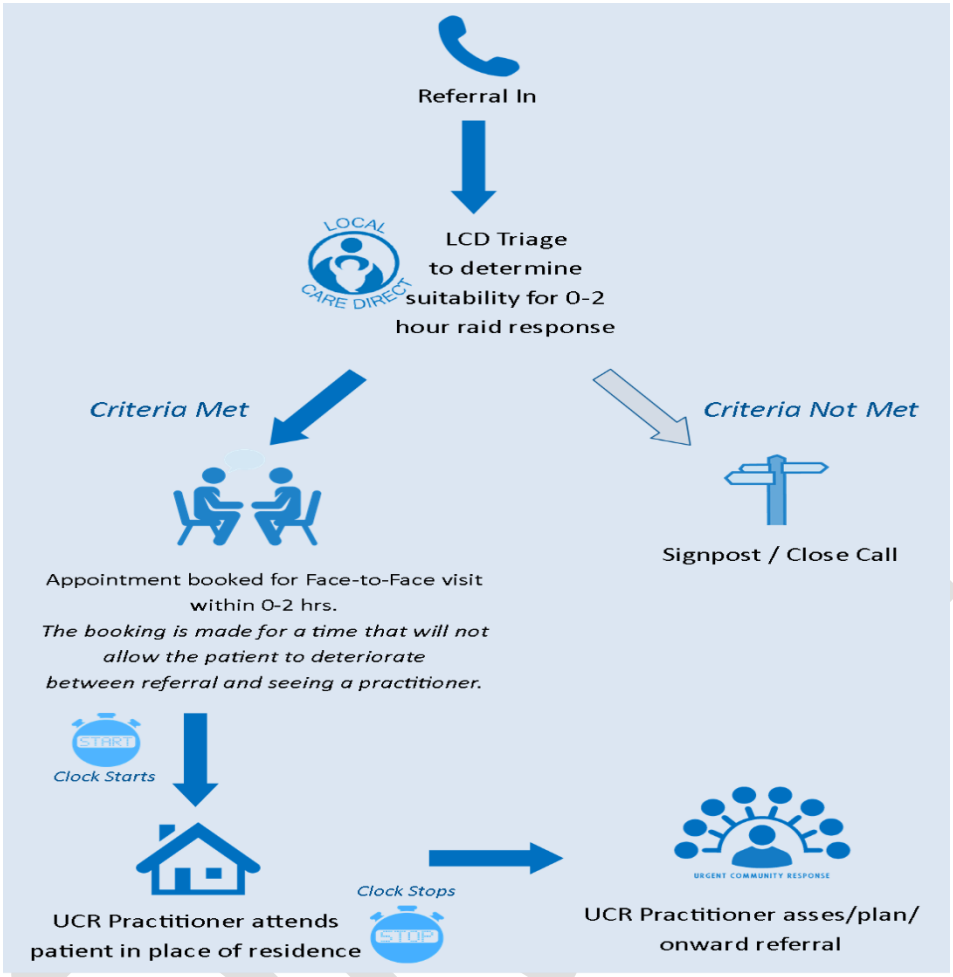
(a) The graphic below provides an illustration of the care pathway;



(b) The graphic below provides an illustration of the service model. The amber pathway is the UCR pathway. However, the red pathway (Urgent & Emergency Care), and Green (non-urgent pathway), attempts to describe the relationship between the three pathways;



(c) The graphic below provides a view of the referral process



1.9 How will the Service work for an individual patient?

- Once LCD receives the call, the referrer will be taken through a pathway by a care navigator to determine if the person meets the criteria for the UCR service. The questions differ dependent on the referrer. The care navigators use a system-wide developed script (in line with Kirklees). This process will rule out any immediate life-threatening conditions and record details of the presenting condition. If the person does not meet the criteria for the service, the care navigator will signpost to other services; the reason for not meeting the criteria will be recorded.

- If the person is deemed appropriate for the service but clinical advice is required as to whether a face-to-face appointment is required, the Care Navigator requires clinical support in triaging the case, this can be passed to an ANP within the LCD UCR hub. All referrals will undergo a clinical assessment within the hub.

- A clinician (ACP) will perform a telephone or video consultation to clinically assess whether the person meets the criteria for a 0-2 hour responses and/or to decide if the person requires a face to face appointment or can be completed via the phone/video assessment.

- A SystmOne case will be created on the LCD SystmOne Out of Hours Unit.

- If the patient meets the referral criteria and requires a face-to-face appointment the ACP will remote book the patient into the next available appointment for the UCR team on SystmOne. A Care Coordinator in the UCR team will manage all bookings.

- If following remote clinical consultation by the LCD hub clinician the person does not meet the criteria for the service, the person will be signposted to other services. The reason for not meeting the criteria will be recorded.

- People that require only social care intervention are referred via Gateway to Care processes.

- Referral information required can be seen in Appendix 1.

- If a referral is received after 17:30, the referral would be rejected by the LCD Hub for same day visiting assessment, however, telephone assessment and advice is still provided until 20:00. Following this, if further assistance is required, the referrer would be requested to seek advice from other services such as GP in hours / out of hours / extended access, 999, community services.

- Following a UCR rapid response, individuals will have an onward referral (i.e., be discharged from the UCR service) to another health or care service to support longer term needs. There is no UCR case load.

- Follow ups will be managed via tasks in SystmOne. EMIS practices will be provided with an email summary of the visit to the practice generic email provided – not to individual referring GP.

- It is expected that the UCR team monitors all referrals and identify trends or any repeated referrals, to enable a MDT review for ongoing support plans.

- For UCR visits to care homes, a verbal update will be given to the care home manager or nurse to ensure onward needs are noted and actioned. All UCR visited care home residents should be discussed at the next weekly Enhanced Health in Care Homes ('EHCH') 'home round' (MDT meeting) and the SystmOne templates will be set up to flag the residents to be discussed.

- Should visiting clinicians' IT systems fail. LCD clinicians will complete the first aspect of the form in appendix 2 and email to clinicians to continue care. The visiting clinician will email to the person's GP to upload onto their electronic patient record. Paper FP10's will be available to visiting clinician to enable the service to issue prescriptions and ensure no delay in treatment.

- Should LCD/assessment system fail, then the UCR visiting clinicians will take on role of assessment and visit.

2 Failed access

The service has a protocol for UCR visiting clinician should failed access to person's property occur;

- Review of SystmOne notes to see if any hospital admission - would be on system
- Ring person's provided numbers
- Ring Next of Kin
- Ask 2 closest neighbours either side of property if applicable
- Ring GP to check correct address
- Ring police to attend to enable access to property
- Inform Care Coordinator/Team Leader
- Consider if a safeguarding referral is required

3 Safeguarding adults at risk in Calderdale

The service will undertake its work in line with the provider organisation's internal safeguarding Adults Policy, and the West Yorkshire, North Yorkshire and York Multi-agency Safeguarding Procedures:

To raise a safeguarding adults concern, telephone Gateway to Care on: 01422 393000, or the EDT (out of hours): 01422 288000 or email:

Gatewaytocare@calderdale.gov.uk

4 Clinical Governance and Risk Management.

- All complaints, serious incidents, litigations etc will be managed through existing provider policies and procedures dependent on the UCR staff member involved.

- The organisation which receives the complaint should coordinate the response to the complaint, including liaising with other UCR providers if required. All UCR providers should share a summary of all UCR complaints received with the other UCR providers.

- On a monthly basis Clinical Governance issues will be discussed by the UCR Operational Group to ensure shared learning and support.

- All incidents and untoward events will be managed through existing provider policies and procedures

- Key partners involved in the UCR service are expected to have robust policies, systems, and processes for the management of risk that would be in place to support the safe delivery of the UCR pathway.

- Risk Management involves having robust systems in place to understand, monitor and minimise the risks to patients and staff and to learn from mistakes. When things go wrong in the delivery of care, clinical staff should feel safe admitting it and be able to learn and share what they have learnt. It is expected that providers have robust processes for audit schedules to provide assurance of compliance with all the protocols below:
  - Adherence to local and national IPC and PPE guidance
  - Complying with protocols (hand washing, identifying patients correctly, infection control etc.)
  - Learning from mistakes and near-misses (informally for small issues, formally for the bigger events – see next point)
  - Raising a safeguarding alert where appropriate (see safeguarding policies)
  - Reporting any incidents (including Serious Untoward Incidents) via Datix and to look at in the UCR Operational Group, in a regular reviewing cycle to drive quality improvement
  - Reporting all complaints, whether verbal or written
  - Assessing the risks identified for their probability of occurrence and the impact they could have if an incident did occur. Implementing processes to reduce the risk and its impact (the level of implementation will often depend on the budget available and the seriousness of the risk)
  - Promoting a blame-free culture to encourage everyone to report problems and mistakes

5 Education and Training

It is expected that staff are competent in doing their jobs and to develop their skills so that they are up to date and can meet the changing needs and complexity of patients

being cared for outside of a hospital setting. Professional development needs to continue through lifelong learning. In practice, for all clinical and care staff (this includes but is not exclusive to services such as Community nursing, and Intermediate Care), this involves:

- Attending courses and conferences (commonly referred to as CPD – Continuous Professional Development)
- Regular assessment, designed to ensure that training is appropriate
- Regular assessment of competencies. E.g., IV training / Clinical Assessment
- Annual appraisals with 6 monthly review
- UCR clinical supervision

It is expected that all staff in the UCR team will be employed by CHFT or Calderdale Council. Such employing organisations are responsible for ensuring the education and training requirements of staff.

6 Data Collection

The UCR standards require systematic collection of new data items. Commissioners and providers should ensure that this mandated data is reported to the Community Service Data Set (CSDS) and in EPR systems.

In Calderdale, data will be collated using the SystmOne module daily and the raw data will be passed through a series of validation checks. Once verified, a summary report will be generated daily to show the metrics listed below. Calderdale Council will collate data from the system 'hospital to home' for submission.

The NHS England Technical Guidance provides detailed information on the required data collection for the UCR service.

The Technical Guidance states that "Providers need to take one CSDS submission at provider level to cover all relevant services; it is not possible to make separate submissions for different aspects of the provider's services".

Calderdale and Huddersfield NHS Foundation Trust ('CHFT') will be the lead provider to submit the data to CSDS. LCD and Calderdale Council will submit data to CHFT to be included in the reporting.

The following data is required for activity:

- Number of patients referred to the UCR Hub and numbers of people accepted by source
- Number of patients not accepted
- Number of patients meeting criteria unable to be referred
- Referral source
- Clock start and stop – 0-2hr and 2day
- Diagnosis and Type of intervention

- Activities undertaken
- LOS on the service
- Destinations of patients on discharge

The other data to be reviewed includes:
- reduction in attendances at A&E
- reduction in 999 calls
- reduction in non-elective admissions

As part of its approach to quality improvement, the service will also seek to proactively gather the views on insights from service users who have used the UCR pathways. This could take the form of case studies, focus group, as well as Friends and Family Test. The aim would be to enable the service to make real time changes to the way the model works. The aim would be to include staff insights into this process to maximise learning

7 Information & IT

It is recognised that the Health and Social Care System is moving on a digital journey to support improvements in productivity, efficiencies and patient satisfaction and experience. The Calderdale UCR service will work, where possible, towards an integrated patient record and System-Wide interoperability. However, there is the expectation that the UCR providers will ensure that:
- The SystmOne UCR shared template is used across providers
- Patient data is accurate and up to date
- The NHS Number is used as the core identifier
- Confidentiality of Patient data
- Full and appropriate use of the data is made to measure quality of outcomes (e.g. through audits) and to develop services tailored to local needs
- Consent is obtained in the case of patient information sharing across agencies, including Social Services

8 Prescribing and Medicines Optimisation

Prescribers should have due regard for local and national guidance, including traffic light classifications for medicines and shared care guidance from the South West Yorkshire Area Prescribing Committee www.swyapc.org and the NHSE low priority prescribing guidance.

The persons' registered practice should be informed of any medication prescribed to as part of the urgent care encounter.

SOP Appendix 1

Referral information required for Calderdale UCR service

When you call the Calderdale UCR Hub, they will need the following information from you:

1. Contact Tel Number
2. Address Check
3. Symptoms
4. Callers Name
5. Residents Name
6. D.O.B
7. Surgery Name
8. Surgery Telephone Number
9. Has the Patient Consented to the Referral: (if not able to are the family aware and is it in the patient's best interest?)
10. What type of Referral is Needed - Rapid Response and Treatment for Care Homes? this this should all be 0-2 hour, 2 day
11. What are Patients current condition: i.e. breathless, experiencing diarrhoea/vomiting, swollen and painful lower leg etc.
12. REFERRAL GOALS AND ADDITIONAL INFORMATION – e.g. Avoid hospital admission
13. Is the Patient on the EOL Register

When the Calderdale UCR contacts you, they will require the following information:

1. Current status – including observations
2. Symptoms
   a. Past medical history (brief)
3. Special questions
   a. Is the patient breathing?
   b. Is the patient conscious?
   c. Does this patient require medical optimisation to prevent immediate admission to hospital ?
   d. Provisional diagnosis?
   e. Does the patient have an advanced/emergency care plan?
   f. Is the patient moderate or severely frail?
   g. Is the patient end of life?
   h. Exclusion criteria – fall with head or facial injury/msk deformity/Fracture / long term drug or alcohol misuse
   i. Is the patient clinically safe to wait for 2 hours ?
4. Mobility status including transfers; and access to toilet facilities during the 2-hour period
5. When did patient last see a clinician?
6. Please have all MAR sheets available

SOP Appendix 2 LCD Assessment Form if IT Fails

KEYSAFE/ANY PROPERTY LOCATION DIFFICULTIES/RISKS TO VISITING CLINICIAN

OBS:

ACP/DNACPR:

TO BE SEEN BY:

CLINICAL VISIT:

TIME ARRIVED:

TIME IN PROGRESS:

H:

E:

D:

P:

PRESCRIPTION:

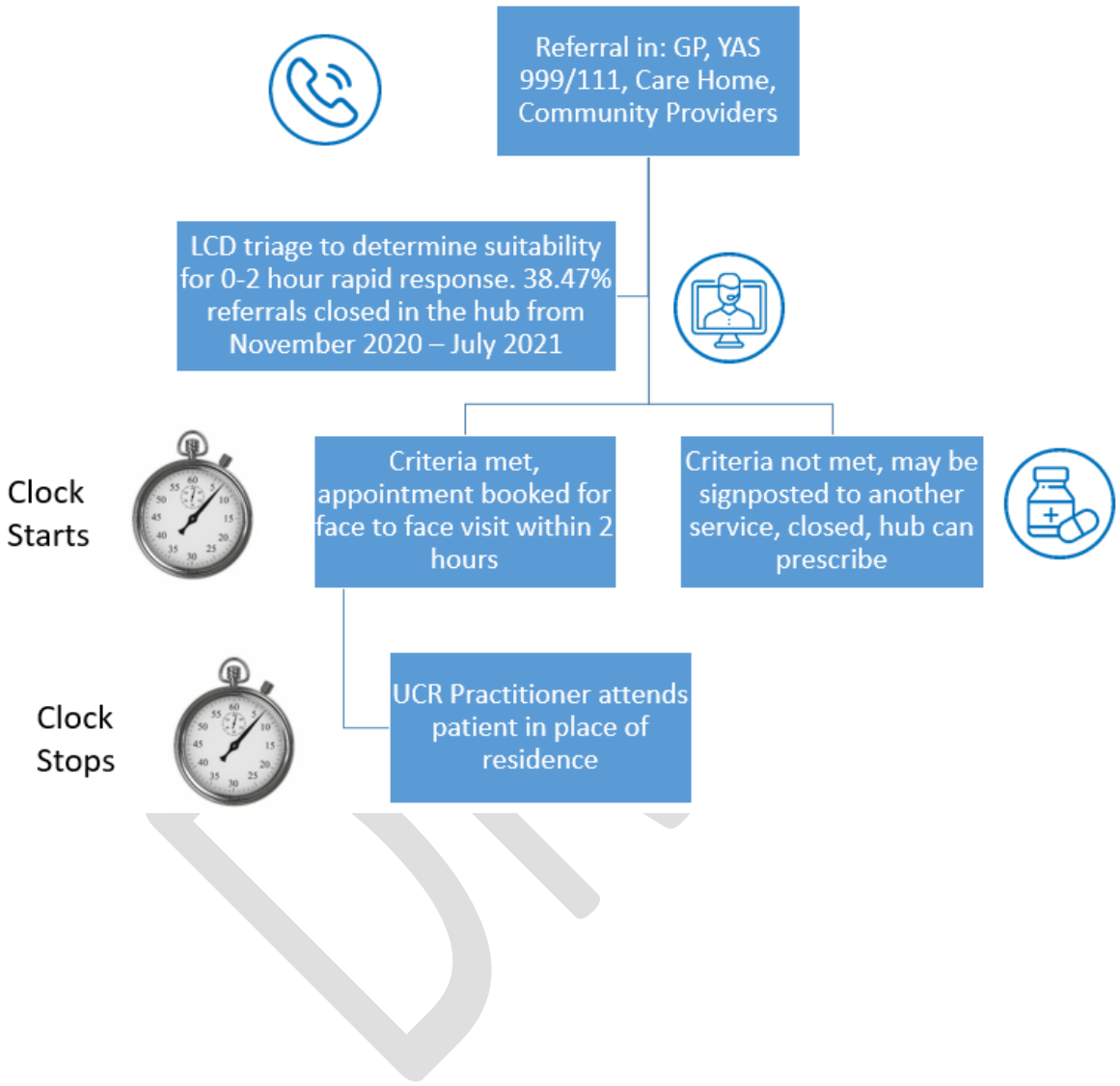
ONGOING REFERRALS:

TIME FINISHED:

SOP Appendix 3: Practice secure email addresses

Practice	Practice secure e-mail
Bankfield Surgery	*Removed for Governing Body*
Beechwood Medical Centre	
Boothtown Medical Centre	
Boulevard Medical Practice	
Brig Royd Surgery	
Calder Community Practice	
Caritas Group - Woodside Surgery	
- Mixenden Stones Surgery	
- Shelf Health Centre	
Church Lane	
Hebden Bridge Group Practice - Valley Medical Centre	
- Grange Dene Centre	
- Mini Clinic Luddenden	
Horne Street Surgery	
Keighley Road Surgery	
King Cross Practice	
Longroyde Surgery	
Lister Lane Surgery	
Northolme Practice	
Plane Trees Group Practice	
Queens Road Surgery	
Rastrick Health Centre	
Rosegarth Practice - Rothwell Mount	
- Siddal	
Rydings Hall Surgery	
Southowram Surgery	
Spring Hall Group Practice	
Stainland Road Medical Centre	
Station Road Surgery	
Todmorden Group Practice	

SOP Appendix 4 Clock Start & Stop Times for Referrals



Appendix B

Quality Impact Assessment

Concise Impact Assessment

Please complete all sections. (See instructions / comments)

Title of scheme	Urgent Community Response
Scheme lead name	Helen Webster-Mair (CHFT) – Programme Lead Sarah Garforth (CCG) – Programme Support
Scheme lead email	Helen.webster-mair@cht.nhs.uk s.garforth@nhs.net

A: Type of change	Adjust existing (i.e. enhancement)
CCG	Calderdale system (not CCG 'owned') – joint partners leading: CHFT/CCG/CMBC

B: Description of change - Describe below the proposed change to the service, why it is being proposed, the expected outcomes and intended benefits for patients. Please also include expected implementation date. (Or any key dates we need to be aware of).

NHS England and West Yorkshire and Harrogate Care Partnership Ageing Well programme have been established to support the implementation of the NHS Long Term Plan ambitions.

A key part of the National Ageing Well Programme is the establishment of urgent community response delivering against 0-2 hour and 2 day response targets in line with national directive.

As part of the NHS Long Term Plan to support England's ageing population and those with complex needs local health services and council teams will begin the roll out of Urgent Community Response teams. Currently some community health and social care services already provide an urgent response, however, the intention is to enhance the response to provide consistent service delivery in a fully integrated way. From December 2021 the UCR team will provide a 7-day, 8am-8pm service; increasing during 2022 to a 24/7 service.

The Urgent Response team will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs. Calderdale residents will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

The national minimum requirements of the UCR is to:

B: Description of change - Describe below the proposed change to the service, why it is being proposed, the expected outcomes and intended benefits for patients. Please also include expected implementation date. (Or any key dates we need to be aware of).

- Provide services at scale: to achieve full geographic coverage of two-hour crisis response care across systems

- Provide services from 08:00-20:00, 7 days a week at a minimum

- Accept referrals into crisis response services from all appropriate sources and make crisis response services accessible via 111

- Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard

Alongside this 0-2 hour response, a two day standard will also apply for teams to put in place tailored packages of crisis care, or therapy/reablement services, for individuals in their own homes (including care homes), with the aim of restoring independence and confidence after a hospital stay.

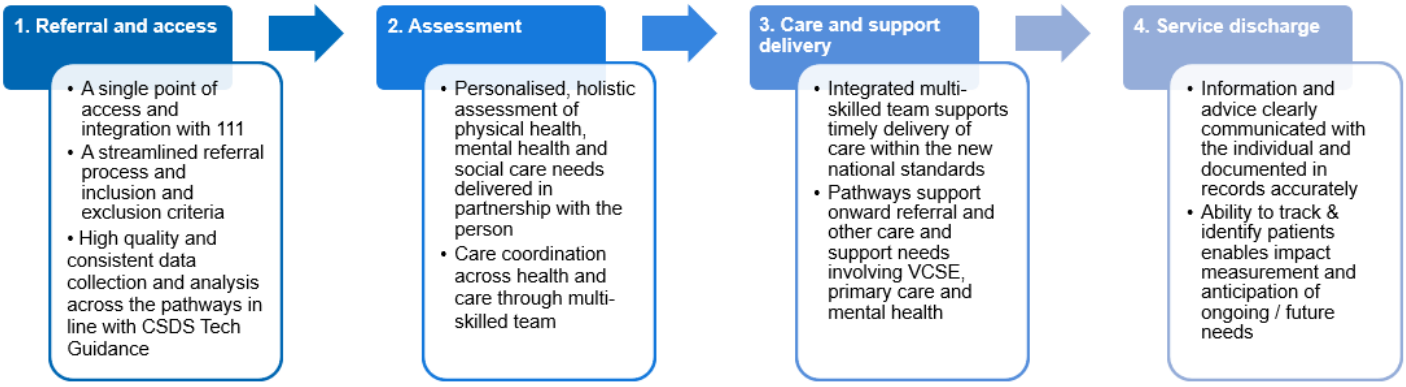
These 0-2 hour and 2 day urgent response standards are part of a range of commitments which aim to help keep adults well at home and reduce pressure on hospital services.

The service aim for the Calderdale UCR is to rapidly respond to Calderdale residents (aged 18 or over) who require a 0-2 hour response in the place of their residence in order to prevent avoidable admissions and readmissions by managing the patient at home with appropriate ongoing community support.

The criteria for individuals accessing the UCR service is set out in Appendix 1 (*note this is currently **draft)***

Five core principles underpin the design and delivery of UCR:

1. Early multi-agency identification of people in need of urgent community response at home
2. Timely and appropriate holistic assessment and delivery of care and support
3. Joined up commissioning and collaboration across health, social care, local government and VCSE
4. Personalised care planning and coordination, involving the person, carers, family and friends as required
5. High quality data collection through Community Services Data Set to monitor activity growth and outcomes and ongoing analysis of demand for the standards to inform rollout trajectory



Benefits for patients:
•Delivery of a consistent national offer.
•Available in all care environments and doesn't exclude care home residents.

B: Description of change - Describe below the proposed change to the service, why it is being proposed, the expected outcomes and intended benefits for patients. Please also include expected implementation date. (Or any key dates we need to be aware of).
•Accelerating the treatment of people's urgent care needs closer to home. •Increased choice to support a personalised approach. •Only having to tell their "story" once. •Reducing the risk of hospital acquired deconditioning and reduce risks of delirium. **Benefits for service providers and their teams:** •Providing clarity around common clinical needs that require a two-hour response and common crisis assessment tools and interventions. •Enhancing and investing in community health services. •Increased visibility of the services and impact. The UCR approach is the largest investment into Community services within the past 10 years. Access to the service is via referrals into the Local Care Direct Hub, who asses, and where appropriate, refer into the Calderdale UCR team. Referrals can be made by; (NB further detail available in the UCR Standard Operating Procedure) • Health and care professionals (including home care providers) • YAS • 111 • Self-referral Consent for access to records will be obtained on the first phone call into the hub. This will apply for all UCR specific services. Phase 1 of the roll out is aimed to 'go live' December 2021. Phase 2 (24/7) will go live during 2022 following evaluation and review.

C: Service Change Details – (Engagement and Equality)	**Yes or No**
Could the project change the way a service is currently provided or delivered?	Yes
As mentioned, some services already provide an urgent or crisis response, however, this is fragmented and not always mandated. The UCR programme is enabling services to move towards 24/7 working, which therefore improves the delivery of some current services. Engagement is happening across all health and social care and VCS partners so they are aware of the programme and the pace at which it is being implemented.	
Could the project directly affect the services received by patients, carers and families? **If yes, is it likely to specifically affect patients from protected or other groups?** see I6 below	Yes
Yes, per response above. All groups are able to access the services.	

C: Service Change Details – (Engagement and Equality)	Yes or No
Please refer to the EIA.	
Could the project directly affect staff? **If yes, is it likely to specifically affect staff from protected groups?**[1] (as above)	Yes
Staff consultations are currently underway as staff working hours may change – hours being worked will not increase, but the working times may differ. CHFT are undertaking 3 consultations with staff (45 days) – line manager conversations have already taken place and staff have intimated a positive response to the proposal. Calderdale Council is due to undertake a consultation also.	
Does the project build on feedback received from patients, carers and families, including patient experience? **If yes, what feedback and please include links if available.**	Yes
As highlighted, this is a nationally mandated programme of work. Feedback has been gathered over several years via the below engagement mechanisms which have informed the scope and work of the CCG, to ensure programmes are consistent with our thinking on Care Closer to Home, and strategic direction set out in Calderdale Cares: • CHFT collection of Friends and Family Test. • All commissioned services submit qualitative and quantitative information. • Right Care, Right Time, Right Place. • Care Closer to Home. • All partner organisations continuously monitor patient experience and use this to improve services. • Calderdale Council undertake the following: • annual perception survey (linked to the Council's vision for 2024 • statutory surveys for adult social care users (annually) and their carers (biannually). • Individual/patient feedback Due to Kirklees CCG launching their UCR service a year ago, contact has been made with the Kirklees' Complaints Manager to identify if anything has been raised which could influence the scope of the Calderdale service.	

[1] For example, would staff need to work differently / could it change working patterns, location etc.?

C: Service Change Details – (Engagement and Equality)	Yes or No
We have worked very closely with Kirklees throughout the design and implementation to use their learning to support the Calderdale model and roll out. We have also linked in with WYH colleagues, and national webinars and resources to share learning and understanding. As this is a brand new service in Calderdale, we do not have any information, however, data and demand modelling has been undertaken to design the model. Once the service has gone live, we will be reporting into the Community Services Data Set ('CSDS')which is a national requirement. We will also monitor patient and family experience and satisfaction through the FFT, and complaints. The CSDS also captures quality outcomes for patients eg in terms of treatment times.	

D: To be completed by Engagement and Equality leads only:	Yes or No
Engagement activity required Insert comments	No
Formal consultation activity required Insert comments	No
Full Equality impact assessment required Given the scope of the project and the planned expansion to 24 / 7 care the advice is to complete a full EIA to ensure all aspects and risks are mitigated and that opportunities to ensure an appropriate service is developed to meet the needs of Calderdale's diverse communities.	Yes
Communication activity required (patients or staff) Insert comments	No

E: Impact Assessment (Quality/Equality/Safeguarding)	
1. How does this project/decision impact patients?	**Quality** Safety ES1a) The UCR service aims to provide people with an urgent response so they have quicker access and treatment for their urgent care needs, as close to home as possible.

	ES1b) A telephone assessment function (LCD care navigators; and if needed, Advanced Care Practitioners 'ACPs') using robust algorithms will identify the appropriate response. ES1c) The UCR will be supported by a multi-skilled workforce from the point of triage through to the 0-2 hour visits with clinical support from Advanced Clinical Practitioners. The aim is for to provide people with a more holistic, personalised care approach: ○ The workforce comprises: ○ Advanced Clinical Practitioners (ACPs) ○ Community Nurses ○ Care Coordinator ○ Team Leader ○ Assessors (health) ○ Independent Living Officers ○ Rehabilitation Assistants ○ Occupational Therapists ○ Physiotherapists ○ Pharmacists ○ Handy-person(s) ES1d) Implementation will be phased as the workforce is identified and trained, to ensure appropriate skill mix is in place to support patient needs. Phasing the service will ensure standards and processes are embedded prior to rolling out fully to a 24/7 service. ES1e) The model is an enhancement of existing services from local providers who already meet contracting requirements around policy/procedures/ training and CQC. ES1f) The intended impacts of the UCR model are: to avoid unnecessary hospital attendance/admission; to reduce HCAIs by avoiding conveyance to secondary care; to ensure an efficient referral onto other services for ongoing support. <u>Effectiveness</u> EE1a) Clinicians have been integral to each element of the model and are involved in planning implementation. EE1b) The model will be consistently delivered across Calderdale

	EE1c) Data collection and monitoring are a key part of the national programme EE1d) The model is innovative and has been developed to meet local needs/built on best practice. The premise of the model is built around a 2 hour/2 day response. Responding to urgent needs within 0-2 hours will support medically fit patients to remain at home and avoid unnecessary hospital attendance. EE1e) Use of evaluation & learning from accelerator sites (Kirklees for example) have informed the UCR pathway. Learning from accelerator sites will assist in determining the criteria for 0-2 service and assessment algorithms EE1f) Patient records will be shared across appropriate organisations for direct patient care purposes with patient consent. Activity data will also be shared across the appropriate governance forums in Calderdale. Clear referral criteria will aid appropriate response EE1g) Appropriate patients will receive an urgent community response within 2 hours which will: Assess; Treat; Plan and avoid unnecessary hospital attendance/admission/refer onto other services for ongoing support. The patient should have to only tell their story once. Equipment is also available in the timeframe and services are being set up to be able to deliver to this timeframe. Appropriate patients will be able to access reablement services within 2 days of referral. EE1h) Ongoing monitoring will determine service capacity and inform the need to expand the service. Impact will be reviewed using data from partner organisations alongside A&E attendance/admission data EE1i) Appropriate patients will be managed at home avoiding unnecessary hospital admissions EE1j) All clinicians can access the same level of detail and information to aid clinical decision making. <u>Experience</u> EEx1a) Patient preferences will be respected from the point of assessment through to discharge/referral onto other services

	EEx1b) The model will enhance coordination/integration of care EEx1c) Sharing of records is integral to the model EEx1d) Support of self-care and personalised care planning are integral to assessments EEx1e) Access will be via referral routes EEx1f) Patients/cares will be treated sensitively and referred on for any ongoing support needs EEx1g Care-givers will be involved in decision-making and ongoing plans where ever practical and possible. EEx1h The service will be closely monitored for adherence to the 2 hour/2 day targets continuously alongside patient satisfaction measures EEx1i Plans will be tailored to individuals needs and preferences EEx1j Patients may be referred to their GP/Community services/Emergency services/other should the service be at capacity. The service will develop a business continuity plan to describe the scenarios and actions which will take place should demand exceed capacity. EEx1k Identification of ongoing support needs is part of the assessment process EEx1l Management plans will meet the needs of the patient and carer EEx1m PDSA cycles will be implemented where improvements are required in response to achieving targets and patient feedback
2. How does this project/decision impact protected or vulnerable groups? E.g. their ability to access services and understand any changes? (see notes in Section I6)	**Equality** Recommendation to complete a full EIA to consider how to maximise opportunities and design the service to meet diverse community needs.

3. How does this project/decision impact on the duty to safeguard children, young people and adults at risk (including Human Rights e.g. restrictions of liberty and adherence to Mental Capacity Act)?	**Safeguarding** All organisations have Safeguarding policies and procedures in place. People below the age of 18 years are not included within this service.
4. Are there any other impacts to consider? E.g. Workforce, organisational or system wide	4a) Delivery of the model requires building up the UCR workforce which will be supported by early release of funding to allow recruitment and training ahead of the start date. 4b) There is a risk that staff morale may be effected by delivery of the programme on top of existing pressures. 4c) The impact of the 0-2 hours element will free up capacity in general practice and some community teams 4d) A continual workforce plan will be required to maintain the service 4e) Inability to recruit adequate / appropriate workforce could potentially derail the project 4f) Stakeholder organisations have provided data around demand and capacity modelling which has informed workforce requirements 4g) New staffing will be required for the UCR Hub – some of these are from existing teams; some roles are being recruited; new hybrid roles are also in development 4h) A phased approach has been planned for all elements of the model with full staffing expected to be in place by the end of Year 1. 4i) Robust activity monitoring is required to monitor impact 4j) Early identification should demand begin to outweigh capacity or demand be low

F: Risks and Mitigations	
1. What actions can be taken to reduce any negative impacts? (If none please state so)	EE1c) Ongoing monitoring will be in place to measure demand and capacity/evaluate referral criteria etc and monitor quality outcomes for patients. Regular governance meetings are

	planned whereby these will be sighted and discussed. EE1g) Local Care Direct will deal with inappropriate referrals by assessing and sign posting to relevant services EE1f) Patients will be asked to consent to sharing their records across appropriate teams meaning the patients should only need to tell their story once. If consent is not provided, they will be referred back to the referrer. EEx1j) Patients may be referred to their GP/Community services/Emergency services/other should the service be at capacity. The service will develop a business continuity plan to describe the scenarios and actions which will take place should demand exceed capacity. 4a&e) Most of the staff are current roles that are moving into the UCR team and taking the previously urgent aspects of their role, with them. Where required, backfill is going to be put in place (looking at skill mix). Some posts are new and will be a hybrid across CCG and CMBC, work has been undertaken and continues to be ongoing to make the roles attractive (ie consistent pay bands and opportunities for career progression). This is being worked up jointly by CHFT, CCG & LA. 4b) Currently in staff consultation but anecdotal information suggests staff are happy with the proposed changes. Post 'go live' staff feedback and retention will be monitored.
2. How could the impacts and/or mitigating actions be monitored?	The data/activity monitoring of the programme will be undertaken at a local level, and also monitored nationally (and at ICS level). On a Calderdale system level, the overall programme has a strict governance process in place as described in F3. This will continue until the programme is fully rolled out in 2022, and

	regular monitoring meetings will take place following implementation.
3. Are there any communications or engagement considerations or requirements?	All partners have been involved since the outset. Briefings have gone to various governance forums across the organisations such as Integrated Commissioning Executive, Urgent and Emergency Care Board, PCN Enhanced Health in Care Homes meetings, LMC, CCG SOG and SMT; Calderdale Community Collaborative Programme Board. It is going to Quality, Finance & Performance Committee (23.09.21), CHFT Divisional Board. It is also going to Health & Social Care Scrutiny, Health & Well-Being Board and Calderdale Council Cabinet. There is a weekly Programme Task and Finish Group attended by colleagues from across the system, and this reports on a weekly basis to a 'Community Oversight Group' to maintain governance and provide assurance. Workshops are also being arranged with PCNs, care homes. Finally, comms leads from all organisations have been made aware of UCR and will be involved in disseminating messages to all stakeholders (patients, carers, and services).

G. Data Protection Impact Assessment (DPIA) is carried out to identify and minimise data protection risks when personal data is going to be used and processed as part of new processes, systems or technologies.	**Yes / NA**
Does this project/decision involve a new use of personal data, a change of process or significant change in the way in which personal data is handled? If **yes**, please email the IG Team at calccg.igsharedservice@nhs.net in order to complete the screening form.	Data sharing agreements already in place

H: Decision/Accountable Persons	
1. Agreement to proceed?	Yes / No Delete as appropriate and add detail or rationale

2. Any further actions required?	E.g. risk to be added to COVID-19 Programme Risk Register
3. Names and roles of accountable decision makers	Rhona Radley, Deputy Director of Improvement (Acute and Community), C CCG
4. Date of decision	Calderdale QFP 23rd September 2021

I: For Team use only	
1. Reference	IA/35
2. Form completed by	Helen Webster-Mair (CHFT) – Programme Lead Clare Wyke, Quality Improvement Lead, CCG Sarah Mackenzie-Cooper, Equality and Diversity Manager, CCG Sarah Garforth, Project Coordinator (Service Improvement), CCG Catherine Borrill, Quality Improvement Lead, CCG Lucy Walker – Quality Manager – NHS Calderdale CCG.
3. Form agreed to be decision ready on	14/09/2021
4. Proposed review date	March 2022
5. Notes	

6. Equality considerations	In order to answer C and E2 the groups that need consideration are; Protected characteristics; age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation (Use the hyperlinks for further information)

	Other groups would include, but not be limited to, people who are; carers, homeless, living in poverty, asylum seekers / refugees, in stigmatised occupations (e.g. sex workers), problem substance use, geographically isolated (e.g. rural) and surviving abuse

J: Review (to be completed following implementation).	
1.Review completed by	
2.Date of Review	
3.Scheme start date	

4. Were the proposed mitigations effective? (If not why not, and what further actions have been taken to mitigate?) Put details in box below

5. Is there any intelligence/service user feedback following the change of the service? If yes, where is this being shared and have any necessary actions been taken as a result of any feedback? Put details in box below

6.Overall conclusion Please provide brief feedback of scheme in box below i.e. its function, what went well and what didn't.

7. What are the next steps following the completion of the review? Provide next steps in box below i.e. Future plans, further engagement/consultation required?

Appendix 1; **Draft** Criteria:

Inclusion Criteria:

- Over 18 years of age*
- Living in their home or residential/care setting
- Is in a crisis and needs intervention, within 2 hours to stay safely at home/usual place of residence
- Can be living with dementia - best practice is to share responsibility of older people's mental health teams**

Exclusion Criteria:

- Is acutely unwell or injured and requiring emergency care intervention and admission to an acute hospital bed
- Is experiencing mental health crisis and requires referral/assessment by a specialist mental health team
- Needs acute/complex diagnostics and clinical intervention for patient safety in hospital

** Services that provide assessment, treatment and support to patients in their own home who are experiencing a health or social care crisis and who might otherwise be admitted to hospital.*

***Patients with mental health conditions can access UCR if they have an unplanned physical health or social care need. Patients with deteriorating mental health needs must be referred to mental health SPA.*

For information, these are common clinical conditions or needs that may lead to a patient requiring a two-hour response in a crisis. This list is **not meant to be exhaustive or used to exclude patients**.

- Fall
- Decompensation of frailty
- Reduced function/ deconditioning/ reduced mobility
- Palliative/end of life crisis support
- Urgent Equipment provision
- Confusion/ delirium
- Urgent catheter care
- Urgent support for diabetes
- Unpaid carer breakdown

Appendix C

Equality Impact Assessment

Project Name	Urgent Community Response Service	**Project Objectives**
Project Lead	Rhona Radley Helen Webster-Mair	The Urgent Community Response (UCR) Service is a national programme with an aim to treat urgent issues in the community and avoid unnecessary hospital attendance/admission. The UCR model includes the following elements; a triage hub, a 2 day response for intermediate care and a 0-2 hour response for urgent clinical/social issues.
Clinical Lead	Helen Davies	
Equality Lead	Sarah Mackenzie-Cooper	
SRO	Debbie Graham	
EIA Status	Positive	
Sign off date	23rd October 2021 at QF&P	

1.0 Evidence-Base

What evidence has been used to inform this assessment?

NHS England and West Yorkshire and Harrogate Care Partnership Ageing Well programme have been established to support the implementation of the NHS Long Term Plan ambitions.

A key part of the National Ageing Well Programme is the establishment of urgent community response delivering against 0-2 hour and 2 day response targets in line with national directive and guidance.

The aims of the Ageing Well agenda, both at system and at place, are to enable an overall improvement in the health and wellbeing of our older populations, based on population health principles and as part of a wider 'left shift', where services are increasingly integrated and provide proactive and personalised support around what matters to individuals, at home and close to home.

The Partnership's Ageing Well programme was formally established at the start of 20-21. The programme forms part of the remit of the Primary and Community Care Board and includes a specific focus on transformations within community health services. The initial phase of the programme was affected by the immediate priorities of Covid-19 resulting in on-going work to build an approach that meets the Partnership's ambitions for Ageing Well, consistent with our Five-Year Strategy and the 'three tests', enabling delivery of national Long Term Plan priorities whilst also supporting and bringing together developments at place.

The national scope set out in the Long-Term Plan which focusses on community physical health services for adults and encompasses:

- Urgent Community Response – development of community-based two-hour urgent care and two-day reablement services for adults of all ages.

- Enhanced health in care homes – implementation of the national EHCH framework across primary care and community health services.
- Anticipatory Care – a model for delivery of proactive, personalised and preventative care, based on population health management principles and support through MDTs, which is intended for adults of all age.

As part of the NHS Long Term Plan to support England's ageing population and those with complex needs, local health services and council teams will begin the roll out of Urgent Community Response teams. In addition, Local Care Direct will provide the 'single and integrated point of access' for people requiring crisis support.

Local activity has been reviewed to inform the scope of this model, such as: referrals into CHFT Frailty team; >18 years admissions which focussed on avoidable admissions for adults; 0-1 day length of stay (volume of referrals into frailty team over time; day of referral & time of referral). Kirklees' UCR activity and heat map was also analysed to help scope the Calderdale model.

Currently some community health and social care services already provide an urgent response, however, the intention is to enhance the response to provide consistent service delivery in a fully integrated way. From December 2021 the UCR team will provide a 7-day, 8am-8pm service, increasing during 2022 to a 24/7 service.

The Urgent Response team will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs. Calderdale residents will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

Alongside this 0–2-hour response, a two-day standard will also apply for teams to put in place tailored packages of crisis care, or therapy/reablement services, for individuals in their own homes (including care homes), with the aim of restoring independence and confidence after a hospital stay.

These 0-2 hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people aged 18 or over, well at home and reduce pressure on hospital services.

The service aim for the Calderdale UCR is to rapidly respond to Calderdale residents including vulnerable adults and socially deprived groups (aged 18 or over) who require a 0–2-hour response in the place of their residence to prevent avoidable admissions and readmissions by managing the patient at home with appropriate ongoing community support. This includes people who are homeless; vulnerably housed; or at risk of homelessness.

The NHS England, November 2020, Urgent Community Response – two hour and two-day response standards – technical data guidance includes the following statement on reducing health inequalities:

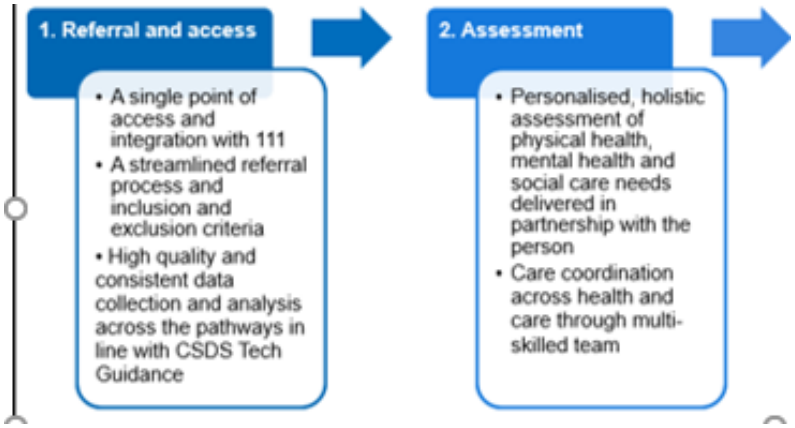
"Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement's values. Throughout the development of the policies and technical guidance defined in this document we have given:
• due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it

• regard to the need to reduce inequalities between patients in equity of access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Scope of service

Single Point of Contact: Local Care Direct will act as the SPoC for the UCR service. Contact is via the telephone with requirement to respond within 2-hours. Referrals are made from health and care professionals, or self-referral.

Care Navigators will undertake the initial assessment and Advanced Clinical Practitioners will undertake the urgent clinical triage (see UCR SOP for further details).



Referral criteria: Lives in Calderdale and is registered with a Calderdale GP and living at home address (including vulnerable adults and socially deprived groups); aged over 18 years and meets the UCR criteria (see UCR Standard Operating Procedure 'SOP' for the full criteria).

Referrals accepted from: Health and Care professional and self-referrals.

Hours of operation: 7-day services, 8.00 am to 8.00 pm starting December 2021. With the intention to roll out this service to a 24/7 service in 2022

Latest evidence base including:

British Geriatric Society, 2011, Quest for quality
British Geriatric Society, 2016. Effective healthcare for older people living in care homes
Care England, 2017. System transformation and care homes: a discussion document
Connecting for Care, Wakefield Vanguard, 2016/17, End of Year evaluation report
Healthwatch, 2017. What's it like to live in a care home? Findings from the Healthwatch network
Posted on 10/08/17
Joseph Rowntree Foundation, 2008, Improving care in residential care homes: a literature review
Kirklees Joint Strategic Needs Assessment, 2017
Kirklees Care Home Strategy, 2016
Loughborough University, Institutional Repository, 2009. Managing resources in later life: older people's experience of change and continuity.
National Audit of Intermediate Care, 2018
NHS England, 2019, Ageing Well Programme
NHS England, 2014. Safe, compassionate care for frail older people using an integrated care pathway
NHS England, 2017, Next steps Five Year Forward view.
NHS England, Quick Guide: Clinical Input into Care Homes
NHS England, New Models of Care, 2017. Enhanced Health in Care Homes – Vanguard learning guide

NHS England, 2018. Care home pharmacists to help cut overmedication and unnecessary hospital stays for frail older patients
NHS England, November 2020, Urgent Community Response – two hour and two-day response standards – Technical Data Guidance
NICE, 2015. Older people in care homes - Local government briefing [LGB25]
NICE, 2017, Intermediate care including reablement [NG74]
NIHR, 2017, Research on living well, ageing well and dying well in care homes
The Health Foundation, 2017, Briefing: The impact of providing enhanced support for care home residents in Rushcliffe
The Kings Fund, 2010, An inquiry into quality of general practice in England
The Kings Fund, 2017. Enhanced health in care homes – learning experiences so far
http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework
https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/preventing-frailty/
http://www.firstresponsetraining.com/news/new-frailty-framework-launched-for-providing-care-and-support/
https://www.longtermplan.nhs.uk/
https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

National and local research

Local demographics / Census data	Approximately 211,500 people live in Calderdale (latest district-level population projections published in March 2020). Projections indicate a period of relatively steady population growth over the coming years, with the total district population projected to grow by around 3,200 between 2018 and 2028 (a 2% increase). The largest growth in population in the next ten years is expected to occur in the older age groups We are likely to see: • The number of people aged 75 - 84 increase by 41% by 2028. • The number of people aged 65 and over increase by 20%. • A small reduction in the number of working age residents aged 18 - 64 (2%). Within that age group, (45 - 54 age group expected to fall by 13.6%); (55 to 64 age group expected to increase by 12.1%). • During the period 2017/18 up to 2019/20 there was despite a 1.3% growth in the population.
Service user equality monitoring data Analyse service user data by protected groups	No data currently available. The service is due to commence Dec 2021; equality monitoring will be part of the specification. The provider will be required to collect, analyse, report on and address equality information. This will help us understand who the service is reaching or otherwise.
Patient experience data e.g. Complaints/Compliments/PALS, national and local patient surveys, Friends and Family test	Patient experience and satisfaction exercises will be undertaken to gather feedback during the rollout of this service by providers. This feedback will be equality monitored to enable the provider to understand if all groups are having similar experiences and where necessary the provider will develop actions to address any inequalities.
Engagement and consultation activity What are the key findings relating to the protected groups?	The Calderdale Community Services, engagement and consultation mapping 2013-19 report, pulled together all the engagement and consultation activity that had taken place in Calderdale from March 2013 to August 2019 on services that directly or indirectly relate to community. This feedback has been utilised to form the CCG Care Closer to Home Prospectus. The Calderdale UCR work has been built on the principles of the C3PB which were based on the outcome of the CC2H Prospectus.

	The need for a multi-agency working was key from the engagement consultation, for example: - triage for a timely response from a single point of access so people only had to tell their story once. - Integrated and personalised care plans, through coordinated care - Delivering more services closer to home. This is important especially for those who are on no or low incomes, older people aged 65+, carers, disabled people and people with impairments, people with long term conditions and parents The hub and 0-2 hour response service will support these needs by creating a single point of contact provided by LCD, virtual team and by enhancing service hours and moving to 7-day services. A common theme was around "ensuring that patients receive the right care, in the right place, at the right time and spend as little time as possible in an acute hospital bed". The UCR service aims to treat urgent issues in the community and avoid unnecessary hospital attendance/admission.
Information from other agencies, e.g. Healthwatch, Community groups and other stakeholders	The model has been developed via The Calderdale Collaborative Community Partnership Board (3CPB) which is the provider and commissioner Alliance which includes the following organisations: • Local Care Direct • Locala • SWYPFT • Overgate Hospice • 5 Primary care Network Clinical Directors • VAC Third Party Voluntary • Calderdale Council (Provider, Commissioner and Public Health) Social Care Services • WY Pharmacy • CCGs • CHFT
Any other evidence?	A demand modelling exercise was undertaken by Business Intelligence in June 2021 to support the development and agreement of trajectories for the Calderdale UCR programme for 2021 to 2022. The fundamental tenet of UCR is admission avoidance The modelling followed a series of steps: Step 1 – an investigation to identify the potential for admission avoidance based on emergency admissions Step 2 – The data from step 1 was refined to show admissions by day of week

	Step 3 – Local CHFT data was looked at, as this data, unlike the national data, shows time of admissions Evidence continues to emerge through the Ageing Well programme and UCR Accelerator site experience and has been incorporated into the NHSE Technical Guidance, November 2020. Equality learning will continue to be shared by the existing accelerator sites.

2.0 Equality Impact Assessment (EIA)

Describe the actual or potential impact (positive and negative) of any proposed changes on the following groups:

Group	Impact and evidence used	Actions / Mitigation
General Issues	This service is planned to be an enhancement for people who might be at risk of a hospital admission and to enable people to stay out of hospital or leave hospital in a supported and managed way, with an urgent care service. The response will be triaged and will be either within 2 hours and within 2 days. This will enable people to stay safely and independently in their own homes, a preferred outcome for most. To access the service they will need to be referred by a professional (this will later extend to self-referral) The calls will be triaged through a single point of contact. Access to the service will be via referral from health and social care professionals other than appropriate patients who have an Emergency Care Plan (ECP) in place who will be able to self-refer (or their family carers) People who have ECPs in place will need to be made aware of the self-referral service, ensuring the UCR model is communicated clearly across all services and patient groups. The SPoC will be accessible to those with sensory and other impairments or language needs, for example translator services available.	When self-referrals are made, a clinical triage will be undertaken to ensure that each referral will benefit from the available service by meeting the requirements of severe frailty and an existing ECP/ACP. Otherwise, the only way into the service for urgent issues is via the existing routes (GP/111/999) There will be a single point of contact that is responsive and appropriate to meet people's needs as part of the 0-2hr and 48hr response. A communication and engagement plan is in development to ensure all stakeholders understand the model and how to refer into UCR. All UCR staff will have good communication skills and have completed equality and diversity and other appropriate training. Once self-referral is enabled the SPoC will need to be able to respond to people who have additional communication needs, languages, BSL or other need. The SPoC will need to respond to people who are distressed and vulnerable. Whether that is the patient or their family / carers.

	Staff who respond to UCR calls will be responsive to patient / service user needs and be able to respond in culturally sensitive and appropriate ways.	
Age	Service is for eligible people from 18 years and over. It is expected that most users will be older people. Care home staff will need to be fully aware of the provision to avoid unnecessary hospital stays.	This is for all Calderdale residents including vulnerable adults and socially deprived groups. As a new service people may not understand how / when it will provide assistance. Communications will need to be developed to raise awareness of the service and its provisions – particularly when self referral is enabled. These communications will need to be shared with stakeholders to build confidence in the responsiveness of the service to meet need.
Disability	People with disabilities will be included in this cohort where the service is relevant to their needs. They may have additional communication and physical needs which the staff will need to be able to respond to in the urgent window. Communication needs to be developed with all types of disability in mind.	The UCR service model will require meeting the Accessible information standard and communication of options for people who cannot use the telephone and provide access to BSL interpreters where needed. The staff team responding may need additional training to respond effect
Gender reassignment	Transgender people may have differential experiences of health care services, including discrimination, leading to a lack of trust in services. Appropriate support is critical, using the correct pronouns, respecting identity.	The UCR service model will require provision of training for staff on working with people undergoing gender reassignment or who identify as Transgender.
Marriage and civil partnership Employment only	N/A	
Pregnancy and maternity	Very few people who are pregnant are likely to be included in this cohort. Support from maternity services will be required for this group.	The UCR service model will require development of processes to refer back to general practice / maternity services where pregnancy affects any care decisions.
Ethnicity	People from different ethnic backgrounds will be included in this cohort. They will need to feel they are being supported by culturally confident staff	The UCR service model will require meeting of communication needs for different languages and provide interpreting services. Comms plan to pick up and address the needs of Black Asian and minority ethnic

	who will meet their or their loved ones needs safely. Staff will need to be able to access language support and not rely on family translators and give people support in their first language as people in crisis are more likely to need reassurance and support.	people and will consider co-production of materials and reflection of themselves in the images used, to ensure the service is highlighted to and is something that Black Asian and minority ethnic communities are aware of. Staff will be trained to support people in their homes in culturally competent ways
Religion or belief	The UCR cohort will include those with different religions or beliefs by accommodating for and understating the impact faith may have and any additional needs for these groups and the role this may play in affecting their access to care and the appropriate provision.	The UCR service model provider will require awareness of the needs for different religions and beliefs through appropriate training. Comms plan to pick up and address the needs of people of faith and will consider co-production of materials and reflection of themselves in the images used. This will be in place and relevant as part of phase three. This would be linked to the emergency plan as the gateway to self-referral.
Sex	Both female and male people will be included in this cohort, with the added recognition that women often live longer than men, so may be overrepresented in the service.	
Sexual orientation	LGB people may have differential experiences of health care services, including discrimination, leading to a lack of trust in services. Older LGB people may have their sexual orientation erased or denied in services.	The UCR service model will require awareness of the needs of people with different sexual orientation through appropriate training. Comms plan to pick up and address the needs of LBG people and will consider co-production of materials and reflection of themselves in the images used.
Carers	Good communication with carers is an essential part of decision-making and planning care. Carers will need their confidence built to be able to trust this service to respond effectively. This could be paid carers in care homes or family carers. Otherwise people may still be directed to A&E.	The UCR service model will require that carers have the opportunity to contribute to decisions and care planning. They can be part of the self-referral process where individuals cannot refer themselves.
Any other groups e.g. people from low income backgrounds,	All adult can access the UCR service irrespective of income; background or housing.	Work with groups that support those who are vulnerably housed, homeless or with other needs to understand whether this service can flex to meet those needs.

rural communities, homeless people, asylum seekers and refugees	Where people are vulnerably housed or located in temporary accommodation services will need to be triaged to ensure they can adequately meet the need in the environment.	
Human Rights		
Health Inequalities Refer to Public Health Information such as JSNA	The UCR service will initially be phased in to allow for operational testing and develop the workforce. Phase 1 - commences Dec 2021 and is focused on 7-day service 8.00 am to 8.00 pm. Phase 2 – roll out to 24/7 service by 2023	

3.0 Action Plan

Describe the actual or potential impact (positive and negative) of any proposed changes on the following groups:

Action	Timescale	Lead
The UCR service model will require provision of training for staff on working confidently with people of different backgrounds and needs; including ethnicities, sexual orientations, impairments, faiths and/or gender identities.	By service launch December 2021	UCR Programme Lead
A communication and engagement plan is in development to ensure all stakeholders understand the model and how to refer. This will be extended to be suitable for service users / their carers when self-referral is available.	By October 2021	UCR Programme Lead
The UCR service model will require development of processes to refer back to general practice / maternity services where pregnancy affects any care decisions.	By December 2021	UCR Programme Lead
The UCR service model will meet the Accessible Information Standard, understanding and meeting patient needs and communication options for people who cannot use the telephone and provide access to BSL / other interpreters where needed.	From April 2022 onwards	UCR Programme Lead
Self-referrers (inc carers) SPoC will triage service users to ensure they have are eligible and able to access / benefit from the service if not they will be advised to approach the usual routes for urgent care needs (GP/111/999)	From April 2021 onwards	LCD
The UCR service model will meet the language communication needs of service users provide interpreting services for triage and for service delivery	Dec 2021 onwards	UCR Programme Lead
The UCR service model will, where consent is in place, ensure carers have the opportunity to contribute to decisions, care planning and to self-refer their cared for.	Dec 2021 onwards	UCR Programme Lead

Patients who have an ECP/ACP understand how to use the service will be supported to understand how the service works and how they / their carers can refer to the service to help in an emergency to avoid hospital admission. A communications plan will be developed reflecting the service users needs and to build confidence for them and their carers in the service	By Dec 2021	UCR Programme Lead

Add rows as required

4.0 Implementation			
	Name of individual, group or committee	**Role**	**Frequency**
How will the impact and effectiveness of the actions be monitored and reviewed?	UCR Operational Group	Monitor impact and effectiveness	Via monthly meetings
How will these actions be embedded into mainstream activity?	UCR Operational Group	Through monitoring delivery of a service which meets the service model requirements	Via monthly meetings
Who will review the outcome of the proposed changes and when?	UCR Programme Lead	As per suggested timescale	As required

5.0 For Equality Lead Only	
Subject Matter Expert sign off	
Equality Lead	Sarah Mackenzie-Cooper
Recommendations	The EIA sets out the requirements to establish this service, it will need to be updated as the service is designed and delivery is started to ensure all issues have been captured and are being addressed to ensure the service is culturally competent, accessible and delivering to all the communities in Calderdale
Date	14/9/21
6.0 For SRO Only	
SRO Sign off	
SRO	
Recommendations	
Date	

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Calderdale and Huddersfield Reconfiguration – Letter of Support**	**Agenda Item No.**	9
Report Author	Lesley Stokey, Director of Finance	**Public / Private Item**	Public
GB / Clinical Lead	-	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary

The following slides provide the Governing Body with: -

- An update in respect to the next stage in relation to the business case for the reconfiguration of the Calderdale and Huddersfield Hospital sites
- A timeline in respect to the letter of support for the two parts of the reconfiguration
- A review of the financial tests in respect to the financial impact of the business case to the CCG
- Overview of the financial diligence and costs in respect to the YAS costs attributable to the reconfiguration of services

Previous Considerations

Name of meeting	NA	**Meeting Date**	
Name of meeting	NA	**Meeting Date**	

Recommendations

The Governing Body are asked to:

1. To provide approve that two letters of support are provided from the CCG to NHS England and Improvements in relation to the Full Business Case for Huddersfield Royal Infirmary and the Outline Business Case for Calderdale Royal Hospital.

Decision ☒	**Assurance ☐**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	None identified.
Resources / Financial Implications (including Staffing/Workforce considerations)	As outlined in the paper
Sustainability Implications	None identified

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	• Achieving the agreed strategic direction for Calderdale • Improving value	**Risk (include risk number and a brief description of the risk)**	None identified.
Legal / CCG Constitutional Implications	None identified.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest arising from this paper will be managed in accordance with the CCG Management of Conflicts of Interest Policy.

CHFT Reconfiguration – Letter of Support

Timeline and required action

- In 2019, the CCG provided a letter of support of the reconfiguration of CHFT. This was required, due to the size of the scheme as part of the SOC process
- This was following approval of the outline business case financials presented to Governing Body in April 2019
- The next stage of this process is to support the Final Business Case for the first part of the scheme relating to HRI and the second part of the scheme the Outline Business Case (OBC) for CHFT
- The CCG originally in April 2019, in order to provide support, measured the business case on a 3 financial test principle –

1. Does it improve the system financial position?
2. Do we agreed with the financial assumptions made
3. Are the plans affordable

- The Governing Body is asked to provide <u>two letters of support</u> in relation to the Reconfiguration of Calderdale and Huddersfield Foundation Trust as part of the approval route.

CCG Letter of Support

- The CCG is required to provide two letters of support for both the HRI and CHT business cases (these have now been split – this is due to NHSE capital requirements).

    1. Letter of Support for the HRI Final Business Case in October 2021
    2. Letter of Support for Calderdale in December 2021

- The letters of support should outline the following:

    - The CCG's commitment to the scheme
    - That is aligns to the strategic aims of the CCG
    - Support of the Activity and Income assumptions of the Business Case
    - Overview of the Position of the Consultation

- It is important to note our role as a CCG is not to provide the financial due diligence of the business case – that is the role of the Trust and NHS England/Improvement

- The focus of these slides is the finance aspects of the business case and assuring that the 3 financial test principals continue to be met.

Test one – Does it improve the system financial position?

- **Original 2019 Assessment:-**

- The reconfiguration has estimated savings of £10m p.a. for CHFT
- The CCG is projecting to continue a breakeven position
- The Trust is expected to breakeven in 2027 (without central support) following the reconfiguration
- The reconfiguration will help towards the removal of reliance on central support from NHS funds

- ***Updated 2021 Assessment:-***
- ***No change to assumptions in respect to growth or income assumptions from the original SOC***
- ***The reconfig is financially beneficial when compared to the Business as Usual or Do nothing options***
- ***Out continued financial target continues to be breakeven for the CCG***
- ***There are caveats due to the unknowns with allocations, but not expected to impact the targets in Business Case. The Trust has raised this with NHSE/I***
- ***The Reconfiguration is expected to deliver significant social and economic benefits***

Test two – Do we agree with the financial assumptions?

Original 2019 Assessment :-

- The 19/20 Trust and CCG activity and finance plans align
- The activity is expected to grow on an annual basis at the projected levels.
- It is expected from 19/20 growth in Day Case, Elective and Outpatients will be at 0%. This value is net of transformation and service delivery (growth contained).
- From 2025/26 growth in A&E and NEL growth will be at 0%. This is due to the impact of ongoing service transformation and delivery (growth contained expected)
- Trust growth assumptions do not exceed CCG allocations (except 20/21 – see below)
- Within 20/21 MRET adjustment will be paid via CCG tariff rates - allocation does not reflect at this stage
- Growth higher up until 25/26 when average drops to 1.6%-1.7% for length of business model
- Tariff rates included – reflect national assumptions

- **Updated 2021 Assessment :-**
- ***No changes to assumptions to date, all the same in line with income and growth assumptions, previously presented***
- ***Final business is still to be reviewed by the CCG, but the changes do not alter the assumptions from original at this stage***
- ***There is an expectation that CCG/ICP will move into population based budgets again from 22/23, with contracts resuming. It is expected that this will not alter our previous position around support***
- ***The efficiency targets of the Trust are in line with national assumptions – if not slightly higher and not unreasonable. A number of projects are linked with system working***

Test three – Are the plans affordable

- **Original 2019 Assessment:-**
- CHFT income assumptions realistic and affordable to CCG.
- SOC maintains acute bed base and therefore not reliant on out of hospital investment.
- McKinsey report recognised additional investment of circa £6m per CCG for out of hospital care to be best in class.
- Out of hospital investment will therefore progress in line with affordability.
- The CCG has started to build in additional funds within 19/20 plans to support the development of out of hospital services.
- YAS costs yet to be determined but expected to be affordable at this stage.
- The SOC identify no other additional costs for the CCG

- ***Updated 2021 Assessment:-***

- **No changes at this stage – the CCG has started the out of hospital investment strategy. This has been expedited by Urgent Care Response pilot, Ageing Well release of funds and investment into primary care services**
- **Based on current modelling these plans are affordable – this would only change is growth and income assumptions change – this is not expected or any significant changes to our allocation – again not anticipated**
- **The additional YAS costs have been quantified at approx. £0.7m pa (CCG share).**

Conclusion & Recommendation

- Whilst the final business case numbers will be reviewed in the forthcoming weeks. The CCG has been working closely with the Trust and there are no known changes made since the SOC that impact the financial assessments already undertaken by the CCG.
- The reconfiguration generates both financial savings for the health system but has significant social and economic benefits – these will have a major positive impact to Calderdale and its population
- Whilst there are additional costs relating to YAS and ambulance costs – this increase is approx. 0.2% of the CCG cost base and therefore deemed affordable
- There are potential savings in relation to Patient Transport Services and general transport services that may reduce these gross costs for the system
- It is deemed all 3 financial tests have been met

Recommendation – The Governing Body is asked to approve that two letters of support are provided from the CCG to NHS England and Improvements in relation to the Full Business Case for Huddersfield Royal Infirmary and the Outline Business Case for Calderdale Royal Hospital.

Name of Meeting	**Governing Body**	**Meeting Date**	28 October 2021
Title of Report	**Director of Finance Report**	**Agenda Item No.**	10
Report Author	Lesley Stokey, Director of Finance	**Public / Private Item**	Public
GB / Clinical Lead	-	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary

Finance

- The CCG continues to operate under temporary financial arrangements due to the impact of Covid-19.
- The CCG submitted a draft financial plan in April for the period April 2021 to September 2021. The plan was to achieve a balanced position for that 6-month period.
- The CCG is currently forecasting an overspend due to expenditure items which currently fall outside of our baseline allocation. Additional allocations are expected to be received to match against these costs.
- The CCG has a revised QIPP target of £2.0m for H1.
- Planning guidance for the period October to March was issued on 30th September.
- The ICS has received allocation notification and CCGs and Providers are drafting financial plans with the ICS submission due on 16th November.
- The CCG has developed plans to deliver the Mental Health Investment Standard in 2021/22.

Contracting

- To update the Governing Body on Month 4 2021/22 (where available) contract position highlighting other issues where appropriate.

Performance

The report outlines:

- the progress being made towards achieving the standards set out in the NHS Constitution
- the impact of covid 19 on access and performance to NHS services
- an update on the latest NHS planning round to support H2 (2021/22)

Previous Considerations

Name of meeting	NA	**Meeting Date**	
Name of meeting	NA	**Meeting Date**	

Recommendations
It is recommended that the Governing Body: 1. Agree the use of the urgent decision-making arrangements for the approval of the CCG planning submissions 2. Note the forecast and the expected mitigating allocations 3. Note the QIPP requirement and forecast 4. Note the risks and mitigations 5. Note the contents of the contract updates reported 6. Note the progress being made towards achieving the standards set out in the NHS Constitution and the impact covid 19 is having on the restoration of access levels to NHS services. 7. Note the requirements to the latest NHS England planning round to support H2

Decision ☒	**Assurance ☒**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	None identified.
Resources / Financial Implications (including Staffing/Workforce considerations)	None identified.
Sustainability Implications	

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	• Achieving the agreed strategic direction for Calderdale • Improving value	**Risk (include risk number and a brief description of the risk)**	None identified.

Legal / CCG Constitutional Implications	None identified.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest arising from this paper will be managed in accordance with the CCG Management of Conflicts of Interest Policy.

1.0 FINANCE

1.1 Key Messages

This report updates the financial position as at month 6, key messages are:-

- The CCG continues to operate under temporary financial arrangements due to the impact of Covid-19.
- The CCG submitted a draft financial plan in April for the period April 2021 to September 2021. The plan was to achieve a balanced position for that 6 month period.
- The CCG is currently forecasting an overspend due to expenditure items which currently fall outside of our baseline allocation. Additional allocations are expected to be received to match against these costs.
- The CCG has a revised QIPP target of £2.0m for H1.
- Planning guidance for the period October to March was issued on 30th September.
- The ICS has received allocation notification and CCGs and Providers are drafting financial plans.
- The CCG has developed plans to deliver the Mental Health Investment Standard in 2021/22.
- The CCG will not receive any additional uplift to budgets for the 3% Agenda for Change pay award for 2021/22.

1.2 Planning Update

NHS England published planning guidance and allocations for the period April to September 2021 on the 25th March 2021. The ICS issued a local timetable for financial plans to be submitted by the 16th of April and ICS consolidated submission to NHS England on the 6th May. The draft financial plan for the first half of the year (H1) was approved by Governing Body on 29th April 2021.

NHS England published planning guidance and ICS level allocations for the period October 2021 to March 2022 (H2) on the 30th September. CCGs are expected to submit initial plans to the ICS in October and the ICS is expected to submit its plan by 16th November.

The financial planning guidance key points are as follows:

- H2 system envelopes are based on H1 system envelopes adjusted for higher efficiency requirement, pay awards, capacity funding and inflationary impacts.
- Increased efficiency requirement in H2 .

- H2 envelopes include funding for the H1 and H2 impacts of the pay award.
- Block payment arrangements will remain in place – changes to blocks should be actioned to reflect changes to the overall system envelopes including pay awards.
- An activity-based elective recovery fund will continue, with additional capital available to support delivery.
- NHS provider other income support – H2 funding will reduce to 75% of H1 funding levels.
- H1 and H2 will be treated as a single financial period and organisations need to achieve financial balance for the year as a whole.
- Hospital discharge programme funding (HDP) out of envelope will fund costs incurred up to 31 March 2022 i.e. not the cost of 4 week discharge that extend beyond that date.
- Continued requirement to meet the Mental Health Investment Standard.
- Contingency requirement reduced from 0.5% to 0.25%.
- Systems envelopes will be adjusted for an overall and targeted efficiency requirement.
- Additional capacity funding to systems for Elective Recovery, Urgent Emergency Care and specific Ambulance/111 capacity funding.

The CCG is still developing its financial plan and at this stage it is expected that this will be to deliver a balanced financial position in 2021/22.

The CCG is intending to submit its plans in line with the local ICS timetable for consolidation by 16th November. As these timescales fall outside of the CCG routine governance meetings **it is recommended** that the Governing Body approve the use of the urgent decision-making arrangements to approve the CCG plan as set out in Section 9.13.3. of the CCG Constitution:

"*The powers which the Governing Body has reserved to itself may, in an emergency or for an urgent decision, be exercised by the Accountable Officer (or in his absence by the Chief Finance Officer/Deputy Chief Officer/Deputy Chief Officer) and the Chair (or in his absence by the Deputy Chair), after having consulted at least two other Governing Body members. The exercise of such powers by the Accountable Officer and Chair shall be reported to the next meeting of the Governing Body in public session for formal ratification."*

1.3 **CCG Financial forecast 2021/22**

The CCG is forecasting to meet the financial plan however the CCG is showing an overspend of £0.7m in relation to costs for the Hospital discharge programme and other costs which sit outside of the allocation envelope. These costs will be reimbursed separately on a retrospective basis so the overspend is due to timing issues.

There are a number of variances in the forecast which can be seen in appendices A-C and summarised below: -

- **Acute:** Currently forecasting £0.4m underspend. The CCG has block contract arrangements in place with NHS providers. Independent sector activity is charged on an activity basis which is showing some underspends.
- **Mental Health**: Is showing a forecast underspend due to a reduction in some individual high-cost placements and also as the baseline includes an allowance for the pay uplift which has not yest been transacted. Plans are in place to meet the MHIS and are being refreshed in light of this variance and also the Agenda for Change settlement.
- **Prescribing**: Currently forecasting online with budget. The CCG has received activity information for the period to August 2021 and this is indicating that spend is broadly in line with the planned budget. Cost pressures may emerge due to potential increases in NSCO, Cat M and general price increases and potential under delivery of QIPP due to COVID pressures.
- **Primary Care (Not delegated)**: Currently forecasting online with budget.
- **Primary Care – Delegated**: Currently forecasting slightly under budget due to a budget alignment issue in relation to an allocation received in September which in part covers the period October to March. The CCG is currently not showing any overspends in relation to Primary Care Additional Roles as it is expected that additional allocation can be claimed for forecast spend over the budget currently included in the baseline.
- **Community:** showing a small underspend.
- **Continuing Healthcare:** currently forecasting an underspend of £0.1m. The finance team is working with the continuing healthcare team to refine the forecast.
- **Other / Reserves**: Showing an overspend due COVID-19 related hospital discharge costs which will be matched by additional allocations and also due to budget alignment issues.
- **BCF**: Forecasting online and includes the increase in the planned 21/22 BCF contribution.
- **Running Costs**: The CCG plan for running cost has a requirement for £50k savings in order to meet the running cost allocation of £2,058k for H1. There are a number of

vacant posts in the structure, and it is forecast that the planned savings target will be met through vacancy savings. The forecast includes the impact of the Agenda for Change pay uplift of 3%.

1.4 **Public Sector Payment Policy**

The CCG has a target of 95%, and performance is currently between 95.93% and 99.96% across NHS and Non-NHS invoices.

Appendix D shows the public sector payment policy in more detail.

1.5 **QIPP**

The CCG has a QIPP target of £2m for H1. As outlined in budget setting this is a challenging target and there is currently a level of unidentified QIPP. The table below summarises the M6 QIPP forecast position.

QIPP		Target £'m	Risk Adjustment %	Projected Delivery £'m	Risk £'m
Prescribing	R	0.25	100%	0.29	0.04
CHC	R	0.25	100%	0.25	0.00
Other	NR	0.71	100%	0.71	0.00
Gap	NR	0.80	0%	0.00	(0.80)
Total		**2.01**		**1.25**	**(0.76)**

The forecast risk on delivery of QIPP for H1 is £0.76m. The CCG is utilising the contingency to mitigate against QIPP under delivery whilst further QIPP plans and mitigations are being developed.

1.6 **WY& H ICS Financial Position**

The ICS consolidated month 5 financial position is showing a forecast position of a £2.3m surplus for the end of H1. The forecast scenarios collated for the ICS show a worst-case scenario of £10.8m deficit and best case of £11.6m surplus. The ICS is now forecasting a lower Elective Recovery Fund (ERF) of £35m which is £20m lower than initially planned. Appendix F shows more detailed information in relation to the ICS financial position.

1.7 **Risks and Mitigations**

The CCG has a number of risks to manage in the new financial plan:

- Risk of QIPP delivery against the new £2.0m QIPP target.

- Risk of overspends on prescribing.
- Risk of increase on independent sector activity above budgeted levels.
- Risk of overspend on continuing healthcare.
- Mitigation of development of further QIPP savings plans.
- Mitigation of identification of non-recurrent underspends and savings opportunities.
- Mitigation of use of the 0.5% contingency budget.

2.0 CONTRACTING

2.1 Acute and Independent Sector providers

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place until March 2022. Therefore, no CCG contracts are in place with NHS providers and contracted NHS acute providers are paid on a nationally set block amount.

Work continues with CHFT in relation to Elective Recovery with further insourcing and outsourcing opportunities being explored. Increased demand continues to be experienced at A&E departments causing pressures in the system.

New 6-month contracts were put in place from April 2021 with Spire Elland and BMI Huddersfield via the Framework for Increasing Capacity in Independent Sector providers. New contracts have been awarded again under the framework for the remainder of the 6 months of the 2021/22 contract year. The contract position with Spire Elland is under-delivering mainly due to pre-op capacity pressures.

2.2 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic will remain in place until end of March 2022. Therefore, no contracts are in place and SWYPFT are paid on a nationally set block amount. For 2021/22 the Month 1 to 6 block payments were £12,400,226 for Calderdale CCG. This includes 0.5% for inflation/ efficiency. SWYPFT will get more funding on top of these block payments from various sources, such as: 2021/22 CCG growth funding (i.e., MHIS funding), Service Development and Spending Review Funding, separate ICS funding (e.g., crisis). Details of this additional funding are still being finalised at the time of writing this report.

2.3 **Yorkshire Ambulance Service (YAS) 999 Ambulance**

Initial performance information for Month 4 for Calderdale shows that the 999-service responded to 3,270 incidents. Of this number, 2,868 were responded to on the scene. 402 were 'Hear and Treat' responses. YAS overall responded to 113,908 calls in Month 4, significantly higher than the number in Month 4 of 2020/21 (79,754 calls).

2.4 **Integrated Urgent Care (IUC, formerly NHS 111) and West Yorkshire Urgent Care (WYUC)**

IUC overall in Month 4 showed 140,246 answered calls in July, which was 3.9% below the Annual Business Plan baseline volume. Calls answered in July were 6% above the same month last year. Validated overall WYUC activity shows 21,804 cases for Month 4, an increase of 19.9% from Month 4 of 2020/21.

2.5 **Posture and Mobility (Wheelchairs) Service (Ross Care)**

Total new referrals increased to 282 in July. For Calderdale there were 81 adult referrals with 40 of these being re-referrals. There were 18 paediatric referrals for Calderdale with 13 being re-referrals.

2.6 **Procurements**

Service description	Status	Contract start date	CCG Annual contract value
Community Ophthalmology Service	AQP procurement completed	01.08.2021	Estimated £750,000 across all contracted providers
Designated Beds (COVID-19): Calderdale / Kirklees /Wakefield	Procurement completed	21.06.21	£1,165 per bed x 6 (potential to rise to 12)
Non Obstetric Ultrasound	Provider accredited following evaluation	01.07.21 (1x new provider)	Estimated £153,000 across all contracted providers
Community Dermatology Service	Procurement paused	01.10.2022	£350,000
Community Phlebotomy	Procurement completed	To be confirmed (mobilisation started)	£151,333 based on 20,500 venepunctures
Continuing Healthcare Domiciliary Care	Re-opening of a procurement in July 2021 for 4 weeks and annual process until March 2025	From 01.04.2021	Approximately £1m across all contracted providers
Community Based Day Opportunities	Procurement underway	01.04.2022	Approximately £3m across all contracted providers (CBMC & CCG)
Intermediate Care Beds Lead Provider Model	Market Test closed and mini-evaluation underway	01.04.2022	To be confirmed
IAPT	Procurement under discussion	To be confirmed	To be confirmed
Mental Health (Neurodiversity ASD/ADHD)	AQP procurement under discussion	To be confirmed	To be confirmed

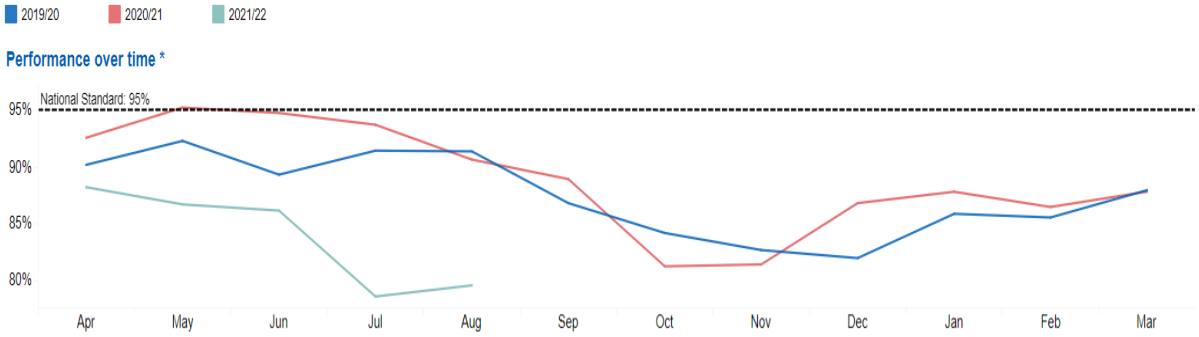
3.0 PERFORMANCE

3.1 Urgent and Emergency Care

3.1.1 A&E - % waiting under 4 hours

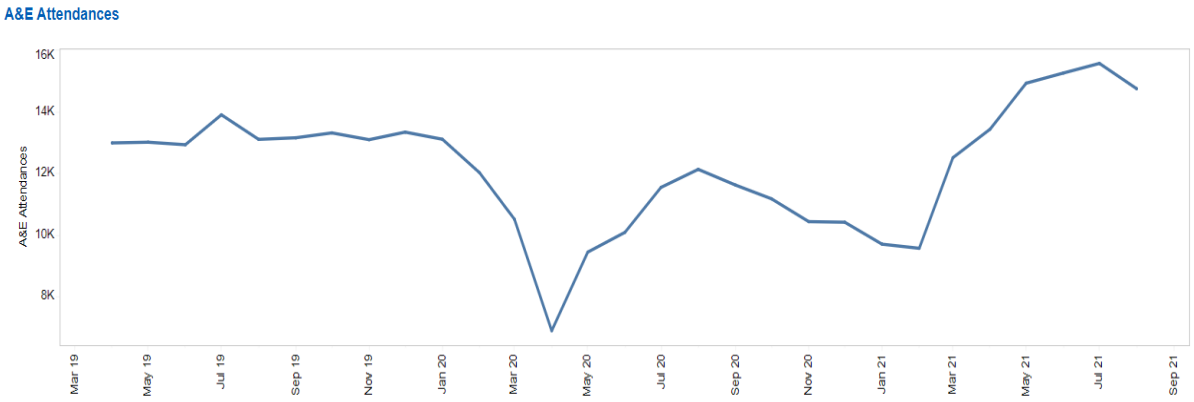
A&E performance refers to the percentage of patients discharged, admitted or transferred within 4 hours of arrival at the A&E Department. Calderdale performance is aligned with the performance achieved by the local acute provider Calderdale and Huddersfield Foundation Trust (CHFT).

A&E performance achieved 79.6% in August 2021. This is below the national standard (95%) however this level of performance is stronger than the national average (77.0%) and ranks 6th in the region (North East and Yorkshire).



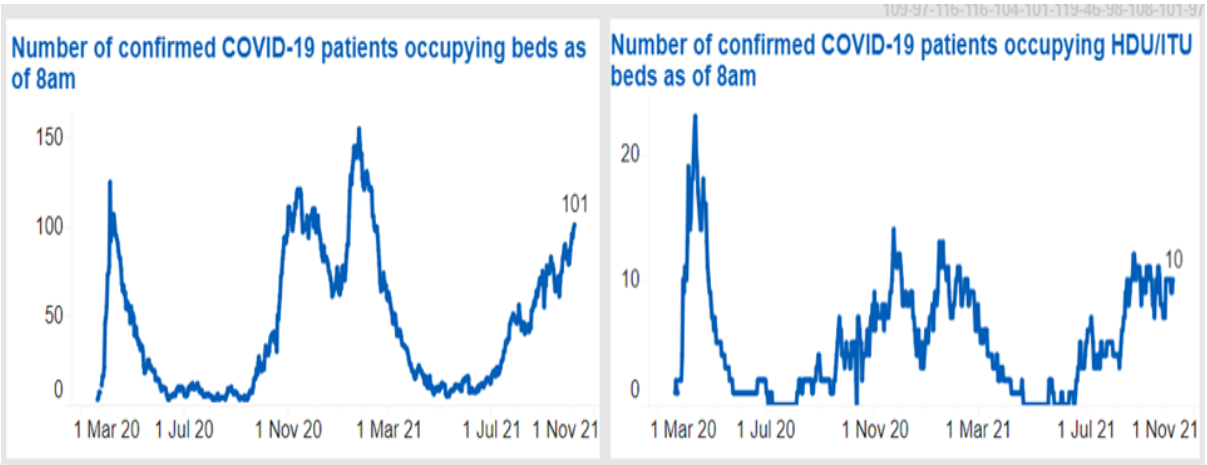
3.1.2 Attendance

The chart below compares the volume of A&E attendances to CHFT by month during the last 3 years. The impact of the pandemic on the volume of attendances can be noted during throughout 2020/21. Since the start of 2021 there has been significant and continual increase in the volume of attendance to A&E which have surpassed pre-covid levels of activity.



3.1.3 **Impact of Covid 19**

The activity levels associated with covid at CHFT have been increasing since June 2021. As a consequence, this is placing pressure on the bed base and theatre capacity available within the hospital to support the NHS recovery programme.



3.1.4 **Calderdale and Greater Huddersfield Urgent and Emergency Care Board (UECB)**

The Board continues to monitor and have oversight of urgent and emergency care system across Calderdale and Kirklees. The system is currently facing unprecedented challenges due to; increasing demand, increasing acuity due to late presentation and deconditioning, and significant staffing pressures. All organisations are reporting very high level of staff absence due to; sickness, fatigue and covid contact, and the direct impact this is having on their ability to deliver high quality services. Our pressures are being exacerbated by the challenges faced by our social care providers, and their ability to provide resilient home care and care home offers.

The Board has continued to work on its key priorities:

1. Implementation of Urgent Community Response Services (particularly an acceleration of the timeline in Calderdale – bringing forward the implementation date from March 2022 to December 2021
2. Implementation of Hubs in both Emergency Departments in order to meet the increasing demands for patients attending for minor injuries and minor ailments (an immediate model went live in July, and we are working on an interim model which transitions into the urgent care offers which are a part of the Right Care Right Time Right Place (RCRTRP) model on which we consulted
3. Improving discharge processes throughout the transfer of care pathway through the appointment of a new System Discharge Co-ordinator, and a governance structure lead by executive discharge leads from the CCG, CMBC and CHFT
4. Working with general practice – early work on the development of optimised same day offers, reducing demand on both general practice and secondary care.

In addition, the Board has started development of its Winter Plan for this year. The work commenced with a system 'perfect storm' session, which is being followed up at the September UEC Board in order to develop the detail. The product will be shared with committee at a future meeting. NHSE/I have started to develop their approach to winter planning. Systems will be issued a set of key lines of enquiry which will form the basis for their winter assurance process.

The system continues to come together weekly for a system silver call, where we identify organisations' status, risks and any asks for mutual aid. Both CCGs are supporting the internal CHFT gold meetings which take place three times a week. These meetings identify operational issues where the CCGs and the broader system can provide support. The CCG representatives continue to be the conduit into the wider system.

The Board has clear links to the West Yorkshire UECB, both its Board meetings, and its three work-streams; pre-hospital, hospital, and post hospital.

3.2 Elective Care

3.2.1 Referral to Treatment (RTT)

In April 2019, Professor Stephen Powis published an Interim Report on the Clinically-led Review of NHS Access Standards. The report set out a series of proposals regarding changes to the national access standards for urgent and emergency care, elective care, cancer diagnosis and treatment and mental health care.

Twelve field sites (including CHFT) had been invited to test using the average wait for all patients on incomplete pathways as the headline measure of RTT performance.

The standard for the field testing would continue to use incomplete pathways as the cohort of patients that performance is measured against. But it is important to note that field test sites would not be assessed using the existing standards for elective care and *will be excluded from national reporting during this period*.

The change in focus to monitor the average wait for these patients is expected to drive significant behavioural changes, both clinical and managerial. The intention is that the focus clearly shifts to a position where every day on a patient's pathway counts in order to establish good performance against the standard.

A new reporting and performance management regime commenced on the 1st August 2019 and the pilot was initially expected to last 4 months, but the development of the field test has been suspended during the NHS response to covid. We await further updates from NHS England on the next steps.

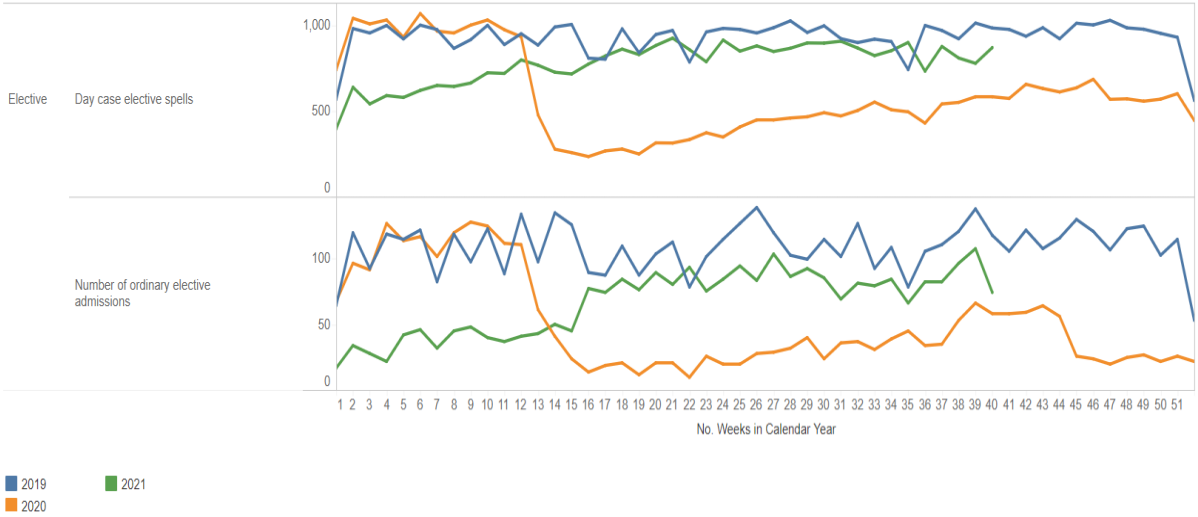
3.3 System Recovery Post Covid

The latest national planning programme placed greater emphasis on services returning activity to pre-covid levels. Local elective recovery plans submitted to NHS England have set an ambition to return elective activity to pre-covid levels from quarter 2 2021.
A further planning round to support this will commence during September 2021/22.

Provisional data (from NHSE) up to 3rd October 2021 (week 40) – see charts below - illustrates the increasing volume of inpatient and outpatient activity being undertaken since the initial lockdown was introduced in March 2020:

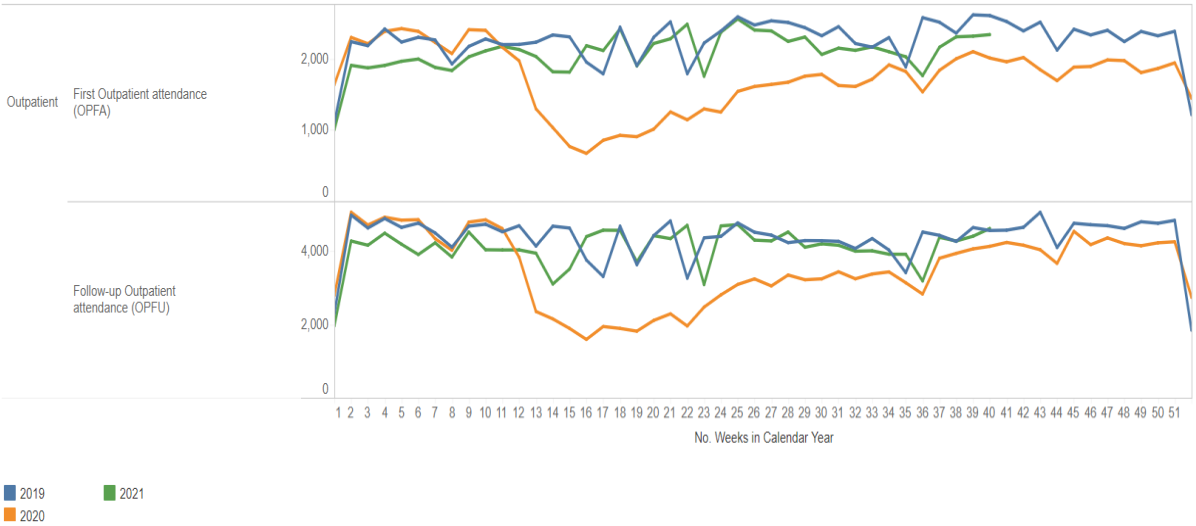
Inpatient Recovery

- Daycases - currently reporting Q2 activity at 90% of pre-covid levels reported in Q2 2019
- Inpatient electives - currently reporting Q2 activity at 78% of pre-covid levels reported in Q2 2019



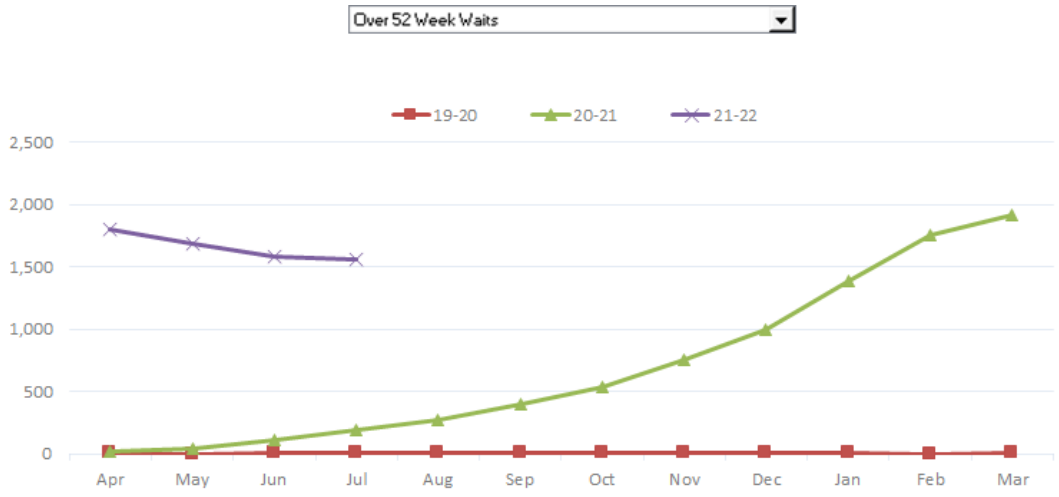
Outpatient (OP) Recovery

- First OP appointments - currently reporting Q2 activity at 91% of pre-covid levels reported in Q2 2019
- Follow up OP appointments - currently reporting Q2 activity at 99.5% of pre-covid levels reported in Q2 2019



3.4 Long Waiters and High Priority Patients

Given the significant number of patients whose care has been delayed due to the pandemic, returning services to pre-covid levels will only form part of the picture as the NHS begins the process to address long waits.



Due to the scale of the operational pressures in CHFT the CCG has offered support to elective recovery by embedding a number of staff within the divisional structures to focus on increasing elective capacity. This has been done by insourcing providers to deliver additional clinics and theatre sessions at weekends.

The specialties were prioritised based on clinical risk and length of waiting times, taking account of both people waiting for outpatients appointments and people waiting for operations.

The most pressured specialty was ENT and as a result of the work undertaken we have so far agreed contracts which has meant approximately 70 additional patients a week have been seen since the beginning of August and an additional 8 patients a week are having their operations since the beginning of September.

We have a second provider working for CHFT and they start providing clinics from the 25th September. Between the providers this will increase capacity by approximately 800 appointments a month for ENT. As a result of the work being undertaken the number of people waiting longer than 12 months for an ENT appointment has reduced from 591 to 376 (as at 9th September).

Ophthalmology also has a large number of patients waiting where the clinical risk is high, so additional weekly Glaucoma Diagnostic clinics have been contracted and will be delivered from the middle of September, with General Ophthalmology clinics starting every weekend from the beginning of October.

The other specialty where we have an agreed start date is for Neurology , and from the 18th September an additional 32 appointments a week have been agreed. Approximately 75% of these are expected to be virtual.

Additional Orthopaedic clinics have been agreed to start from the 9th October.

To support additional operating activity we continue to work closely with the local Independent Sector providers and CHFT to deliver an aligned recovery where possible.

The team supporting CHFT is also working to identify insourcing providers who are able to supply theatre teams to increase the weekday capacity in CHFT and provide more resilience to elective operating.

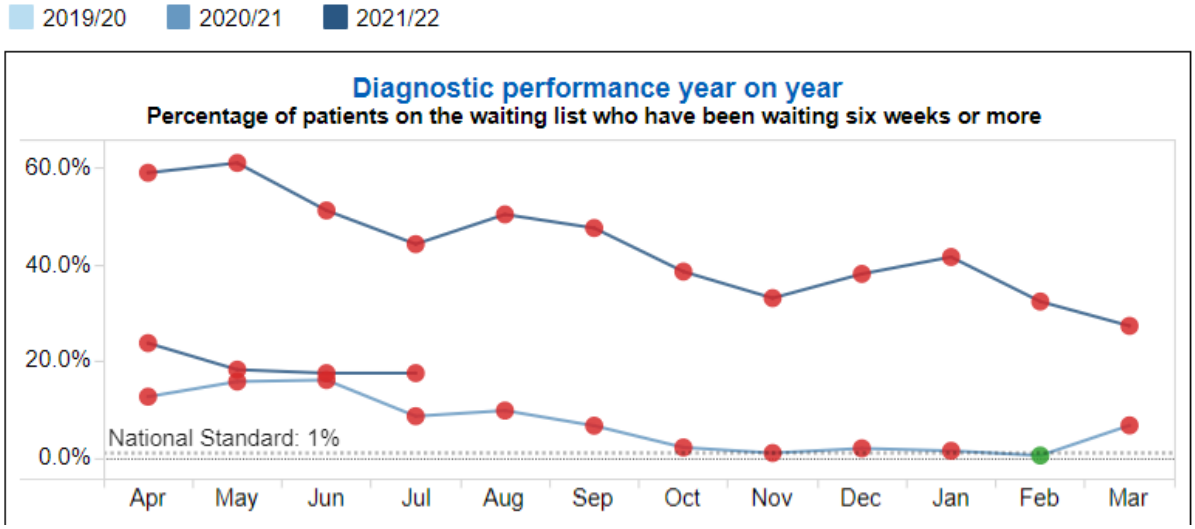
The Leeds Nuffield has offered and opportunity to do and additional 20 joint replacements a month which we are working to secure.

We will continue to work across the system, replicating the learning from these examples, to provide as much additional capacity to the highest priority areas over the remainder of the financial year.

3.5 Diagnostic Waiting Times

Patients referred for a diagnostic test should wait less than 6 weeks following their referral from a GP. The NHS Constitution requires no more than 1% of patient waits to breach this standard.

Covid has had a significant impact on the overall performance reported in this area – see chart below. In July 2021, 17.5% of patients experienced waits greater than 6 weeks across the spectrum of diagnostic tests. The national average is 23.5%.



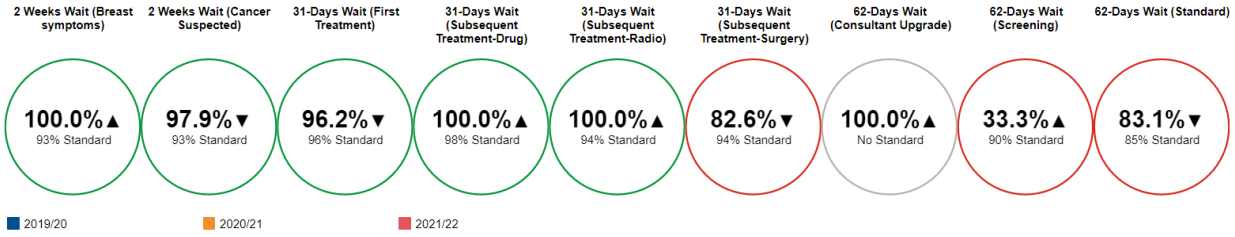
Overall performance levels are expected to improve in the coming months as the volume of activity, with a particular focus on endoscopy, increases – a combination of theatres now operating at full capacity post and the insourcing of additional capacity to support the recovery.

The transformation work coordinated by the Elective Care Improvement Group maintains oversight of the diagnostic waiting list and the prioritisation of patients.

3.6 Cancer Waiting Times

In June, Calderdale continues to sustain strong levels of performance across the majority of the cancer waiting times standards – see summary below.

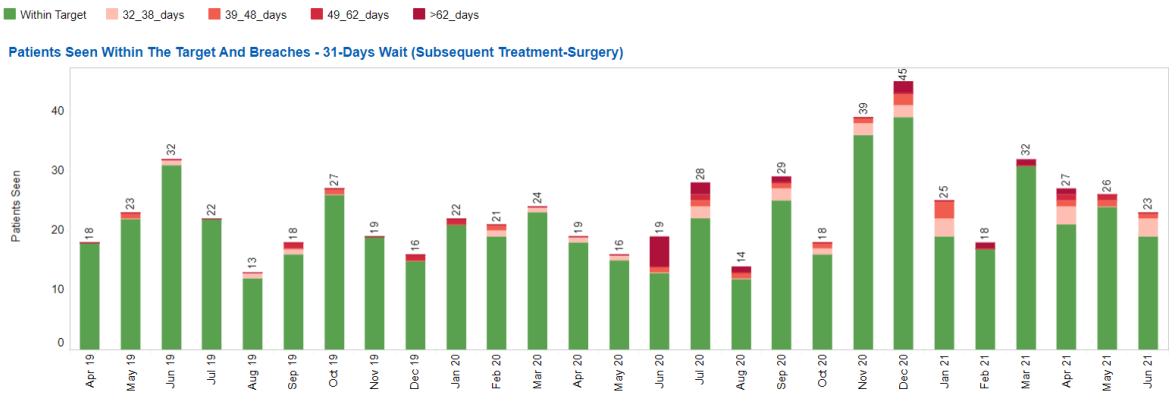
The volume of referrals remains higher than normal and this is consistent across the region however CHFT continues to perform strongly.



3.6.1 31 Days to Subsequent Treatment (Surgery)

Patients who require subsequent surgery for their cancer should receive this treatment within 31 days. Performance in June was 82.6%. The standard to achieve is >94%.

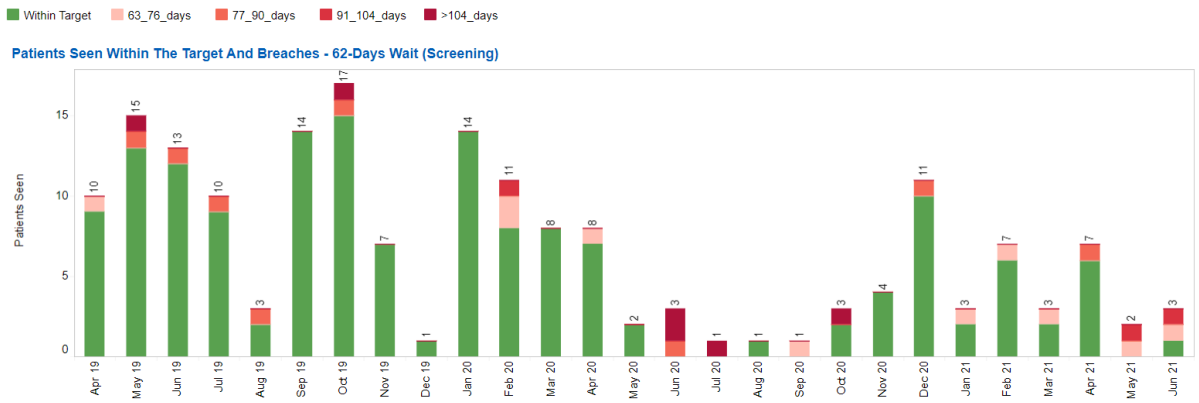
In June, 19 patients received their subsequent surgical treatment within 31 days. There were an additional 4 patients who breached the standard. Each of the breaches were associated with provider capacity issues. Each patient has now received their treatment.



3.6.2 62 Days Wait - Screening

Following their referral from a screening programme, patients should receive their first definitive treatment within 62 days. The performance in June was 33.3%. The standard to achieve is >94%.

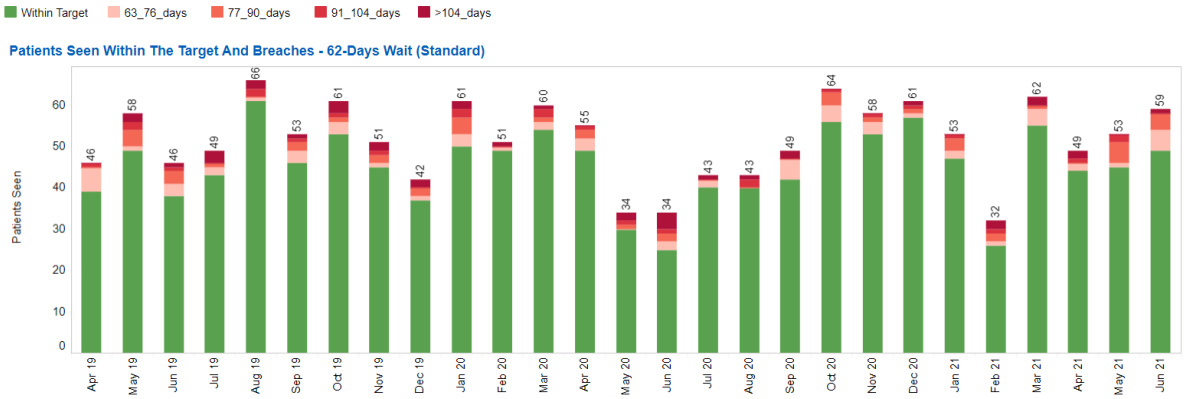
In June, 1 patient received their treatment within 62 days. There were 2 breaches of the standard were associated with provider capacity issues. Each patient has now received their treatment.



3.6.3 **62 Days Wait - Referral to Treatment**

Following their referral, patients should receive their first definitive treatment within 62 days. Performance in June was 83.1%. The standard to achieve is >85%.

In June, 49 patients received their treatment within 62 days. There were 10 breaches of the waiting time standard. 5 of the breaches were associated with provider capacity issues ,4 related to complex pathways and 1 related to a patient initiated delay. Each patient has now received their treatment.



3.6.4 Overall levels of activity associated with the cancer waiting times have been sustained throughout the pandemic. Cancer networks have focused their efforts to ensure theatre capacity has been available for cancer patients so they can receive their treatment in a timely fashion.

Performance against all the cancer waiting times continues to be reviewed by the Cancer Locality Group and Cancer Network across West Yorkshire & Harrogate (WY&H).

The West Yorkshire and Harrogate Cancer Alliance continues to work across all tumour sites to improve consistency of approach and introduce new ways of working aligned to best practice. Increasingly the inclusion of pre-referral checks and tests undertaken in primary care will support the improvements in quality of referrals and will ultimately support the implementation of rapid diagnostic hubs

3.7 Mental Health

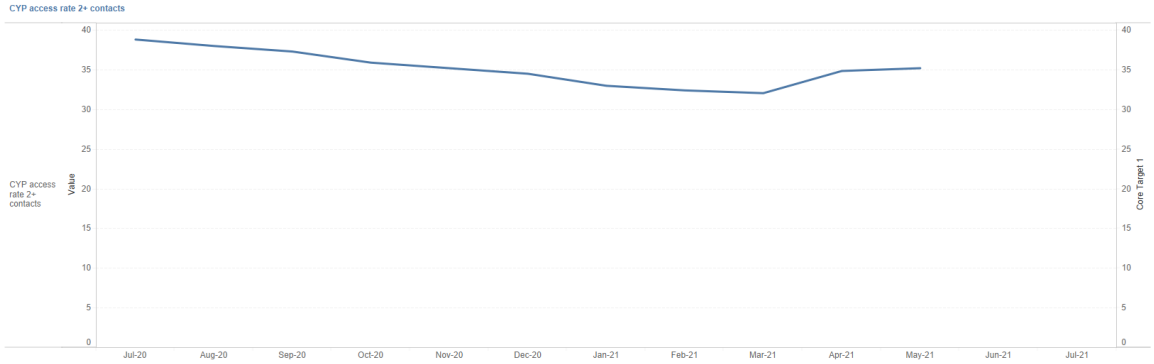
The latest position for the core mental health indicators is captured in the summary table and narrative below. Overall, services continue to achieve the majority of the performance targets.

	Current Standard	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
IAPT														
IAPT Access (monthly)	NA			335	485	385	370	410	430	510	470	390		
IAPT Access Rate (rolling quarter)	NA	4.56%	4.04%	4.14%	4.52%	4.64%	4.77%	4.48%	4.66%	5.19%	5.42%	5.27%		
IAPT Recovery Rate (monthly)	50.0%			48.0%	51.0%	51.0%	48.0%	58.0%	66.0%	61.0%	55.0%	54.0%		
IAPT 6 Week Waits (monthly)	75.0%			97.0%	93.0%	97.0%	98.0%	100.0%	99.0%	100.0%	98.0%	100.0%		
IAPT 18 Week Waits (monthly)	95.0%			100.0%	100.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Dementia														
Dementia Diagnosis Rate	66.7%	59.9%	59.5%	58.5%	58.3%	58.1%	57.8%	58.3%	58.5%	58.6%	58.6%	58.4%	59.6%	60.4%
Children and Young People														
CYP Access Rate (2+ contacts)	NA	38.8%	38.0%	37.3%	35.9%	35.2%	34.5%	33.0%	32.4%	32.1%	34.9%	35.2%		
CYP Access (2+ contacts)	NA	1,665	1,630	1,600	1,540	1,510	1,480	1,415	1,390	1,375	1,495	1,510		
CYP Eating Disorder Waiting Time - Urgent	95%			96.0%			50.0%			71.4%			60.0%	
CYP Eating Disorder Waiting Time - Routine	95%			96.0%			90.3%			91.4%			81.8%	
Perinatal														
Perinatal Access	NA	115	110	115	120	115	120	125	130	135	140	145		
Perinatal Access Rate	Q1 7.5%	4.7%	4.5%	4.7%	4.9%	4.7%	4.9%	5.1%	5.3%	5.5%	5.7%	5.9%		
Adult Mental Health														
Discharges Followed Up Within 72 Hours	80.0%				63%	90%	96%	79%	95%	81%	65%	74%		
EIP Waiting Times - MHSDS	60%	83.0%	70.0%	81.0%	90.0%	96.0%	96.0%	96.0%	95.0%	100.0%	100.0%	100.0%		
SMI physical health checks	60%			13.7%			11.7%			10.7%			15.2%	
Individual Placement and Support	NA	30	35	40	50	50	55	60	60	70	15	20		

Key areas of variance to note include:

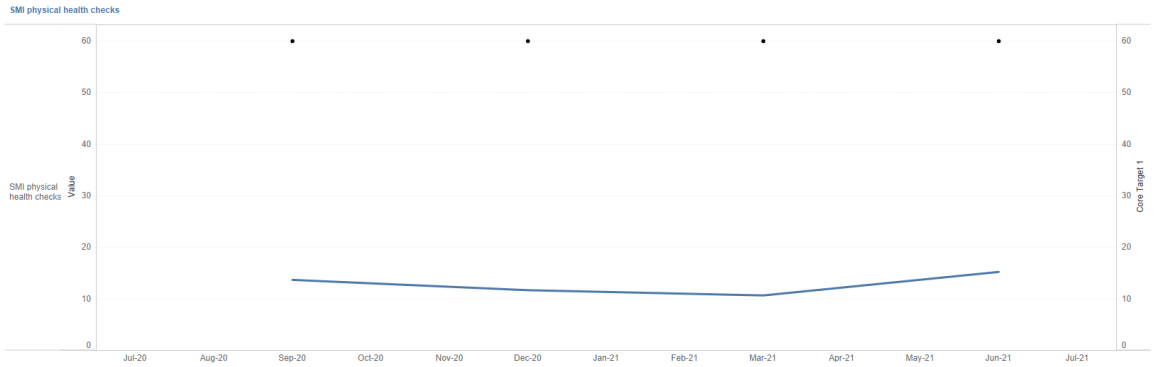
3.7.1 Children and Young People (CYP) Eating Disorders Waiting Times

This remains an area of pressure and work continues both at WY&H level and in place to address, this includes using non recurrent spending review money to enhance the current service to address the increased waiting list, intervene at an earlier opportunity.



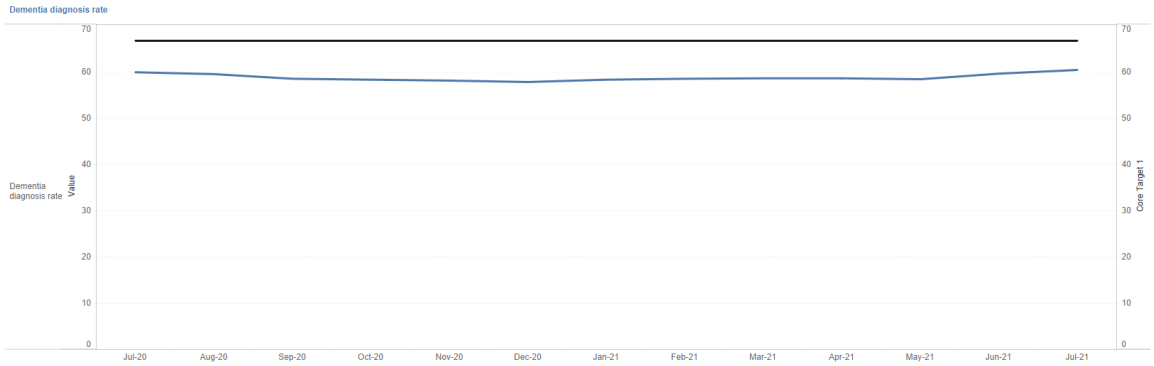
3.7.2 **Serious Mental Illness (SMI) % Achievement**

A workstream established to review the learning from the successful approach used with people with learning disabilities and look to apply the principles to increase the take up of health checks by people with complex mental health needs. Focused work planned with PCN's includes sharing performance data, alongside a suite of patient templates, correspondence coproduced with people with lived experience, designed to bolster understanding of and uptake of health checks. The workstream also undertaken similar exercise to promote take of Covid 19 vaccine for people with a SMI.



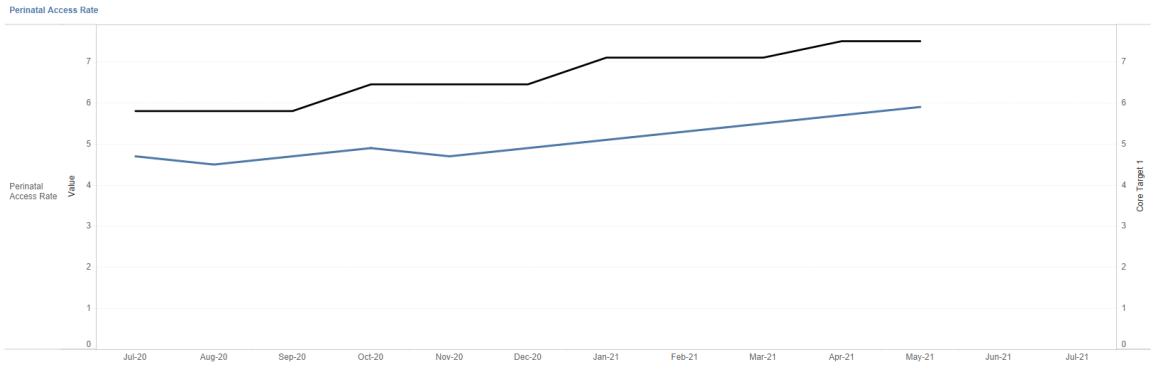
3.7.3 **Dementia Diagnostic Rate**

The dementia diagnostic guidelines are being updated and will be recirculated. Spending review money will fund additional memory clinics which benefits both the waiting list and diagnostic rate.



3.7.4 **Perinatal Access Rate**

A recovery plan is in place to achieve the access rate by Quarter 3.



3.8 NHS Planning - H2 2021/22

3.8.1 In March, NHS England published the 2021/22 priorities to support operational planning for H1. These focused on:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention.

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities.

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (EDs), improve timely admission to hospital for ED patients and reduce length of stay.

F. Working collaboratively across systems to deliver on these priorities

Since then, the health and care system has risen to the challenge of restoring and transforming services while continuing to meet the needs of patients with COVID-19 and dealing with increases in urgent and emergency care (UEC), primary and community care and mental health demand.

The planning guidance to support the remaining 6 months of the financial year was published by NHS England in October 2021:

https://www.england.nhs.uk/operational-planning-and-contracting/

Meeting both planned and unplanned patient demand, including that from COVID19 and seasonal viral illnesses will require a robust whole system plan. It is in this context that health and care systems are required to pay particular attention to the areas outlined below.

- Managing through a challenging autumn and winter
- Ensure dedicated capacity to enable elective recovery
- Full restoration of cancer services

3.8.2 Activity Profiles

The table below summarises the activity and capacity profiles to be developed to support the period October to March 2021/22.

Electives	• Total number of specific acute elective spells in the period • Total number of specific acute elective day case spells in the period • Total number of specific acute elective ordinary spells in the period
Non-electives	• Number of Specific Acute non-elective spells in the period • Number of Specific Acute non-elective spells in the period with a length of stay of zero days • Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days • Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (COVID) • Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more days (Non-COVID)
RTT	• Number of Completed Admitted RTT Pathways • Number of Completed Non-Admitted RTT Pathways • Number of New RTT Pathways (Clockstarts)
RTT - Incomplete pathways	• The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period • The number of incomplete RTT pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period • The total number of incomplete RTT pathways at the end of the reporting period (often referred to as the size of the RTT waiting list)

Number of patients waiting 63 or more days after referral from cancer PTL	• The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non site specific symptoms
Adult Critical Care Bed occupancy	• Average number of occupied ACC beds • Average number of open ACC beds
General and Acute overnight bed occupancy	• Average number of overnight G&A beds occupied • Average number of overnight G&A beds available • Average number of overnight G&A beds available which are reserved for elective patients only
General and Acute day bed available	• Average number of day case G&A beds available • Average number of day case G&A beds available which are reserved for elective patients only

3.8.3 **Narrative Plan**

Each ICS is required to provide a narrative plan covering the second half of the financial year (H2) specifically outlining:

- The assumptions and actions that underpin the trajectories within the activity submissions
- By exception, any key areas of concern and emerging risks associated with delivery including any proposed mitigation to be taken forward.

Areas for the narrative to cover include:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Restore full operation of all cancer services
- Restoring and increasing access to primary care services
- Transforming community services and improve discharge

As a place, Calderdale will be developing its narrative to be shared with West Yorkshire and Harrogate ICS in accordance with the timeline below.

3.8.4 **Timeline**

12th October Provider only submissions on elective recovery

- 104 weeks waiters
- Total waiting list
- 62-day cancer activity

18th October	Submission of elective recovery narrative (provider only submission)
1st November	ICS checkpoint meeting with senior leads for place
12th November	Submission of place-based plans to ICS to support: - Activity profiles - Narrative plans

3.8.5 **Approach**

The guidance published by NHS England is focused on the development of provider plans to support the H2 requirements.

West Yorkshire and Harrogate ICS are holding weekly meetings involving representatives from each place to review the guidance and develop the plans.

It is anticipated, although not yet confirmed by NHS England, that the final submissions made on 12th November will be required for both providers and place. Calderdale is proceeding on this basis and engaging with local stakeholders to develop the plans required for H2.

Weekly updates are provided to SMT on the requirements of the planning round and the progress being made.

4.0 RECOMMENDATIONS

4.1 It is recommended that the Governing Body:

1. Agree the use of the urgent decision-making arrangements for the approval of the CCG planning submissions.
2. Note the forecast and the expected mitigating allocations.
3. Note the QIPP requirement and forecast.
4. Note the risks and mitigations.
5. Contracting
6. Note the progress being made towards achieving the standards set out in the NHS Constitution and the impact covid 19 is having on the restoration of access levels to NHS services.

7. Note the requirements to the latest NHS England planning round to support H2

5.0 APPENDICES

5.1 **Appendix A** – shows a summary of the CCG's programme budgets.

Appendix B – shows a summary of the CCG's running cost budgets at cost centre level.

Appendix C – shows a summary of the CCG's delegated primary care budgets.

Appendix D – shows a summary of the CCG public sector payment policy target performance.

Appendix E – shows a summary of the CCG's allocation.

Appendix F – ICS consolidated financial position month 5.

Calderdale CCG Resource Allocation Summary as at 30th September 2021 — Appendix A

Centre Code / Name	Annual Budget (£)	In Month (£) Budget	In Month (£) Actual	In Month (£) Variance	Year To Date (£) Budget	Year To Date (£) Actual	Year To Date (£) Variance	Forecast (£) Outturn	Forecast (£) Variance	Mth 5 Forecast Outturn	Mth 5 Forecast Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS IN YEAR	(177,336)	(29,599)	(29,599)	0	(177,254)	(177,254)	0	(177,254)	83	(177,336)	83
ACUTE	95,431	15,805	15,418	(388)	95,431	95,029	(401)	95,029	(401)	95,634	(604)
MENTAL HEALTH	20,686	3,530	3,412	(118)	20,686	20,153	(533)	20,153	(533)	20,099	54
CONTINUING CARE	11,900	1,983	1,705	(279)	11,900	11,794	(106)	11,794	(106)	12,056	(263)
PRESCRIBING	18,229	3,038	3,047	9	18,229	18,262	33	18,262	33	18,261	2
PRIMARY CARE	3,503	588	590	2	3,503	3,504	0	3,504	0	3,529	(26)
DELEGATED CO-COMMISSIONING	16,897	2,810	2,810	0	16,824	16,824	0	16,824	(73)	16,897	(73)
COMMUNITY HEALTH SERVICES	1,506	251	245	(6)	1,506	1,496	(10)	1,496	(10)	1,497	(0)
OTHER	1,213	202	191	(11)	1,213	1,158	(55)	1,158	(55)	1,183	(25)
BCF	7,079	1,214	1,169	(45)	7,079	7,071	(7)	7,071	(7)	7,079	(7)
COMMISSIONING RESERVE	925	183	1,150	967	916	2,635	1,719	2,635	1,710	1,823	811
UNIDENTIFITED QIPP	(798)	(133)	0	133	(798)	0	798	0	798	0	0
CONTINGENCY	765	128	0	(128)	765	0	(765)	0	(765)	0	0
Grand Total	**(0)**	**(0)**	**136**	**136**	**(0)**	**673**	**673**	**673**	**673**	**722**	**(49)**
Anticipated HDP costs reclaim	0	0	(136)	(136)	0	(580)	(580)	(580)	(580)	(722)	142
Anticipated COVID costs	0	0	0	0	0	(93)	(93)	(93)	(93)	0	(93)
Anticipated ERF costs reclaim	0	0	0	0	0	0	0	0	0	0	0
Expected year end surplus	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**0**	**(0)**

The position reported above excludes the cumulative brought forward surplus of £5.6m

Calderdale CCG Running Cost Allocation Summary at 30th September 2021 — Appendix B

Centre Code / Name	Annual Budget (£)	In Month (£) Budget	In Month (£) Actual	In Month (£) Variance	Year To Date (£) Budget	Year To Date (£) Actual	Year To Date (£) Variance	Forecast (£) Outturn	Forecast (£) Variance	Month 05 Outturn	Month 05 Movement
ADMINISTRATION & BUSINESS SUPPORT	20	3	1	(2)	20	15	(5)	15	(5)	16	(1)
CEO/ BOARD OFFICE	312	52	54	2	312	301	(11)	301	(11)	304	(3)
IM&T	42	7	17	10	42	47	4	47	4	47	(0)
CORPORATE COSTS & SERVICES	84	14	18	4	84	89	5	89	5	87	2
EQUALITY AND DIVERSITY	20	3	3	(0)	20	17	(3)	17	(3)	17	0
PATIENT AND PUBLIC INVOLVEMENT	41	7	6	(1)	41	28	(12)	28	(12)	28	0
CONTRACT MANAGEMENT	180	30	31	1	180	188	8	188	8	192	(4)
MEDICAL DIRECTORATE	203	34	33	(1)	203	172	(31)	172	(31)	178	(7)
HUMAN RESOURCES	18	3	3	(0)	18	17	(1)	17	(1)	17	0
STRATEGY & DEVELOPMENT	316	53	62	9	316	299	(18)	299	(18)	297	2
BUSINESS INFORMATICS	180	30	27	(3)	180	119	(61)	119	(61)	114	5
QUALITY ASSURANCE	188	31	31	(1)	188	168	(21)	168	(21)	172	(4)
ESTATES AND FACILITIES	82	14	24	10	82	107	25	107	25	107	(0)
FINANCE	248	41	30	(12)	248	188	(60)	188	(60)	197	(9)
GENERAL RESERVE - ADMIN	(50)	(8)	(14)	(6)	(50)	209	259	209	259	191	18
CORPORATE GOVERNANCE	174	29	19	(11)	174	95	(79)	95	(79)	94	1
Grand Total	**2,058**	**343**	**343**	**0**	**2,058**	**2,058**	**0**	**2,058**	**0**	**2,058**	**(0)**

Calderdale CCG Delegated Primary Medical Services Summary at 30th September 2021 **Appendix C**

PRIMARY CARE SERVICES:	Annual	In month			Year To Date (£)			Forecast to P6 (£)		Mth 05 Forecast	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	9,585	1,597	1,582	(15)	9,585	9,540	(45)	9,540	(45)	9,585	(45)
PMS	1,237	206	205	(1)	1,237	1,236	(1)	1,236	(1)	1,237	(1)
APMS	381	63	63	(0)	381	381	(0)	381	(0)	381	(0)
QOF	1,540	257	257	0	1,540	1,540	(0)	1,540	(0)	1,540	(0)
Enhanced Services	268	39	50	11	268	229	(39)	229	(39)	158	71
Premises - Reimbursed Costs	1,631	272	282	10	1,631	1,686	55	1,686	55	1,644	43
Premises - Other	40	7	7	0	40	41	0	41	0	40	0
Prof Fees Prescribing & Dispensing	90	15	20	5	90	70	(20)	70	(20)	90	(20)
Other GP Services (inc. PCO)	161	27	50	23	161	227	66	227	66	161	66
Other Non GP Services	480	80	62	(18)	480	476	(4)	476	(4)	468	8
PCN	1,398	233	233	(0)	1,398	1,398	(1)	1,397	(1)	1,398	(1)
Reserves - Contingency (91811060)	84	14	0	(14)	84	0	(84)	0	(84)	84	(84)
Total Primary Care Medical	**16,897**	**2,810**	**2,811**	**1**	**16,897**	**16,824**	**(74)**	**16,824**	**(74)**	**16,787**	**37**

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 30th September 2021

Supplier	In Month				Year To Date			
	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target
NHS	40	95.24%	£17,275,643.76	99.98%	258	96.27%	£103,759,932.71	99.96%
Non NHS	645	98.77%	£8,023,957.03	97.54%	4,202	97.93%	£53,433,365.86	95.93%
Total	685	98.56%	£25,299,600.79	99.19%	4,460	97.83%	£157,193,298.57	98.55%

Appendix E

Calderdale CCG Resource Allocation Summary at 30th September 2021

Resource Allocation	Programme Costs (£'000)	Co-Commissioning Costs (£'000)	Running costs (£'000)
H1 Running Costs			(2,058)
H1 Delegated Co-commissioning		(16,787)	
H1 Core Allocation	(155,419)		
CCG Covid allocation - From H1 Plans	(1,428)		
Primary Care: GP IT Infrastructure and Resilience	(12)		
Primary Care: Improving Access	(337)		
Mental Health: SDF: CYP community and crisis	(129)		
Mental Health: SDF: 18-25 young adults (18-25)	(39)		
Mental Health: SDF: MHST 20/21 sites wave 3&4 (MHST20/21)	(281)		
Mental Health: SR: Children & Young People's Eating Disorders (CYPED)	(23)		
Mental Health: SR: CYP community and crisis	(87)		
Mental Health: SR: Adult Mental Health Community (AMH Community)	(112)		
Mental Health: SR: Adult Mental Health Crisis (AMH Crisis)	(25)		
Mental Health: SR: (IAPT)	(62)		
Mental Health: SR: 18-25 young adults (18-25)	(25)		
Mental Health: SR: Memory assessment services	(31)		
Mental Health: SR: Discharge	(168)		
Mental Health: SR: Physical health outreach	(23)		
Maternity: LTP - SBL Pre-term Birth	(18)		
Primary Care: Improving Access	(337)		
Distribute H1 Ageing Well SDF to places 21/22	(506)		
Distribute Primary Care SDF - COVID support 21/22	(453)		
PCT FELLOWSHIPS	(51)		
PCT SUPPORTING MENTORS SCHEME	(7)		
PCT FELLOWSHIPS	51		
PCT SUPPORTING MENTORS SCHEME	7		
GP IT Infrastructure and Resilience	(12)		
SDF Crisis monies H1 allocation	(61)		
CMH Transformation H1 funding	(177)		
ERF Transfer	(79)		
Hospital Discharge Programme	(360)		
Distribute assessment funding for long COVID	(87)		
Enhanced occupational health fund-place grant	(50)		
Workforce capacity and demand digital primary care scheme	(80)		
To cover DQ support 21/22 from ICS Diabetes Programme	(9)		
Primary Care for Long Covid		(110)	
ERF Transfe	(11)		
Carry Forward Historic surplus - 2019/20	(5,569)		
Grand Total	**(166,008)**	**(16,897)**	**(2,058)**

Summary report			
Agenda item:	7 & 8		
Report title:	**Month 5 financial position (revenue and capital)**		
Author:	Adrian North		
Presenter:	Adrian North		
Purpose of report:			
Recommendation		Comment	X
Assurance	X	Decision	

Executive summary

Key headlines relating to the Month 5 financial position are as follows:

Income and expenditure

- Month 5 YTD position is a £9.1m favourable variance (change from £15m in M4 – consistent with forecast trajectories).
- YTD position driven predominantly by ERF income (£35m estimate for Q1) – no further income assumed for M4-6 however, hence in month deterioration in reported I&E position as cost base remains higher.
- £2.3m surplus forecast by the end of H1.
- Risk range now indicates the 'most likely' scenario is to deliver the £2.3m forecast surplus noted above
- Although this report relates to H1 only, financial performance will still be assessed across the full financial year

Capital

- ICS envelope: forecast spend of £161m which is £5m over plan. This relates to the RAAC issue at Airedale.
- Work ongoing to understand the risk range associated with capital forecasts – expect to be complete for M6 reporting
- National capital: forecast spend of £34m which is £29m under plan.

Recommendations and next steps

The WY&H ICS Finance Forum are asked to note the Month 5 financial position.

WY&H Integrated Care System

Financial Reporting Month 5 2021/22

Financial Summary

24 September 2021

Income and Expenditure

Headlines

- ICS has **break-even plan** at system and organisation level for the first half of 2021/22 (H1)
- Month 5 YTD position is a **£9.1m favourable variance** (change from £15m in M4 – consistent with forecast trajectories)**.**
- YTD position driven predominantly by **ERF income** (£35m estimate for Q1) – no further income assumed for M4-6 however, hence in month deterioration in reported I&E position as cost base remains higher.
- **£2.3m surplus forecast** by the end of H1.
- Risk range now indicates the **'most likely'** scenario is to deliver the £2.3m forecast surplus noted above
- Although this report relates to H1 only, financial performance will still be assessed across the full financial year

Month 5 2021/22 and forecast

Organisation	I&E YTD					I&E forecast		
	Plan £m	Surplus / (Deficit) £m	Reported Variance £m	CCGs ONLY: expected allocns £m	Adjusted variance £m	Plan £m	Surplus / (Deficit) £m	Variance £m
NHS Bradford District & Craven CCG	0.0	(0.6)	(0.6)	0.6	**0.0**	0.0	0.0	0.0
Airedale NHS Foundation Trust	0.0	0.1	0.1		**0.1**	0.0	0.0	0.0
Bradford District Care NHS Foundation Trust	0.0	0.0	0.0		**0.0**	0.0	0.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	0.0	0.4	0.4		**0.4**	0.0	0.0	0.0
Bradford District and Craven Total	**0.0**	**(0.2)**	**(0.2)**	**0.6**	**0.4**	**0.0**	**0.0**	**0.0**
NHS Calderdale CCG	0.0	(0.5)	(0.5)	0.5	**0.0**	0.0	0.0	0.0
Calderdale And Huddersfield NHS Foundation Trust	0.6	2.2	1.6		**1.6**	0.0	0.0	0.0
Calderdale & Huddersfield Total	**0.6**	**1.6**	**1.1**	**0.5**	**1.6**	**0.0**	**0.0**	**0.0**
NHS Leeds CCG	0.0	(1.3)	(1.3)	1.9	**0.6**	0.0	0.0	0.0
Leeds and York Partnership NHS Foundation Trust	0.0	0.3	0.3		**0.3**	0.0	0.0	0.0
Leeds Community Healthcare NHS Trust	0.0	1.0	1.0		**1.0**	0.0	0.0	0.0
Leeds Teaching Hospitals NHS Trust	0.4	0.6	0.2		**0.2**	0.0	0.0	0.0
Leeds Total	**0.4**	**0.6**	**0.2**	**1.9**	**2.1**	**0.0**	**0.0**	**0.0**
NHS Kirklees CCG	0.0	(0.7)	(0.7)	0.7	**0.0**	0.0	0.0	0.0
NHS Wakefield CCG	0.0	(0.7)	(0.7)	1.2	**0.5**	0.0	0.0	0.0
Mid Yorkshire Hospitals NHS Trust	0.0	2.2	2.2		**2.2**	0.0	0.0	0.0
Wakefield & Kirklees Total	**0.0**	**0.7**	**0.7**	**1.9**	**2.6**	**0.0**	**0.0**	**0.0**
South West Yorkshire Partnership NHS Foundation Trust	0.0	2.2	2.2		**2.2**	0.0	2.3	2.3
Yorkshire Ambulance Service NHS Trust	0.0	0.1	0.1		**0.1**	0.0	0.0	0.0
Other Providers Total	**0.0**	**2.3**	**2.3**	**0.0**	**2.3**	**0.0**	**2.3**	**2.3**
West Yorkshire ICS Total	**1.0**	**5.1**	**4.1**	**5.0**	**9.1**	**0.0**	**2.3**	**2.3**

Commissioner Total	0.0	(3.9)	(3.9)	5.0	1.1	0.0	0.0	0.0
Provider Total	1.0	9.0	8.0	0.0	8.0	0.0	2.3	2.3
West Yorkshire ICS Total	**1.0**	**5.1**	**4.1**	**5.0**	**9.1**	**0.0**	**2.3**	**2.3**

Month 5 forecast scenarios

Organisation	Scenarios		
	Best Case Variance £m	Likely Case Variance £m	Worse Case Variance £m
NHS Bradford District & Craven CCG	0.0	0.0	(0.8)
Airedale NHS Foundation Trust	0.1	0.0	(0.2)
Bradford District Care NHS Foundation Trust	1.0	0.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	1.0	0.0	(1.0)
Bradford District and Craven Total	**2.1**	**0.0**	**(2.0)**
NHS Calderdale CCG	0.0	0.0	(1.2)
Calderdale And Huddersfield NHS Foundation Trust	0.0	0.0	(1.0)
Calderdale & Huddersfield Total	**0.0**	**0.0**	**(2.2)**
NHS Leeds CCG	0.0	0.0	(3.4)
Leeds and York Partnership NHS Foundation Trust	0.5	0.0	0.0
Leeds Community Healthcare NHS Trust	1.0	0.0	0.0
Leeds Teaching Hospitals NHS Trust	0.0	0.0	(3.5)
Leeds Total	**1.5**	**0.0**	**(6.9)**
NHS Kirklees CCG	0.0	0.0	(1.0)
NHS Wakefield CCG	1.0	0.0	(1.0)
Mid Yorkshire Hospitals NHS Trust	4.0	0.0	0.0
Wakefield & Kirklees Total	**5.0**	**0.0**	**(2.0)**
South West Yorkshire Partnership NHS Foundation Trust	3.0	2.3	2.3
Yorkshire Ambulance Service NHS Trust	0.0	0.0	0.0
Other Providers Total	**3.0**	**2.3**	**2.3**
West Yorkshire ICS Total	**11.6**	**2.3**	**(10.8)**

Commissioner Total	1.0	0.0	(7.4)
Provider Total	10.6	2.3	(3.4)
West Yorkshire ICS Total	**11.6**	**2.3**	**(10.8)**

Capital

Provider capital – ICS system envelope

- **ICS envelope**: forecast spend of **£161m** which is **£5m over plan**. This relates to the RAAC issue at Airedale.
- RAAC issue highlighted nationally and a decision on the use of national slippage to mitigate is still to be made.
- **Year-to-date underspend of £10m** against envelope – this is reduced from a £13m year-to-date underspend in M4).
- The reduction in underspend is due to an increased run-rate. Average spend per month to Month 4 was £4.2m, and in Month 5 this increased to £11.2m (against a planned increase of £8.8m)
- Forecast over-spends in BTHFT offset by underspends in CHFT and SWYPFT. Agreement to re-allocate resources in 22/23.
- Work ongoing to understand the risk range associated with capital forecasts – expect to be complete for M6 reporting

Provider capital – ICS system envelope

Name	Month 5 PLAN £000s	Month 5 Actual (to complete) £000s	Month 5 Variance £000s	Total Capital Plan 21/22 £000s	21/22 FOT (to complete) £000s	FOT Variance £000s
Airedale NHS Foundation Trust	8.0	3.9	-4.0	18.7	23.7	5.0
Bradford District Care NHS Foundation Trust	2.7	1.8	-0.9	6.0	6.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	6.8	6.0	-0.8	21.1	26.1	2.8
Calderdale and Huddersfield NHS Foundation Trust	3.5	2.4	-1.1	10.8	8.3	-2.5
Leeds and York Partnership NHS Foundation Trust	2.7	0.6	-2.1	9.0	9.0	0.0
Leeds Community Healthcare NHS Trust	1.0	0.2	-0.8	3.7	3.7	0.0
Leeds Teaching Hospitals NHS Trust	9.3	12.6	3.3	46.0	46.0	0.0
Mid Yorkshire Hospitals NHS Trust	4.3	3.2	-1.1	15.2	15.2	0.0
South West Yorkshire Partnership NHS Foundation Trust	0.9	0.5	-0.4	9.6	9.2	-0.3
Yorkshire Ambulance Service NHS Trust	3.2	0.8	-2.4	14.1	14.1	0.0
ICS total	**42.3**	**32.0**	**-10.4**	**154.3**	**161.4**	**5.0**

Provider capital – nationally supported schemes

- **National capital**: forecast spend of **£34m** which is £29m under plan.
- Year to date underspend of £10m – this is up from the £7m year-to-date underspend reported at M4). Key components:

  i) STP scheme (£2m) slippage in CHFT
  ii) (£5m) slippage on scheme in LYPFT
  iii) (£22m) under-spend at LTHT; Building the Leeds way HIP scheme and Pathology STP scheme and LIMS.
  iv) The above schemes will be re-phased in agreement with NHSEI so slippage in this financial year will be available in future years

- Note that **slippage on national capital cannot be used to offset ICS capital**

Provider capital – nationally supported schemes

Name	Month 5 PLAN £000s	Month 5 Actual (to complete) £000s	Month 5 Variance £000s	Total Capital Plan 21/22 £000s	21/22 FOT (to complete) £000s	Total Capital Plan 21/22 £000s
Airedale NHS Foundation Trust	0.4	0.0	-0.4	1.6	1.6	0.0
Bradford District Care NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Bradford Teaching Hospitals NHS Foundation Trust	0.9	-2.6	-3.5	3.6	1.1	-0.3
Calderdale and Huddersfield NHS Foundation Trust	2.0	1.0	-1.1	8.5	6.5	-2.0
Leeds and York Partnership NHS Foundation Trust	0.7	2.6	1.9	-0.7	-5.7	-5.0
Leeds Community Healthcare NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
Leeds Teaching Hospitals NHS Trust	9.9	3.2	-6.7	46.0	24.1	-21.9
Mid Yorkshire Hospitals NHS Trust	1.7	1.2	-0.5	6.1	6.1	0.0
South West Yorkshire Partnership NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Yorkshire Ambulance Service NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
ICS total	**15.6**	**5.3**	**-10.2**	**65.1**	**33.7**	**-29.3**

H2 planning

H2 planning update

- Allocations for H2 still unknown at ICS level – NHS settlement now agreed, allocations to be confirmed
- Planning guidance expected to be released mid September
- Finance plan submissions expected in November (M8)
- Anticipate reduction in allocations for H2 of c2-3%. Scenario modelling indicates potential allocation reduction of upto c£70m based on a 3% reduction.
- Expect growth for elective pressures (via H2 ERF) and non-elective pressures as part of allocation settlement
- Currently refreshing underlying run-rate model and undertaking an initial review of efficiency opportunities.
- Expecting first-cut H2 plans at system level by the end of September

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Quality and Safety Report and Quality Dashboard**	**Agenda Item No.**	11
Report Author	Louise Horsley, Quality Manager and Debbie Winder, Head of Quality	**Public / Private Item**	Public
Clinical Lead	Dr Caroline Taylor	**Responsible Officer**	Penny Woodhead, Chief Quality & Nursing Officer

Executive Summary

This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

The report also includes a copy of the Quality Dashboard for September 2021, providing quality and safety information on our main providers, as well as updates on the following:

- Becton Dickinson (BD) blood specimen; national shortage of collection bottles
- Neonatal Bacillus Calmette-Guérin Vaccine (BCG) for tuberculosis (TB)
- Care Homes
- Update Medical examiner progress (in both acute Trusts)
- CQC assessments and ratings https://www.cqc.org.uk/news/providers/how-we-will-assess-quality-update-ratings-august-2021
- Patient Safety Specialists

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	23.9.21
Name of meeting		**Meeting Date**	

Recommendations
It is recommended the Governing Body: Receives this update on Quality and Safety information to provide assurance regarding its main providers, plus the following updates: • Becton Dickinson (BD) blood specimen; national shortage of collection bottles • Neonatal Bacillus Calmette-Guérin Vaccine (BCG) for tuberculosis (TB) • Care Homes • Update Medical examiner progress (in both acute Trusts) • CQC assessments and ratings • Patient Safety Specialists

Decision ☐	**Assurance ☒**	**Discussion ☒**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	This paper is applicable to vulnerable and protected patient groups. Concerns and risks relating to quality and safety are highlighted within the paper and reflected in the risk register. No Quality Impact Assessment required.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Not required
Resources / Financial Implications (including Staffing/Workforce considerations)	N/A
Sustainability Implications	N/A

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale	**Risk (include risk number and a brief description of the risk)**	1932 – There is a risk to patient safety and experience due to the CQC suspending Mediscans registration. A risk of delay for a diagnostic scan and subsequent treatment for patients referred into the service. There is also an unknown risk of exposure of potential harm for patients previously seen by the service. 1635 – There is a risk to timely management of infection outbreaks in Calderdale due to the staffing, capacity and demand of the provision within the infection control team. 1361 – There is a risk to patient safety,

			experience and quality of care delivered by Local Care Direct (LCD) via the West Yorkshire Urgent Care (WYUC) contract. This is due to the service receiving more referrals than originally anticipated.
Legal / CCG Constitutional Implications	None identified	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None identified

1. Purpose

1.1 This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

2. Introduction

2.1 The quality dashboard received at the CCG's Quality, Performance and Finance Committee provides a high-level overview of the main acute, mental health and learning disabilities, ambulance, and community care providers through the monitoring of key quality and safety measures. These include national quality requirements, the outcomes of CQC inspections, clinical and patient related outcome measures and patient and staff experience measures.

2.2 The quality dashboard seeks to provide the Quality, Performance and Finance Committee with a view of individual areas of concern, shown on the exception report, and an overall summary of the provider. The aim is for the Quality, Performance and Finance Committee to agree the level of surveillance for each provider organisation and also for any individual areas that are performing below expected levels.

2.3 For any providers that have areas of concern showing enhanced surveillance, a plan will have been agreed, with timescales, and can be monitored for improvement by the Quality, Performance and Finance Committee. Individual areas that are on enhanced surveillance does not mean that the organisation as a whole is on enhanced surveillance, but that further scrutiny is being given to the areas causing concern.

2.4 Further information on these can be found in the Quality Dashboard, Appendix 1. Please note that this is not currently an accessibly compliant document but the CCG is working towards making this document more accessible. The information can be supplied in accessible format on request.

3. Becton Dickinson (BD) blood specimen; national shortage of collection bottles

3.1. On 26th August 2021, NHS England and Improvement (NHSE/I) issued a letter informing primary care, acute Trusts, Clinical Commissioning Groups and Integrated Care System

leads of a shortage of products alerted to them by Becton Dickinson affecting their Blood Specimen Collection Portfolio impacting across most main blood tube supplies.

3.2. Working closely with the Department of Health and Social Care (DHSC), NHS Supply Chain, the Medicines and Healthcare products Regulatory Agency (MHRA) and colleagues from the devolved administrations, given the impact on other parts of the UK, NHS England and NHS Improvement is co-ordinating the NHS' response in England, on a national basis.

3.3. The supply position remains constrained and is forecasted to become even more constrained. While it is anticipated that the position will improve from the middle of September, overall supply is likely to remain challenging for a significant period.

3.4. Primary and Community Care: All primary care and community testing was halted until 17 September 2021, except for clinically urgent testing. Examples of clinically urgent testing include:

- Bloods that are required to facilitate a two week wait referral
- Bloods that are extremely overdue and/or essential for safe prescribing of medication or monitoring of condition
- Bloods that if taken could avoid a hospital admission or prevent an onward referral
- Those with suspected sepsis or conditions with a risk of death or disability

3.5 NHSE/I issued updated guidance on 16 September in which testing in primary and community care could resume, stocks permitting, from 17 September. Acute trusts, community hospitals and mental health units are required to continue to reduce demand by a minimum of 25%, until 8 October. Best practice guidance to optimise blood testing in primary and secondary care was also issued by NHSE/I.

3.6 Due to the potential impact on patient safety NHS England and NHS Improvement have informed CQC and confirmed with NHS Resolution that any resulting clinical negligence claims will be captured in the usual way by the respective state indemnity schemes for both Primary and secondary care.

3.7 The position for our local providers is:

3.7.1 Guidance has been shared with Calderdale Primary Care for circulating via the Primary Care bulletin. Further support and guidance regarding this will be provided to individual areas if required.

3.7.2 Conversations are ongoing with Calderdale and Huddersfield Foundation Trust (CHFT) Quality colleagues to seek assurances and identify areas of any emerging risk.

4. Neonatal Bacillus Calmette-Guérin Vaccine (BCG) for tuberculosis (TB)

4.1. Public Health England (PHE) mandated changes nationally to new-born BCG delivery which were due to start on 1st September. The changes have significant impact to the timing of delivery of the vaccination to eligible babies and creates substantial risk to both uptake of BCG vaccination and potential subsequent increase in Tuberculosis rates.

4.2. This is due to a pilot which adds an additional screening test into the new-born blood spot test for Severe Combined Immunodeficiency (SCID), a group of rare, inherited disorders which cause major abnormalities of the immune system. The changes require BCG vaccination administration from prior to post-natal discharge after birth to administration at 28 days of age which creates risk of non-attendance. There is no additional funding to support the changes this requires to a safe delivery model.

4.3. Maternity services across West Yorkshire and Humber (WY&H) have opposed implementation of the change due to concerns of capacity to deliver necessary amended models; risks it will adversely impact on vulnerable families and babies as well as the fact that WY&H are not included in the pilot so no babies will be screened for SCID.

4.4. This has resulted in agreement that NHS England/Improvement support West Yorkshire with a transition approach for adoption of the programme. The CCG are supporting the development of a joint WY&H Equality and Quality Impact Assessment (EQIA) undertaken to consider the impact of proposed changes due to be completed by the end of September which will inform proposals of a sustainable service model design. It has been agreed that eligible babies will be tracked from 1 September 2021, with plans underway to ensure service provision at 28 days (from 29 September 2021) plus a bespoke service to follow up any babies that ‘did not attend’, the bespoke service will be funded by NHS E/I.

5. Care Homes

5.1. The CCG Quality team is working closely with Local Authority colleagues to agree an enhanced supportive strategy due to the risk of an increasing number of care homes being found to have quality and safety concerns which were previously unknown due to limited visits in person during the pandemic. The CQC has re-started inspections and is operating an inspection schedule based on risks/issues being flagged to them. The CCG/Local Authority are increasing face to face opportunities for identifying quality issues and working collaboratively to increase proactive quality and leadership support. The CCG is working closely with the CQC to align visit schedules and quality assurance methods.

6. Medical Examiner progress update

6.1. Following the update to the last committee on expansion of the Medical Examiner role into other settings the CCG Quality team have been involved in conversations on how this is being progressed by acute providers. Established medical examiner offices are working with stakeholders partners to implement the required incremental approach to build additional capacity with appropriate skills and develop necessary systems and processes.

6.2. CHFT: Are planning to trial new processes by jointly reviewing deaths at Overgate Hospice in September with a view to then rolling out into primary care. A further update on how this will happen including engagement with primary care will be provided.

6.3 South West Yorkshire Partnership Foundation Trust (SWYPFT): The Quality Manager has been liaising with SWYPFT to establish how they plan to progress and if there are ways we can support partnership working and share best practice. The Quality Manager has been invited to SWYPFT Medical leaders advisory group which consists of Medical Clinical leads and Associate Medical Directors from across the Trust to discuss the medical examiner service. This meeting took place on 17th September which was attended by the CCG Quality Manager and Lead Medical Examiner for Barnsley NHS Foundation Trust to discuss the medical examiner role and requirements to extend it to community and mental health trusts. The Medical Examiner for Barnsley NHS Foundation Trust explained the role of the medical examiner officers in gathering information and liaising with families and how they plan to integrate with general practice. The medical director for SWYPFT has asked the CCG Quality Manager and Lead Medical Examiner for Barnsley NHS Foundation Trust to

attend future medical examiner planning meetings, to progress with the requirements and agree processes and reporting. Further updates will continue to be provided to the Quality Committee with progress and developments.

7. Care Quality Commission (CQC)

7.1. The CQC are introducing some changes to how they regulate providers from August 2021, following their consultation on changes for flexible and responsive regulation.

The changes enable the CQC to be more flexible in how they assess and rate providers. They also take in to account the ongoing challenges that many providers face as we move into the next stage of the pandemic. The CQC aim to be more dynamic, proportionate and a flexible regulator in line with their new strategy.

7.2. What this means for providers of health and social care:

7.2.1. The purpose of the CQC has not changed – they ensure health and social care services provide people with safe, effective, compassionate, and high-quality care, and they encourage services to improve.

7.2.2. The CQC will no longer set a maximum interval, based on previous ratings, between inspections. Historically, the CQC have always needed to carry out a site visit to give a rating. Going forward, they will start to use a wider range of regulatory approaches to assess quality and rate providers. Initially, these will be in a limited number of circumstances as they continue to develop the regulatory approach outlined in their strategy. They will use professional judgement to determine when this is appropriate and be clear about the methods when they inspect services.

7.2.3. The CQC will provide further information about when they will rate a service as they implement their strategy.

7.2.4. The CQC will use a different regulatory approach for example when:

- making more use of technology to support how they gather evidence in all services
- updating a rating without a site visit: where they have gathered evidence of a deterioration in quality or taken enforcement action – they are less likely to do this in some settings such as residential settings, where it's necessary to observe care or the environment

- they ask a provider to show that they have addressed the concerns that affected their rating in a previous inspection

7.2.5. Site visits to homecare services won't always be required following successful pilots carried out in 2020.

7.2.6. The CQC will continue to assess whether services are safe, effective, caring, responsive and well-led using their assessment frameworks for healthcare and adult social care and will also carry-on using inspections where they focus assessments on specific areas.

7.2.7. Adult social care providers and GP providers will continue to receive inspections that are more focused to update ratings in line with CQC published guidance.

7.2.8. A more flexible approach to assessing and rating other primary care services will also be developed further.

7.3. NHS trusts: the CQC consultation response set out changes to how they will rate NHS trusts from Spring 2022. For this year, the CQC will also carry out some well-led plus core service inspections and rate at NHS trust level. Using information from monitoring, they will be proportionate when deciding which core services to include in the inspection. They will also use their ratings principles in a more flexible way along with professional judgement to depart from these where appropriate, either in response to concerns or where there has been improvement.

7.4. Key points these changes do not affect:

- The CQC will continue to use their assessment frameworks and ratings characteristics
- Inspection teams will still use the five key questions and key lines of enquiry (KLOEs) to structure their assessments
- The valuable views of people who use services, and staff, will still be gathered and used to inform assessments and ratings
- Health and social care services will still be rated as either: outstanding, good, requires improvement or inadequate
- The CQC will continue to use their ratings principles
- Reports will still be published following services inspected
- The reporting and factual accuracy process is unchanged
- The process to request a rating review still applies

- The enforcement policy is unchanged
- Mental Health Act (MHA) monitoring visits to protect the rights of vulnerable people will continue

7.5. As the approached is developed to assess and rate services the information available will be updated. This includes other changes proposed in the consultation – specifically removing ratings for population groups in our inspections of GP practices and changes to NHS trust level ratings.

8. Patient Safety Specialists

8.1. The creation of the Patient Safety Specialist role was identified in the NHS Patient Safety Strategy in 2019 but roll out of this has been affected by the pandemic. These individuals are the lead patient safety experts in their organisations, working full time on patient safety and all NHS organisations are required to have one identified. CCGs were required to nominate an individual and in Calderdale CCG this role is the Head of Quality. It has been acknowledged the role differs in provider and commissioning organisations but the important part commissioning plays in system approach to Patient Safety is recognised.

8.2. Patient Safety Specialists provide leadership, visibility, and expert support to the patient safety work within their organisation, they support the development of a patient safety culture and safety systems, and the local implementation of the national NHS Patient Safety Strategy.

8.3. They also have a key role in supporting their Executive Team to understand the most effective approaches to improving patient safety and ensuring that any patient safety-related responsibilities held by different executives are effectively aligned.

8.4. Patient Safety Specialists lead, and may directly support, patient safety improvement activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes. There are regular national bulletins and webinars with short and medium-term priorities published.

8.5. Further updates will be provided against the priorities which are:

- Just culture
- National Patient Safety alerts

- Improving quality of Incident reporting
- Supporting transition from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) to the Patient Safety Incident Management System (PSIMS)
- Involvement in implementing the new Safety Incident Response Framework
- Implementing the framework for involving Patients in Patient Safety
- Patient Safety education and training
- National Patient Safety Improvement programmes
- Covid -19 recovery planning.

9. Implications

9.1. Quality and Safety Implications

9.1.1. The Committee should note that this report contains information relating to vulnerable patient groups and contains information in relation to the quality of health services commissioned by the CCG.

9.2. Resources / Finance Implications

9.2.1. The Committee will be provided with a verbal update on the implications of the pandemic on the resources and capacity within the CCG Quality team due to the constantly changing situation and responses necessary.

10. Recommendations

10.1. It is recommended that the Governing Body receives this update on Quality and Safety information to provide assurance regarding its main providers, plus the following plus the following updates:

- Becton Dickinson (BD) blood specimen; national shortage of collection bottles
- Neonatal Bacillus Calmette-Guérin Vaccine (BCG) for tuberculosis (TB)
- Care Homes
- Medical examiner progress
- CQC assessments and ratings
- Patient Safety Specialists

11. Appendices

11.1. Appendix 1 – Quality Dashboard.

Please note that this is not currently an accessibly compliant document but the CCG is working towards making this document more accessible. The information can be supplied in accessible format on request.

Calderdale CCG Quality Dashboard
September 2021

CCCG Exception Report

Indicator	Target	Month/ Quarter	Month data from	YTD 2020-21
C-Diff	24	1	July 2021	11
MRSA	0	0	July 2021	0
MSSA	No target	8	July 2021	19
E-Coli	155	10	July 2021	37
Pseudomonas	9	2	July 2021	4
Klebsiella	38	2	July 2021	7

Healthcare Acquired Infections (HCAI). PHE has released the national objectives where applicable and these have been updated on the dashboard accordingly.

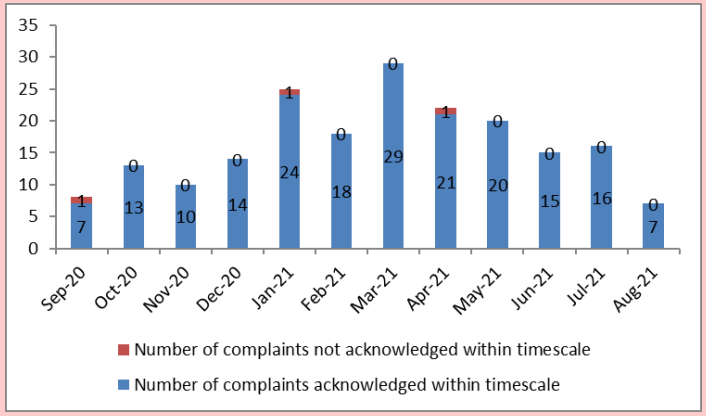
Broad Spectrum antibiotics:

The prescribing of broad spectrum antibiotics as a % of all antibiotics prescribed over a 12 month period up to June 2021 has slightly decreased against March 2021 to a value of 7% which is well within the NHSE target of 'at or below 10%'.

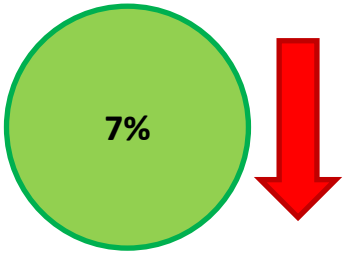
Total antibiotic prescribing per 1000 STAR-PUs:

This is currently well below the NHSE target from April 2019 of 965 or below – but significantly above the England average. Following the nationwide drop in prescribing during the pandemic, there has been an increase after April 2021 - this pattern has reflected in Calderdale. However the increase means Calderdale is once again only just outside the worst quartile for prescribing of antibiotics. There remains concerns around remote prescribing of empirical antibiotics.

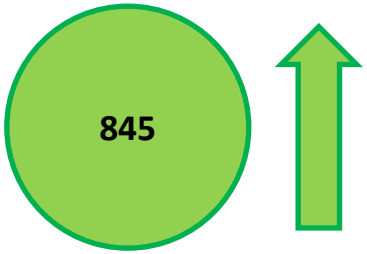
Complaints – acknowledged within 3 working days



During the Quarter the complaints team continued to receive a number of complaints regarding GP appointments and have continued to work closely with primary care colleagues to help supress the continuing trend. This included providing generic information to the local MPs so they could share this with their constituents to avert the case being referred onto the CCG.



Broad spectrum antibiotics as % total antibiotics prescribed
June 2021
(updated August 2021)



Total antibiotic prescribing items per 1000 STAR PUs
June 2021
(updated August 2021)

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – September 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Central Alerting System (CAS)/National Patient Safety Alerts (NPSA).	Following the publication of the CQC insight report the Trust continues to show as an outlier with regards to CAS/NPSA alert indicators. Progress on this indicator is not yet evident. The Trust have noted the slow progress and do not benchmark favourably nationally.	The matter was escalated to the Company Secretary and a quality assurance review has been undertaken to review the standard operating procedures and governance processes. The review highlighted weaknesses in regards to the ownership of CAS alert actions and the processes for recording and subsequent closure of the alert. Assurances on the progress and achievements of CAS alert and associated actions are received through the attendance at the Trust Internal Quality Committees. The Trust are monitoring this indicator on a monthly basis via internal monitoring meetings.	A revised process is in place and an increase in timely closure of the data is expected in the coming months but this will take time to become embedded within the Trust.

Calderdale and Huddersfield NHS Foundation Trust
Overview/triangulation

This page provides a summary in relation to the Quality and Safety of services provided at Calderdale and Huddersfield NHS Foundation Trust (CHFT) for the period up to July 2021.

Central Alert Systems (CAS) Indicators

Although not demonstrated in the current data set assurances continue to be received from the Trust regarding this indicator. This indicator continues to remain off track and the Trust note that they benchmark worse than expected nationally. The Trust have established mechanisms to monitor individual alert timescales on a monthly basis. Papers continue to be shared with commissioners to detail information relating to patient safety alerts that are:

- Beyond deadline – *Including progress updates, expected completion dates and risks to closure.*
- Within deadline – *Including current status and progress against the alert closure deadline.*
- Confirmed closures

Individual patient safety alert titles are included and mechanisms in place for the Trust to monitor this in a robust efficient way.

Patient Experience Network National Awards (PENNA)

CHFT have been shortlisted as finalists in 7 categories. These are: Commissioning for Patient Experience – CHFT Bereavement Support Service. Providing effective online care during the COVID-19 pandemic, CHFT – Co-produced Innovations Improving Patient Experience. Personalisation of Care - CHFT Bereavement Support Service. Patient Experience Team of the Year – CHFT Co-production "What matters most to you, diagnosis through to end of life." Staff Engagement and Improving the Staff Experience - CHFT Bereavement Support Service and Using Insight for Improvement – CHFT Co-produced Innovations Improving Patient Experience with cancer patients. Winners will be announced at the virtual ceremony on 17 September 2021

Complaints

During May and July the Trust achieved 100% within this indicator. Making Complaints Count was allocated as one of the Trusts focussed quality priorities this year. The Trust have reported that complaints received are increasing with current themes identified regarding increasing waiting times within the Emergency Department which is reducing patient experience. The July SPC chart has been included to demonstrate the improvement within this area.

Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours – BPT based on discharge

Work commissioned within Surgery to look into #NOF performance with a view to provide recommendations on how to improve performance particularly at the time of surges. Action plans are in place and performance has increased month on month.

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2021

			CHFT			Trend information															
						Direction of Travel			2020-21										2021-22				
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	YTD 2021-22	Month / Period / Year data from	Previous Month / Period	Corresponding month 2020-21	J	A	S	O	N	D	J	F	M	A	M	J	J	A
Safe	C Diff	Monthly	tbc	1	8	Jul-21	↑	↑	7	2	2	4	2	6	4	1	3	1	2	4	1	-
	E Coli	Monthly	n/a	0	0	Jul-21	↔	↑	1	0	0	0	0	0	0	0	0	0	0	0	0	-
	MRSA	Monthly	0	0	0	Jul-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	MSSA	Monthly	n/a	0	0	Jul-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	Never Events	Monthly	0	0	1	Aug-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Serious Incidents	Monthly	n/a	2	15	Aug-21	↓	↔	2	2	4	2	1	3	5	2	2	4	2	6	1	2
	Overall essential safety compliance	Monthly	>=90% Green >=90%<85% Amber <85% Red	95.48%	-	Jul-21	↓	↓	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	-
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	0.0%	-	rolling 6 months - Feb - July 21	↔	↓	37.1%	34.5%	37.5%	36.4%	30.0%	27.0%	15.0%	31.0%	16.7%	27.3%	0.0%	0.0%	0.0%	-
	VTE Risk Assessment	Monthly	>=95%	95.31%	95.28%	Jul-21	↑	↓	96.26%	96.14%	95.46%	95.37%	96.13%	95.74%	95.67%	95.97%	96.03%	95.55%	95.10%	95.22%	95.31%	-
Caring	EMSA	Monthly	0	0	0	Jul-21	↔	↔	0	0	0	2	3	0	0	0	1	0	0	0	0	-
Responsive	% Complaints closed within target timeframe	Monthly	100%	100.0%	95.83%	Jun-21	↑	↑	70.0%	71.0%	62.0%	44.00%	50.00%	41.70%	63.00%	52.90%	60.00%	100.0%	87.5%	100%	in arrears	-
	No of complaints re-opened	Monthly	n/a	7	14	Jun-21	↓	↓	1	4	3	1	0	0	0	0	3	4	3	7	in arrears	-
	% Last minute cancellations to elective surgery	Monthly	< 0.65%	0.09%	0.28%	Jul-21	↑	↑	0.13%	0.36%	0.38%	0.30%	0.23%	0.00%	0.16%	0.07%	0.32%	0.41%	0.34%	0.27%	0.09%	-
	Percentage Non-elective #NoF Patients with admission to Procedure of < 36 hours	Monthly	>=85%	60.90%	59.22%	Jul-21	↑	↑	42.86%	51.06%	74.36%	75.68%	67.39%	61.70%	45.83%	64.29%	65.85%	62.50%	72.30%	41.18%	60.90%	-
	12 hour breaches in A&E (A&E trolley waits)	Monthly	0	1	1	Jul-21	↓	↓	0	0	0	15	21	0	0	0	0	0	0	0	1	-

Arrow key:

↑ movement towards target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2021

Good **CQC Inspection rating** June 2018	99.91 **SHMI** - One year rolling data Mar 20 – Apr 21 Updated May 2021	88.99 **HSMR** - One year rolling data Apr 20 – May 21 Updated May 2021
Staff Survey – satisfied with the quality of care to patients/SUs 80.3% Improvement from previous year (78.4%). Below national average (82%) Annual – updated April 21	**Staff Survey** – recommend as a place to work 63.8% Improvement from previous year (57.4%). Below national average (66.9%) Annual – updated April 21	
CQC Inpatient Survey – respect and dignity 9.0 about the same as other trusts Annually – updated July 20 (next publication Oct 2021)	**CQC Inpatient Survey** – involved in care decisions 7.4 about the same as other trusts Annually – updated July 20 (next publication Oct 2021)	

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – September 2021

Routine Monitoring

Proposed indicators to return to Routine Monitoring:

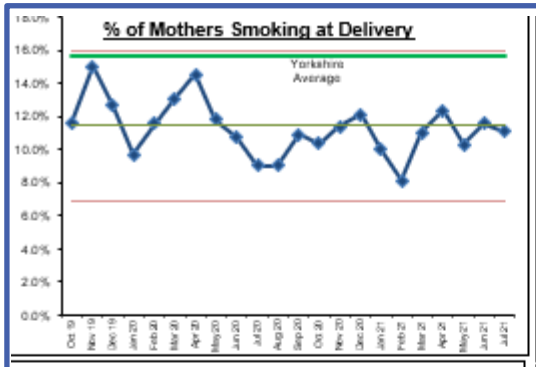
Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard – September 2021

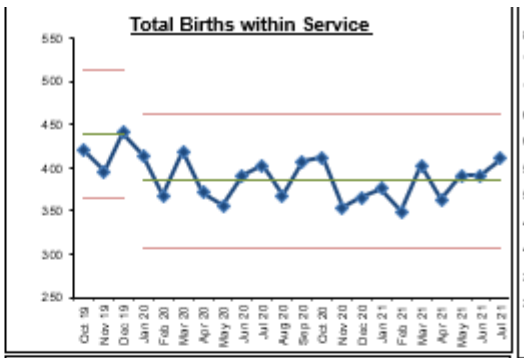
Key Indicators

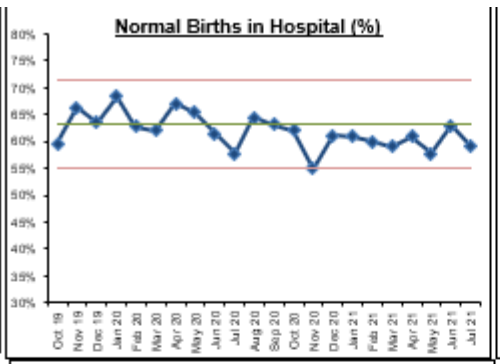
	Thresholds			Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	YTD		
	Green	Amber	Red																	
Total Bookings	>90%	-	<90%	92.6%	94.0%	94.7%	90.6%	92.7%	93.2%	90.6%	90.0%	90.5%	94.6%	90.6%	90.6%	91.4%	90.2%	90.7%		
Total Births within Service	Monitoring Only			391	402	368	407	412	354	365	376	349	403	363	391	391	411	1556		
Normal births	>57%	-	<57%	61.38%	57.71%	64.40%	63.1%	61.7%	55.4%	61.1%	60.6%	60.2%	58.8%	60.6%	57.8%	63.4%	59.1%	60.2%		
Assisted vaginal births	<12.4%	-	>12.4%	9.72%	9.70%	10.05%	10.57%	10.92%	11.86%	9.04%	9.57%	11.46%	9.68%	8.54%	9.46%	7.42%	9.98%	8.9%		
Elective C/S deliveries	<13.2%	-	>=13.2%	11.78%	13.03%	10.14%	10.42%	9.61%	11.65%	11.81%	9.43%	12.14%	13.53%	10.64%	12.60%	10.03%	11.08%	11.10%		
Emergency C/S deliveries	<16.9%	-	>16.9%	15.18%	18.30%	14.52%	15.14%	16.50%	21.02%	17.86%	19.41%	15.61%	17.04%	18.49%	19.54%	18.51%	19.46%	19.01%		
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	1.7%	0.3%	1.3%	1.1%	2.0%	1.2%	0.9%	1.1%	0.3%	0.9%	0.6%	0.8%	0.5%	1.0%	1.2%		
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	2.6%	7.7%	5.4%	4.7%	4.4%	4.8%	0.0%	0.0%	0.0%	2.6%	9.7%	8.1%	3.4%	0.0%	5.1%		
PPH ≥ 1500ml	<3%	<3.4%	>=3.5%	4.19%	3.26%	4.11%	2.98%	3.69%	3.41%	2.20%	2.43%	1.73%	3.26%	1.12%	2.57%	3.08%	1.97%	2.21%		
Total stillbirths	0	<3	>=3	1	2	1	1	2	3	0	3	1	2	3	3	3	2	11	5	6
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	1	3	1	1	2	3	0	3	2	3	3	3	3	4	13	8	5
Low birth weight at term - live births - % of live babies at term < 2200g	0%	<1%	>=1%	0.28%	0.54%	0.00%	0.79%	0.00%	0.90%	0.59%	0.00%	1.55%	0.53%	0.61%	0.56%	1.91%	1.07%	1.05%		
1:1 Care in Labour	>=98%	>=97%	<97%	99.2%	99.5%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.7%	99.7%	98.9%	100.0%	100.0%	98.2%	99.3%		
Induction Rate	Monitoring Only			38.9%	42.7%	42.7%	41.6%	39.2%	46.9%	48.6%	46.1%	44.1%	45.5%	47.6%	42.4%	44.3%	40.4%	43.6%		
Planned Home Birth	Monitoring Only			2.62%	1.00%	1.37%	3.23%	2.71%	3.69%	2.47%	2.96%	2.02%	2.46%	2.80%	2.57%	1.80%	2.46%	2.40%		
Smoking at Delivery	< 11%	-	> 11%	10.73%	9.02%	9.04%	10.92%	10.34%	11.36%	12.09%	9.97%	8.09%	11.03%	11.76%	10.28%	11.57%	11.08%	11.16%		
Smoking at Delivery (Not recorded)	3%		>3%	0.5%	0.0%	0.0%	0.0%	1.2%	0.6%	0.3%	3.2%	3.2%	3.0%	1.7%	4.6%	2.6%	1.2%	2.5%		
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	81.1%	76.1%	75.3%	72.89%	76.5%	77.7%	75.3%	75.3%	75.7%	75.8%	73.2%	64.0%	49.7%	48.8%	60.9%		
No. Mothers breastfeeding as First Feed Not Recorded														4	7	20	140	171		

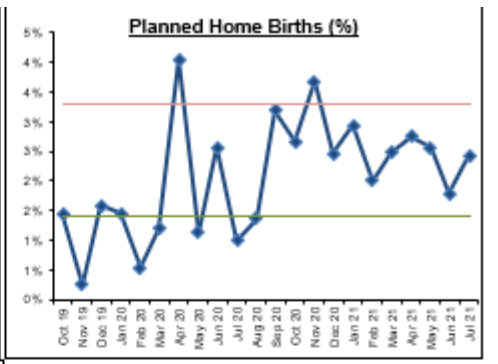
Variance to Same Period in 2019/20
4.2%
Variance to Same Period in 2019/20

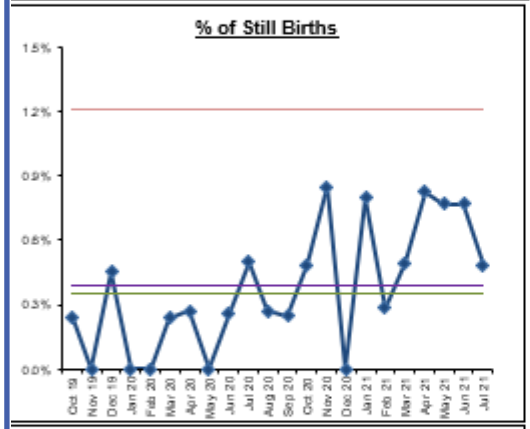
Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard – September 2021

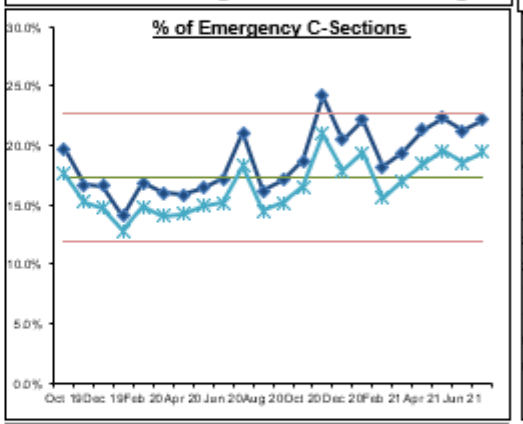


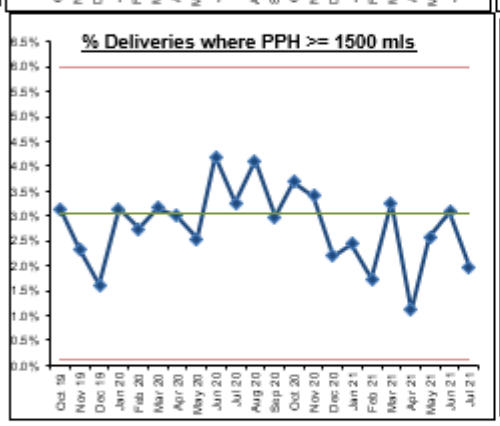


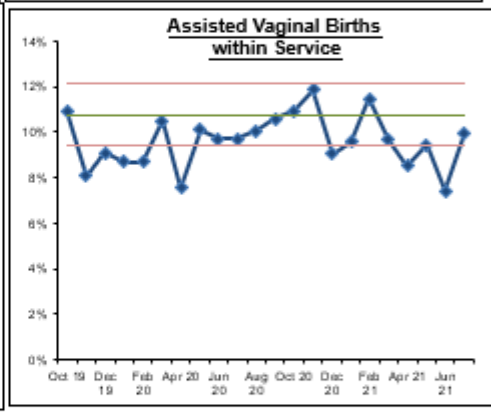


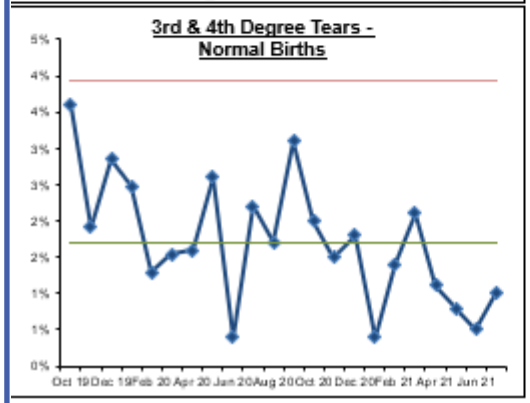


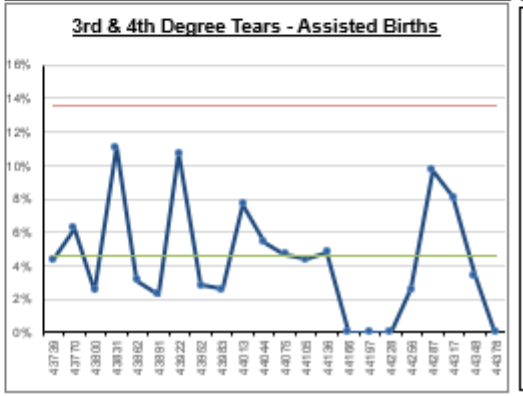


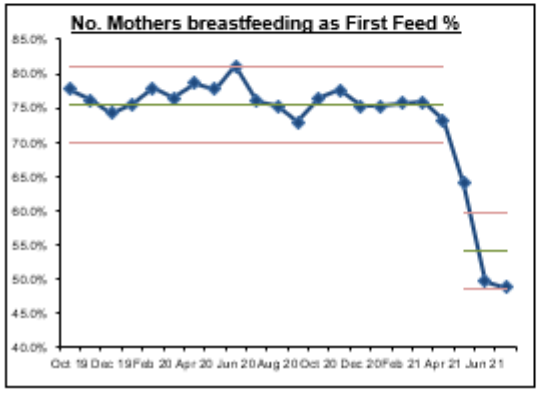








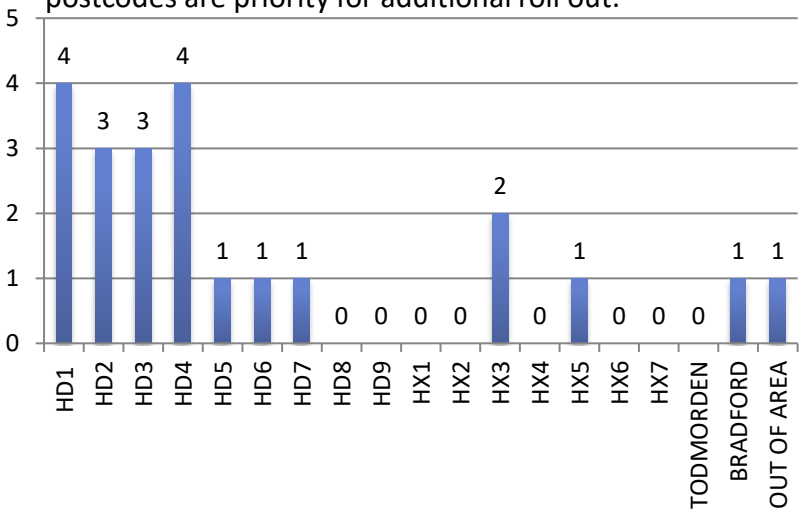




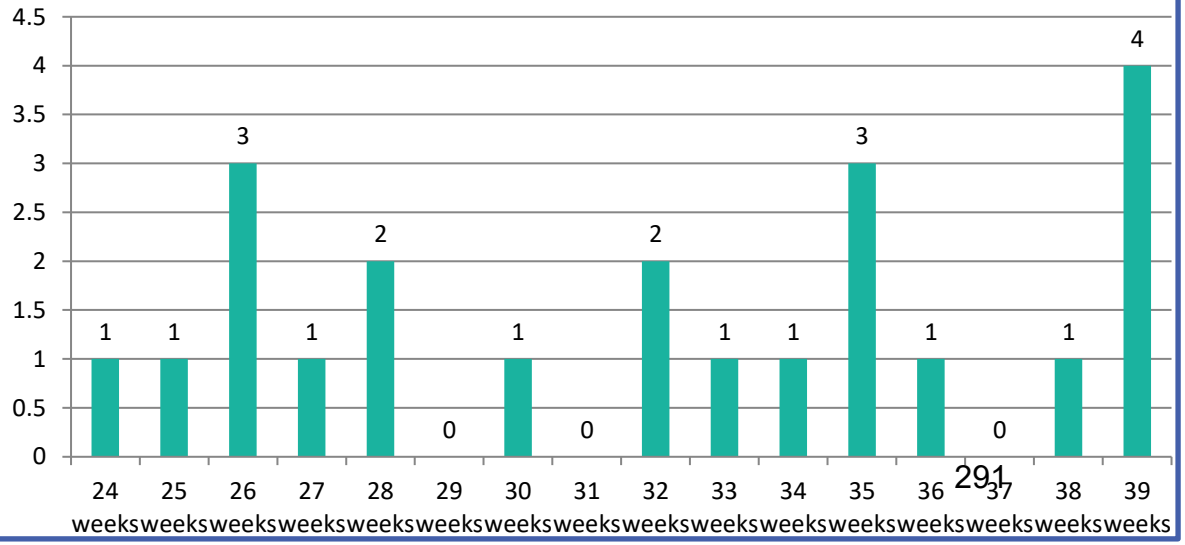
Calderdale and Huddersfield NHS Foundation Trust
Maternity update

Stillbirths- CHFT have undertaken a detailed review of all stillbirths in recognition of an increase in numbers on last years total, and that numbers increased during Covid-19. The review included all stillbirths from 1/6/20—31/5/21 which included a total of 22 cases.
CHFT have acknowledged they are an outlier with a rate of 22/4742 or 4.6/1000 births in comparison with the national rate of 3.83/1000births.
The review identified themes of congenital abnormality, maternal smoking, late to book, deprivation, ethnicity.
The maternity services are using information from the review to inform their vision for development and improvements. These include a new post of Health Inequalities Midwife to work strategically using change methodology to oversee the Public Health and Health Inequalities agenda to ensure workstreams are co-ordinated, data robustly analysed taking into account multiple risk factors and Health Inequality demographics plus previous national research findings. Plans are also progressing to increase Continuity of Care capacity and specialist midwives roles. Discovery Interviews are scheduled to focus on cohorts who would not normally engage to link into Health Inequalities programme
Plans are underway to increase support offers for smokers and use of lay service users to allow more appropriate questioning of what substances women are smoking or chewing.

The graph below demonstrates the number of stillbirths by IMD/ postcode.
Health inequalities review has identified increased complexity in HD1-4 with multi-deprivation evident.
One of the Continuity of Carer teams is based in this locality with targeted improvement plans underway and other high rate postcodes are priority for additional roll out.



The graph below shows the gestation of all stillbirth cases in the review. The Head of Midwifery is planning to instigate regular Perinatal Morbidity and Morality meetings with neonatology and other disciplines to allow detailed review, including health inequalities and multi disciplinary identification of learning.



South West Yorkshire Partnership NHS Foundation Trust
Exception Report – September 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Complaints closed with in 40 days	Prior to Covid-19 (March 2020) the Trust had reached 78% against a target of 80%, which was significant progress from the 20% baseline. Since reopening the complaints process in July 2020 they have seen : •Increased number of complaints •Increase in complexity •Reduction in availability of clinical investigators due to commitments and response to Covid 19 pandemic.	A pilot of a new set of key performance measures on timeframes for handling complaints has recently been approved by the executive management team as a pilot to run between April to July 2021. SWYPT have identified this an a Quality priority within their annual Quality Account. The pilot will categorise the complaints as complex, moderate or low and each category will be assigned a set amount of working days to be closed. Ranging from 25 to 60 days depending on severity. All complaints are risk assessed to ensure there is no risk to patient safety and not detrimental to health and well being.	The findings of the pilot will be published in August 2021 The Trust are extending complaint handling training to enable more staff to be lead investigators.

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – September 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Number of records with up to date risk assessment – Inpatient and Community (Target 95%)	During September and early October 2020 services have moved from the Sainsbury tool on SystmOne to the FIRM (formulation of informed risk assessment) tool which supports the Trust values.	A task and finish group has been established to agree new performance measures and review effectiveness of FIRM A formal evaluation process was started in January and closed on 23rd April with 282 responses. Detailed evaluation of the outputs has not been started, but over 60% of respondents agreed the tool was relevant to their clinical practice, allowed the user the opportunity to explain/formulate risks adequately, to clarify interventions to reduce risk adequately and to view identified risks. A report is produced which shows the number of FIRM risk assessments started (completed) and reviewed. It also includes other questionnaires where assessment of risk has been recorded. This is reported into the Operational Management Group via the Clinical Risk Report, and will be supported by local dip sample audits to review the quality and completeness of the risk assessment.	As FIRM has not yet been in use for twelve months, assurance is provided through existing alternative risk assessments such as Sainsburys or those within medical care plans. The trajectory is 80% completion of FIRM by Q3 and 90% completion by Q4. Responsibility for the quality of FIRM sits within the BDU and will be monitored via audit and exceptions reported into the Clinical Governance Group for escalation to the Clinical Governance, Clinical safety Committee. Training sessions are available between August 2021 and May 2022 for new starters and refreshers.

South West Yorkshire Partnership Foundation Trust
Overview/Triangulation

The following 2 pages provide a summary in relation to the quality and safety of services provided at South West Yorkshire Partnership Foundation Trust (SWYPFT) for the period of up to August 2021, dashboard data to June 2021.

FFT 81% of service users would recommend community services (target 85%) and 97% of service users would recommend mental health services (target 98%)

- 83% (741) of respondents felt that their experience of services had been very good or good across Trust services.
- 97% (n=106) of respondents felt that their experience had been very good or good across community services.
- 81% (n=635) of respondents felt that their experience had been very good or good across mental health services.

The Trust is adapting how Friends and Family Test question is asked via text message in response to the low number of free text comments. A URL will be sent by text to encourage respondents to provide accompanying comments to their ratings.
The quality improvement team are also leading on a piece of work with CAMHS to improve accessibility to giving feedback for children and young people and ensuring the service is listening and acting on feedback.

Safer Staffing Inpatients – The Trust continues to experience a high demand on inpatient services and they acknowledge that this does impact on community services they offer. Despite business continuity plans being in place and support being reallocated across the services there has been an added pressure of staff absences due to isolating through test and trace. As of 22nd July 161 staff were absent due to covid related reasons. The Trust is working in collaboration with Bradford District Care NHS Trust & Leeds & York Partnership NHS foundation Trust for on recruitment of permanent and bank staff. Any incidents where the registered nurse cover has fallen below the expected establishment are supported by local escalation plans which remain robust in the face of the staffing pressures. Each incident where a Preceptee is left alone because of an emergency, i.e. sickness or clinical incidents, are looked at and assurances have been given around what support was in place for that incident. No ward has fallen below the 90% overall fill rate threshold in June, which is consistent with the last four months.

Reducing Restrictive Physical Intervention The number of restraint incidents have increased from 106 to 170. This is an increase of 64 (60.4%) incidents in May2021 which was 106 incidents. Of the different restraint positions used in the 170 incidents, standing position was used most often 84 (49.4%) followed by seated at 46 (27%). Prone restraint was reported 16 (9.4% of total restraints) times in June 2021, this is a decrease of 2 (11%) from last month. All the prone restraints were directly linked to seclusion (16) or medication (10) events.
Incidents where prone descent immediately turned into a supine position were recorded at 14 (8.2%) this is a separate entity to prone restraint.
Wakefield recorded 9 prone Restraints; Kirklees 3, Calderdale and Barnsley both reported 2, learning disabilities and Forensics reported no prone restraints in this period. The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In June the percentage of prone restraints lasting under 3 minutes was 93.75% which is a reduction of 6.25%. Each incident of prone restraint has been reviewed by a member of the RRPI team. The team continue to provide face to face training in line with current IPC guidance. Although Covid restrictions have impacted on our delivery the Trust have maintained a compliance of over 80% in all courses.

South West Yorkshire Partnership Foundation Trust
Overview/Triangulation

% Service users on CPA offered a copy of their care plan - Reporting has now been developed to enable the Trust to monitor performance against this metric. To meet the standard all care plans for an individual have to have been identified as offered to the service user. For example, if an individual has 5 care plans, all of these must be marked as offered to the service user for this to achieve the standard. Work is ongoing to improve data quality. Further work is underway also to review the way that this is recorded and reported with the emphasis on people having the conversation with service users about copies of the care plans.

Incidents – Incident reporting levels have been checked by the Trust and are reported to be within the expected range. All serious incidents are investigated using system analysis techniques and the quality manager and CCG SI team continue to meet with the Trust bimonthly to discuss serious incidents and evidence reviews against action plans.

NHS Improvement: The trust patient safety specialists are joining national and regional patient safety discussions/information sessions and share this information throughout the Trust. NHS England/Improvement have identified 9 short to medium term priority areas to progress with. These are:

- Just culture – introducing NHS England's just culture guidance or other framework
- Implementation of Patient Safety Incident Management System (PSIMS) – will replace national reporting and learning system (NRLS) and STEIS
- Patient Safety alerts – ensuring effective processes are in place to manage alerts
- Improvement quality of Incident reporting – ensuring robust processes for reviewing and accessing data on NRLS
- Implementation of the New Patient Safety Incident Response Framework (PSIRF)
- Involving patients in patient safety (partners) – guidance issued 30/6/21
- Safety Improvement Programmes – number of programmes, active presently is for mental health for Reducing restrictive interventions
- Patient Safety education and training (curriculum) – curriculum published, e-learning for all staff expected to be available this summer
- COVID-19 recovery planning – ongoing work within organisation

Work to map the patient safety specialist role against existing resources is ongoing, along with identifying operational leads for all areas of work

Learning Library: The Trust have developed a learning library to gather and share examples of learning from experience. http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

Performance for CAMHS Referral to Treatment - The number of children waiting for CAMHS have increased. Although currently this has not had an impact on the 18 weeks performance, services have highlighted that sustained increases will negatively impact on the length of wait.

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – September 2021

			SWYPFT				Trend information																
							Direction of Travel		2020-21												2021-22				
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	YTD 2021-22	Month/ Period/Year data from	Previous Month/Period	Corresponding month 2020-21	J	A	S	O	N	D	J	F	M	A	M	J	J	A
Safe	Never Events	Monthly	0	0	0	Aug-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	2	10	Aug-21	↑	↑	2	6	1	0	3	2	1	0	2	4	0	1	3	2
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	100.0%	-	rolling 6 months - Feb 21- July 21	↔	↔	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	92.0%	92.0%	91.7%	91.0%	83.3%	100.0%	100.0%	-
Effective	% Admissions Gate kept by SRS Teams	Monthly	95%	100.0%	-	Jul-21	↑	↑	96.8%	96.4%	95.2%	100.0%	100.0%	98.0%	100%	99.1%	99.1%	100.0%	100.0%	99.1%	100.0%	-
	No. of records with up to date risk assessment – Inpatient	Monthly	95%	59.1%	-	Jul-21	↑	↓	84.3%	93.4%	81.0%	20.9%	46.6%	54.0%	55.5%	53.0%	53.2%	61.6%	68.3%	56.1%	59.1%	-
	No. of records with up to date risk assessment – Community	Monthly	95%	70.4%	-	Jul-21	↑	↑	70.0%	74.6%	77.4%	37.3%	47.7%	51.9%	56.0%	63.2%	57.3%	51.8%	46.9%	68.9%	70.4%	-
Caring	EMSA	Monthly	n/a	0	0	Jul-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Responsive	Complaints closed within 40 days	Monthly	80%	20%	-	Jul-21	↓	↓	100%	-	30%	60%	73%	11%	50%	0%	58%	39%	29%	42.0%	20.0%	-
	No of complaints re-opened	Monthly	n/a	0	5	Jul-21	↓	↓	0	-	0	0	2	2	0	1	0	2	0	-	3	-
	CAMHS - under 18's admitted to adult wards	Monthly	tbc	3	12	Jul-21	↔	↓	0	3	3	2	4	2	2	1	3	3	3	3	3	-
	Delayed Transfers of Care	Monthly	3.5%	1.9%		Jul-21	↓	↓	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1.8%	1.6%	1.8%	1.2%	1.1%	1.3%	1.9%	-
	% Service users on CPA followed up within 7 days of discharge	**Monthly**	95%	99.3%	-	Jul-21	↑	↓	100.0%	98.8%	99.1%	98.9%	100.0%	100.0%	98.90%	100.0%	97.0%	96.8%	98.8%	98.1%	99.30%	-
	Out of Area Beds Days	Monthly	-	86	-	Jul-21	↑	↑	336	224	177	106	88	122	91	78	82	122	204	177	86	-
Well-led	Information Governance Confidentiality Breaches	Monthly	<12	11	37	Jul-21	↔	↑	25	17	19	12	17	12	12	13	13	7	8	11	11	-

Arrow key:

↑ movement towards target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – September 2021

CQC Inspection rating published August 2019

Good

Staff Survey – satisfied with the quality of care to patients/SUs

81.9%

Improvement from previous year (81.5%). Below national average (82.3%)
Annual– updated April 21

Staff Survey – recommend as a place to work

69%

Improvement from previous year (61.5%) . Above national average (67.7%)
Annual – updated April 21

Spire Elland/BMI
Exception Report – September 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track

Routine Monitoring

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Risk Register Position Statement Risk Cycle 3 2021-22 (16 Aug – 1 Sept 2021)**	**Agenda Item No.**	12
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby	**Responsible Officer**	Neil Smurthwaite (Chief Operating Officer)

Executive Summary

This paper presents the high-level risk report at the end of the third risk review cycle of 2021-22

The Calderdale Clinical Commissioning Group (CCG) risk register currently contains a total of 40 risks with 7 marked for closure

Of these open risks, there are:

- 3 critical risks (scoring 20)
- 5 serious risks (scoring 15-16)

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	23 September 2021
Name of meeting	Senior Management Team	**Meeting Date**	7 September 2021

Recommendations

It is recommended that the Governing Body:

- Confirms that it is assured that the high-level risk register represents a fair reflection of the risks experienced by the CCG at the end of risk cycle 3 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee on 23 September 2021

Decision ☐	**Assurance ☒**	**Discussion ☐**	**Other:**

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	No quality and safety implications
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	No engagement has been undertaken as it is not required An equality impact assessment has not been completed as there are no equality implications
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no resource or finance implications
Sustainability Implications	There are no sustainability implications

Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes ☐**	**No ☐**	**N/A ☒**

Strategic Objectives (which of the CCG objectives does this relate to?)	▪ Achieving the strategic direction for Calderdale ▪ Improving Governance ▪ Improving Quality ▪ Improving Value	**Risk (include risk number and a brief description of the risk)**	As identified in the risk register
Legal / CCG Constitutional Implications	Risk is managed in line with the CCG's Integrated Risk Management Framework	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any interests will be managed in line with the CCG's Management of Conflict of Interests policy

1. Introduction

1.1 To provide assurance on the process for the detailed review of the CCG's risks

1.2 To set out all risks rated 15 or above (see Appendix 1)

1.3 To provide a detailed report on critical risks 1493, 187 and 62 (see Appendix 2)

2. Risk Review: Risk Cycle 3

2.1 Risk Cycle 3 commenced on 16 August 2021. Following updates by Risk Owners and review of individual risks by the allocated Senior Manager, the Corporate Risk Register was reviewed by the Senior Management Team (SMT) on 7 September 2021.

2.2 All risks were submitted to the Quality, Finance and Performance Committee for review at their meeting on 23 September 2021.

2.3 There were three critical risks rated 20 at the end of Risk Cycle 3 (see 2.7). These were the same risks that were on the risk register during the last risk cycle.

2.4 The CCG Risk Register for Risk Cycle 3 has now been archived.

Risk Register Summary: Risk Cycle 2

2.5 At the end of Risk Cycle 3 the CCG had 40 risks on the Corporate Risk Register. There are 7 marked for closure this risk cycle meaning there are 33 open risks.

2.6 36 of total CCG risks (90%) are categorised as quality, finance and performance risks and 4 (10%) are categorised as commissioning of primary medical services (CPMS) risks.

High Level Risks

2.7 There are three critical risks (scoring 20) on the risk register at the end of Risk Cycle 3.

The three open risks rated as critical this risk cycle are:

Risk ID	Risk Summary	Risk Score	Risk Movement
1493	Risk that patients being discharged from hospital are subject to delays in their transfer of care 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 recovery plans which require minimum delayed patients.	20	Static for 6 risk cycles
187	There is a risk that reduced access to elective care services, due to the impact of the pandemic (surgery, day case and out-patient) will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution. The risk extends to our ability to commission additional capacity to support	20	Static for 3 risk cycles

	improved access, and the associated financial risk of this approach as we go into H2.		
62	That the system will return to the pre-C19 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.	20	Static for 7 risk cycles

See **Appendix 2** for the critical risk reports

2.8 There were 5 open risks rated as serious (with a score of 15 or 16) during the current risk cycle.

The 5 open risks rated as serious this risk cycle is:

Risk ID	Risk Summary	Risk Score	Risk Movement
1942	There is a risk of harm to patients with LTC/frailty due to the system's inability to proactively manage patients and optimise their treatments due to the impact of Covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities.	16	New – open (previously risk 1734 closed this risk cycle) See 2.9
1941	There is a risk of harm to patients due to increase demand on same day services as a result of the impact of Covid on capacity and access, resulting in increased morbidity, mortality and widening of health inequalities.	16	New – open (previously risk 1734 closed this risk cycle) See 2.9
1729	There is a risk that care provision planned for a new specialist service across CKWB Transforming Care Partnership (TCP) for people with a Learning Disability may not be robust and fit for purpose in line with commissioning intentions resulting in the CCG having to revisit the outcome of the procurement process.	16	16 (from 12) to reflect the current situation (Kirklees' risk register has similarly been updated to reflect this).
1501	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as Delayed Transfers of Care (DTOC). This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	16	Static for 6 risk cycles
1866	The risk is we fail to manage running cost spend within the ring fenced allocation of £4.1m which means will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG. There are a number of risks within the principal risk which contribute to the overall score which include the uncertainty in relation to the annual pay award. The CCG has received confirmation that the AfC pay	15	Increasing

	increase is 3% and that no additional running cost allocation will be received to cover this increase.		
240	There is an increased risk due to the COVID-19 pandemic that the lack of availability of Appointment Slots at Calderdale and Huddersfield Foundation Trust (CHFT) exceed the agreed 4% due to CHFT having fewer outpatient appointments available for patients to book into. This potentially results in patients being unable to access their provider of choice, poor patient experience and reputational damage to both provider and commissioner.	15	Static for 5 risk cycles

2.9 Closed risks

Two serious risks were closed during this risk cycle:

Risk ID	Risk Summary	Risk Score	Risk Movement
1734	There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on the Quality Outcomes Framework (QOF), screening and elective referrals, in addition to patients not presenting with symptoms and challenges faced with “reset” resulting in increased morbidity and mortality and widening of health inequalities. This risk may be increased by Primary Care Network involvement in COV-19 vaccine deployment which puts further pressure on clinical capacity.	16	This risk has been redefined to reflect the pressure in the system of same day access and management of long term conditions/frailty. It has been replaced by 1941 and 1942 The risk relating to workforce availability due to covid vaccine delivery is reflected in the covid vaccine programme risks - each PCN has provided assurance that delivery of general practice will not be affected through submission of workforce plans, however this will continue to be monitored.
1366	There is a risk to patient safety, experience and quality of care for the delivery of the GP Out of Hours Service provided by Local Care Direct (LCD) via the West Yorkshire Urgent Care (WYUC) contract. Due to COVID 19 response and subsequent publication of national guidance, business as usual performance management in relation to NQRs is suspended until 31st July 2020. The focus of the current risk is responding COVID 19 pandemic and risk log is	16	Reached tolerance

	established for the delivery of service during the pandemic, changing/different interpretation of national guidelines on Personal Protective Equipment (PPE) and refusal of clinicians to see face to face patients.		

3 Recommendations

3.1 It is recommended that the Governing Body:

Confirms that it is assured that the high-level risk register represents a fair reflection of the risks being experienced by the CCG at the end of risk cycle 3 of 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee meeting on 23 September 2021.

4 Appendices

4.1 Appendix 1: High level risk log for risk cycle 3 as of 11 October 2021

Please note that this is not currently an accessibly compliant document, but the CCG is working towards making this document more accessible. The information can be supplied in accessible format on request.

4.2 Appendix 2: Critical risk reports for 187, 1493 and 62

All high level risks for risk cycle 3 2021-22

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score Components	Target Risk Rating	Target Score Components	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1493	28/02/2020	Quality	20	(I4xL5)	8	(I4xL2)	Neil Smurthwaite1	Risk that patients being discharged from hospital are subject to delays in their transfer of care 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 recovery 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 covid pandemic.	(a) UEC Board review performance as a standing item monthly (b) Weekly discharge touchpoint in place across C&GH (c) Optimum range for number of people on TOC list for Calderdale confirmed as 13-21 (same as Kirklees) (d) System call in place weekly to review risks and mitigating actions - continued through C19 period (e) Multiple weekly MADE meetings to continue to support flow (f) Surge and Escalation processes documented and agreed by UEC Board (g) New assurance regime/dashboard initiated by NHSE	Outcome of discussions on potential risk summit	(a) UECB highlight report considered by QF&P as a standing item, now includes performance (b) Performance updated to QF&P includes TOC performance (c) TOC list reviewed daily during weekdays (d) New System Discharge post recruited to, postholder started (e) Process now in place for reviewing patients on the Reason to Reside list	(c) Mutual aid across Calderdale and Kirklees to mitigate some of risks around any D2A bed capacity (covid beds and EMI covid beds) (d) Positive comparative performance in relation to % patients admitted within 7, 14, 21 days of admission	(a) Ensuring availability of 7 days services to ensure flow of weekend discharges. (b) Systems' ability to commission for the discharge needs of a EMI patients, particularly those with challenging behavior (c) TOC list remains higher than the agreed level - developing timeline to reduce pre the August Bank Holiday (d) Improvement in the % patients discharged before 17.00 hours (e) The changes needed in our community model to reduce the Reason to Reside list and provide service out of hospital. (f) Quantification of additional CMBC cost associated with additional home care capacity, and risks associated with cease in national DTA bed funding. (g) Outcome of discussions on a risk summit to consider harm to patients related to delayed transfer.	Static - 6 Archive(s)
187	19/03/2012	Finance	20	(I4xL5)	8	(I4xL2)	Penny Woodhead	There is a risk that reduced access to elective care services, due to the impact of the pandemic (surgery, day case and out-patient) will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution. The risk extends to our ability to commission additional capacity to support improved access, and the associated financial risk of this approach as we go into H2	a) Joint C&GH approach to the safe restart of elective services, being clinically led by the Elective Improvement Group b) Joint (GP, Consultant) clinical reviews of patients in high volume specialties c) Joint work between CCGs, CHFT and Independent sector to ensure we maximise all available capacity d) A key element of the CCG Reset Plan and CHFT's Incident Management Plan e) Joint approach to gathering thematic views of patient harm via agreed clinical assurance routes.	No gaps in controls	a) System have agreed joint principles and priorities to underpin reset work b) CCG Reset plan held by SMT and progress shared with QF&P c) Average waiting time is reported to QF&P d) Elective recovery is a key element of the planning submission/assurance; weekly system meeting in place	a) Joint communications group established to oversee messaging to patients and system. b) Joint approach to the roll-out of referral support systems to support minimum data sets for referrals, to support effective clinical assessment and triage c) Series of specialty specific Joint Clinical Interface Sessions across the C&GH system d) CCCG staff supporting CHFT directly through establishment of in/our sourcing team e) Maximizing use of elective recovery fund in H1	a) Harm to patients on waiting list b) Sufficient capacity available to deliver on planning expectations c) Financial risk associated with H2 for system	Static - 3 Archive(s)
62	13/06/2013	Finance	20	(I4xL5)	8	(I4xL2)	Neil Smurthwaite1	That the system will return to the pre-C19 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.	(a) Surge & Escalation processes triggered to mitigate performance risk in line with agreed plan (b) UEC Board focus work on understanding and mitigating performance risk at each meeting (monthly) (c) QF&P consider F&FT response rate and satisfaction included in Quality Dashboard reviewed monthly (d) QF&P receives quarterly reports on any serious incidents- including A&E	(a) There are no gaps in key controls	(a) Performance reviewed at QF&P and GB (c) Quality Team have oversight of any learning from 12 hour breaches (d) Approach from 19/20 - 23/24 accepted by NHSE, ie no fully functional UTC established until at least 23/24 (e) Winter Reset action Plan in development	(a) CHFT remain in the upper quartile. (b) Extended access in general practice now in place (c) GPs and A&E clinicians meet formally on acute issues to strengthen working relationships. (d) New interim ED model in place to support large number of minor illnesses and injuries attending, learning for model pre 23/24 model (e) 111 First in place in both A&Es (f) Proactive system communications on use of A&E taking place throughout winter period.	(a) Urgent Treatment Centre new build timeline is 2023/24 - completion and implementation of work on interim integrated urgent care offer on both hospital sites; risks relate to; workforce, finance (b) Duration of post-pandemic surge in demand on both sites	Static - 7 Archive(s)
1942	31/08/2021	Quality	16	(I4xL4)	8	(I4xL2)	Debbie Robinson	There is a risk of harm to patients with LTC/frailty due to the system's inability to proactively manage patients and optimise their treatments due to the impact of Covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities.	Amendments to national GP contract to re-prioritise work including a re-focus of the Quality and Outcomes National Framework • Commitment to reduce unnecessary bureaucracy to focus on clinical care • Additional CCG investments made to PCNs to support local winter resilience and increase in demand • Investment of the Calderdale share of the £150million Covid-19 resource to support further increase in capacity and focus on 7 identified goals Additional investment of Calderdale share of the £120 million Covid-19 resource announced from April 2021 to support further increase in capacity and focus on 7 identified goals 2021/22 PCN Priorities have been published including CVD diagnosis, anticipatory care, early cancer diagnosis and personalised care Population Health Management approach working in all 5 localities and identifying and working with patients with a rising risk, particularly around frailty with impact being measured. This involves a multi -agency approach. This will mitigate risk of people further de-conditioning Community/GP meeting established to understand pressures within the system and agree approach to prioritisation when escalation is required PCN Priorities published for 2021/22 with links to the Innovation and Investment Fund Enhanced Health in Care Home Team	Long Term Condition Review Backlog unquantified at Practice, PCN or Calderdale level Staffing pressures in terms of vacancies and sickness within community teams Availability of blood tests has been disrupted due to shortage of blood bottles Prioritisation to be agreed between Community and General Practice Staffing pressures due to continued requirement to deliver the covid vaccination programme Community Pharmacy Role in managing long term conditions and being part of system working Clarity of plans for the community division	Continue to use soft-intelligence e.g. complaints or stakeholder feedback to monitor and address issues. • Continued engagement of CDs, PMs and LMC to respond to feedback and address any concerns • Continued use of datix and serious incident process to identify where this has resulted in harm and ensure cases are reviewed and identified learning implemented National PCN dashboard now available and updated monthly GP dashboard will be fully operational by Sept/Oct 2021 and monitored through CPMSC Operational Group Quarterly Director of Primary Care Report to CPMSC	No rise seen in incidents reported or serious incidents	Unknown level of harm from the pandemic to these patients	New - Open

1941	31/08/2021	Quality	16	(I4xL4)	8	(I4xL2)	Debbie Robinson	There is a risk of harm to patients due to increase demand on same day services as a result of the impact of Covid on capacity and access, resulting in increased morbidity, mortality and widening of health inequalities.	Urgent Care hub in place to support A&E with minor ailments and injuries Same day emergency frailty unit at CHFT to reduce admissions Social Care Hospital Avoidance Team at CHFT Additional Funding to General Practice through the Covid Expansion Fund Clear public messaging across the system through "Together we can" and "Choose Well" Campaigns Additional Roles Funding available to PCNs Surge and Escalation processes triggered to mitigate performance risk in line with agreed plan Silver and Gold Tactical System Calls UEC Board focus work on understanding and mitigating performance risk at each meeting (monthly)	Further opportunity to maximise the Community Pharmacy Consultation Service Reliable data to quantify increased demand in General Practice Urgent Community Response – in development for go live Dec 2021 Absences in workforce due to increase of covid 19 infection rates and requirement to isolate – although adoption of recent guidance will potentially reduce that impact Capacity to enable General Practice Voice in system escalation calls.	Provider Quality Dashboards considered quarterly at Quality, Finance and Performance QF&P receives quarterly reports on any serious incidents from all providers delivering NHS Contracts CPMSC ops group will receive quarterly general practice dashboard to be reviewed monthly (from September/October 2021) with CPMSC receiving it quarterly System Silver and Gold Calls as required System Sit rep developed and shared across partners weekly General Practice Weekly Opel Situation Report	Additional roles utilisation Q1 and Q2 Majority of practices reporting level 2 with last few weeks showing a reduction in the number of practices at level 3	Understanding risk associated with 111 demand	New - Open
1734	03/03/2021	CPMSC	16	(I4xL4)	8	(I4xL2)	Debbie Robinson	There is a risk of harm to patients given the backlog of work post COVID-19 due to pauses on QOF, screening and elective referrals, in addition to patients not presenting with symptoms and challenges faced with "reset" resulting in increased morbidity and mortality and widening of health inequalities. This risk may be increased by PCN involvement in Covid-19 vaccine deployment which puts further pressure on clinical capacity.	• Amendments to national GP contract to re-prioritise work including a re-focus of the Quality and Outcomes National Framework • Commitment to reduce unnecessary bureaucracy to focus on clinical care • Additional CCG investments made to PCNs to support local winter resilience and increase in demand • Investment of the Calderdale share of the £150million Covid-19 resource to support further increase in capacity and focus on 7 identified goals Additional investment of Calderdale share of the £120 million Covid-19 resource announced from April 2021 to support further increase in capacity and focus on 7 identified goals 2021/22 Planning Guidance has been issued 20/5/2021 Update SOP for General Practice has been issued	Final national contract for 2021/22 to include details of how to manage the backlog Backlog unquantified at Practice, PCN or Calderdale level	•Continue to use soft-intelligence e.g. complaints or stakeholder feedback to monitor and address issues. • Continued engagement of CDs, PMs and LMC to respond to feedback and address any concerns • Recent guidance to focus on clinical prioritisation to support clinical capacity at practice level and focus on the 7 priority goals detailed in the General Practice Covid Capacity Expansion Fund • Continued use of datix and serious incident process to identify where this has resulted in harm and ensure cases are reviewed and identified learning implemented	CPMSC Head of Primary Care Report - Quarterly	• Reconfirm the Quality Indicators that will be monitored in the absence of the new national dashboard including impact on different communities. • Systematic monitoring of the 7 key goals listed in the General Practice Covid Capacity Expansion Fund letter • Once quantified, system needs to be in place to monitor progress against the backlog.	Closed - This risk has been redefined to reflect the pressure in the system of same day access and management of long term conditions/frailty. It has been replaced by 1941 and 1942 The risk relating to workforce availability due to covid vaccine delivery is reflected in the covid vaccine programme risks - each PCN has provided assurance that delivery of general practice will not be affected through submission of workforce plans, however this will continue to be monitored.
1501	12/03/2020	Finance	16	(I4xL4)	4	(I2xL2)	Neil Smurthwaite1	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as DTOC. This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	The CCG is working as part of the local and regional systems to respond to the COVID-19 pandemic. The CCG is participating in local place based, regional and national calls and meetings. The CCG is working with providers to understand their plans in responding to the pandemic. The CCG is designing and implementing swab testing processes for drive in locations and home testing. The CCG has identified a site for drive through testing. A new coronavirus monitoring system across WY and Harrogate is being established for coordination of all coronavirus patients and reporting to NHS E. The CCG is identify if the CCG has internal clinical capacity to help in the running of the swab testing drive through service. The CCG has internal communications processes in place with Staff around COVID-19. The CCG is playing a key role in the roll out of the vaccination programme across Calderdale.	The CCG is reviewing own work plans with a view to stopping any low priority work. The CCG is reviewing what staff it has available with a clinical background. The CCG is scoping further sites for drive through swabbing.	Participating in all regional, national and local calls. CCG has implemented appropriate national guidance. CCG is providing specific returns to NHSE regarding response to the pandemic.	The CCG is delivering on the key expectations of NHSE. The Vaccination uptake in Calderdale is performing well.	The national response to the pandemic is changing on a daily basis.	Static - 6 Archive(s)
1866	03/06/2021	Finance	15	(I5xL3)	4	(I4xL1)	Neil Smurthwaite1	The risk is we fail to manage running cost spend within the ring fenced allocation of £4.1m which means will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG. There are a number of risks within the principal risk which contribute to the overall score which include the uncertainty in relation to the annual pay award. The CCG has received confirmation that the AfC pay increase is 3% and that no additional running cost allocation will be received to cover this increase.	The CCG developed plans for meeting the required reductions in running costs in 2019/20. The CCG has met its running cost allocation target in 2020/21. The draft plan for 2021/22 was agreed by Governing Body in April 2021. A more detailed running cost plan was considered at Q,F&P committee in June 2021 outlining the draft detailed budgets and further savings plans agreed to be implemented. These plans will be agreed with budget holders. Plans will be further reviewed in light of the AfC pay award which is unfunded.	Impact of pay review unknown and only estimated in plan. Estimate in the plan was 1.25%, the actual agreed in August 2021 was 3%. Work required to understand the risk in relation to this. Impact of Covid 19. Impact of temporary financial regime and adjustments to allocations.	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 F&P paper. Detailed review of impact of pay review scenarios - work undertaken to mitigate impacts Heads of Service are reviewing budgets in light of savings target, work to be completed on reviewing vacant posts.	Previous Internal audit report assurances and annual internal audit review plan. Running costs reported monthly to Finance and Performance committee and Governing Body.	None at this stage	Increasing
240	10/06/2013	Finance	15	(I3xL5)	2	(I2xL1)	Martin Pursey	There is an increased risk due to the COVID-19 pandemic that the lack of availability of Appointment Slots at Calderdale and Huddersfield Foundation Trust (CHFT) exceed the agreed 4% due to CHFT having fewer outpatient appointments available for patients to book into. This potientially results in patients being unable to access their provider of choice, poor patient experience and reputational damage to both provider and commissioner.	a) Discussed as part of the CHFT Contract Management Group b) Responsibility of the monthly Outpatient Transformation Group within CHFT Partnership Arrangements c) ASI's filled where possible each day in CHFT Appointment Centre d) Reported within CHFT to their Executive Board meetings within integrated performance report.	a) The 'switch off' of elective work in response to COVID-19 effectively removed all routine slots b) The phasing of routine electives will need to be understood and what impact it will have c) ASI related complaints reported through DATIX d) Managing lower capacity (reset/new normal)	Regular updates on performance against the ASI target included in the F,P and C report (target is maximum 5% of patients awaiting an appointment) and discussed at the following monthly meetings - a) CCCG, GHCCG and CHFT Quarterly Partnership Board b) Discussed at Elective Care Improvement Group	Jan 2021 - 56%. Feb - 73%. Mar - 79%. April - 70%. May - 64%. June - 77%. * Due to the Covid-19 pandemic, CHFT has received more referrals as appointment slot issues (ASI) rather than as direct bookings. In many cases, these have not yet been booked in e-RS. As a result, the ASI per booking percentage shows as a higher proportion than usual, as there may be a higher number of ASIs recorded than bookings performed in e-RS. Sourced from NHS Digital on a monthly basis.	Reduction in Contract governance as a result of NHS Covid Financial Regime has reduced the opportunity for formal review. However discussed as part of the Elective Board arrangements. 1. Pilot Clinical and Referral Assessment Services have been implemented at CHFT to assist with pandemic and post pandemic backlog. There are no appointment slots for patients to book into this service 2. ASI figures in April 2020 onwards will shown a great increase in percentage due to COVID 19 crisis as all routine outpatient booked appointments made via ERS were cancelled for re-referral until post crisis.	Static - 5 Archive(s)

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 187

Risk Type: Quality, Finance & Performance

Risk Category: Quality

Date first issued: 20th December 2016

Date last reviewed: 14.10.21

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 (L) x 4 (I) = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	16
3	Risk description	There is a risk that reduced access to elective care services (surgery, day case and out-patient care) due to the impact of the pandemic will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution.
4	Current position (include any relevant data as attachments)	• Our system has taken a clear stance to collectively own elective recovery. CHFT is seen as an outlier in WY in relation to its backlog and its number of long waiters • The rate of referrals into some of CHFT's specialties is much higher than others within WY, particularly where CHFT are the only provider • CHFT, as a previously high performing trust for Referral to Treatment targets, did not necessitate commissioner development

		of a market to support delivery of elective care in the way other systems needed to. This lack of a market is now a key limiting factor in our recovery
-	Assessment of the issues	• Planning guidance indicates that CHFT should increase elective capacity to levels undertaken in 2019/20, and reduce long waiters to a minimum by March 2022 (particularly 104 week waiters) • Elective Recovery is a critical element of our system recovery work, and work is taking place at pace to mitigate risk and reduce patient harm. However, this is impacted upon by the current non-elective pressures • Our local Independent Sector (IS) capacity, provided by Spire and BMI Hospital capacity is vital, as is other IS capacity •
6	Actions	• CHFT is focusing on delivering of elective care on the basis of clinical priority and health inequalities. • This is supported through a new contracting regime which started on 1 April 2021 and plans for an optimum amount of capacity to be used to support CHFT's recovery • Independent sector providers have been contracted directly by CHFT, and by the CCG, through an Any Qualified Provider route. • CCG staff have supplemented CHFT's divisional management by providing additional capacity to support recovery activities (working as an In and Outsourcing team) • The team have quickly identified a range of new and existing providers who can support the system with additional elective capacity – either out-sourcing CHFT activity, or bringing providers into CHFT to maximise the use of their estate theatres. • ENT was the first specialty, focusing on increasing capacity for those patients awaiting a first appointment, follow ups and procedures. • As part of these plans, over 400 additional patients have been seen as out-patients, and additional operating lists have been taking

		place every weekend since the beginning of September 2021. • On 2 October capacity for a further 150 patients per weekend in ENT commences, and Virtual Clinics for Neurology will take place starting 2nd October (32 per weekend). • Current work is focusing on; in-sourcing of theatre teams to increase resilience in the weekday operating lists, working innovatively with Primary Care to increase capacity for Rheumatology follow-ups, and getting in-sourced Ophthalmology outpatients and operating weekend services up and running (October 15th). • An Advice and Guidance task and finish group is working towards an agreed minimum data set for Advice and Guidance and to explore a pilot for submitting referrals through Advice and Guidance rather than NHS e-Referral Service. The A&G group will also identify the first specialty to test the concept of all routine referrals going through A&G. • Work also continues on implementation of the second wave of Evidenced Based Interventions
7	Identified gaps	• A full view of any harm to patients currently waiting for care • A timeline for full elective recovery

Relevant data: CCG has access to a live elective care dashboard.

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Cae)

Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 14.10.21

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 1493

Risk Type: Quality, Finance & Performance

Risk Category: F&P – Performance

Date first issued: 20th December 2016

Date last reviewed: 07.07.21

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
3	Risk description	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experience, harm to patients, and also pressure on acute post-C19 bed plans which require minimum delayed patients
4	Current position (include any relevant data as attachments)	In Calderdale a snapshot of the number of people on the Transfer of Care (TOC) list at any one time increased to a peak of 49 people on the TOC list in October 2021. Throughout Q2 2021, to date, this number has been increasing. There were 6.4 referrals onto the TOC list per day in Quarter 1, compared to 6.8 referrals per day in Quarter 2, an increase of 0.4referrals per day on average. With this increased demand the joint

		discharge teams have been working harder to maintain the position and flex their capacity. This increased demand has had an impact on the average referral to discharge (length of time a patient is on the TOC list) which has been increasing month on month through Quarter 2 and is currently at 7.5 days. This figure was at 14.5 days back in March 2020 however, so this shows that progress is still being made. In addition, new datasets are being developed for the Urgent & Emergency Care Board showing those in hospital for 7, 14 and 21 days, in line with priorities set out in new Planning Guidance, and increased NHS England scrutiny on these metrics through a new data platform. The national ambition is to have no more than 40% of beds occupied by patients with a LOS of 7+ days and no more than 12% of beds occupied by patients with a LOS of 21+ days. Currently CHFT are above this ambition with 42% for 7+ and 14% for 21+. Throughout Q1 CHFT met the ambition but recent pressures have worsened the position. CHFT still benchmarks well performing better than the ICS and national position. Another national ambition is to discharge 70% of patients with no reason to reside by 17:00. CHFT is currently at 20% which matches the ICS performance and is slightly better than the national position. It's recognised significant work is required to get to the ambition of 70%
5	Assessment of the issues	• The number of patients whose discharge is delayed is a significant factor in hospital resilience. Current covid cases and patients on the transfer of care list account for 40% of the current CHFT bed base. • These issues are exacerbated by delays in discharging patients from community beds, due to a significant deficit in home care

		capacity. • The number of patients delayed currently exceeds the number built into CHFT's bed capacity planning. • Our system is currently not meeting requirements for the % of patients discharged before 17.00 hrs.
6	Actions	The UEC plan committed the system to a set of actions to safely reduce transfer of care to a minimum. • We have confirmed organisational and system executive leads – who come together regularly and have oversight of discharge in Calderdale • We have confirmed full governance arrangements for discharge optimisation. • Established a new work-stream to optimize seven day discharge. • Implemented to Reason to Reside methodology which identifies new cohorts of potential patients who could be discharged if other community offers were in place or strengthened. • Established a Care Home Programme jointly with CMBC which continues to focus on the safe discharge of patients from hospital into care homes. • Commissioned dedicated step down discharge to assess beds for covid patients and patients who have been in contact with covid patients needing discharge from hospital • Implemented a set of actions to improve flow into intermediate care beds – including development of a dependency tool to support the matching of capacity with demand, providing additional workforce capacity into current offers. • Set up mutual aid arrangements with Kirklees Council for community beds • Set up daily touchpoints between; CHFT, Calderdale Council and the CCG to identify and resolve issues at pace • Developed business cases for additional hospital avoidance and assessment capacity in CMBC.

7	Identified gaps	• Output of using the Reason to Reside programme in Calderdale to enable us to understand the true scale of patients who could be receiving post-acute care in a different setting. • Assurance on ability to deliver discharges at the levels included in CHFT bed modelling assumptions. • Assurance on our ability to increase the % of patients discharged before 17.00 hrs • Outcome of business cases for additional assessment and hospital avoidance capacity

Relevant data; Included above.

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Care)
Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 14.10.21

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 62

Risk Type: Quality, Finance & Performance

Risk Category: F&P – Performance

Date first issued: 20th December 2016

Date last reviewed: 14.10.21

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 3 = 15
3	Risk description	The system will not deliver the NHS Constitutional target of 95% of patients seen in 4-hours when attending Accident and Emergency (A&E) units for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in patient care and patient experience being compromised.
4	Current position (include any relevant data as attachments)	• At time of writing (15.10.2021) – the average 7-day A&E performance was 75.8% • Attendances at A&E significantly increased from March 2021, September has seen a 28% increase in attendances compared to previous year – it is the only month out of the previous five which is not a record breaking high in terms of attendances. • Calderdale and Huddersfield Foundation Trust (CHFT) is still in the

		top quartile regionally and nationally. Pressures are being felt nationally with some trusts delivering close to or below 50% towards the 4 hour standard.
5	Assessment of the issues	Delivery of the 4-hour target is an important element of the NHS Constitution and the local urgent and emergency care system. Whilst performance is challenging locally, CHFT perform well against their comparators. There is recognition that CHFT have continued to run four A&E streams throughout the pandemic (a red and a green stream on each site), this has continued to put pressure on A&E staffing levels. There has also been a significant increase in demand from March 2021 to date, which is impacting on performance.
6	Actions	The Calderdale and Greater Huddersfield Urgent and Emergency Care Board continues to have oversight of delivery of the 4 hour target, and the following actions are taking place: • Developed an immediate new offer in both EDs, with additional ANPs, streaming Priority 4 and 5 patients (those whose needs could be met through a primary care intervention). This commenced on 5 July and will run until December 21 in its current form. • The learning from this is being built into a longer-term interim offer which will see a more fully integrated ED team working on both sites, in advance of implementation of RCRTRP UTC model. • An audit of current attendances to understand themes and learning has been conducted by the new A&E Medical Director • Continuing to deliver our communications strategy for winter. This includes generic messaging on choosing well, and also targeted approaches for those patients who are awaiting planned care at CHFT. • Implementation of the 111 First model which promotes local offers as alternatives to A&E attendance and ambulance call outs, by strengthening the local Directory of Services used by 111 and creating opportunities for 111 to book patients into A&E if

		necessary. Additional funding is being made available centrally to support the resilience of 111F through winter 21/22
7	Identified gaps	• Clarity of status of current demand wave, and its duration. • Funding for the interim Integrated ED model

Relevant data: A&E performance data is available to commissioners and is available on request

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Care)

Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 14.10.21

Name of Meeting	Governing Body	**Meeting Date**	28 October 2021
Title of Report	**Emergency Preparedness, Resilience and Response (EPRR) - annual update**	**Agenda Item No.**	13
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Chief Operating Officer (Accountable Emergency Officer)	**Responsible Officer**	Rob Gibson, Corporate Systems Manager

Executive Summary							
Please include a brief summary of the purpose of the report	▪ To provide the Governing Body with a summary of the CCG's activities in relation to emergency preparedness (EP) and business continuity throughout the year. This is in line with the Emergency Preparedness, Resilience and Response (EPRR) core standards which require that a report covering the emergency planning activity is produced at least once a year for the Governing Body. ▪ A more detailed report was received by the Audit Committee as part of its delegated role in scrutinising the Emergency Planning and Business Continuity functions of the CCG. ▪ The CCG is also required to complete a self-assessment of its compliance against the relevant EPRR core standards as part of the assurance process.						
Previous consideration	**Name of meeting**	Audit Committee		**Meeting Date**	14 October 2021		
	Name of meeting			**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: ▪ **RECEIVES** and **NOTES** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications	
Quality & Safety implications	The Quality and Safety implications of Health Protection issues are reviewed by the Quality, Finance and Performance Committee as part of the the Infection Control and Prevention Papers

Engagement & Equality implications	None identified					
Resources / Finance implications	All staff need to receive regular awareness raising training or skill development/refresher training commensurate with their roles in emergency planning and business continuity.					
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	x

Strategic Objectives	▪ Improving Quality and Safety ▪ Improving Governance	**Risk** (include risk number and a brief description of the risk)	None identified
Legal / CCG Constitutional Implications	▪ Civil Contingencies Act 2004 ▪ NHS Act 2006 (as amended 2012) ▪ NHSE EPRR Core standards	**Conflicts of Interest** (include detail of any identified/potential conflicts)	No conflicts of interest have been identified. Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.

1.0 Emergency Preparedness, Resilience and Response (EPRR)

1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires NHS England (NHSE), NHS commissioners and providers to demonstrate that they can deal with such incidents whilst maintaining services to patients. In the NHS this programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

1.2 As a Category 2 responder, the CCG has a role in working with NHS partners and Calderdale Council both in planning and prevention and in responding to emergencies. The CCG fulfills this role in a number of ways including:

- Active participation in the local, system-wide and regional emergency planning fora;
- A senior manager on-call rota for the organisation;
- Participation in local, regional and system wide desk top and 'live' exercises;
- Coordination of the local health response, working with local emergency planning partners across the health and care system and supporting NHS England as required dependent upon the nature of incident;
- Review of existing plans to ensure that any learning is taken on board following exercises or incidents to improve our preparedness to respond to different categories of incident should we need to.

1.3 The Audit Committee has a delegated role in scrutinising the Emergency Planning and Business Continuity functions of the CCG. As part of this role, the committee receives regular updates on emergency planning activity as well as the annual self-assessment of compliance against the EPRR core standards, prior to submission to NHS England. Last year there was a change to this annual requirement whereby the CCG was required to submit a statement of assurance primarily concerning the CCG's response to the first wavr of COVID19. For 2021 the requirement to complete a self-assessment has been reestablished. A full report of the year's activities and this year's self certification of compliance was received by the Audit Committee at its meeting on the 14 October 2021.

1.4 CCG Emergency Planning Partnership Working

The CCG is actively involved in local, system-wide and regional emergency planning arrangements. The main forums for coordination, joint working, planning and prevention are the:

- Local Resilience Forum (LRF) West Yorkshire
- A&E Delivery Board Calderdale and Greater Huddersfield footprint
- Local Health Resilience Partnership (LHRP) West Yorkshire
- Calderdale Council (Emergency planning and community Safety Partnership structures)
- Calderdale Health Protection Advisory Group (CHPAG)

2.0 Emergency Planning activity over the past year

2.1 The emergency planning and business continuity activity across the West Yorkshire Local Resilience Forum is informed by the risks identified on the West Yorkshire Community Risk Register and the national EPRR core standards. This in turn informs the review of the CCG's emergency planning arrangements and Business Continuity Plan and associated action plans.

2.2 There has been a continued focus on our emergency planning activity throughout the year –which included the area of cyber security at the very beginning of the year (see 2.4).

2.3 COVID-19

On 23 March 2020 the Government announced a full lockdown of the UK in response to the outbreak of COVID19 and the British population were instructed to stay at home. The CCG offices were closed with immediate effect and staff advised that they should work from home. The CCG also adopted its own response to the pandemic and all meetings continued to be held remotely via MS Teams. From July 2021 staff were permitted to work in the office but subject to strict to social distancing and infection prevention rules. At the time of writing of this report higher level face to face meetings are starting to be arranged.

As of 4 October the CCG officially opened its new office accommodation at Westgate House in Halifax town centre. However strict rules on social distancing and infection prevention are still mandatory and only half of the desks at Westgate House are permitted to be used to allow for continued social distancing. The CCG has updated its guidance on how to work safely in the office to reflect the new office move.

2.4 Training, exercises and planned events

The CCG continues to take full part in the desk top and live exercises organised across the system to test existing plans against different scenarios. Due to the impact of COVID-19 and lockdown these exercises have been limited in number:

Date	Type of exercise	Aim	Area covered	Main learning
16 Feb 2021	A 'live' exercise focusing on cyber security (in line with new Data Protection and Security Toolkit requirement) across Calderdale, Kirklees and Wakefield CCGs	The aims of the exercise were for each organisation to: understand how well they were protected against phishing e-mails understand how they could recover from a subsequent	Calderdale, Kirklees and Wakefield health economy	Remind staff of importance of being vigilant to phishing e-mails/malware especially with working from home (this has been undertaken)

		ransomware infection including backing up of data raise awareness of their own business continuity arrangements		Develop list of gatekeepers to top level folders (work is ongoing)
20 April 2021	Communications exercise	To test the efficiency of the communication arrangements for the team within a large service area of the CCG	Contracting Team – Calderdale CCG	No learning identified, exercise went without incident
12 May 2021	Desktop exercise focusing on the issue of reinforced autoclaved aerated concrete (RAAC) and the impact on Airedale Hospital and surrounding trusts with regards to patient evacuation	To test the activation and emergency receiving arrangements of regional partners in the event of a whole site evacuation of Airedale General Hospital as part of wider contingency planning and risk mitigation measures.	West Yorkshire South Yorkshire	Organisations to go back to their local systems and work through the practicalities of the agreed option (2) - *to spread the patient group across more Acute Trusts and types of clinical services need to be balanced* (evacuation plan at CHFT being reviewed and decisions on managing patient flow)

Planned Events

A ‘live’ exercise focusing on cyber security specifically to understand the controls that the CCG gas in place to support home and remote working to minimise the risk of data compromise is planned for 24 November. The exercise will be run in conjunction with partners from Kirklees and Wakefield CCGs.

In quarters 3 or 4 of 2021/22 a desktop exercise is to be faciltitated by the NHSE EPRR regional team for partners across West Yorkshire. The theme of this proposed exercise is currently unknown

Normally the CCG participates in the Tour de Yorkshire every year however the event was cancelled in 2020 and 2021. It has recently been announced that next year’s event is also to be cancelled.

2.5 Business Continuity

The CCG has a business continuity plan in place which is triggered if any incident occurs which has the potential to affect the smooth running of the organisation. Any actions identified as a result of incidents are carried out. There were no business continuity incidents in the last 12 months.The plan is due to be reviewed to reflect the office move from Dean Clough to Westgate House.

2.6 On-call arrangements

Until May all members of the SMT were members of the Greater Huddersfield (now Kirklees CCG) and Calderdale CCGs’ on-call rota. As of 14 May 2021 Calderdale CCG established its own on-call arrangements and a number of Calderdale senior managers also joined the on-call rota. A training session was undertaken for these new on-call managers to ensure they were fully briefed on their additional roles and responsibilities. There was also a period of shadowing from established on-call managers should additional support be required.

2.7 **Flu vaccination programme**

As per last year the national flu immunisation programme will continue to be essential to protecting vulnerable people and supporting the resilience of the health and care system. This year as part of the wider planning for winter the seasonal flu vaccination will be offered to 4 additional cohorts including in secondary school years 7 -11. This year the uptake ambition for those aged 65 or over is now 85% (was 75% last year) and 85% for frontline health workers (was 75% last year).

The Calderdale flu group has been reestablished for this year's flu programme. This group consists of partners from across Calderdale including CHFT and CMBC. One of the main functions of the group is to identify and escalate risks to flu uptake.

2.8 **Dissolution of CCG and ICS transition by 31 March 2022**

The CCG is a category 2 responder for the purposes of the Civil Contingencies Act 2004 however as of 31 March 2022 the CCG will no longer be a legal entity and its powers will be transferred to the ICS. At the time of writing of this report it is thought that the West Yorkshire ICS will be classified as a category 1 responder which means it will have similar responsibilities to that of an NHS trust or local authority however this is yet to be decided. No further details on future emergency planning arrangements for April 2022 onwards have been made available at this time.

3.0 EPRR Annual Assurance Process: reporting on compliance against the national Core Standards

3.1 There is a statutory requirement for the CCG to formally assure NHSE of its EPRR readiness. This is evidenced through the completion of the annual national EPRR core standards (with the exception of last year). The results of this self-assessment and proposed statement of compliance are included in this report for comment and assurance. In 2019 the CCG reported 'full' compliance. Although assurance is being collected again in 2021 this is on a reduced number of standards and organisations

remain statutory responsible for the full set of standards. In 2021 the CCG is also reporting ‘full’ compliance

3.2 The Audit Committee has delegated authority in relation to ensuring the adequacy and effectiveness of emergency planning, preparedness and business continuity. At their meeting on 14 October the Audit Committee supported the self-certification of compliance with the EPRR core standards as ‘full complaince’ for sign off by the organisation’s Accountable Emergency Officer (Chief Operating Officer).

4.0 Recommendations

4.1 It is recommended that the Governing Body:

- **RECEIVES** and **NOTES** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year

MINUTES OF CALDERDALE
COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE
26TH AUGUST 2021
VIA MS TEAMS

Due to the COVID 19 public health emergency this meeting was not held in public.

PRESENT:

John Mallalieu (JM)	Chair, Lay Member (Finance and Performance) and Deputy CCG Chair
Alison MacDonald (AM)	Lay Member (Patient and Public Involvement)
Lesley Stokey (LS)	Director of Finance
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Debbie Robinson (DR)	Director of Improvement - Community and Primary Care
Emma Bownas (EB)	Senior Primary Care Quality and Improvement Manager
Neil Coulter (NC)	Senior Primary Care Manager - NHS England /Improvement
Karen Huntley (KH)	Healthwatch Representative
Helen Foster (HF)	Medicines Optimisation Lead (Minute 50/21)
Martin Pursey (MP)	Head of Contracting and Procurement (Minute 51/21)
Rob Gibson (RG)	Corporate Systems Manager (Minute 53/21)
Suzanne Howarth	Contracts Manager Primary Care (Minute 55/21)
Zoe Akesson (ZA)	Governance Support Officer (minute taker)

Members of the public were able to watch the meeting, as it was live cast, however they were not able to participate.

CONTENTS

43/21 APOLOGIES FOR ABSENCE

Apologies were received from Neil Smurthwaite (NS), Dr Steven Cleasby (SC) , Dr James Gray (JG), Penny Woodhead (PW) and Cllr Tim Swift (TS). The Chair confirmed the meeting would be quorate as the Director of Finance was present and the GP members were not required for quoracy.

The Chair informed Committee the Interim Phlebotomy Contract Award paper had been withdrawn from the agenda, as the Officers believed the matter was not yet ready to progress to a decision.

44/21 DECLARATIONS OF INTEREST

There were no interests declared by those present however the Chair made known the following declarations involving the GPs and Cllr Swift, which on this occasion were mitigated due to them not attending the meeting. The Chair described how these would have been managed had they been present.

SC and JG would have declared a **non- financial professional interest** in the item titled, Calderdale General Practice Dashboard and Trigger Criteria, as there would be a perception the GPs could influence the process for managing their own performance. The GPs received the paper and would have stayed for the discussion but not be involved in the decision making.

Within the Finance report there was a decision seeking approval for a virtual meeting with non-conflicted members to approve discretionary spend. Nobody in attendance would be influenced by the discretionary spend or be part of any decision making.

SC and JG would have declared a **direct financial and professional interest** in the item titled, Potential Surgery Branch Closure. As SC is a partner at the surgery and JG is partner at a neighbouring surgery and any patient movement would affect them. Cllr Swift also declared a **professional interest**, as the practice sits within Cllr Swift's ward. The conflicted members did not receive the paper and would have been asked to leave the meeting for this item.

The Committee members agreed to the conflicts being managed in this way.

45/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

46/21 MINUTES OF THE LAST MEETING

The Committee received the minutes of the last meeting on 27th May 2021, which had been approved between meetings and submitted to the Governing Body in July.

47/21 MATTERS ARISING

The action log was reviewed.

35/21 To share the draft Estates Strategy document at the next CPMSC development session: To remain open until a date has been agreed with PCNs.

38/21 To redefine R1734 around the risk of harm to patients relating to the backlog of work post Covid and to re-look at the score. Closed, refer to minute no: 53/21.

41/21 To provide a brief overview of previous year's utilisation and role occupancy at the next meeting. Closed, refer to minute no: 48/21 and 52/21.

48/21 DIRECTOR'S REPORT

In presenting the report, the following key pieces of work were highlighted:

Additional Roles Reimbursement Scheme - the Committee was provided with information about the occupancy, providing an understanding of the number of roles that had been filled and the benefits of investment into these roles. However, there was still concern around the difficulties recruiting to these positions. The data articulated financial impact, but not actual roles filled to target. A major area of risk was around the mental health practitioner role, due to the allocation not being sufficient to cover the cost on Agenda for Change for these people. This had been flagged nationally. A forward-thinking approach was taken, and meetings are happening at a system level to find a solution, seeking a change to the process through partnership working and recruitment models. Assurance was given that engagement has taken place with PCN Clinical Directors. A planning tool had been

devised to help with recruitment plans encouraging PCNs to pick up early and utilise the money available for when recruitment starts.
In response to a question around informing the public about the additional roles, EB acknowledged this was important and the team would take away and work through how this could be done consistently across the 5 PCNs. Healthwatch offered to contribute to this work. EB also agreed to the keep the Committee updated on the roles (headcount) filled to target for 20/21 and 21/22, as these were funded as part of the delegated budget

ACTION: EB to provide an update on the roles (headcount) filled to target for 20/21 and 21/22 in the next Director's report to Committee.

General Practice Access and Patient Experience - this section of the report highlighted the continued demand for services and associated risks. The Committee's attention was drawn to the 17% increase in activity for GP practices in June 2021 on the previous month and that 57.2 % GP appointments that took place in June were on a face-to-face basis. It was noted that activity undertaken at scale, such as Pennine GP Alliance and PCNs, is not captured within the NHS Digital collection and the CCG is currently working with local providers to capture this information until the issue is resolved. The report also highlighted the consequences that took place in response to the announcement to step forward the national covid response plan from 19 July 2021, which included the removal of Standard Operating Procedures. Key headlines from the latest GP Calderdale survey and a link to the published report in July 2021 were also detailed in this section.
An observation was made that it would be helpful to make comparisons to pre-pandemic data rather than from 2020 as this gives a distorted view.

ACTION: DR to make a comparison to 2019 data in the next Director's report to Committee.

The Chair also pointed out that 12 practices were not offering online booking. In response, DR explained the PC team is investigating the reason for this as the team continues to encourage all practices to do face-to-face appointments.

The Care Quality Commission have carried out an announced inspection of the extended access services that are run by the Pennine GP Alliance. The provider was

rated as good except for the section 'Are Services Well Led?', which was rated as requires improvement. CCG officers have formally followed this up with the provider.

An Internal Audit is to be undertaken to provide assurance that the CCG is carrying out and effectively discharging the functions that NHSE has delegated to it in respect of Commissioning Primary Medical Services.

Serious Mental Illness Health Checks - performance is lower than the CCG's expected requirement. A plan is in place to move this forward. The ambition is for 60% uptake by March 2022. The chair asked for an update at next Committee.
ACTION: DR to include an update in the next Director's report to Committee

The Committee **NOTED** the contents of the report.

49/21 CALDERDALE GENERAL PRACTICE DASHBOARD AND TRIGGER CRITERIA

The Committee were reminded that the quarterly assurance and monitoring process were agreed at the last meeting however further work was required on the actual dashboard. A paper was presented to the Committee asking for agreement on the proposed indicators and trigger criteria. EB explained how she worked with colleagues to consider how best to use the resources available to populate the dashboard and an agreement was reached to share indicators already in use in Kirklees CCG. The dashboard was presented to the Committee.
EB informed the meeting she was in conversation with the Local Medical Committee on which indicators would be used as a trigger. Since submitting the paper, a proposal has been made to add another trigger around medicine prescribing and optimisation.

In response to a comment around the early warning being a supportive rather than punitive process, a suggestion was made to remind the Committee every time the data is used.
A question was asked on how the trigger is defined, as it appears practices would have to reach a really challenging situation before the trigger takes place. It was also raised that an example with data would have been helpful for the Committee to consider. Following a short discussion, the Chair concluded that until the data is seen the effectiveness of the trigger would not be known and asked the Committee

to reserve the right to consider the triggers after the operational group had met and then for it to come back to Committee in 3 months' time to review the layout and check the metrics are right.
Although some members of the Committee would like to see more data adding to the dashboard it was advised to see how it works in the first instance unless there was another significant event such as the pandemic.

The Chair concluded the Committee agreed for the team to progress with the dashboard but would like the operational group to reconsider the triggers to ensure they are reflective, identify what they need to do and to double check the RAG status and criteria.

The Committee **NOTED** the content of the paper.

DECISION: The Committee **APPROVED** the Calderdale General Practice Dashboard, Indicators and Trigger Criteria.

50/21 MEDICINES OPTIMISATION PROGRAMME UPDATE

The paper provided a high-level summary of performance data for Calderdale's Primary Care prescribing and an overview of the CCG medicines optimisation workstreams that impact on quality and safety of prescribing. Attention was drawn to the following key points:

- The benefits of using the Optimize RX software, in relation to cost effectiveness, quality, and safety in prescribing continues.
- Calderdale performance on reducing low priority prescribing is good.
- Antibiotic prescribing continues to be a challenge. Several actions were referenced in the report to help mitigate this.
- Calderdale pharmacies and patients continue to benefit from electronic repeat dispensing.
- Collaborative networking between pharmacists in the system is increasing.

The team's significant contribution to the CCG's QIPP target was remarked upon and on behalf of the Committee the Chair thanked the team for influencing behaviours to move in the right direction. An observation was made around the

dietetic input that had been highly beneficial and how this could be replicated across other areas.

The Committee **NOTED** and was **ASSURED** with the contents of the report. The Committee advised the report should be presented to Committee on an annual basis and agreed an action that any significant changes should to be notified through the Director's report.

ACTION: HF/DR to raise any significant medicine optimisation issues within the year in the Director's report.

51/21 CONTRACTING UPDATE

The report was received by the Committee and provided an update on contractual changes and sign-up to services. It was noted at present there were no incorporation or novation requests to consider, however expressions of interest had been received.

In response to a question around why there was such a low uptake locally in the direct enhanced services for 'GP Choice Out of Hours', SH explained this could be due to people accessing services better from their work area rather than from their own residential area.

The Committee **NOTED** and was **ASSURED** with the contents of the report.

52/21 FINANCE REPORT

The report was received, and the CCG was forecasting to deliver a balanced position.

An overspend was reported on the additional roles however extra allocations are due to come into the CCG to match this expenditure and following the work with PCNs it was hoped the forecast would improve further and in turn reduce the overspend. The budget for next year had increased making it possible to bring some of the planning forward around these roles into this financial year. The Committee should see some of the additional roles coming into play towards the end of this financial year.

With regards to financial planning, the allocations for H2 are expected in September, which would allow the team a month to work on the plan ready for submission in

November. LS anticipated no major changes for this budget but would update Committee at the next meeting.

The Committee **NOTED** the 2021/22 financial position on Primary Medical Services delegated budgets. There were no further comments on the report.

The report was seeking approval to set up an additional virtual meeting in private with **non-conflicted members** to approve any discretionary investment proposals within the allocation. Considering the current pressure and onset of Winter, LS proposed to spend a full year's reserves, as it was expected there would be no change in H2. The process would help develop plans and gain approval for investment for proposed schemes in a timely manner without having to wait for the next committee meeting. The Committee felt this was reasonable.
ACTION: LS to work with DR on a timeline for the virtual meeting(s) in private with non-conflicted members to approve any discretionary investment proposals.

DECISION: The Committee **APPROVED** the setting up the additional virtual meeting(s) in private with non-conflicted members to approve any discretionary investment proposals.

53/21 Risk Register Position Statement Risk Cycle 2 2021-22 (17 May - 2 June 2021)

The report provided an update on risk cycle 2.
There were 2 open risks, 1628 and 1629, that had been discussed in conversations earlier . The Chair asked that the mitigation for these risks is reviewed and reflected in their scores.
Following a review of risk R1734 around the different care pathway programmes, RG concluded the risk is not confined the general practice due to the pressure felt by the system. It was proposed the risk was closed and 2 new risks created, one that focusses on management of long-term conditions and frailty and one that focusses on urgent and on the day access both which are impacted by challenges of covid. The Chair requested that SMT consider, when dividing this risk, that any specific risk element to primary care is not lost.

It was pointed out that system wide risks are taken into Quality Finance and Performance Committee for consideration however the CCG chair was keen for

CPMSC to remain sighted on the primary care elements and it was agreed the 2 new risks would also come to this committee for oversight unless displaced for something specific to PC

The Committee **REVIEWED** the Risk Register and the management of Commissioning of Primary Medical Services risks

DECISION : The Committee **APPROVED** the CCG Risk Register for commissioning of primary medical services risks reporting to Governing Body for risk cycle 3, the work around the amendments proposed for risk 1734 and the review of risks 1628 and 1629.

54/21 REVIEW OF WORKPLAN

The Committee members received and agreed the workplan.

55/21 APPLICATION FOR A BRANCH CLOSURE

The Committee was asked to consider an application for branch closure that was received from Spring Hall Group Practice. The correct process for applying for this had been followed and the task and finish group set up to oversee this process recommended the decision to retrospectively close this branch surgery, located in Boots plc, Market Street Halifax, on a permanent basis. As the landlord gave notice, the decision was made, and the practice had no choice but to accept the closure however the CCG was still required to see if there was a need for a town centre branch.

Following an engagement exercise, the practice could not define regular users from its data set and from the engagement evaluation it revealed there was not the demand to establish a town centre location, as there were other alternatives available.

The Chair highlighted the line in the report referring to the CCG re-approving rent reimbursement, but the rent was never re-imbursed. EB explained the Committee approved prior to October a rent reimbursement to be paid to Boots going forwards (prior to that it was free) however 2 months later the landlord decided to give notice.

The Committee **NOTED** the content of the paper and **ACKNOWLEGED** the process to ensure the commissioning decision could be made and that it has been carried out in line with the NHSE policy and guidance manual.

DECISIONS:

The Committee **APPROVED** the retrospective closure of the branch surgery at Boots, Market Street, Halifax.

The Committee **APPROVED** the issuing of a contract variation to remove the branch surgery address from the core GMS Contract by the contracting team.

56/21 DATE AND TIME OF NEXT MEETING IN PUBLIC:

Thursday 25th November 2021, 3.00 – 5.00pm, tbc

Calderdale Commissioning Primary Medical Services Committee Meeting 26 August 2021 Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
HOPC Report	35/21	To share the draft Estates Strategy document at the next CPMSC development session	DR	**Open**	October date to be agreed with PCNs
Quality Assurance and Monitoring Process for General Practice	36/21	To present a first draft of the local dashboard at the next Committee.	DR/EB	Closed	Presented to CPMSC 26/08/21
Risk Register Position Statement Cycle 1	38/21	To redefine R1734 around the risk of harm to patients relating to the backlog of work post Covid and to re-look at the score. To complete critical risk template and re-share definition and score with committee before next meeting in August.	EB	Closed	Revised definition and score shared prior to meeting. Discussed under the risk register item 26/08/21.
Finance Report	41/21	LS to provide a brief overview of previous year's utilisation and role occupancy at the next meeting.	LS/DR	Closed	Covered in the Director and Finance reports 26/08/21.
Director's Report	48/21-a	EB to provide an update on the roles (headcount) filled to target for 20/21 and 21/22 in the next Director's report to Committee.	EB/DR	Open	
	48/21-b	DR to make a comparison to 2019 data in the next Director's report to Committee.	DR	Open	
	48/21-c	DR to include an update on Serious Mental Illness Health Checks in the next Director's report to Committee.	DR	Open	
Medicines Optimisation Programme	50/21	HF/DR to raise any significant medicine optimisation issues within the year in the Director's report.	HF/DR	Open	

Finance report	52/21	LS to work with DR on a timeline for the virtual meeting(s) in private with non-conflicted members to approve any discretionary investment proposals.	LS/DR	Open	

MINUTES OF CALDERDALE'S
SINGLE ITEM COMMISSIONING PRIMARY MEDICAL SERVICES
COMMITTEE MEETING
1ST OCTOBER 2021
VIA MS TEAMS

Due to the COVID 19 public health emergency this meeting was not held in public.

PRESENT:

John Mallalieu (JM)	Chair, Lay Member (Finance and Performance) and Deputy CCG Chair
Alison MacDonald (AM)	Lay Member (Patient and Public Involvement)
Neil Smurthwaite (NS)	Chief Operating Officer, Chief Finance Officer
Lesley Stokey (LS)	Director of Finance
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Debbie Robinson (DR)	Director of Improvement - Community and Primary Care
Penny Woodhead (PW)	Chief Quality and Nursing Officer
Martin Pursey (MP)	Head of Contracting and Procurement
Zoe Akesson (ZA)	Governance Support Officer (minute taker)

57/21 APOLOGIES FOR ABSENCE

Apologies were received from Cllr Tim Swift, and colleagues from Healthwatch (Karen Huntley) and NHS England (Neil Coulter).

58/21 DECLARATIONS OF INTEREST

Dr Steven Cleasby and Dr James Gray both have a direct financial interest in the item due to them being existing providers of phlebotomy services. As they could be conflicted in the conversation and the decision, they did not receive the papers or invited to participate in the meeting. The Committee was **CONTENT** with the approach taken.

59/21 INTERIM COMMUNITY PHLEBOTOMY SERVICE

In presenting the paper, MP explained the scope of the service is for the additional community phlebotomy service capacity until the end of March 2022. The process involved a market test to determine interest. 2 potential providers were identified and invited to tender. The CCG expressed a desire for a collaborative approach and following a conversation a joint bid was received from the bidders resulting in 2 separate bids and a joint bid. The paper set out the moderating scores with the joint bid (3) scoring the highest.

Comments and questions were invited.

The Committee questioned the request for the collaborative bid when the first provider scored excellent as a standalone bid. MP explained although it met the 60% threshold it didn't meet the required delivery model. The combination of the 2 offered a robust distributed delivery model that covered the geographical footprint and could deliver the numbers within the available funding.

From the paper it didn't appear that a member of the Quality Team had been part of the evaluation team. MP assured the Committee that the panel did include a member of the Quality Team and the quality evaluation did take place. This was an oversight in the paper.

LS emphasised this was non-recurrent funding that had been identified for this purpose and further conversations would be required with CHFT in relation to commission arrangements after March 2022. It was acknowledged this had already been paid for in the existing CHFT contract however due to the current demand and recovery the Committee took a pragmatic approach to commissioning the service and recognised the non-discretionary funding would be used for additional capacity to alleviate the backlog.

After clarifying the bloods requested were community capacity purchased from the Trust, RA queried if we were paying for bloods that might not be required. Although this was not easily identifiable, DR explained that guidance issued around the shortage of blood tubes was sent to General Practice, which challenges if the test is

required and therefore naturally demand should decrease however it was recognised there is a longer-term piece of quality work in relation to this which will become more important for the service going forward next year. DR added that a piece of work around a revised model for the 2 providers is underway and using the improvement methodology for this system, Working Together to Get Results, has commenced with CHFT and colleagues in General Practice.

The Committee **NOTED** that the process undertaken confirms that a robust process had been followed for selecting the providers for the Calderdale CCG Interim Community Phlebotomy Service, understanding why 2 providers were put together and noted that a quality input was present during the process.

DECISION: The Committee **APPROVED** the award of the contract by Calderdale CCG to the identified bidders.

60/21 DATE AND TIME OF NEXT MEETING

Thursday 25th November 2021, 3.00 – 5.00pm, tbc

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Minutes of the meeting held in public on Tuesday 6th July 2021

Held virtually by Microsoft Teams

Members	Initials	Role and organisation
Marie Burnham	**MB**	Independent Lay Chair
Ruby Bhatti	**RB**	Lay member
Stephen Hardy	**SH**	Lay member
John Mallalieu	**JM**	Lay member
Dr James Thomas	**JT**	Chair, NHS Bradford District and Craven CCG
Helen Hirst	**HH**	Chief Officer, Bradford District and Craven CCG
Dr Steven Cleasby	**SC**	Chair, NHS Calderdale CCG
Neil Smurthwaite	**NS**	Chief Operating Officer, NHS Calderdale CCG (deputy for Robin Tuddenham)
Dr Khalid Naeem	**KN**	Chair, NHS Kirklees CCG
Carol McKenna	**CMc**	Chief Officer, NHS Kirklees CCG
Dr Jason Broch	**JB**	Chair, NHS Leeds CCG
Tim Ryley	**TR**	Chief Officer, NHS Leeds CCG
Dr Adam Sheppard	**AS**	Chair, NHS Wakefield CCG
Jo Webster	**JW**	Chief Officer, NHS Wakefield CCG
Apologies		
Robin Tuddenham	**RT**	Chief Officer, NHS Calderdale CCG
In attendance		
Esther Ashman	**EA**	Programme Director, Commissioning Futures
Karen Coleman	**KC**	Communications and Engagement Lead
Stephen Gregg	**SG**	Governance Lead, Joint Committee of CCGs (minutes)
Sarah Halstead	**SH**	Specialised Commissioning, NHS England
Ian Holmes	**IH**	Director, WY&H HCP
Anthony Kealy	**AKe**	Locality Director WY&H, NHS England & NHS Improvement
Catherine Thompson	**CT**	Director, Planned Care Programme.
Jonathan Webb	**JWb**	Director of Finance lead, WY&H HCP
Rob Webster	**RW**	Chief Executive Lead, WY&H HCP

Item No.		Action
21/21	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting. Apologies were noted.	

22/21	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. None were declared.	
23/21	**Questions and deputations**	
	The Chair advised that as the meeting was being held virtually, members of the public were able to watch the livestream of the meeting and had been invited to send questions in advance. None had been received:	
24/21	**Minutes of the meeting in public – 6th April 2021**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 6th April 2021.	
25/21	**Actions and matters arising – 6th April 2021**	
	SG presented an updated the action log. CT noted that NICE guidance on the use of flash glucose monitoring had changed and recommended that action 40/19 be closed.	
	The Joint Committee: Noted the action log and agreed that action 40/19 be closed.	
26/21	**Evidence-based interventions – List 2**	
	Catherine Thompson (CT) presented a report on the NHS England and Improvement (NHS E/I) Evidence Based Interventions programme. In collaboration with the Academy of Medical Royal Colleges, NHSE/I had developed a list of 31 treatments and procedures which should not be routinely commissioned/provided. Impact assessments had identified the need to adjust the guidance to meet the needs of highrisk groups linked to age, gender and race. The guidance supported but did not replace clinical decision making. It aimed to ensure that people were offered the most appropriate treatment for them and were not subject to unnecessary or ineffective procedures. The proposals would be implemented alongside plans for elective care recovery. In response to a question from SH, CT and JW advised that as national consultation and engagement had been undertaken on the proposals and had include patient voice, no further local consultation had been carried out. CT emphasised that the interventions were not being withdrawn. The aim was to apply evidence-based criteria to ensure that that they would only be offered to people who would benefit from them. JT confirmed that the proposals had the full support of the Clinical Forum. The Planned Care Alliance would support places in ensuring effective implementation.	
	The Joint Committee: **Supported** the Evidence Based Intervention guidance for adoption as commissioning policy.	

27/21	**All age autism assessment and diagnosis**	
	Helen Hirst (HH) presented proposals for a collaborative, strategic approach to planning all age autism assessment and diagnosis. Current service levels across WY were not meeting demand, which was leading to long waits and large waiting lists. There was an opportunity to use 'one-off' funding to undertake a detailed review, understand demand better, share learning and develop a more strategic approach. In response to a question from JM about the impact on outcomes for people, HH said that that although there might be some impact in-year, sustained progress would be unlikely until 2022/23 and beyond. TR noted that whilst diagnosis was important, there was a need to also focus on broader population health outcomes. He noted the one-off nature of the funding available and the need for a robust exit strategy. In response to a question from SC, HH confirmed that there would be a strong focus on tackling the health inequalities experienced by people with autism. RW highlighted the need to work with a range of partners including the voluntary, community and social enterprise sector and local authorities to ensure that supporting services were available. JW noted the benefits of collaborative working in Wakefield on this agenda,	
	The Joint Committee: **a) Supported** joint work on autism across West Yorkshire. b) **Supported** the proposal to use the additional resources collaboratively to make the greatest impact in the short term and establish the basis of future collaboration.	
28/21	**White Paper and legislative change: ICS Design Framework**	
	Rob Webster (RW) presented an update on the legislation, which was 'catching up' with how we already worked in partnership across WY&H. Our arrangements at place and system level provided a very strong platform. Our Memorandum of Understanding set out our principles and ways of working and our five year plan and ten big ambitions ensured a strong focus on reducing health inequalities and improving health and wellbeing. RW highlighted the positive impact that collaborative working had had on responding to COVID, tackling health inequalities and improving outcomes. For example, the Joint Committee had led work to share learning from Bradford and establish the WY&H Healthy Hearts programme. Under the new arrangements, places would remain at the centre of planning and decision-making, with provider collaboration supporting effective delivery at both place and system level. A top priority was to ensure that CCG staff affected by the changes were well supported during the transition period. SH highlighted the importance of building on our strong approach to accountability and transparency. RW responded that citizen involvement and independent challenge would remain a key part of our approach at both place and system level.	
	The Joint Committee: a) **Noted** the update on the Health and Care White Paper.	

29/21	**Risk management**	
	Stephen Gregg (SG) presented the significant risks to the delivery of the Joint Committee work plan. Controls, assurances and planned mitigating actions were set out for each risk. There were currently 7 risks scored at 12 or above after mitigation. 2 risks would be removed from the register after the meeting, as the risk level was now below 12.	
	The Joint Committee: Reviewed the risks to delivery of the Joint Committee workplan and **noted** the actions being taken to mitigate the risks.	
30/21	**West Yorkshire and Harrogate Memorandum of Understanding for Collaborative Commissioning**	
	Stephen Gregg (SG) presented the report. The MoU which underpins the work of the Joint Committee, had been agreed by the WY CCGs in September 2020. To ensure that the Joint Committee could continue to carry out its delegated functions, it was proposed that the MoU be extended until 31st March 2022. No material changes to the MoU or the terms of reference of the Joint Committee were proposed.	
	The Joint Committee: Recommended that CCG Accountable Officers sign off an extension of the MoU to 31st March 2022.	
	Any other business	
	There was none.	

Next Joint Committee in public – Tuesday 5 October 2021, 11am – 1pm.