Public Section of the Governing Body Meeting

Thursday 29th April 2021 at 2pm via Video Conference (Microsoft TEAMS)

Due to the COVID-19 public health emergency this meeting was not held in public.

MINUTES

Present

Dr Steven Cleasby (SC)	Chair, GP Member
Robin Tuddenham (RT)	Accountable Officer and Chief Executive, Calderdale Metropolitan Borough Council
Neil Smurthwaite (NS)	Chief Operating Officer
Lesley Stokey (LS)	Director of Finance, Calderdale Clinical Commissioning Group
Dr Caroline Taylor (CT)	Clinical Vice Chair
John Mallalieu (JM)	Deputy Chair, Lay Member (Finance and Performance)
Dr Farrukh Javid (FJ)	GP Member
Dr James Gray (JG)	GP Member
Penny Woodhead (PW)	Chief Quality and Nursing Officer
Alison MacDonald (AM)	Lay Member (Patient and Public Experience)
Dr Rob Atkinson (RA)	Secondary Care Specialist
Prof Peter Roberts (PR)	Lay Member (Audit)
Denise Cheng-Carter (DCC)	Lay Advisor
Prof Rob McSherry (RM)	Registered Nurse

Deborah Harkins (DH)	Director of Public Health, Calderdale Metropolitan Borough Council,

In Attendance

Debbie Graham (DG), Head of Integration and Partnerships (for item 5, minute 23/21)

Iain Baines (IB) Director of Adult Services, Calderdale Metropolitan Borough Council

Jill Holbert (JH) Assistant Director, Commissioning and Partnerships Manager, Calderdale Metropolitan Borough Council (for item 5, minute 23/21)

Robert Gibson (RG) Corporate Systems Manager, Calderdale Clinical Commissioning Group (for item 6, minute 24/21 and item 12, minute 30/21)

Debra Varley (DV), Primary Care Administrator, Calderdale Commissioning Group

Minutes prepared by Karen Rodgers, Administrator Calderdale Commissioning Group

Contents

18/21 APOLOGIES FOR ABSENCE

There were no apologies for absence. The Chair welcomed the return of RM following a period of absence due to illness.

19/21 DECLARATION OF INTEREST

There were no declarations of interest.

The CCG's Register of Interest can be obtained from the CCG's website

20/21 MINUTES OF THE LAST MEETING

PW requested **two amendments** be made on page 15/20 of the pack; the continuity of carer target is **already** a target and is **not** an action. It should therefore be **removed** from the action log**.** Secondly, the name of the adult safeguarding board chair is incorrect and should be **Marian Hughson**.

DECISION

The minutes of the public section of the Governing Body meeting held on 28 January 2021 were **RECEIVED** and **ACCEPTED WITH TWO AMENDMENTS** as a correct record.

21/22 UPDATE OF ACTION LOG

Workforce Report 0/21 - NS advised that staff are being reminded of the process of how to record appraisals but more work is required on recording the process. NS and JM will raise this at a future Governing Body meeting.

22/21 ACCOUNTABLE OFFICER'S REPORT

RT presented the report drawing attention to the following key matters:

- COVID-19 now has an element of moving from an epidemic to an endemic stage. Underlying rates are falling across Calderdale although there are a disproportionate number of areas with the highest rates.
- Localised work is ongoing with tracing, including contacts as well as those who are positive.
- Vaccine programme – thanks were given to the voluntary community sector, primary care networks, local authority staff and partners. Pop

ups and one-off events have helped to engage those who may be hesitant about having the vaccine and lessen the gap across different parts of the authority both in the community and the workforce. On 24 March 233 people with learning disabilities remain to be vaccinated out of approximately 1,500. To reach these people, bespoke clinics will be held between 1 May to 8 May 2021, after which a specific offer will be developed for those who have not received their vaccines and this will be replicated for those with serious mental health issues.

- Right care, right time, right place work around the reconfiguration of the Calderdale and Huddersfield sites is at an important phase working across Greater Huddersfield as well. A lot of work is being undertaken to engage the community which inform the outline business case being put forward in June.
- The elective care recovery element focusses on how performance has been maintained where it has been challenging around cancer. The Integrated Care Service has been working with Julian Hartley at Leeds Foundation Trust to support the work around cancer care.
- The impact on mental health has required investment and focus. The mental health hub has received funding.
- An outstanding assessment has been received for the oversight framework
- An independent audit process has begun on the transition roles for RT, NS and LS and will report to the Remuneration and Nomination Committee

NS updated The Governing Body on the vaccine programme

Comments and questions were invited.

SC queried whether the figure of 15% of people with learning disabilities (LD) not having received their first vaccine was still correct. NS advised this figure has now been reduced to 10% and anticipates this will fall further.

Accountable Officer Role Review

As part of the approval of the new Chief Operating Officer and Director of Finance, the Governing Body requested a review of the arrangements after 6 months to ensure these arrangements supported the Accountable Officer and Governing Body in discharging the CCG's responsibilities. This review is currently being undertaken independently by Audit Yorkshire and is on course to report to the Remuneration and Nomination Committee in September. JM reminded RT of the invitation to talk at the Remuneration and Nomination Committee following his interview with the auditor which RT accepted.

DCC asked about the challenge for elective care in Calderdale and about the return of face to face appointments with General Practitioners (GPs). In response SC advised that approximately 75,000 people are waiting for an appointment and approximately 5,000 are waiting for an elective procedure. RT confirmed that throughout the pandemic digital and telephone methods have been used for appointments but that GPs have been seeing patients face to face with the NHS being open. However, the initial point of contact is still digital or via telephone. NS also concurred that every practice has been open in Calderdale for face to face appointments and this has been a requirement since October.

AC enquired about the long-term plans for the vaccination programme which may release primary care staff to return to GP surgeries. RW advised work was ongoing at the West Yorkshire and Harrogate (Integrated Care System) to model and plan for a level of vaccination in the summer and then plan for boosters in the autumn. The Clinical Commissioning Group (CCG) is awaiting a timetable from NHS England and will then come back to The Governing Body.

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

23/21 UPDATE ON CALDERDALE CARES

RS, JH and DG presented the paper and slides "our Integrated Care Partnership (ICP) journey". Calderdale Cares is the key element of the CCG's

place-based plans for Calderdale and has been in place for the last three years. The presentation shows the proposal to adapt to the National White paper while keeping the integrity and focus of Calderdale Cares.

Approval is sought from The Governing Body for the recommendation to move forward on the development of the Calderdale ICP, particularly relating to organisational development and revised governance structure.

PR enquired how this system would operate with Kirklees in relation to the oversight of Calderdale Hospital Foundation Trust (CHFT). DG advised the current architecture would remain in place. NS noted it would need to be designed in partnership with Kirklees.

DG advised shadowing arrangements would commence in October 2021 and a Clinical Forum possibly being held in June 2021.

DECISION: The Governing Body **APPROVED** the recommendation for the direction of travel and governance structure proposed.

24/21 OVERVIEW OF AMENDMENTS REQUIRED TO THE CCG'S KEY GOVERNANCE DOCUMENTS

a) Updates to the constitution, changes to Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)

RG presented this report which proposes changes to the CCG's Constitution (including SFIs) and SORD as a result of changes to the Governing Body's structure.

The Governing Body **noted** that the SFIs have been **recommended** for **approval** by **the Audit Committee.**

DECISION: The Governing Body **APPROVE**D the changes to the Constitution and Scheme of Reservation and Delegation.

Paper b)

RG presented this report which proposes an update to the Terms of Reference for the Audit Committee to reflect the changes to the organisation's structure following the Accountable Officer appointment.

The Governing Body noted the proposed Terms of Reference have been **approved** by the **Audit Committee**.

DECISION: The Governing Body **APPROVED** the changes to the Terms of Reference

Paper c)

RG presented the paper to update the Terms of Reference for the Remuneration and Nomination Committee to reflect the changes to the organisation's structure following the Accountable Officer appointment.

The Governing Body noted the Terms of Reference have been **approved** by the **Remuneration and Nomination Committee**.

DECISION: The Governing Body **APPROVED** the changes to the Terms of Reference

25/21 QUESTIONS FROM THE PUBLIC

No questions from the public were noted.

26/21 PATIENT STORY

PW presented a video of a lady in Liverpool who has been suffering from long COVID-19 for four months.

FJ updated the Governing Body on the new pathways launched in Calderdale for those experiencing long COVID-19. Guidelines were published in December 2020. GPs have been advised they should also investigate if a patient's symptoms could be due to their other health complications.

CT discussed the case of two females in their forties in her practice who were delighted to find a clinic where this has been launched and so did not feel abandoned.

The Governing Body noted that hospitals were providing their own support to long COVID-19 patients who had been hospitalised. As there is no treatment available currently, patients with long COVID-19 are being managed in a gradual rehabilitation process as if they are suffering from chronic fatigue. RA highlighted that those who have also been suffering from other post viral chronic fatigue symptoms **not attributable** to COVID-19 should not be forgotten.

ACTION: FJ/PW to bring a patient experience of someone who is going through or has been through the service and their outcomes to a future meeting.

DECISION: The Governing Body **NOTED** and **RECEIVED** the contents of the long COVID-19 video

27/21 PUBLIC SECTOR EQUALITY REPORT

PW presented the report which provides an annual update of quality activity undertaken by the CCG. It is available in the new accessible format with links to other documents. It details a number of systems and mechanisms that are in place to ensure that equality is included throughout any work commissioned by the CCG. The CCG has a role

- as an organisation to make sure any they work commission takes regard of equality
- which provides assurance what its providers do
- which works with Calderdale providers

The Governing Body members will be invited to attend an equality panel, an open session, where the CCG will be challenged about what they are doing.

Systems and processes have developed significantly over the past 5 to 8 years. CT highlighted the need to focus on where there are population **health** i**nequalities**.

PR thanked PW for submitting such a clear and precise report.

DECISION: The Governing Body **NOTED** the content and **APPROVED the** equality report

8/21 DIRECTOR OF FINANCE REPORT

LS presented the report noting the CCG submitted its final year end account on 27 April 2021 and the financial plan had been met to deliver a small surplus.

Highlights of the report are:-

- The ICS financial position forecasting to deliver a better than expected position. A first draft financial plan for the next half year was submitted on 16 April 2020, following publication of CCG planning guidance at the end of March 2020.
- Level of growth received vs. assumptions on cost grow. This is challenging in terms of the financial plan for next year – see table on page 4 of the report, page 294 of the pack.
- Planned for 2% increase on prescribing
- Uplifted continuing healthcare (CHC) budget by 4.8% to mirror increase Calderdale Council has awarded in respect of living wage demands
- Overall growth in allocation is an 0.8% uplift on last year which is less than the growth in planned costs leaving a significant cost pressure
- The draft plan in the pack has a level of savings requirement of £1.4 million, however, since writing the paper for Governing Body the financial plan has been refreshed and the savings requirement has increased to £2 million.
- The CCG has identified QIPP savings of £0.5m and also a contingency of almost £0.8m and will have a challenge to deliver

£0.7m of savings or QIPP to achieve the overall £2m savings required for a balance financial plan.

- The CCG has not received allocations or planning guidance for the second half of the year.

Comments and questions were invited.

DCC enquired whether there was a risk attached to the additional money (£258,000 surplus) of it not being spent on the primary care additional roles. LS advised there is no risk to the financial plan submitted for 2021 and that allocations have been issued. The Governing Body agreed to the recommendation to submit a balanced plan.

JM, however, highlighted that this relates only to the first half of the year and the probability exists that the contingency will be used in the first half. He supports the recommendation to submit a balanced plan but reminded members that this is only for the half year with the potential that the same issue will arise again in six months' time.

DECISION: The Governing Body **APPROVED** the draft financial plan for the period April to September 2021**.**

CONTRACTING REPORT

The following were highlighted from the report:-

- From 1 April 2021 the CCG is now contracting for capacity in the independent sector to help address the waiting list
- Reinstatement of having to have contracts in place with non-NHS providers

PERFORMANCE REPORT

- Accident and Emergency (A&E) attendances are returning to pre-COVID-19 levels which is adding to pressure as well as has having to maintain streaming. This is being discussed at the A&E Delivery Board and is part of discussions around the re-set plan.
- Elective is still a challenge
- Pressures exists in diagnostics, particularly endoscopy
- There has been a significant increase in mental health wait times, particularly for children and young people (acute beds)
- Reset activity planning is underway over this six-month period
- ICS consolidated plans will be submitted on 6 May 2021

The Calderdale place plan will be brought to the next Governing Body or Quality Finance and Performance Committee, whichever occurs first.

Comments and questions were invited.
PW advised that Health Watch will be conducting work to find out people's experience of waiting, and how that can be improved.
CT noted a long delay in diagnostics and people having to wait well over a month. She also reported a 30% increase in mental health referrals. She is attempting to get one practitioner in each primary care network for children and one for adults.

DECISION: The Governing Body **RECEIVED** and **NOTED**
The reports

29/21 QUALITY AND SAFETY REPORT AND QUALITY DASHBOARD

In presenting the report PW highlighted the following key areas:

- the CCG is now awaiting the final guidance from the Care Quality Commission (CQC) on inspection framework following its consultation. Key messages are expected to be around doing more intelligence driven inspections and how to inspect across pathways, systems, etc.

It was noted targeted face to face inspections have now resumed for those services which may be classed as inadequate or require improvement.

- host commissioner guidance for people with learning disabilities and autism. The CCG does not have its own facilities in Calderdale but places people in other authorities and so need to share information with those host commissioners.

Dashboard

Dashboard highlights include:

- The need to work with CHFT around the fracture neck femur performance
- A slight deterioration was noted in the standardised hospital mortality indicator

Maternity

- A review is being conducted on all quality account priorities for all providers which are due to be published at the end of June 2021
- A national Quality Board guidance around quality was published on 28 March 2021. Consultation is expected on a quality dashboard in during quarter one.

Infection Prevention Control

The level of the National Patient Safety Agency (NPSA) alert figures was queried. PW advised these are a rolling target so it will take a while before an improvement will be noticed. She highlighted it is not about non-compliance but merely a reporting issue.

Comments and questions were invited:

RA enquired whether any changes could be detected in the dashboard due to improvements in health care infections as a result of improvements in hygiene. PW advised that while Methicillin-resistant staphylococcus aureus

(MRSA) is low, numbers for C Diff and E Coli are still higher. She is contacting colleagues to discuss the next steps for infection, prevention and control arrangements.

RA noticed a big increase in complaints around quality and communication and DCC also queried the big red circles (staff surveys) on the CHFT Quality Dashboard. PW has asked for action plans from CHFT to address this issue. AC enquired whether the complaints were due to numbers or to staffing issues.

ACTION: PW to investigate the reasons for complaints with both providers and report back to the next Governing Body

RM asked about staff morale. PW has already asked for more detail from providers from their committees.

30/21 RISK REGISTER POSITION STATEMENT CYCLE 1 2021 – 22 15 FEBRUARY - 3 MARCH 2021

RG presented the first risk review cycle of 2021/22. Of the 38 risks open, 3 are critical and 5 are serious. Risk 1734 (score of 16) is new and refers to the backlog of work paused due to COVID-19.

RG confirmed that each risk is reviewed regularly by the risk owner, a senior manager and by the Quality, Finance and Performance Committee.

The Governing Body **accepted** the register as a true statement and **accepted** that mitigations were in place.

DECISION: The Governing Body **RECEIVED** and were **ASSURED** by the Risk Register position statement cycle 1 2021-22

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31/21 COMMITTEE MINUTES

The Governing Body received the following:

- The minutes of the Audit Committee meeting held on the 25 February 2021

From the Audit Committee, PR highlighted item 013/21 Items for Governing Body:

- Standing Financial instructions which were approved with certain caveats and agreed to receiving further amendments between meetings.
- IP Policy handbook – approved the amendments and agreed the role of Audit Committee was to approve the consolidated document. It was still expected that other Committees would use their expertise for areas they have responsibility for
- Local Security Management Policy
- Audit Committee Terms of Reference
- Agreed the Committee work plans for 2020-21 and 2021-22
- To note the gaps in the Governing Body mandatory training
- To report both internal and external audit processes are on track

Members are asked to **check** their mandatory training requirements on the schedule.

DECISION: The Governing Body **RECEIVED** and **NOTED** the minutes of the Audit Committee held on 25 February 2021

- The minutes of the Quality, Finance and Performance Committee meeting held on 17 December, 25 March 2021

DECISION: The Governing Body **RECEIVED** and **NOTED** the minutes of the Quality, Finance and Performance Committee meeting held on 17 December, 25 March 2021

- The minutes of the Commissioning Primary Medical Services Committee held on 4 March 2021
  It was noted that the minutes from 21 January 2021 were **missing** from the pack

DECISION: The Governing Body **RECEIVED** and **NOTED** the minutes of the Commissioning Primary Medical Services Committee held on 4 March 2021

32/21 EXTERNAL MEETINGS

DECISION: The Governing Body **RECEIVED** and **NOTED** the minutes of the meeting of the West Yorkshire and Harrogate Joint Committee of CCGs held on 12 January 2021.

33/21 KEY MESSAGES FOR PRACTICES

DECISION: The Governing Body **agreed** the following key messages for member practices:

PW to send a short reminder regarding health inequality objectives

JF to send reminder that the long COVID-19 service is now available

34/21 DATE AND TIME OF NEXT MEETING IN PUBLIC

The Governing Body noted that the next meeting would take place on 29th July 2021, 2.00pm, via Video Conference

The Governing Body Meeting 30 April – 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	Open	-
Workforce Report	09/21	To review the process for recording	NS/JM	Open	-
Patient Story	25/21	To develop a patient story as part of the long COVID-19 pathway	PW/FJ	Open	

Name of Meeting	**Governing Body**	**Meeting Date**	29 July 2021
Title of Report	**Accountable Officer's Report**	**Agenda Item No.**	5
Report Authors	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 provide the Accountable Officer update to the Governing Body on a number of current issues relevant to the CCG and the wider health and social 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. **Note** the contents of this update 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 is written in the context of continued severe pressures on our health and care system as we continue to respond to the pandemic, deliver the vaccination programme, support recovery of elective care, ensure effective early intervention to enhance wellbeing, and respond to the new Health and Care Bill. In that context, I would like to thank all staff in the CCG, and everyone who works in primary care in Calderdale. You have shown tenacity, compassion and determination to do the best we can for our communities in unprecedented circumstances.

As from the 19th July we have moved to Step 4 of the Governments COVID-19 roadmap. We have worked with partners in the system in Calderdale and at ICS level to prepare and respond to this. We have issued guidance to staff to reflect on what this can mean to them. The national decision has been taken mainly because of the huge success of the vaccination programme, we cover more on that in the next section but I feel I should highlight to the Governing Body the incredible work our partners, especially our Primary Care Networks, practices and Community Pharmacy have had in achieving and contributing to the success.

However, the pandemic is not over and all health and social care services are experiencing huge levels of demand and pressures on precious resource. As COVID restrictions are lifted we welcome the freedoms but need to ensure we embody our values of kindness and resilience. We know this continues to be a challenging time and we know people have different views, the CCG and staff will continue to support each other and our partners. As some of the updates show we are an adaptable and flexible organisation

2.0 Covid-19 Update

2.1 COVID-19 Vaccination Programme

We are proud of our work in implementing this programme, and all involved should share that sense of pride.

As of 24th June, over 140,000 adults have been vaccinated in Calderdale with dose one, which is over 79% of the adult population. Over 110,000 adults, which is over 61% of the adult population have been fully vaccinated (received the second dose).

Those in the JCVI cohorts 1-9 (50+, CEV and those with an Underlying Health Condition) who have received their vaccination are as follows :
1st dose - 91,970 (90%)
2nd dose - 87,657 (86%)

Those in JCVI cohorts 10-12 (aged 18-49) the figures are as follows :
1st dose - 56,636 (64%)
2nd dose - 28,426 (32%)

We continue to focus on reaching everyone in the priority cohorts. Contact tracers have been phoning those in cohorts 1-9 who have not accepted their vaccine to encourage uptake, which includes assistance with booking or the offer of speaking with a clinician. Contact details are being cross checked with council tax registers to ensure we make every effort possible to reach out to everyone.

Calderdale's Covid-19 vaccination figures will be updated at the meeting as the number changes every week. Calderdale now has 8 fixed sites across the Borough. Of these sites 7 can be booked via the national booking system https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/book-coronavirus-vaccination/. The programme continues to include pop-up clinics to tackle vaccine inequalities and to reach out to where young people are.

The Piece Hall walk-in site was very successful vaccinating over 1000 people within 2 days and one evening and the subsequent weekend approx. 350 people were vaccinated at the Sowerby Bridge pop-up and over 500 people at Boots. These were mainly first doses to younger people and provided easy access for some people struggling to book through the traditional methods. Most sites will now be offering walk-in capacity and these will be listed and updated on the CCG website and regularly promoted https://www.calderdaleccg.nhs.uk/walk-in-vaccination-clinics/

Phase III planning for the Autumn boosters is underway. Working with providers to ascertain those interested to be involved, established estates if it is not possible to co-

administer the Covid vaccination with flu at and identifying workforce wishing to be involved and skilling up volunteers as appropriate.

We are working hard to reduce health inequalities and support uptake with a roving model in development, which will be hosted by one of our PCNs. This will enhance our work to address vaccine inequalities over the summer and provide access to vaccination in innovative ways.

2.2 Blood Pressure at Home for People with Diagnosed Hypertension

The CCG is supporting PCNs to implement home blood pressure monitoring for patients with a diagnosis of hypertension which is poorly controlled, to allow treatment to be optimised, where it would be of benefit. Approximately 900 blood pressure monitors have been delivered to each PCN for disseminating across practices; for clinical teams to target patients with poorly controlled hypertension, prioritising those most at risk of becoming seriously ill with COVID or suffering heart attacks and strokes.

During the COVID-19 pandemic, patients with cardiovascular risk factors may not be receiving their usual reviews and subsequent treatment adjustment for their hypertension. Evidence shows that every month of disruption to pro-active hypertension management and intensification of medication where needed will likely result in additional acute cardiovascular events. NHS England modelling has estimated that a 9 month period of disruption to the delivery of routine care for those diagnosed with hypertension could result in around 12,000 additional acute cardiovascular events (strokes and heart attacks) or deaths over a three year follow up, as compared to what might have been expected from pre-COVID levels of achievement. Therefore, home blood pressure monitoring has been identified as a priority for cardiovascular disease (CVD) management to ensure that patients who are vulnerable to becoming seriously ill with COVID-19 can manage their hypertension well and remotely, without the need to attend GP appointments.

The use of self and telemonitoring of blood pressure is also supported by evidence as it is: cost-effective, saves GP time by shifting care from GPs to other members of the multidisciplinary team, and over five years reduces the incidence of clinical events such as death, heart attack or stroke.

3.0 Urgent and Emergency Care

The A&E Delivery Board has been renamed the Calderdale and Huddersfield Urgent and Emergency Care Board (UEC Board), and recently held a workshop to clarify priorities and focus. This reflects the architecture at West Yorkshire (WY) and also the geography, in that the Board only covers one half of Kirklees. The Mid Yorkshire A&EDB covers the remainder. The Board is chaired by the Council's Director of Adult Social Care and Wellbeing reflecting our collaborative ethos, and has been required to instigate emergency meeting arrangements through Gold/Silver to address the sustained pressures on all parts of the system responding to high levels of acuity, and those with milder symptoms needing support in dealing with long term conditions.

The workshop confirmed the Board's role and strategic aims, which are aligned to those of the WY ICS UEC Board. The role of the Board is to hold the system to account for delivery of the following Vision:

- To ensure our system provides high quality, appropriate, and responsive **rapid and urgent care** services that deliver care as close to home as possible for our population
- Ensuring those people with more serious or life-threatening **emergency care** needs have access to specialist care to maximise a good recovery.

Strategic Aims:

- Enabling effective access to, and navigation through, rapid, unplanned care through integrated urgent and emergency care pathways
- Enabling provision and equity of local rapid and urgent and emergency care services
- Ensuring agreed standards of quality, safety and patient experience
- Ensuring clear communications to develop confidence of our population and partners of our offers
- Addressing health inequalities associated with access to rapid, urgent and emergency care services
- Encouraging collaboration, and creating relationships across pathways and providers, particularly focusing on the important role of our third sector
- Ensuring we support the health and wellbeing of our staff

4.0 Elective Care

Our system has taken a clear stance to collectively own elective recovery. There has been good progress in addressing the backlog of treatment in testing circumstances not experienced in over twenty years, however, it has been recognised at an executive level that there is a need to accelerate the pace. Calderdale CCG stepped forward to supplement CHFT's divisional management by providing additional capacity to support recovery, helping patients to be seen quicker by identifying a range of new and existing providers who could support the system with additional elective capacity. The first speciality identified is ENT, and we should start to see the impact of this work in July. We anticipate we will need to consolidate and broaden this approach given the pressures will be ongoing throughout the summer period and beyond.

5.0 Further Developing Calderdale Cares

The Health and Care Bill went through its first and second reading on the 7th July and 14th July respectively and we are anticipating the legislation will be passed to meet the timescale for the full transition to the West Yorkshire ICS by 1 April 2022. Rob Webster has been appointed the interim full-time Chief Executive, and recruitment to the Chair and Chief Executive role will commence shortly.

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. This will involve the exit arrangements for the CCG, to move to shadow arrangements by the autumn and transfer to the ICS on 1 April 2022. This is not an end point for Calderdale Cares, but a stage in our journey towards more integrated care.

Developing this partnership is the continuation of an ongoing journey in Calderdale, building on the progress achieved to date and moving forwards with more formalised arrangements and a clear strategic direction. A programme of work – the Calderdale ICP Development Programme – has been set up to support Calderdale Cares with the next stage of its journey. It's really important to retain a sense of purpose in this work, which is about providing the right conditions to deliver high quality health and care and promote wellbeing through effective prevention focusing on reducing health inequalities. Our aim is for

everyone to live a larger life, a fuller life, and our local system needs to align effectively with the West Yorkshire system to achieve that, showing compassion and kindness.

Key priorities for the programme are:

- Governance: This priority covers designing and implementing a formal governance structure, accounting for the structural changes being brought about through the new ICS arrangements, to facilitate the partnership as it moves forward. A Memorandum of Understanding will abe developed, to reconfirm the Calderdale Cares priorities and ways of working.
- System development: This priority covers the further strengthening of the Calderdale Cares partnership, using the ICS's Place Development Framework to assess the partnership's strengths and areas for further development in three key domains: Ambition and Vision; System Leadership; and Design and Delivery.
- Communications and engagement: This priority covers agreeing and distributing a shared narrative about the developments that are taking place, and ensuring that the right people – both in our communities and in our organisations – are being engaged as we take this next step as a partnership.
- Maximising Calderdale's voice: This priority covers building a strong, unified voice for Calderdale and influencing ICS developments through ensuring there is appropriate Calderdale representation in ICS groups and workstreams. This also includes a focus on our workforce in the CCG who will transfer to the ICS in April, and all those not at Board level have an employment commitment outlined in NHSE guidance.

6.0 CCG Assurance

6.1 NHS Calderdale CCG Annual Assessment 2020-21

I am pleased to enclose the CCG annual assessment letter from NHS England. This is part of the annual NHS assurance process. The letter reflects and recognises the strong leadership and teamwork we have developed across Calderdale. I would like to thank the team and Governing Body for the leadership shown over the last twelve months, as we have responded and adapted to the multiple challenges experienced in Calderdale and the organisation.

The performance seen across the 5 main areas assessed is assuring to the Governing Body, the areas assessed are:

- Improving the quality of service
- Reduce health inequalities
- Involve and consult the public
- Comply with financial duties
- Leadership and Governance

6.2 NHS System Oversight Framework 2021-22

Following last year's assessment NHS England has issued the framework for System Oversight. This continues the shift from just organisation level to both system and organisation, recognising the best way to manage NHS resources to deliver high quality, sustainable care is to focus on both elements. Across Calderdale and West Yorkshire we have been moving to this way of assessment, working and collaborating with partners on risks, issues and support needs. This is recognised in the 20/21 assessment covered above.

The framework can be found in the link below, in summary the framework:

- provides clarity to integrated care systems (ICSs), trusts and commissioners on how NHS England and NHS Improvement will monitor performance; sets expectations on working together to maintain and improve the quality of care; and describes how identified support needs to improve standards and outcomes will be co-ordinated and delivered

-will be used by NHS England and NHS Improvement's regional teams (regional teams) to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require

- describes how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local level to ensure our activities are aligned

- introduces a new integrated and system focused Recovery Support Programme (RSP) that replaces the previously separate quality and finance 'special measures' regimes for provider trusts.

NHS England » NHS System Oversight Framework 2021/22

As we develop our place-based arrangements, as part of the transition arrangements to the new ICS arrangements, we will continue to report detailed performance against the metrics within the framework to the Quality Finance & Performance Committee.

7.0 Health Inequalities – Building an Anti-Racism Movement

The CCG is committed to tackle all aspects of health inequalities, and work with the West Yorkshire ICS to learn from the impact of the pandemic. We played a key part in the review undertaken by Dame Donna Kinnear last year and are supporting one of the recommendations to develop an anti-racism movement within health and care in West Yorkshire. This will be launched formally on 23 August, and we are arranging a local event in partnership with Calderdale Council. This will include a commitment to improve outcomes for our communities, support workforce inclusion and development for minority ethnic staff, and support voice and influence in all aspects of the health and care system. We are also working across the CCG, Council and CHFT to enhance our data and intelligence on the health inequalities experienced in Calderdale to better target our resources.

8.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

I have appended a summary of the discussions and decisions reached at the Joint Committee of CCGs, which took place on Tuesday 6 July.

9.0 Recommendations

It is recommended that the Governing Body:

1. Note the contents of this update report.

10.0 Appendices

1. Appendix 1 NHS Calderdale CCG Annual Assessment 2020-21 Letter
2. Appendix 2 WY&H Joint Committee Key Decisions 6th July 2021

NHS England & NHS Improvement
North East and Yorkshire
Room 6E12
Quarry House
Leeds
West Yorkshire
LS2 7UE

Robin Tuddenham, Accountable Officer,
Dr Steven Cleasby, Clinical Chair,
NHS Calderdale CCG

xx July 2021

Via email

Dear Robin and Steven

2020/21 NHS Calderdale CCG Annual Assessment

NHS England has a statutory duty to undertake an annual assessment of each CCG's performance. The approach to the 2020/21 assessment has been simplified due to the continued impact of Covid-19 and the change in priorities this has required to enable the CCG to respond. This means that CCGs will not be given an overall performance rating. Instead, this letter provides a narrative assessment of CCG performance.

The 2020/21 narrative assessment is based on the NHS operational priorities set out in July and December 2020, focusing on the CCG's contribution to local delivery of the overall system plan for recovery, with a particular emphasis on the effectiveness of working relationships within local systems.

This letter summarises the key points of the discussion at the year-end review meeting for NHS Calderdale CCG (which took place as part of the whole place review) and draws on any feedback we have received from stakeholders. It is focused around the following five priority areas.

1. Improve the quality of service

The CCG has played an important leadership role in developing and maintaining effective partnership arrangements to co-ordinate the Calderdale response to the pandemic. Services in Calderdale were able to reopen to new referrals at an early stage in the recovery. This has helped to manage the number of people waiting for treatment through a single approach, with a single waiting list instead of creating backlogs in primary care.

Staff wellbeing is a key element of the CCG recovery plan. Focused support is

being provided to staff, especially in community services, to enable staff some 'breathing space' in order that staff can reset and pause and then be ready to recommit.

In common with other places, you have challenges in relation to long waiting times for ASD diagnosis. You confirmed in our review that the CCG has a clear plan for improvement, developed with people with lived experience.

Maintaining performance on screening has also been a challenge, and we agreed that this should have greater focus in recovery plans.

2. Reduce health inequalities

The actions taken by the CCG to support people with learning disabilities, especially the work undertaken to support children with special educational needs and disabilities is recognised as best practice and has contributed to Calderdale being names Children's Service of the Year. Work is also underway with Sport England on tackling obesity, which has attracted new funding and are also looking into developing arts and health arena.

The CCG has 12 pilots to address health inequalities underway with funding guaranteed for four years.

The approach taken by partners in Calderdale to manage waiting lists through a health inequalities lens is being shared more widely as an example of good practice, achieved through effective partnership working.

The number of people with learning disabilities receiving annual health checks has increased substantially, and now stands at 80%, with some practices reporting 100%. This is also a good example of partnership working and a clear leadership approach adopted by the CCG.

3. Involve and consult the public

The CCG has a joint strategy, 'Involving People' with a shared set of principles with partners. The strategy supports the delivery of the Calderdale Cares, Wellbeing Strategy and Vision 2024. Engagement and consultation with the public is embedded within the CCG commissioning with engagement champions who work within the voluntary and community sector and are trained to engage with the local population.

The CCG has played a key role in the programme of public engagement surrounding the plans for the reconfiguration of acute hospital services in

Calderdale and Huddersfield. This has continued well over the last year despite the challenges of the pandemic.

The delivery of the vaccination programme is a good example of how engagement has taken place with the aim of reducing health inequalities and increasing access to services.

It will be important to ensure that future partnership arrangements in Calderdale are co-produced with local citizens, and to be clear what support will be required from the wider system across West Yorkshire.

4. Comply with financial duties

The CCG achieved its required break-even position for 2020/21 and achieved its financial performance targets for management of both revenue and capital expenditure. The Mental Health Investment standard was met and the CCG's administrative costs were contained within its running cost allocation.

The financial position of the CCG should also be seen in the context of the two local NHS providers in the Calderdale place, South West Yorkshire Partnership NHS FT and Calderdale and Huddersfield NHSFT, both of which achieved financial balance in 2020/21.

5. Leadership and governance

The CCG has effective clinical and non-clinical leadership. Robin's joint role as Accountable Officer and Council Chief Executive has been successful in strengthening partnership working in Calderdale. This has been demonstrated in Calderdale's success as one of the first places to establish a local test and trace service and being one of only two places approved to undertake local follow-up with the contacts of confirmed positive cases.

The CCG is making good progress to develop the place partnership arrangements in anticipation of the changes proposed in the White Paper and is working well with PCNs to re-frame the role of primary care leadership to ensure it is appropriate for the changing needs of the system.

The CCG has robust systems of internal control. The Governance Statement evidences effective leadership and governance. Additionally, the draft Head of Internal Audit Report confirms a high level of assurance for Governance and Risk Management Arrangements.

I am pleased to be able to congratulate you on a very successful year during which the CCG has played a critical leadership role in responding to the pandemic, while

continuing to maintain essential services and strengthen partnership working across Calderdale. Impressive work is happening that, even during this difficult time, has improved services and the lives of the population. Calderdale has a good platform to build on, especially in relation to health inequalities.

I look forward to working with you and continuing to support your CCG through this transitional year, in improving healthcare for your local population and system. Please let me know if there is anything in this letter that you would like to discuss further.

The CCG may wish to publish a summary of this 2020/21 annual assessment.

Yours sincerely,

Anthony Kealy
Locality Director
West Yorkshire and Harrogate

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 6th July 2021

Evidence based interventions - List 2
The Committee considered 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 high risk groups linked to age, gender and race. The guidance supported but did not replace clinical decision making, and aimed to ensure that people were offered the most appropriate treatments and were not subject to unnecessary or ineffective procedures. The proposals would be implemented alongside plans for elective care recovery. Discussion covered the national consultation and engagement that had been undertaken on the proposals, including with the public.
The Committee: Supported the Evidence Based Intervention guidance for adoption as commissioning policy.
All age autism assessment and diagnosis
The Committee considered proposals for a collaborative, strategic approach to planning all age autism assessment and diagnosis. Current service levels across WY were not meeting demand, which led to long waits and large waiting lists. There was an opportunity to use 'one-off' funding to undertake a detailed review, understand demand better and develop a more strategic approach. The Committee noted the importance of tackling the health inequalities experienced by people with autism. Discussion 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. The Committee noted the one-off nature of the funding available and the need for a robust exit strategy.
The 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.
Health and Care legislative change
The Committee considered an update on the legislation, which was 'catching up' with how we worked across WY&H. Our arrangements at place and system level provided a strong platform. A top priority was to ensure that CCG staff affected by the changes were well supported during the transition period. The update highlighted the impact that collaborative working 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 new arrangements, places would remain at the centre of planning and service delivery, with provider collaboration supporting effective delivery. Discussion focused on the importance of building on our strong approach to accountability and transparency. Citizen involvement and independent challenge would remain key.
The Committee: Noted the update.
WY&H Memorandum of Understanding (MoU) for Collaborative Commissioning
The Committee noted that 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 Committee: Recommended that CCG Accountable Officers sign off an extension of the MoU to 31st March 2022.

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.

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Burnt Bridges Report - Learning and Actions**	**Agenda Item No.**	6
Report Author	Rhona Radley - Deputy Head of Service Improvement Emma Bownas - Senior Primary Care Quality and Improvement Manager	**Public / Private Item**	Public
Clinical Lead	Dr Helen Davies, GP Associate	**Responsible Officer**	Debbie Robinson, Director of Improvement - Community and Primary Care

Executive Summary

This report provides 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 recommendations draw out three key areas for health to address:

- Training and Education: Ensuring health care staff, including those in general practice have received training in relation to the impact of trauma on people's lives.
- Integration and Collaboration: Strengthening the co-ordination of health commissioning arrangements to ensure it works closely with partner agencies and ensure services are joined up, reviewed, and monitored as part of the commissioning cycle.
- Timely and Modified Access: Improving speed of access to specialist and diagnostic services as required and improving the way services are offered to people to encourage engagement in health services

Work relating to all three areas has started with some outreach work being undertaken with homeless people and a multi-agency group working together to address the issues.

Engagement is taking place across West Yorkshire and local engagement will be undertaken with people from these communities when looking at designing outreach offers.

Previous Considerations

Name of meeting	Senior Management Team	**Meeting Date**	11/05/2021
Name of meeting	Quality, Finance & Performance Committee	**Meeting Date**	24/04/2021

Recommendations
It is recommended and requested that Governing Body: 1. **NOTE** the learning and specific actions assigned to the CCG 2. **NOTE** and **AGREE** the CCG action plan 3. **NOTE** the governance approach to address the actions and monitoring of the action plan

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Quality and Safety implications will be explored in the proposed monitoring process for the SAR case action plan via the CCG SOG process
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Equality and engagement implications will be explored in the proposed monitoring process for the SAR case action plan via the CCG SOG process
Resources / Financial Implications (including Staffing/Workforce considerations)	Financial implications will be explored through the priorities identified in the action plan. Any impact on workforce/finances will be raised with SMT
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 • Improving quality • Improving value	**Risk (include risk number and a brief description of the risk)**	The risk would only be added in the event that the CCG fails to provide a response to the statutory process
Legal / CCG Constitutional Implications	SAR's are statutory processes and the CCG has a responsibility to put in place actions to address learning that is relevant to the role and function of the organisation	**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

The Burnt Bridges Thematic Safeguarding Adult Review (SAR) was commissioned by the Calderdale Safeguarding Adults Board (CSAB) in 2019 in response to the deaths of 5 men, living street-based lives, in short space of time during the winter of 2018/19.

The report makes a number of recommendations under the following themes (see appendix 1 for a full list of recommendations):

- Multiple and complex needs
- Access to and engagement in healthcare and other services
- Homeless Strategy /Access to suitable and sustainable accommodation
- How do we prevent such deaths?

1.1 Final scrutiny and approval of the Safeguarding Adult Report (SAR) report took place on the 18th May 2021 in a planned extraordinary meeting of the Calderdale Safeguarding Adult Board (CSAB). The report has now been published. A final overarching multi-agency action plan is currently being developed by the SAR case panel from CSAB (see Appendix 1).

1.2 Whilst much of the learning can be identified as the responsibility of all partners across the system in Calderdale, there are specific areas that relate to health commissioning and therefore a detailed action plan has been developed by the CCG. (Appendix 2).

1.3 Calderdale CCG has established an internal group (chaired by the Deputy Head of Service Improvement and represented by leads from Safeguarding, Primary Care, Quality and Contracting) to specifically develop and deliver the CCG Action Plan.

1.4 The Thematic Review and CCG action plan was shared with the CCG Senior Management Team (SMT) in March 2021 and CCG Governing Body Members in April 2021, ensuring they were sighted on the recommendations and recognise the areas of learning that fall within the CCG remit.

1.5 The CCG Action Plan was shared with the CCG Quality, Finance and Performance Committee (QF&P) on the 24th June 2021. The Committee formally approved the plan, recognising this is a live document that is likely to be refined further and agreed to receive assurance quarterly on progress and delivery.

1.6 Calderdale Community Collaborative Partnership Board (3CPB) is also sighted on the work taking place by the Multi Partner Community and Primary Care group (established to focus on improving access to services for this client group)

2.0 Specific areas of learning attributed to the CCG for action

2.1 Whilst much of the learning can be identified as the responsibility of all partners, the specific areas that relate to health commissioning include (taken from learning and recommendations in appendix 1 where the actions attributed to the CCG are identified):

- Action 1.2: Review commissioning arrangements by health and social care to ensure the needs of the client group are fully embedded in commissioned services.
- Action 2.3: Consider opportunities for Primary Care to in-reach / out-reach with services such as the Gathering Place and drug and alcohol treatment services
- Action 2.4: Develop opportunities for services and pathways for rapid access to Mental Health and Dual Diagnosis services
- Action 2.5: Explore how to develop rapid access to services for diagnosis and support with intellectual disability
- Action 2.8: The Clinical Commissioning Group (CCG) to consider how the co-ordination of healthcare commissioning for homeless people can be strengthened, to ensure it works closely with partner agencies and ensure services are joined up, reviewed and monitored as part of the commissioning cycle
- Action 2.9: Local GPs and practice staff would benefit from training in relation to treating this patient group to develop understanding of the trauma they have experienced, how they live, the complexity of their health needs and how fragile the nature of their engagement with health services can be.

There are other actions which are not specific to the CCG but will require CCG support including seeking assurance of commissioned providers action plans and developing a trauma informed system.

3.0 Progress Against Actions to Date

3.1 It is of note that several actions have been taken and are included within the action plan; these include:

- A Multi Partner Community and Primary Care Group has been established to focus on improving access to services for this client group. This has resulted in practitioners delivering services in different ways e.g. provision from Calderdale and Huddersfield Foundation Trust Community Matron into the Gathering Place, initially focusing on wound care management. Learning from this will inform commissioning decisions and identify gaps that are required to improve outcomes.

- Primary care group established focusing on improving access to services for this client group led by the CCG Clinical lead for Community and Population Health Management

- Community Matron from CHFT input into the Gathering Place, initially focusing on wound care management

- The proposal is that the CCG Multi-disadvantage group will report directly to the CCG Senior Operational Group for oversight of the progression of the action plan, to provide support and guidance to the group and to make any recommendations to SMT for formal sign off once the action plan is completed.

- A piece of engagement has been undertaken in May 2021 by Groundswell across Calderdale, Kirklees, and Wakefield and is due to be reported in July 2021 (Groundswell is an organisation who work with people with experience of homelessness, offering opportunities to contribute to society and create solutions to homelessness). The project aims to understand how COVID-19 and the response to it affecting the lives of people who are homeless and including the

voices of people experiencing homelessness. The outcome and learning from this will specifically inform action will be included in local decision-making process.

- CCG representation has been established on various multi-agency forums across Calderdale and West Yorkshire including Calderdale MEAM Strategic Steering Group, WY Multiple Disadvantage Consortium with the goal of ensuring that as Commissioners of health the CCG are involved and sighted on the work of these groups.

4.0 Recommendations

4.1 It is recommended and requested that Governing Body:

1. Note the learning and specific actions assigned to the CCG
2. Note and agree the CCG action plan
3. Note the governance approach to address the actions and monitoring of the action plan

5.0 Appendices

Appendix 1: The overarching CSAB recommendations from the Burnt Bridges report

Appendix 2: The CCG action plan to address specific CCG actions

Appendix 1; Burnt Bridges SAR Learning and actions

Multiple and complex needs Recommendations

- Develop a shared understanding across Calderdale of the cohort of people who have Multiple and Complex needs who experience the greatest inequalities.
- Review commissioning arrangements by health and social care to ensure the needs of the client group are fully embedded in commissioned services.
- Explore how the needs of people who experience multiple complex needs can be best met by all agencies in a joined up, multi-agency way.
- Support the workforce to enable it to be sufficiently skilled, competent and resilient to effectively engage with this cohort of people and support their needs.
- The lessons from national Multiple and Complex Need initiatives, particularly locally the WYFI experience should be embedded in new service models and interagency working

Access to healthcare and other services recommendations

Services should work flexibly to be accessible and able to meet the needs of service users with multiple complex needs: recognising that there is often a short window of opportunity to engage a person with multi-complex needs and the need to respond quickly in order to build trust and understanding.

Key areas in this work stream will be:

- Prevent people who have multiple and complex needs becoming disengaged from services and where they do to encourage rapid re-engagement and a develop culture of never giving up. Consider a multi-agency team to ensure individuals have a named care coordinator who can help maximise engagement.
- The High Intensity User Group to ensure that non health partners can effectively engage to support people with Multiple Complex Needs

- Opportunities for Primary Care to in-reach / out-reach with services such as the Gathering Place and drug and alcohol treatment services
- Develop opportunities for services and pathways for rapid access to Mental Health and Dual Diagnosis services
- Explore how to develop rapid access to services for diagnosis and support with intellectual disability
- Review harm reduction services for drug and alcohol users and ensure that people who are not ready to change their substance use behaviour receive support to meet their health, social care and housing needs.
- Review hospital discharge policies for the homeless / people with MCNs to ensure their housing support and ongoing substance use treatment needs are considered.
- In order to maximise access and engagement, agencies to consider reasonable adaptions to appointment arrangements, communication and policies for this group of people.
- The Clinical Commissioning Group (CCG) to consider how the co-ordination of healthcare commissioning for homeless people can be strengthened, to ensure it works closely with partner agencies and ensure services are joined up, reviewed and monitored as part of the commissioning cycle
- Local GPs and practice staff would benefit from training in relation to treating this patient group to develop understanding of the trauma they have experienced, how they live, the complexity of their health needs and how fragile the nature of their engagement with health services can be.

Access to suitable accommodation Recommendations

A review of the Calderdale homeless strategy is scheduled for 2021. Due to the complex needs of this population this strategy must have multi-agency input and engagement. The findings of this SAR should influence this strategy. The governance of this strategy should be overseen by a Partnership Board.

All agencies to recognise that support to gain and sustain a tenancy is not the sole responsibility of one agency. It requires a multi-agency response including housing, health and care.

To explore ways to provide intensive and long-term support to those people who struggle to overcome the barriers in maintaining a tenancy. This should include:

- Addressing accommodation barriers for active drug and alcohol users even if they are not ready to change their drug or alcohol use, learning from good practice in other areas of the country.
- Maximise opportunities to support people to have the rent component of Universal Credit to be paid directly to landlord.
- Whilst acknowledging that much central funding is short term and piecemeal funding for homeless support services, solutions should be sought to secure longer-term funding of posts and services to provide stability to homeless support services.
- That when applying for the anticipated capital funding to develop more direct access accommodation available through the Rough Sleepers Initiative, Calderdale should consider the learning from this review. Accommodation should be developed on PIE (psychologically Informed Environment) principles.
- Options for funding the response to rough sleeping is considered urgently by Calderdale MBC as funding streams end in 2021.

Prevention Recommendations

- The Calderdale Public Health Team consider rough sleepers and those living a street-based life as a priority group in addressing health inequalities and develop a specific JSNA (joint strategic needs assessment) profile to inform service development and commissioning.
- Develop a system to identify and support those people who are at significant risk of developing multiple complex needs which ensures that when an individual's mental and physical health, social and housing needs are deteriorating, that these are recognised and that a coordinated, multi-agency response prevents further decline. The CSAB should consider the development of a process be it multi-agency hub or panel to support those who chronically disengage from services. Such a system should also consider child to adult transition.
- The costs (and therefore the efficiencies) would be spread across the various agencies involved and collective decisions will therefore be needed to realise the benefits, it is recommended that the Homelessness Strategy 2021 should be shared and jointly developed and owned by health, housing, social care and the voluntary sector. This strategy should develop an accountability framework which identifies a Board that will monitor and be accountable for this work.
- Safeguarding processes for this user group are reviewed and that pathways and communication systems are refreshed and shared with all key agencies in order to maximise the potential to safeguard this user group.

- Safeguarding policies and procedures should be reviewed to ensure that this user group are able to access safeguarding services. A multi-agency training package is developed by the CSAB to improve practitioners understanding about eligibility criteria, identification of safeguarding needs, the expected safeguarding response (including promoting use of the self-neglect toolkit), trauma informed practice, professional curiosity and disguised compliance, information sharing arrangements and the application of the Mental Capacity Act for this user group.

Appendix 2:CALDERDALE CCG 'DRAFT' ACTION PLAN - THEMATIC REVIEW – STREET BASED LIVES ACTION PLAN

Key Learning and recommendation from the overarching Thematic Review: Street Based Lives Action Plan		**CCG Actions**	**CCG Lead**	**Timescale**	**Rag rating**	**Progress and comments**
1	Review commissioning arrangements by health and social care to ensure the needs of the client group are fully embedded in commissioned services.	To ensure that existing and new contracts held by the CCG with Healthcare Service Providers include a requirement to address inequalities. Alignment with Population Health Management to understand opportunities to improve outcomes for this group of people. Understand/examine the range of inequalities, recognise the	**YH/DW** **EB/RR (through Calderdale Community Collaborative Partnership Board (3CPB)**	**By April 2022** **To evaluate impact by April 2022**		The following wording should be included at the next contracting round. 'The CCG will work with the Provider to identify actions which the Commissioner and Provider will take to reduce inequalities, including those experienced by people who are homeless, in access to, experience of and outcomes from care and treatment, with specific relation to the Services being provided under this Agreement' Opportunity to use the available support from

		differential impact of gender, age, and disability; community-led place-based delivery; and communities and volunteering.				National Association of Primary Care
2	Consider opportunities for Primary Care to in-reach / out-reach with services such as the Gathering Place and drug and alcohol treatment services	Using the learning from other areas nationally and regionally and work that has taken place within Calderdale, develop a commissioned offer to support delivery of Primary Medical Services to this population.	**EB**	**30th Sept 2021**		Community Matron is undertaking clinics at the Gathering Place and has identified workforce skills and competencies required A Health and Care Provider Network Group has been established to re-design current offers Bespoke Covid Vaccination Sessions were delivered Early scoping for dental response underway led by Locala. NHS health checks and screening being planned for this cohort Work on going to improve GP registration Primary Care education and Training group set up as subgroup of

						Homelessness and Disadvantage Group
3	Develop opportunities for services and pathways for rapid access to Mental Health and Dual Diagnosis services	Work with key stakeholders to learn from risks, learn from the crisis period and review pathways to ensure they are fit for purpose for this cohort accessing MH and DD services Support system to respond more appropriately to shared needs of mothers and children Child wellbeing assessments – ensuring additional learning or support needs to access settled accommodation	**RR**	**July-Aug 2021**		Initiate a MH and DD subgroup to align rapid access for mental health and dual diagnosis services Develop actions (with clear timescales), clarify outcomes and identify organisational leads. Feedback through the multiple Disadvantaged forums ensuring alignment with physical health

4	Explore how to develop rapid access to services for diagnosis and support with intellectual disability	Scope out potential existing services providing occupational therapy assessment and intervention for people with acquired brain injury or where intellectual disability has not been identified.	**RR**	**By March 2022**		
		Raise awareness in general practice in relation to under diagnosis of head injury or intellectual disabilities	**EB**	**By March 2022**		
		General Practice to validate learning disability registers and case find as appropriate to ensure correct support is available	**EB**	**Ongoing with results due by March 2022**		Work ongoing in general population
5	The Clinical Commissioning Group (CCG) to consider how the co-ordination of healthcare commissioning for homeless people can be strengthened, to ensure it works closely with partner agencies and ensure services are joined up,	As an integrated system, through 3CPB, develop and agree standards for inclusion into specifications	**RR**	**March 2022**		
		Develop metrics to measure impact made on health	**EB/RR**	**To evaluate**		It should be noted that any longstanding gains on

	reviewed and monitored as part of the commissioning cycle	outcomes for this cohort through Population Health Management Support into local winter planning e.g. flexible provision in times of extreme weather (summer and winter) and contingency plans.		**impact by April 2022**		health outcomes will be seen over years.
6	Local GPs and practice staff would benefit from training in relation to treating this patient group to develop understanding of the trauma they have experienced, how they live, the complexity of their health needs and how fragile the nature of their engagement with health services can be.	Scope possible training offer using expertise from West Yorkshire and Harrogate ICS and linking to plans being developed through the safeguarding board, to finalise training offer for General Practice Liaise with the Local Medical Committee once the offer has been finalised to ensure it is planned into Practice Learning Time	**LT** **EB**	**End of Oct 2021** **Aim for Training offer to be available by March 2022**		

Recommendations Requiring CCG Support						
7	Support the workforce to enable it to be sufficiently skilled, competent, and resilient to effectively engage with this cohort of people and support their needs. All SAB Members to commit to mandatory training on Trauma Informed Practice.	Link with the Safeguarding Board who are leading on the provision of trauma informed training for Calderdale. Once the approach is defined and the training commissioned employed CCG staff will be required to undertake the appropriate level of training.	**LT**	**End of March 2022**		Timescales dependent on Safeguarding Adult Board developing training and approach.
8	Prevent people who have multiple and complex needs becoming disengaged from services and where they do to encourage rapid re-engagement and a develop culture of never giving up. Consider a multi-agency team to ensure individuals have a named care coordinator who can help maximise engagement.	Through Provider Quality Boards, seek assurance around disengagement and re-engagement policies and risk reviews and how they work with other agencies to continue to try to engage.	**DW/LT**	**End of March 2022**		

Key

Initials	Name and Title
DW	Debbie Winder – Head of Quality
EB	Emma Bownas – Senior Primary Care Quality and Improvement Manager
LT	Luke Turnbull - Head of Adult Safeguarding
RR	Rhona Radley – Deputy Head of Service Improvement
YH	Yvonne Hoorman – Principal Contracts Manager

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Complaints Annual Report 2020 - 2021**	**Agenda Item No.**	7
Report Author	Janet Smart, Complaints Manager	**Public / Private Item**	Public
Clinical Lead	Dr Farrukh Javid, GP GB Member	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary
NHS Calderdale CCG aims to commission high quality services, but occasionally things can go wrong. When they do, it seeks to put them right and learn from the experience to improve services. Complaints are one way of receiving individual perspectives of the service provided and through the outcome of the investigation, areas for improvement identified. This report sets out the position for 2020 and 2021 and details the complaints activity information during the year.

Previous Considerations

Name of meeting	None	**Meeting Date**	None
Name of meeting	None	**Meeting Date**	None

Recommendations
It is recommended that the Governing Body **NOTES** for information the complaint activity regarding services commissioned by NHS Calderdale CCG during 2020 and 2021.

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. However, consideration of the Annual Complaints Report and key themes emerging from complaints are an important part of patients' experience.
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 Quality Improving Value	**Risk (include risk number and a brief description of the risk)**	None identified.
Legal / CCG Constitutional Implications	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require all Clinical Commissioning Groups (CCGs) to provide an annual report regarding complaint activity information.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None identified.

Contents

1. Introduction

1.1 The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009 (the Regulations) require all Clinical Commissioning Groups (CCGs) to provide an annual report regarding complaint activity information. This includes the number and nature of complaints and identifies the lessons learned.

1.2 This is complemented by an additional report to NHS Calderdale CCG's Quality, Finance and Performance Committee at the six month point of the year, outlining complaint, concerns and enquiries activity information.

1.3 This report outlines the complaints received by NHS Calderdale CCG between 1 April 2020 and 31 March 2021. This data outlining the total number of complaints received has been compared in the first table for the previous four years.

1.4 In accordance with Yorkshire Audit recommendations made in 2018, the complaints, concerns and enquiries received in 2020 / 21 have been compared against those received in the previous two years i.e. 2018 / 19 and 2019 / 20.

COMPLAINTS

Total Number of Complaints Received by NHS Calderdale CCG

Year	Number received
2015 / 16	54
2016 / 17	132
2017 / 18	152
2018 / 19	138
2019 / 20	208
2020 / 21	176

Complaints – NHS Calderdale CCG

	2018 / 19	2019 / 20	2020 / 21
Complaints received	138	208	176
Complaints investigated by NHS Calderdale CCG:	47 (34%)	39 (19%)	73 (41.5%)
CCG related	39 (83%)	31 (79%)	68 (93%)
Related to other providers	8 (17%)	8 (21%)	5 (7%)
NHS Calderdale CCG responses within deadline: Yes No Still Open/On Hold	 34 (72%) 11 (23%) 2 (5%)	 23 (59%) 7 (18%) 9 (33%)	 65 (89%) 6 (8%) 2 (3%)
Level (section 4 provides a definition of the levels).	90 (65%) - Level 1 37 (27%) - Level 2 10 (7%) - Level 3 1(1%) - Level 4	169 (81%) - Level 1 33 (16%) - Level 2 4 (2%) – Level 3 2 (1%) – Level 4	115 (65%) – Level 1 56 (32%) – Level 2 5 (3%) – Level 3 0 (0%) – Level 4

2. Detail

2.1 Number of Complaints Investigated

Of the 176 complaints received by NHS Calderdale CCG in 2020/21, not all were investigated by the CCG. This was for several reasons – most commonly because they did not fall within the remit of NHS Calderdale CCG and were passed to another organisation to investigate.

Initial Response	2018 / 19	2019 / 20	2020 / 21
Investigated by NHS Calderdale CCG	47	39	73
Passed to another organisation for investigation and to respond directly to the complainant:			
- NHS Bradford Districts CCG	-	-	1
- Calderdale & Huddersfield NHS Foundation Trust	27	50	28
- Calderdale Council	2	2	2
- NHS Greater Huddersfield CCG	-	2	1
- Locala	-	6	-
- Local Care Direct	-	-	3
- Insight Healthcare	1	-	-
- NHS North Kirklees CCG	1	1	1
- NHS 111	2	2	-

- Opcare	2	10	-
- Primary Care/NHS England	33	38	19
- South West Yorkshire Partnership Foundation Trust	5	7	2
- Yorkshire Ambulance Service	5	2	-
- Other	2	9	4
Enquiry handled by corporate team	-	15	26
Acting as third party to review	5	8	4
For information only	3	-	1
Referred to CHC Operations Manager	1	4	2
Referred to CCG Covid Vaccination Team	-	-	5
Referred to Healthwatch	-	4	1
Closed due to lack of consent	2	5	-
On hold	1	8	-
Withdrawn	-	-	3
TOTAL	**138**	**208**	**176**

2.2 Number of Complaints by Provider

2.2.1 Of the 73 complaints received and investigated by NHS Calderdale CCG during 2020/21 as Level 2, Level 3 and Level 4 complaints, 68 (shown in the table below) related directly to the CCG. This means 5 of the complaints investigated by NHS Calderdale CCG involved other providers.

2.2.2 Complainants can choose to complain directly to the provider of an NHS service or the commissioner of that service. Where a complaint is received, the complainant is informed of this option and given advice to facilitate their choice.

2.2.3 NHS Calderdale CCG is always sensitive to a complainant's needs and endeavours to avoid complainants being passed unnecessarily through numerous organisations. In cases where complaints are complex and involve several different organisations, the CCG is well placed to co-ordinate a response to a complainant.

2.2.4 However, in many instances, a complainant's concerns can be best addressed directly by the provider organisation without NHS Calderdale CCG acting as an intermediary.

Provider	2018/19	2019/20	2020/21
NHS Calderdale CCG	39	31	68
Calderdale & Huddersfield NHS Foundation Trust	1	-	-
Insight Healthcare	-	-	-
NHS 111	-	-	-
Leeds Teaching Hospitals NHS Trust	1	-	-
Opcare	2	4	-
South West Yorkshire Partnership Foundation Trust	1	-	-

Multi Providers: BMI and GP Surgery	-	1	-
NHS Calderdale CCG and Calderdale Council	-	1	-
NHS Calderdale CCG and Opcare	-	-	1
NHS Calderdale CCG and Calderdale & Huddersfield NHS Foundation Trust	1	2	-
NHS Calderdale CCG and Spire Healthcare	-	-	1
Calderdale & Huddersfield NHS Foundation Trust and NHS Bradford District and Craven CCG	-	-	1
NHS Calderdale CCG, Calderdale & Huddersfield NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust	-	-	1
Yorkshire Ambulance Service and Calderdale & Huddersfield NHS Foundation Trust	-	-	1
Insight Healthcare and South West Yorkshire Partnership Foundation Trust	-	-	-
Yorkshire Ambulance Service, Calderdale & Huddersfield NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust	1	-	-
NHS Calderdale CCG, GP Surgery and Calderdale Council	1	-	-
TOTAL	**47**	**39**	**73**

2.3 Complaints by Category

2.3.1 The 73 complaints received and investigated by NHS Calderdale CCG during 2020 / 21 can be categorised as shown in the table below:

Category of complaint	2018 / 19	2019 / 20	2020 / 21
Aids, appliances, equipment, e.g. wheelchairs	3	5	2
Appointments	1	3	1
Attitude of staff	1	1	2
Care and treatment	4	4	3
CAMHS	-	1	2
Choice of provider	-	1	2
Commissioning decisions made by NHS Calderdale CCG: Individual Funding Request (IFR) Access to Infertility Treatment	 2 6	 2 5	 1 1
Communication	1	-	1
Confidentiality	2	-	1
Continuing Healthcare process	9	6	1
Covid vaccination enquiries	-	-	23

Delays in diagnosis	1	-	-
Failure to follow agreed guidelines / processes	-	1	-
Flu Vaccination Enquiries	-	-	6
Ear wax removal / irrigation service	-	2	3
GP / primary care services in Calderdale following national pandemic lockdown	-	-	11
Medication related issues	-	3	4
Mental Health services	-	1	-
Patient records	1	-	-
Practice management	-	1	3
Prescribing changes	9	-	1
Referrals	1	1	3
Reimbursement of costs	1	-	-
Subject Access Request / Complaint	-	1	-
Transport	-	1	1
Travel expenses	1	-	-
Treatment charges	2	-	-
Unprofessional conduct	-	-	1
Waiting times	1	-	-
Weight management	1	-	-
TOTAL	**47**	**39**	**73**

2.3.2 Of the 73 complaints, 34 fell within the following 2 categories and are broken down below:

Covid-19 Vaccination Programme – 23 complaints

All the 23 complaints related to issues connected with the roll out of the Covid-19 vaccination programme in the Calderdale area, such as the timescale surrounding the vaccination of the housebound.

GP/primary care services in Calderdale following the national pandemic lockdown – 11 complaints

All the 11 complaints related to issues connected with the reopening of GP surgeries following the national pandemic lockdown, such as face to face appointments.

2.4 Complaints by Level

2.4.1 All complaints received by NHS Calderdale CCG are classified into a category level based on guidance within NHS Calderdale's CCG Complaints Policy. The definitions of each level are as follows:

Level 1- Simple issues

Level 2 – Low / simple, non-complex issues

Level 3 – Moderate / complex, several issues relating to a short period of care requiring a written response and investigation by provider

Level 4 – High / complex multiple issues relating to a longer period of care, often involving more than one organisation or individual requiring a written response and investigation by provider.

2.4.2 The table below shows the classification of complaints received.

Level of complaint	2018 / 19	2019 / 20	2020 / 21
Level 1	90	169	115
Level 2	37	33	56
Level 3	10	4	5
Level 4	1	2	-
Total	**138**	**208**	**176**

2.4.3 The number of concerns and enquiries decreased significantly during Quarters 1 and 2 of 2020 / 21. This was due to the pause of the NHS Complaints process implemented by NHS England and NHS Improvement between 27 March 2020 and 30 June 2020 so that health care providers in all sectors (including NHS Calderdale CCG) could concentrate on providing front-line duties and responsiveness to Covid-19.

2.4.4 Following the re-opening of the NHS Complaints process on 1 July 2020 the number of concerns and enquiries began to rise. The data indicates the number of Level 2 concerns and enquiries significantly increased by the end of 2020 / 21. This was partly due to the volume of issues received about the roll-out of the Covid-19 vaccination programme in the latter part of the year.

2.4.5 Level 3 complaints remained low during the year as it was identified that many of these cases could be best addressed as Level 2 cases or directly by the provider organisation without NHS Calderdale CCG acting as an intermediary.

2.4.6 No complaints categorised as Level 4 were received during the year.

2.4.7 During Quarter 4 of 2020 / 21 the Complaints Manager helped to develop a process for handling and responding to queries regarding Covid-19 vaccination enquiries. It was agreed that these would be initially screened by the Service Improvement team. Any complaints would continue to be forwarded onto the CCG's complaints team.

2.5 Complaints by Deadline

2.5.1 The NHS Calderdale CCG standard for complaints investigation, as outlined in the Complaints Policy, is that all complaints received are acknowledged in writing within three working days. Once the appropriate consent is received back from the complainant and areas for investigation are outlined, complainants are advised of the date by which they can expect a response to their complaint.

2.5.2 The standard timeframe given is 3 - 5 working days for a Level 1 complaint, 5 - 10 working dates for a Level 2 complaint and 40 working days for a Level 3 and Level 4 complaint. Complainants are kept updated on progress where it is not possible to meet the initial timeframe deadline and an explanation of the delay is provided.

2.5.3 The tables below show whether the final response was sent to the complainant within the original agreed timeframe, both overall and by the investigating provider.

Final Response sent within agreed timeframe	2018 / 19	2019 / 20	2020 / 21
Yes	34	23	65
No	11	7	5
Still Open / On Hold	2	9	3
Total	**47**	**39**	**73**

Final Response sent within agreed timeframe by Provider during 2020 / 21	Yes	No	Still Open/On Hold
NHS Calderdale CCG	65	5	1
Multi agency: Calderdale CCG and Opcare	-	-	1
Multi agency: Yorkshire Ambulance Service and Calderdale and Huddersfield NHS Foundation Trust	-	-	1
Total	**65**	**5**	**3**

2.5.4 Despite many investigators being involved in front-line duties and responsiveness to Covid-19 / the roll out of the vaccination programme, 2020 / 21 continued to see an improvement in complaints being responded to within deadline.

2.5.5 The improvement was also due to changes being made to the sign off process following the appointment of the Chief Operating Officer and agreement that they would be responsible for the review and sign off for Level 3 and 4 complaint responses.

2.5.6 In the 6 instances where NHS Calderdale CCG did not send the response to the complainant within the agreed timeframe this was due to the following reasons:

- Two were due to the workload of the investigator who was also involved in Covid-19 front-line duties / roll out of the vaccination programme.
- Two were due to staff illness.
- One was due to the complexity of the issues raised.
- One multi-provider complaint response was due to the provider no longer being commissioned by the CCG.
- Two of the multi-provider cases were not due for response until Quarter 1 of 2021 / 22.

2.5.7 Where appropriate, the complainant was contacted prior to the agreed response date to advise that the complaint was still underway. They were also provided with an explanation why this was the case.

2.6 Pause of the NHS Complaints Process

2.6.1 At the end of 2019/20 a system wide pause of the NHS complaints process was implemented so that health care providers in all sectors (including Calderdale CCG) could concentrate on providing front-line duties and responsiveness to COVID-19.

2.6.2 The Complaints Manager contacted all the relevant stakeholders, such as local MPs and Healthwatch to inform them about the pause. Information was also placed on NHS

Calderdale CCG's website and email systems.

2.6.3 All the 9 complainants awaiting a response to a complaint were notified that the investigation was on hold.

2.6.4 All new complaints were acknowledged and appropriately logged.

2.6.5 Open channels of communication were maintained with patients and the public.

2.7 Re-opening of the NHS Complaints Process

2.7.1 The NHS Complaints process re-opened during on 1 July 2020.Out of the 9 complaints from 2019 / 20 which were open on 1 July 2020, 8 were responded to during the year.

2.7.2 One complaint was withdrawn.

2.7.3 No further pause of the NHS Complaints Process took place during the year. However, on 3 February 2021 NHS England and NHS Improvement acknowledged that NHS providers may take longer than usual to investigate and respond to complaints. This was to allow providers to continue to concentrate on front-line duties and responsiveness to Covid-19 as well as support the roll out of the vaccination programme.

2.7.4 The Complaints Manager will continue to monitor the situation and effect this may have on complaint investigations. An update will be provided in 2021 / 22.

2.8 Parliamentary and Health Service Ombudsman

2.8.1 Any complainant who remains dissatisfied with the NHS Calderdale CCG's handling of their complaint has the right to contact the Parliamentary and Health Service Ombudsman (PHSO). Information on how to do this is provided to all complainants as part of the CCG's response to each complaint.

2.8.2 The PHSO has not carried out any full reviews on complaints they received in this period. However, during the early part of 2020/21, the CCG was notified by the Local Government and Social Care Ombudsman (LGSCO) that they had decided to investigate a complaint regarding the care and support provided to a client by Calderdale Council, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and Calderdale CCG.

2.8.3 Calderdale CCG fully complied with providing the LGSCO with the information they requested. No outcome of the investigation has yet been received.

2.8.4 The COVID-19 pandemic continues to have a significant impact on the PHSO's workforce and their service. This has been compounded by continuing difficulties in investigating NHS complaints. These escalating pressures have led to people waiting far too long for the PHSO to look at their complaints.

2.8.5 The PHSO will continue to examine all complaints they receive. However, they have notified all NHS organisations (including the CCG) about a change to their service from April 2020 when they will focus on the more serious complaints about health services i.e. those where people may have faced a more significant impact.

2.8.6 For other complaints, i.e., those where someone has faced a lesser impact, the PHSO will consider whether there is anything they can do to help resolve things quickly. If not, they will close the complaint.

2.8.7 If the PHSO receive a similar complaint about the same organisation, or see a pattern from several complaints, they may raise this with the organisation.

2.8.8 The PHSO will continue to liaise with the CCG about these changes and a further update will be provided to the Quality Finance and Performance Committee in 2021 / 22.

2.9 The NHS Complaints Standards

2.9.1 In 2020 / 21 the PHSO announced The NHS Complaint Standards (the Standards) which they are intending to launch across the NHS (including NHS Calderdale CCG) in 2021 / 22.

2.9.2 The Standards will set out how organisations providing NHS services should approach complaints handling.

2.9.3 The Standards aim to support NHS organisations in providing a quicker, simpler and more streamlined complaints handling service, with a strong focus on early resolution by empowered and well-trained staff.

2.9.4 The PHSO intend that all NHS organisations and those independent healthcare providers who deliver NHS-funded care will use the same model complaint handling procedure. It will describe how NHS Calderdale CCG should meet the expectations of the NHS Complaint Standards.

2.10 Learning from complaints

2.10.1 NHS Calderdale CCG is committed to learning from complaints and wherever possible complaint responses include a section which highlights the learning from the complaint and how this will be shared or used in the future. This has been demonstrated by, for example, the Covid-19 vaccination programme team who have continued to make changes to the design of the roll-out as a result of feedback received.

2.11 Provider and GP Practice Assurance on Complaints Handling

2.11.1 Assurance on how NHS Calderdale CCG's main providers; Calderdale & Huddersfield NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust and NHS111, manage complaints is provided in the Quality and Safety dashboard which is presented to the Quality, Finance and Performance Committee. It should be noted that providers are facing challenges in responding within timeframe, there are several reasons for this, and Committees are updated on the actions being taken.

2.11.2 Assurance on GP practice complaints handling remains a function of NHS England. However, practices are required to complete an annual return providing NHS England with numbers and subject matter of complaints. NHS Calderdale CCG usually receives feedback on such submissions but, due to Covid-19, the data collection was suspended

nationally.

2.11.3 NHS England have been working on streamlining their data collections and it is expected that these will re-commence shortly. An update will be provided to the Quality Finance and Performance Committee in 2021 / 22.

3. Next Steps

3.1 The NHS Complaints Standards referred to in section 2.9 will impact upon the CCG's Complaints Policy as it is intended that the all NHS organisations (and those independent healthcare providers who deliver NHS-funded care) will use the same model complaint handling procedure. The Complaints Manager is attending regular updates with the PHSO's Liaison Managers about the expectations and the draft Standards as they develop.

3.2 An update on the NHS Complaints Standards will be provided to the Quality Finance and Performance Committee in 2021 / 22.

4. Implications

None to add.

5. Recommendations

5.1 It is recommended that the Governing Body **NOTES** for information the complaint activity regarding services commissioned by NHS Calderdale CCG during 2020 and 2021.

6. Appendices

None to add.

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Joint Safeguarding Children and Adults Annual Report 2020-2021**	**Agenda Item No.**	8
Report Author	Clare Robinson, Head of Nursing and Safeguarding Louise Fletcher, Designated Nurse Safeguarding Children and Children Looked After Luke Turnbull, Designated Nurse Safeguarding Adults	**Public / Private Item**	Public
Clinical Lead	Dr Stephen Cleasby, CCG Chair	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary
This annual report provides a review in the form of a presentation, of the Safeguarding Adults and Safeguarding Children's work undertaken within and on behalf of Calderdale CCG from April 2020 to March 2021. An overview of the pertinent legislation is provided along with assurance being demonstrated that the CCG has discharged its statutory and legislative responsibilities for Safeguarding Children and Adults at Risk of abuse or neglect. The report details the some of the impact and achievements of the team for the reporting period and the work priorities for 2020/ 21. Overall, the report provides assurance that the CCGs are engaged and supporting work to Safeguard Adults at risk of abuse and neglect and Safeguarding Children that forms part of its responsibilities.

Previous Considerations

Name of meeting	None	**Meeting Date**	
Name of meeting		**Meeting Date**	

Recommendations
The Governing Body is asked to: 1. **Receive** the report 2. **Note** its contents 3. **Confirm that it is assured** that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Included within the report
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The report provides assurance of the engagement with local partners for safeguarding work and activity. An Equality Impact assessment has not been completed.
Resources / Financial Implications (including Staffing/Workforce considerations)	None
Sustainability Implications	None

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)**	
Legal / CCG Constitutional Implications	No current legal or constitutional implications	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None

1. Introduction

1.1 This report provides a presentation that summarises the safeguarding work and activity undertaken by the Shared CCG Safeguarding Service on behalf of NHS Calderdale Clinical Commissioning Group from 1st April 2020 to the 31st March 2021.

1.2 As an NHS organisation and principal commissioner of local health services, the CCG has specific responsibilities and duties in respect of safeguarding children (including looked after children) and adults at risk of abuse in Calderdale

2. Detail

2.1 The purpose of this annual joint report is to assure the Governing Body and members of the public that the CCG is fulfilling its statutory and legislated duties in relation to safeguarding and children looked after in Calderdale, takes account of and provides information about the work of team in fulfilling those duties and responsibilities.

3. Implications

3.1 Quality & Safety Implications

3.1.1 The report provides evidence of safeguarding work and activity being embedded in commissioned providers

3.2 Engagement & Equality Implications

3.2.1 The report provides assurance of the engagement with local partners for safeguarding work and activity however, an equality Impact assessment has not been completed as not required

3.3 Resources / Finance Implications

3.3.1 There are no finance implications as part of this report, however there is recognition that future work including the new Liberty Protection Safeguards legislation which is forecast to be implemented in the coming year, will likely have both resource and financial implications for the CCG.

3.4 Data Protection Impact Assessment

3.4.1 There are no concerns about data impact as a result of this report

3.5 Risk

3.5.1 There are no current risks highlighted within this report. However when the new Liberty Protection Safeguards legislation which is forecast to be implemented in the coming year, will likely risk implications in terms of delivering the requirements

3.6 Legal / CCG Constitutional Implications

3.6.1 There are no legal or CCG Constitutional implications

3.7 Conflicts of Interest

3.7.1 There are no conflicts of interest.

4 Recommendations

The Governing Body is asked to:

1. **Receive** the report
2. **Note** its contents
3. **Confirm that it is assured** that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity.

5 Appendices

Appendix 1: The CCG Safeguarding Annual Report Presentation 2020-2021

Safeguarding Adults & Children Annual Report

April 2020 – March 2021

Report authors:

Clare Robinson: Head of Nursing & Safeguarding

Louise Fletcher: Designated Nurse Safeguarding Children, Children Looked After and Care Leavers

Luke Turnbull: Designated Nurse Safeguarding Adults

Gwen Clyde-Evans: Deputy Designated for Safeguarding Children and Adults, Prevent Lead

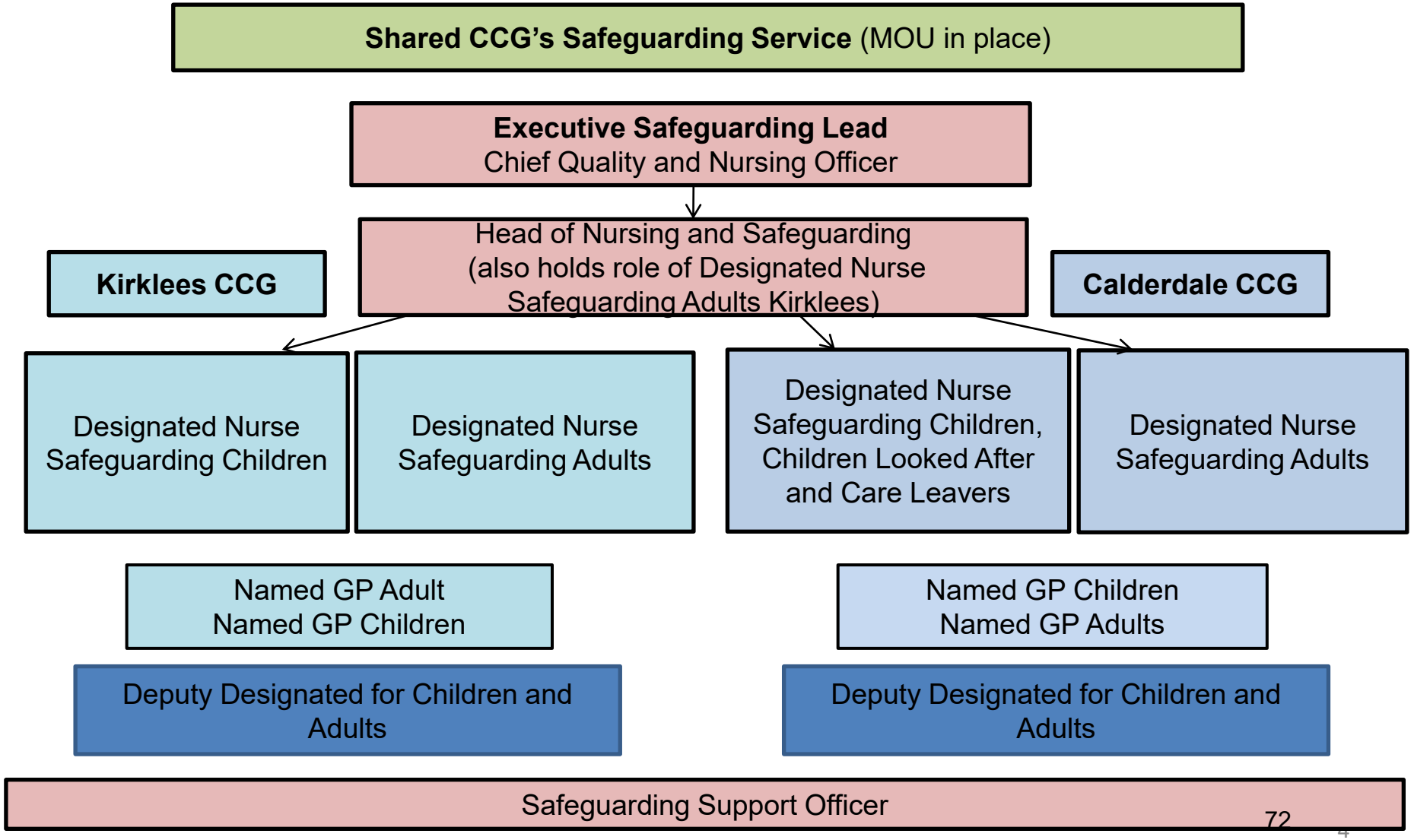
This Annual Report:

Provides an overview of the work undertaken by the CCG shared Safeguarding Team in the last year to demonstrate and provide assurance to the Governing Body, that the CCG has discharged its statutory and legislative responsibilities for Safeguarding Children and Adults at Risk of abuse or neglect

Scope of Safeguarding

- Domestic Abuse
- Neglect and Abuse
- Child Protection
- Adults at Risk
- Mental Capacity Act
- Contextual Safeguarding
- Child Sexual Exploitation
- Deprivation of Liberties Safeguards
- Children Looked After
- Making Safeguarding Personal
- Care Leavers
- Human Rights
- Child Criminal Exploitation
- Adverse Childhood Experiences
- Unaccompanied Asylum Seekers
- Forced Marriage
- Trauma Informed Practice
- Early Support
- Prevent
- Female Genital Mutilation
- Honour Based Violence
- Human Trafficking and Modern Day Slavery

CCG responsibilities: A clear line of accountability for safeguarding, reflected in the CCG governance arrangements i.e. a named executive lead to take overall leadership responsibility & employs or secures the expertise of Designated Professionals to provide health leadership and expertise across local area



NHS England Safeguarding Accountability and Assurance Framework 2019:

https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf-1.pdf

CCG also responsible for securing the expertise of Designated Professionals on behalf of Health system so includes:

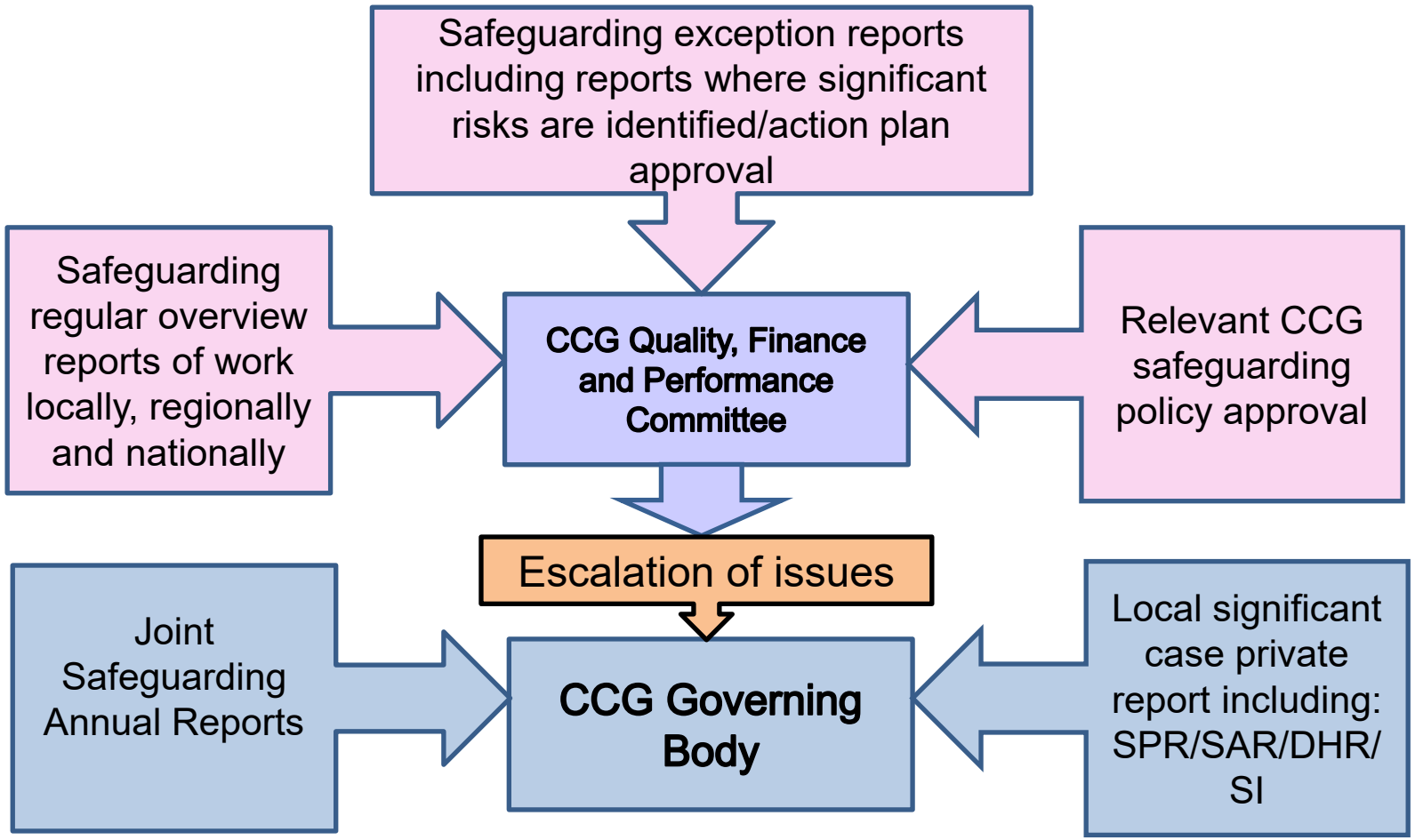
Designated Doctor - Safeguarding Children
Calderdale : Commissioned from CHFT

Designated Paediatrician - Sudden Unexpected deaths in Childhood (SUDIC)
Calderdale : Commissioned from CHFT

Designated Nurse – Children, Children Looked After and Care Leavers
Calderdale CCG

Designated Doctor – Children Looked After
Calderdale: Commissioned from CHFT

CCG Governance arrangements for reporting Safeguarding:



Safeguarding Adults and Children requirements articulated on the Governing Body Assurance Framework (GBAF)

74

Children Looked After (CLA) in Calderdale:

http://www.legislation.gov.uk/ukpga/1989/41/contents

Designated Nurse for Children Looked After and Care Leavers CCCG

Designated Doctor Children Looked After (commissioned from CHFT)

Children Looked After (CLA) Clinical Team
(Commissioned from CHFT)

Governance and CCG Oversight:

Joint performance monitoring with CCG Designated Nurse & LA

Regular reporting to CHFT Safeguarding Committee (attended by Designated Nurse's)

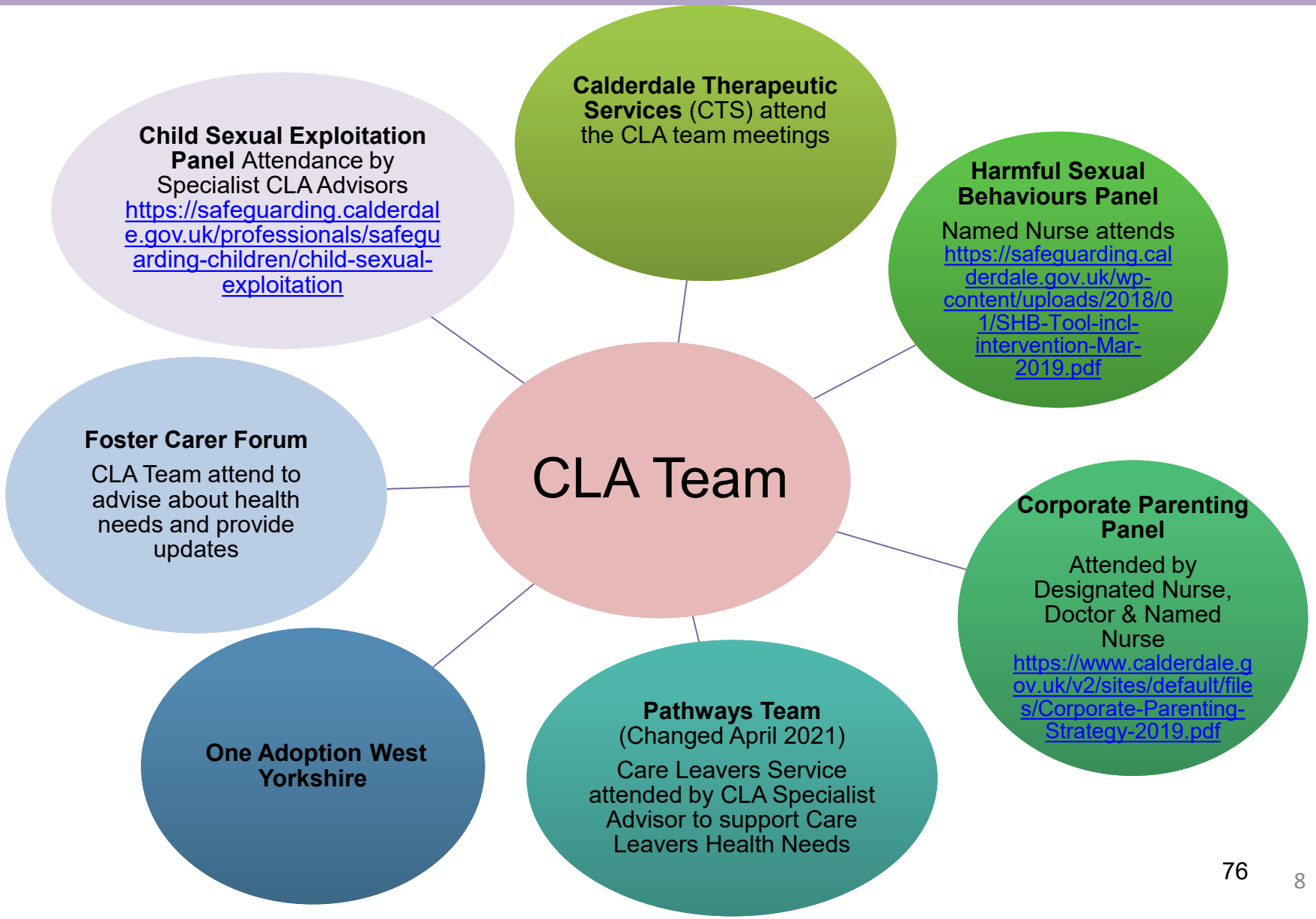
Named Nurse for CLA has Regular 1:1 meetings with CCG Designated Nurse

Regular reporting of data to CCG Quality Committee

Annual Looked After Children report shared with CCG Quality Finance and Performance Committee

Regular attendance at Local Authority Corporate Parenting Board

Children Looked After (CLA) Team Partnership Working:



Examples of wider engagement work conducted by CLA Team

Attendance by Designated Nurse & Doctor at Yorkshire & Humber Looked After Children's Regional Network

Attendance by the Designated Nurse at NHS England Looked After Children's Network

Attendance at training events to support the work with the young people

Regular meetings with Kirklees CLA meeting to share good practice and ways

Designated Nurse has taken part in National Task and Finish Group to make sure the needs of CLA are fed into the Child Care Review which is currently underway

Produced age appropriate leaflets to be sent out with RHA appointments for children & young people

Pathway developed support out of area children being placed in Calderdale being flagged in the acute trust which will make out of area children placed in Calderdale safer

The Team Objectives for 2021-2022

Building & Consolidating on the 2nd full year in operation as a CLA holistic Health Service

Engage and support the process for delivering Children Looked After requirements at ICS level and within Integrated care models

Post Covid 19 Recovery including review and assessment of team effectiveness during the pandemic and potential post-Covid surge in children being made subject to care orders

Engage in Yorkshire & Humber & West Yorkshire CLA working group & network

CLA further support and engagement with

HAIG audit programme

Explore continued use of virtual assessments with national team

Continue to develop support links for Care Leavers over 18 years of age

Designated Nurse to engage with all children's commissioners to ensure the needs of CLA & Care Leavers are considered when commissioning services for children & young people

Collect data for health needs analysis themes & Key Performance Indicators

CCG responsibilities:

Safeguarding policies and processes in place demonstrating the CCG commitment to this agenda, including training, safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate

The Safeguarding Team have updated the CCG Safeguarding Policies to ensure they remain adherent to current legislation and support CCG staff:

Approved by Quality, Finance and Performance Committee :

↓

All reviewed, review date in bracket.

CCG Safeguarding Policy (March 2022)

CCG Domestic Abuse Policy (June 2024)

CCG PREVENT Policy (June 2024)

CCG MCA policy (2022 awaiting Liberty Protection Safeguards)

Up to date required Recruitment and other Policies are also in place:

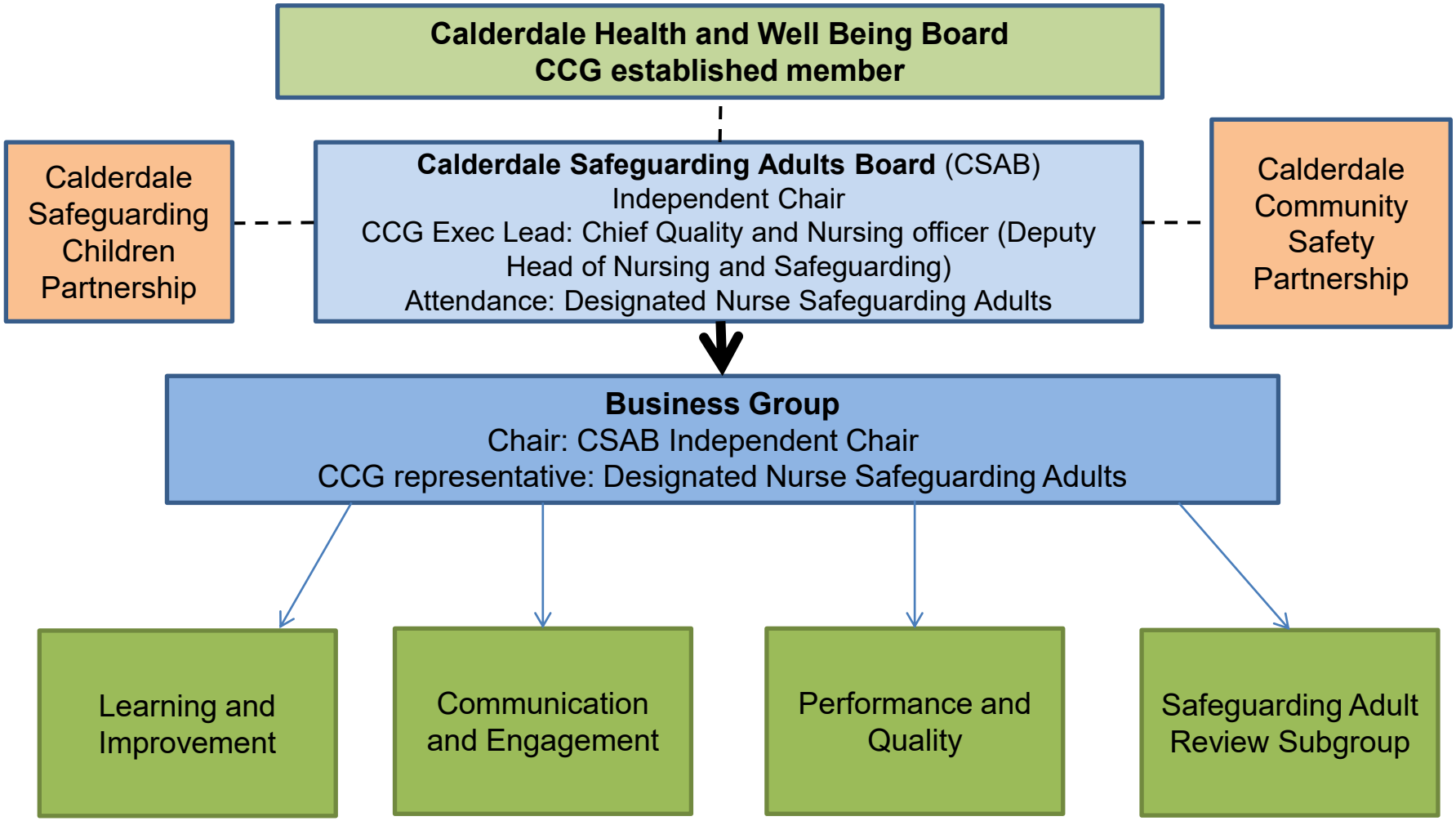
↓

CCG Recruitment and Selection Policy (April 2022)

CCG Whistleblowing (Freedom to Speak Up) Policy (April 2022)

CCG Disciplinary Policy (April 2022)

Calderdale Safeguarding Adults Board (CSAB)



All documents to be available CCG website or are available on: https://safeguarding.calderdale.gov.uk/the-organisations/safeguarding-adults-board

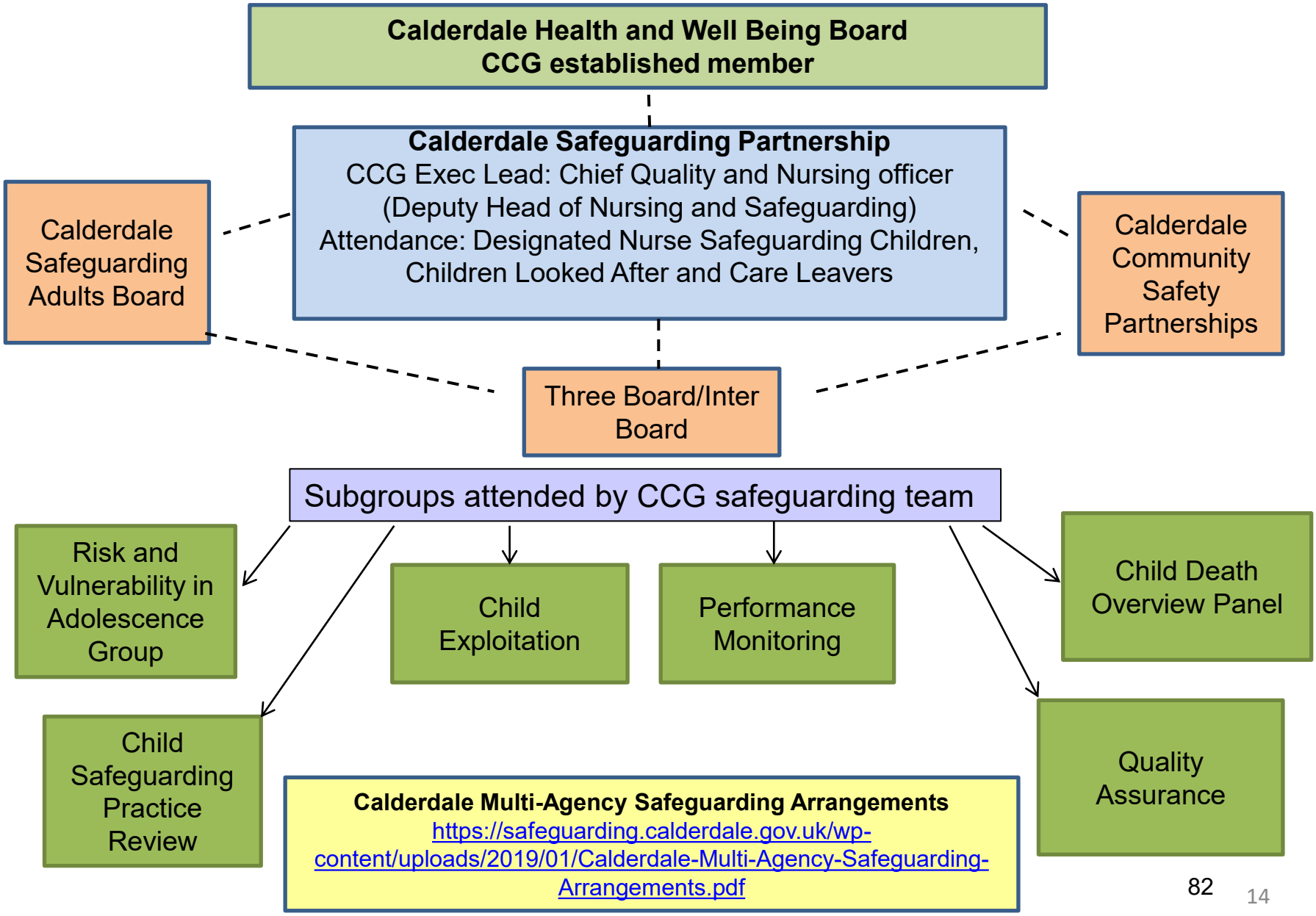
The CCG (adults) have contributed to/ led on:

- Calderdale Safeguarding Adults Board Strategic Plan
- Calderdale Safeguarding Adults Board Annual report
- NICE guidance in Care Homes
- Delivery of multi-agency training e.g. self-neglect

- Burnt Bridges report
- Safeguarding Adult Reviews
- Revision of the Performance Indicator Report
- Austerity, Poverty and Safeguarding
- Health Alliance meetings

- Making Every Adult Matter (MEAM)
- Safeguarding assurance and development during Covid pandemic
- Multi-agency safeguarding audits including: Involvement in adult safeguarding process, repeat referrals

Calderdale Safeguarding Children Partnership



The CCG (children's) have contributed to/ led on:

- Calderdale Safeguarding Children's partnership Annual Report
- Safeguarding Children's Practice Reviews, chair subgroup
- West Yorkshire Adversity, Trauma & Resilience Strategy Group

- Safeguarding Provider Assurance through position statement mechanism
- Launch of ICON (Babies Cry, You Can Cope) (see slide 18)
- Delivered multi-agency training

- 'Multi-Agency Health Audit into the response to Domestic Abuse' by health professionals following an incident discussed at the Domestic Abuse Hub
- An audit on Children Looked After in Calderdale placed from out of area' to review the impact on the use of health services in Calderdale and to establish any gaps in provision

https://safeguarding.calderdale.gov.uk/the-organisations/safeguarding-children-partnership/

Health Assurance & Improvement Group (HAIG) Reporting into CSCP

Health Assurance and Improvement Group (HAIG)

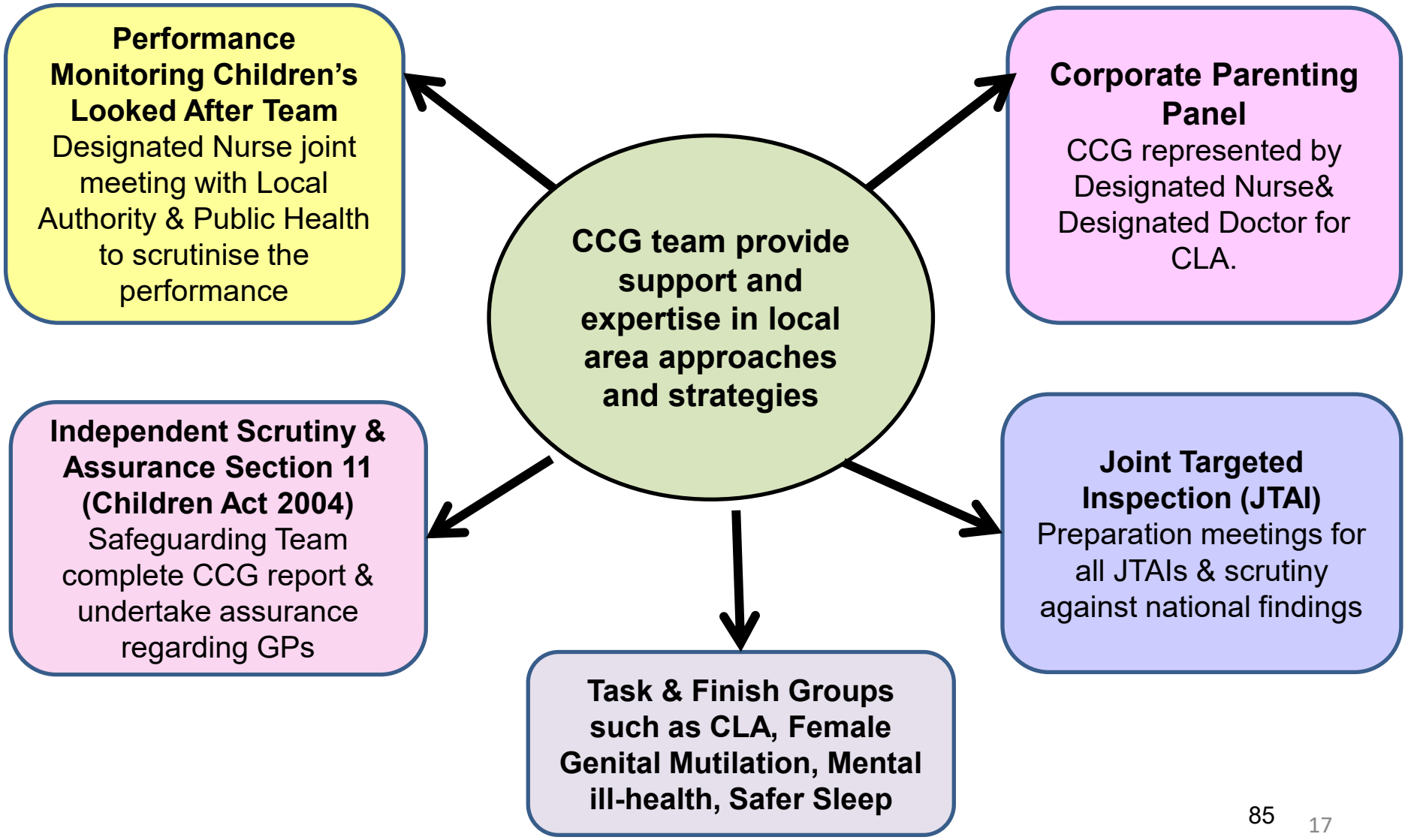
To provide strategic oversight, assurance, improvement and the scrutiny of safeguarding children arrangements across the local health sector.

The overarching aim, to achieve a consistent and responsive approach to meeting the needs of children specifically those who require safeguarding interventions and support the CCG and CSCP in fulfilling their statutory duties.

Membership includes all health providers including Public Health commissioned services, CAMHS, CASH & YAS now widened to include a representative from Calderdale Safeguarding Children Partnership (CSCP)

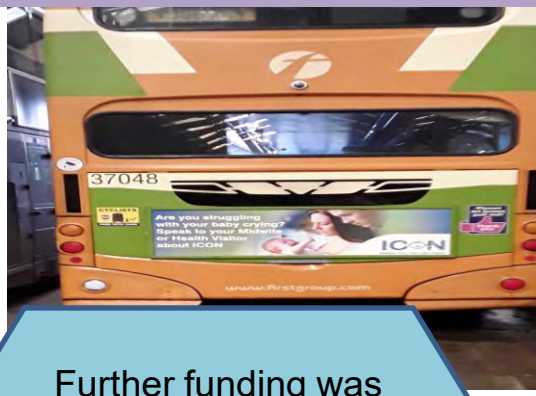
Standing agenda items include thematic review programme, being CLAS inspection ready, review of Calderdale Safeguarding Practice reviews and headline news from each provider organisation.

Other Safeguarding Children's Partnership work



Other Safeguarding Children's Partnership work

Phase 1 was successfully launched in December 2020 for GP Practitioners, Health Visitors and Midwives. Funding for resources was provided by the CCG which included posters, leaflets and a number of banners.



Further funding was obtained from NHS England to support wider promotion within the community via local billboards, bus rears and refuse wagons.

The second phase of ICON was launched in February 2021 amongst the wider partnership colleagues including Children's Social Care, Police, Public Health, Fire Service, Domestic Abuse Services and Children's Centre's

Statutory work on behalf of the CCG and Calderdale status

Safeguarding Children Practice Reviews (SPRs) http://www.legislation.gov.uk/uksi/2018/789/contents/made	These reviews are for Serious Child Safeguarding Cases e.g. - Abuse or neglect is known or suspected; and - The child/young person has died or been seriously harmed. Serious harm includes (but is not limited to) serious and/or long-term impairment of mental health or emotional, intellectual, emotional, social or behavioural development. This should also cover impairment of physical health.	The Designated Nurse Safeguarding Children is the Chair of the CSCP SPR Sub Group and attends all individual case reviews to provide health expertise and oversight. A member of the CCG Safeguarding Team completes any required General Practice Individual Management Reports for cases and disseminates key relevant learning across local health footprint	**Calderdale:** The safeguarding team have provided safeguarding expert support in **2 SPR**s for the period of this report
Safeguarding Adults Review (SAR) (Section 44 of the Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/part/1/crosshead ing/safeguarding-adults-at-risk-of-abuse-or-neglect)	Held when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern about the way agencies worked together to support the individual. The purpose is to learn the lessons about how professionals and organisations work together.	The Designated Nurse Safeguarding Adults is a panellist on all SARs to provide health expertise and coordination. The panel's role is to support and challenge the analysis of the findings and ensure appropriate recommendations are made and implemented. A member of the CCG Safeguarding Team completes any required General Practice Individual Management Reports for cases and disseminates key relevant learning across local health footprint	**Calderdale:** The safeguarding team have provided safeguarding expert support in **3 SAR**s for the period of this report

Statutory work on behalf of the CCG and Calderdale status

Independent Investigations https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/	**NHS England responsible for commissioning** investigations into homicides that are committed by patients being treated for mental illness	Head of Nursing and Safeguarding or Designated Nurses represent CCG's at panel meetings for local cases
Domestic Homicide Review (DHR) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf	A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship Or A member of the same household as himself/herself. Held with a view to identifying the lessons to be learnt from the death.	Designated Nurses attend the Case Panels to provide health expertise and oversight. A member of the CCG Safeguarding Team completes any required General Practice Individual Management Reports for cases and disseminates key relevant learning across local health footprint The safeguarding team have provided safeguarding expert support in **1 DHR** for the period of this report
Child Death Overview Panel (CDOP) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pd	Responsible for reviewing information on all unexpected child deaths. They record preventable child deaths and make recommendations to ensure that similar deaths are prevented in the future	Designated or Deputy Designated Nurse Safeguarding Children attend all local CDOP meetings to provide expertise

CCG responsibilities:

Be able to demonstrate that CCG staff are trained appropriately to be able to recognise and report safeguarding issues at a level that is appropriate to their role

The team have produced a reference guidance for all CCG and practice staff to identify the correct level of safeguarding training each person requires, available on the CCG Intranet site

The guidance is based on:

Intercollegiate document – Adult:
https://www.rcn.org.uk/professional-development/publications/pub-007069

Intercollegiate document – Children
https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies-healthcare-staf

Intercollegiate document – Children Looked After
https://www.rcn.org.uk/professional-development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486

Other training available: Safeguarding Board / Partnership training: https://safeguarding.calderdale.gov.uk/professionals/events/

CCG Staff Safeguarding Training Compliance: end of Quarter 4

	Safeguarding Children	Safeguarding Adults
CCG Staff Members	**87.88%**	**88.89%**
Governing Body Members	**100%**	**100%**

CCG responsibilities:
Have in place a lead for Mental Capacity Act (MCA) that is supported by the relevant policies and training

CCG Mental Capacity Act Lead: Designated Nurse Safeguarding Adults

Liberty Protection Safeguards

Policy and guidance development

Regional and national fora & ICS lead

Supervision

Advice to GPs, Continuing Health Care (CHC), providers, commissioners

Produced guidance on Covid vaccinations and Mental Capacity

Provider assurance

Local interpretation of case law

CHC Deprivation of Liberty assessments

CCG Mental Capacity Act and Deprivations of Liberty Safeguards Policy:
https://www.calderdaleccg.nhs.uk/download/mental-capacity-policy-with-deprivation-of-liberties-safeguards/?wpdmdl=10353&refresh=5eda5350bc9391591366480

CCG engaged in other work at local and regional level

Calderdale Domestic Abuse (DA)
Designated Nurse's for Safeguarding Adults and Children represent the CCG at the DA Strategic Board. The CCG has agreed and signed up to the local 6 step commitments and commissions a health service representative to sit on the DA daily hub on behalf of all health providers.

Strategic Oversight
The CCG has contributed to anticipatory work relating to the enactment of the DA Bill 2021. This work has been to contribute to ongoing multi-agency strategic planning and gathering relevant information for an expected strengths needs assessment in Calderdale.

Partnership
The team are contributing to development work with other key agencies, improving communication, identifying any gaps in service provision and exploring what the data tells us about how we can address DA in Calderdale through audit and learning events. There continues to be close working with the DA Hub health role.

CCG engaged in other work at local and regional level

Safer Sleep
The CCG has engaged in a Task and Finish Group to review the Safer Sleep response following the recommendations of a Thematic Review 'Out of routine a review of sudden unexpected death in infancy (SUDI) in families considered at risk of harm' and is supporting in the production of Safer Sleep multi-agency training, safer sleep risk minimisation tool and Safer sleep practice Guidance.

Independent Review of Children's Social Care
The CCG contributed to a Task and Finish Group which produced a report on the needs of Children Looked After. This was presented to the reviews chair Josh MacAlister and the findings to be considered in the review.

Crown Prosecution Scrutiny Panel (CPS) – Domestic Abuse
The CCG is part of the quarterly audit facilitated by CPS regarding cases involving adult and children victims and perpetrators. The scrutiny of cases based on various topical issues e.g. refusal to give evidence, court summons, declining case based on evidence. Calderdale CCG provides the only health input to the regional multi-agency panel.

CCG engaged in other work at local and regional level

Prevent

The Prevent lead (member of the safeguarding team) is key part of prevent delivery planning groups across Calderdale and Kirklees as well as being Prevent lead for WY&H ICS. The role is responsible for reviewing NHSE data submissions and gaining assurance from providers around the fulfilment of their prevent duty. Part of this is to link in with Prevent Leads, disseminate information and support with embedding prevent delivery plans in their practice.

Calderdale District Silver Programme Precision Meeting

The Prevent Lead represents health partners at the multi-agency meeting. Programme Precision is the new name for work involving West Yorkshire Police, local partners and the public to work together to tackle serious and organised crime in the county. Serious and organised crime covers a range of crimes including drugs, firearms, child exploitation, cybercrime, modern slavery, gangs and county lines.

Calderdale Modern Day Slavery

A member of the Safeguarding Team represent health partners at the multi-agency strategic meeting. Modern slavery is an umbrella term encompassing human trafficking, slavery, servitude and forced labour. The Calderdale Flowchart for Modern Day Slavery NRM Referral

Delivering Assurance

CCG Assurance

- Previous internal audit of Safeguarding Team – High Assurance delivered that CCG is fulfilling its responsibilities
- Monitor CCG compliance with safeguarding training
- Audit/Challenge of Safeguarding Partnership/ Boards (e.g. Section 11 and Peer Challenge events)

Provider Assurance

- Attendance at provider Safeguarding Committees (includes monitoring of training compliance and CQC action plans)
- Provider position statements
- Safeguarding Standards for all main health providers and General Practice
- Monitor *Prevent* returns to NHSE
- Safeguarding and Mental Capacity Act requirements articulated in CCG contracts and Service Specifications
- Regular meetings with independent sector health providers

Safeguarding and the ICS

West Yorkshire and Harrogate Health and Care Partnership

- Group of Designated Nurses / Professionals from each CCG in WY&H ICS called the IDPN (ICS Designated Professionals Network)
- NHSE Engaged
- IDPN chaired by CCG Head of Nursing and Safeguarding

- Aim to "do once and share"
- Developed safeguarding standards
- All members have agreed work stream e.g. MH/ LD and links with ICS lead
- Consider safeguarding response to new pathways across ICS
- Agreed safeguarding aspects of Quality Impact Assessments

- Working with CCG Chief Nurses to develop plan to integrate safeguarding into ICS structures and articulate future model for safeguarding aligned to place and ICS
- Agreed shared approach for safeguarding support for work-streams and programme leads

Examples of the team supportive work this year

Provision of Safeguarding training support:

- Re-engineered the GP Safeguarding Leads meetings (facilitated by the Named GPs on a quarterly annual basis) to include bespoke training sessions for Safeguarding Leads to provide up to date information, provide group supervision and support them in their safeguarding roles in practices
- Bespoke safeguarding training disseminated to Calderdale GP's on Safer Sleep, ICON and Neglect
- Regular 7 minute briefings provided on key topical areas, such as; poverty and safeguarding, ACE's (Adverse Childhood Experiences) Safer Sleep, Learning Disability & Parenting Capacity.

Provision of expert safeguarding advice and support:

Senior Advice calls:
Multiple telephone calls seeking advice and guidance for safeguarding complex cases were responded to by the team (all calls are responded to). The majority of these were from General Practitioners or Practice Staff, but other callers included Dentist, Named Professionals and Safeguarding Leads in commissioned provider organisations, Designated Doctors and Designated Nurses in other organisations. The calls will often require more then one contact and follow-up support and advice is given.

Supervision:
All members of the team provide safeguarding supervision for other specialist safeguarding professionals in other CCGs, health providers in Calderdale and across the WY&H ICS.

Covid Pandemic from March 2021 – what did the team do to respond?

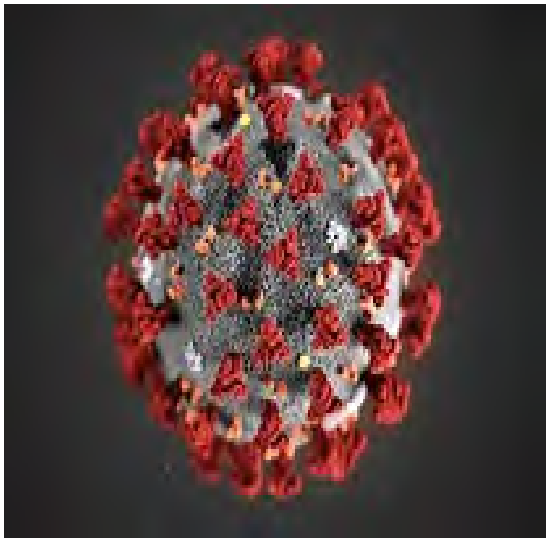
Safeguarding Business Continuity Plan – identified priorities

Supported Rapid Quality Equality Impact with safeguarding recommendations assessments for service change and new service

Monitoring & supporting providers to provide assurance via virtual routes

Delivered supportive safeguarding guidance documents for Primary Care teams

Developed guidance on Covid vaccination and mental capacity



Supported IDPN weekly calls to share work and provide mutual support to colleagues in ICS partnership

Supported the response to NHS England Community Priorities Document

Ensuring support for CLA & Care Leavers maintained during staff re-deployment

Exploring use of virtual technology to maintain contact with CLA & Care Leavers

Worked flexibly, utilising nursing skills to support CCG priorities

Guidance, information on Domestic Abuse

Strategic Objectives for 2021 – 2022

- •Post Covid 19 recovery including review and assessment of team effectiveness during the pandemic and potential post-Covid surge
- •Focus on the intrinsic links between health inequalities, living in poverty and the experience of trauma and adversity for children, young people and adults who require safeguarding interventions.
- •Continue to actively support the Adult & Children's Safeguarding Partnership arrangements in Calderdale, particularly to develop a trauma responsive system

- Support the implementation of recommendations and action from the Burnt Bridges safeguarding adult review
- Continue to develop the Safeguarding Children's Health Assurance and Improvement Group and outcomes focused data set and thematic reviews
- Develop a CCG domestic abuse strategic plan

- Continue to engage and drive the process for delivering Safeguarding requirements at ICS level by being be an active voice in the develop safeguarding structures and model in the new health landscape
- Support provider organisations and GP's to implement new Safeguarding Standards

Continue to promote ICON programme Phase 1 (Health Partners) & Phase 2 (Wider Partnership)
Prepare for and support the implementation of the new Liberty Protections Safeguards including updating the CCG Mental Capacity Act policy
Develop a Prevent action plan to include development of a champion network and improved training availability for CCG and primary care networks

Key legislation that underpins Safeguarding work

Children:

The Children Act 1989, the Children and Adoption Act 2002 and the Children Act 2004:

https://www.legislation.gov.uk/ukpga/1989/41/contents
http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf

The Children and Social Work Act 2017 (section 3):

http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

Working Together to Safeguard Children (2018) updated Dec 2020

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

Safeguarding Children and Young People: Roles and Competencies for Healthcare staff. The Intercollegiate Document 2019

https://www.safeguardingassociatesforexcellence.co.uk/wp-content/uploads/2019/01/2019-Intercollegiate-document.pdf

Looked after Children: Roles and competencies of healthcare staff Dec 2020

https://www.rcpch.ac.uk/resources/looked-after-children-lac

Key legislation that underpins Safeguarding work

Adults:

The Care Act 2014

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

https://www.legislation.gov.uk/ukpga/2006/47/contents

The Mental Capacity Act

https://www.legislation.gov.uk/ukpga/2005/9/contents

NHS England Safeguarding and accountability and Assurance Framework

https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-children-young-people-adults-at-risk-saaf-1.pdf

Adult Safeguarding: Roles and Competencies for Health Care Staff 2018

https://www.rcn.org.uk/professional-development/publications/pub-007069

Domestic Abuse Act 2021

https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Patient and Public Engagement Annual Statement of Involvement 2020 - 2021**	**Agenda Item No.**	9
Report Author	Jill Dufton, Senior Engagement Manager	**Public / Private Item**	Public
Clinical Lead	Alison MacDonald PPI Lay Member	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary

The purpose of the report is to provide an annual account of NHS Calderdale CCG (& our partner's) engagement activity. The report sets out all engagement activity delivered during the period April 2020 to March 2021.

The report also describes engagement activity planned for the forthcoming year April 2021 to March 2022 and details of progress made on previous submissions of engagement and consultation.

Previous Considerations

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

Recommendations

It is recommended that the Governing Body **APPROVE** and **SIGN-OFF** the annual statement of involvement as an accurate account of our engagement activity during the period of April 2020 – March 2021 so the report can be published.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Generate information required to complete project EQIAs.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The report explains the approach to engaging and involving the public, patients, carers / families, and staff. And also, equality – protected groups.
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no financial 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?)	Improving quality Improving value	**Risk (include risk number and a brief description of the risk)**	None
Legal / CCG Constitutional Implications	Section 242 Health and Social Care Act, NHS Constitution, Equality Act.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None

Patient and Public Engagement

Annual Statement of Involvement

2020 - 2021

1. Introduction

1.1 The purpose of this report is to provide an annual account of our engagement activity for the previous financial year April 2020 - March 2021

1.2 The report includes all the engagement activity the CCG has delivered including what we did, the key messages and how the information was used.

1.3 The report also includes wider engagement activity from other health and care providers and our partner organisations including Calderdale Council, West Yorkshire and Harrogate Health Care Partnership (WYHHCP), Voluntary Action Calderdale (VAC), and Healthwatch (HW).

1.4 The report also describes the engagement activity planned for the forthcoming year April 2021 to March 2022 and details of progress made on previous submissions of engagement and consultation.

2. Detail

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

The Involving People Strategy is a shared set of principles with our partners for involving people across Calderdale – supporting the delivery of Calderdale Cares, and the White Paper integration and innovation by working together to improve health and social care for all through its principles of voice, and influence, and addressing inequalities. It is central in helping the CCG embed the voice of patients, carers, families, staff and the public everything we do. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback. The duty to involve local people is

set out in section 14Z2 of the Health and Social Care Act 2012, the Equality Act 2010 and also places a specific duty on CCGs to ensure that health services are provided in a way which promotes The NHS Constitution.

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

2.2 Our approach to public engagement and consultation is to make sure that we use a variety of different mechanisms, methods, and approaches to engage with people. We need to ensure we can involve people when they need to be engaged or indeed want to be engaged.

2.3 We want to make sure we hear from all the people and communities in Calderdale - everyone's opinions matter. We understand that the way we ask for people to share their views can make a big difference to who responds. We also use equality monitoring to assess the representativeness of the views we have gathered.

2.4 The Annual Statement of Involvement is our opportunity to present the work we have done, catalogue our activities and present any changes as a result of this work. The report sets out the engagement activity which has taken place on the following areas:

- Key emerging themes
- Using insight to support commissioning decisions
- Equality
- Involvement activity April 2020 – March 2021 – see below

NHS Calderdale CCG

- COVID-19 Vaccination Engagement
- The impact of Coronavirus (COVID-19) on people's experiences of health and care services living and working in Calderdale
  Enhanced Health in Care **Homes** (EHCH)
- Hospital Reconfiguration (Right Care, Right Time, Right Place)
- Share and learn events – learning disabilities

Calderdale and Huddersfield Foundation Trust (CHFT)

- Cancer - Quarterly Patient Focus Group
- Cancer - Patient Focus Group co-designing cancer support programmes
- Outpatients Transformation
- Children & Young People's service

South West Yorkshire Partnership Foundation Trust (SWYPFT)

- Reform of Mental Health Act (MHA) engagement
- Capturing patient views of services during the pandemic
- Digital Strategy engagement
- Equality, Involvement, Communication and Membership Strategy engagement
- Staff Carer Network
- 'Virtual Visitor'

Voluntary and Community (VAC)

- Engagement Champions – understanding peoples experiences of health and social care during COVID-19

Healthwatch

- Experiences of medication during Covid-19
- The health and care experiences of people living in Calderdale during the Covid-19 outbreak
- Partnership working

Locala

- Doing things differently

West Yorkshire and Harrogate Health and Care Partnership

- Further engagement about Assessment and Treatment Units
- In-depth engagement with people in long-term restrictive complex rehabilitation inpatient settings
- Green social prescribing survey
- Maternity services community action insight
- Ongoing engagement mechanisms
- Engagement and Consultation mapping report 2020/21

Progress update on previous engagement and / or consultation activity

NHS Calderdale Clinical Commissioning Group (CCG)

- Hospital Reconfiguration - Right Care, Right Time, Right Place
- Improving Access to Psychological Services (IAPT)
- Out of hospital care
- Next steps following the Children and Young People's Autism Spectrum Disorder Summit 2020: "Find Your Brave"

Calderdale and Huddersfield Foundation Trust (CHFT)

- Transforming hospital services in Halifax and Huddersfield design principles engagement phase
- Cancer – Macmillan Rehabilitation Project

Healthwatch

- Hypermobility Syndromes 2016-2018
- Adult Autism
- Access to health services for Syrian refugees/asylum seekers and refugees
- Children and adolescent mental health services (CAMHS)

South West Yorkshire Partnership NHS Foundation Trust

- Staff Networks
- Carers Charter
- Dales inpatient wards
- Single Point of Access
- Suicide Bereavement Support Services

West Yorkshire & Harrogate Health and Care Partnership

- West Yorkshire Healthy Hearts Project
- Health and Care Learning Disability Champions

Planned work for 2021-22

- Hospital services
- West Yorkshire and Harrogate Health Care Partnership
- Primary care engagement and consultation

- Equality Objectives 2021/22
- Community Services
- Primary Care Networks (PCNs) and localities
- Transformation programmes
- COVID-19 Pandemic
- White Paper Integration and Innovation: working together to improve health and social care for all

2.5 The report also describes how we have used the insight we have gathered from all engagement and consultation activity to support commission decisions, and how we plan to continue using this intelligence in 2021/22.

2.6 We recognise that it can take several months or even years before any outcomes or changes can be reported on from any engagement and/or consultation activity that takes place. So, we have taken the opportunity to do a look back at previous submissions and reflect on any changes that have been as a result of any engagement and/or consultation.

2.7 An additional section on equality has also been included following an assessment of the engagement functions by the Equality Deliver System (EDS) in 2017/18. This item has been included as the delivery plan for our equality objectives is from April 2018 – March 2022. The CCG want to describe progress in this area to ensure we involve the diverse population of Calderdale and those groups protected by 'The Equality Act 2010'. As an organisation the equality agenda is critical to our success and is reinforced by ourvisions and values. We work to understand the communities we serve and make betterdecisions ensuring the services we plan and buy meet the needs of the population of Calderdale. Calderdale Public Sector Equality Duty (PSED) 2021 provides evidence of our compliance and demonstrates our commitment to equality and inclusion.

2.8 This report will be published on our website, circulated to our GP practices, partners and key stakeholders.

3 Next Steps

3.1 The next steps will be:

- To publish this report on our website
- To continue to deliver and support engagement on the projects identified in 2021/22
- To identify the specific target audience, we want to engage further and continue to develop our approach to engaging these audiences
- To generate the intelligence required to support equality impact assessments
- To continue to catalogue all our engagement and consultation activity

4 Implications

4.1 Quality and Safety Implications

4.1.1 The programmes of work set out in the report all support our equality duty by ensuring activities are monitored using an equality monitoring form. The information gathered also supports the completion of EQIA assessments. This process provides assurance that we are talking to the people who will be impacted by a proposal including our most protected groups.

4.2 Engagement and Equality Implications

4.2.1 The report sets out our annual activity for engaging public, patients, stakeholders, carers / families, and staff. The report also provides assurance that the organisation considers the views of local people in commissioning decisions.

4.3 Resources / Finance Implications

4.3.1 There are no financial implications

4.4 Data Protection Impact Assessment

4.4.1 Not required

4.5 Risk

4.5.1 There are no identified risks

4.6 Legal / CCG Constitutional Implications

4.6.1 The legal and constitutional implications that are supported by this plan are ‘Section 242 Health and Social Care Act’, ‘NHS Constitution’ and the Equality Act.

4.7 Conflicts of Interest

4.7.1 There are no conflicts of interest

5 Recommendations

It is recommended that the Governing Body **APPROVE** and **SIGN-OFF** the annual statement of involvement as an accurate account of our engagement activity during the period of April 2020 - March 2021 so the report can be published.

6 Appendices

Appendix 1 - Patient and Public Engagement Annual Statement of Involvement report from April 2020 - March 2021

NHS
Calderdale
Clinical Commissioning Group

Patient and Public Engagement Annual Statement of Involvement 2020 to 2021

Acknowledgements

We would like to thank all the individuals and organisations who have taken part in our engagement and consultation activities over the past year and for sharing their experiences of using local services. Your contributions have helped to inform our commissioning decisions to ensure your local NHS continues to provide quality and responsive services.

This report gives us the opportunity to share what engagement and consultation activity has taken place over the last year, what people have told us and what's happened as a result of people sharing their experiences and the feedback that they have given.

We've also the take the opportunity to look back over several years and reflect on changes that have been made following engagement and consultation.

Foreword

I first joined NHS Calderdale Clinical Commissioning Group (CCG) in December 2019 as the Patient & Public Layperson barely had time to find my feet when Covid 19 was upon us, what was to follow was an incredibly difficult year for us all and also for our health and care system.

The CCG adapted quickly to support services to continue to function by setting up digital access for video calls, whilst also ensuring telephone and face to face appointments were still offered so that patients could still access medical care. It was impressive to see how services adapted quickly to ensure the NHS remained open.

It's been great to see the amazing work that Calderdale as a place has achieved on the vaccine programme from the setting up of test centres, to the prioritisation of the different cohorts, to also ensuring those who were housebound received their vaccinations. Pop up clinics were set up in mosques, clinics were also set up specifically for those with Learning Disabilities, the teams visited homeless shelters, unpaid carers were also included in the prioritisation list to ensure the most vulnerable could be protected.

Partnerships have grown even stronger with local health and care partners to improve integration between services, this was highlighted as a need from feedback that the CCG received through previous engagement and consultation.

This year has also seen a big step forward to ensure the CCG's new website will be in an accessible format, this will ensure accessibility for those who need it but may have previously struggled to access the website.

Whilst Covid has taken priority this last year the CCG have continued to collect feedback to improve services and to also further address inequalities especially for those inequalities heightened by Covid. This work has been completed with the help of Healthwatch Calderdale, the local authority, and the voluntary and community sector to ensure Calderdale's voices are taken into account when planning and resetting services.

Looking forward to this forthcoming year now that the vaccine programme has protected the most vulnerable and is also going at a great speed to reach the rest of the Calderdale population, we can now hopefully get back to a new normal.

I would also like thank the Engagement team on behalf of NHS Calderdale CCGs Governing Body for their hard work this year, despite the obstacles of Covid they have continued to ensure that patient and public voice is heard. I'd also like to thank the Calderdale community for their feedback and for sharing their experiences which is incredibly important to ensure that the services provided work for us all and can be accessible to all.

Thankyou
Alison Macdonald
Patient and Public Lay Representative

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Summary of Calderdale CCG engagement 2020/21

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

The Involving People Strategy is a shared set of principles with our partners for involving people across Calderdale – supporting the delivery of Calderdale Cares, and the White Paper integration and innovation by working together to improve health and social care for all through its principles of voice, and influence, and addressing inequalities. It is central in helping the CCG embed the voice of patients, carers, families, staff and the public everything we do. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback. The duty to involve local people is set out in section 14Z2 of the Health and Social Care Act 2012, the Equality Act 2010 and also places a specific duty on CCGs to ensure that health services are provided in a way which promotes The NHS Constitution.

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

Due to the COVID-19 pandemic we recognise that some of our usual activity has not taken place which has resulted in us having to adapt and refocus our activity which is reflected in this report. It's important that we capture the work that has happened over the last 12 months, during these worrying and uncertain times.

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

During the summer 2020 the CCG worked in partnership with Healthwatch Calderdale to gather feedback from anyone who had contacted or tried to contact health and care

services during the Covid -19 outbreak. NHS and care services had to quickly change the way they work and deliver services in response to COVID-19. Whilst NHS and care staff were doing everything, they could, to keep us well during this crisis, we know that things could be improved.

The key themes from what people told us were:

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

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

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

Supporting the roll out of the COVID Vaccination programme has also been a priority for the CCG and partners. Joint working and regular discussions across organisations and with colleagues to ensure consistency of the messages across Calderdale by NHS and council colleagues and all our partners have been integral to the programme. Calderdale CCG Engagement led on the coordination of engagement and insight through the system (at place) in relation to the Covid Vaccination programme with as many partners as possible. Through this group, engagement and insight was retained by the Covid Vaccination Programme by using the various methods: -

- Talk back panel - A short engagement activity of two weeks to enable a 'temperature check' on how people are feeling about the vaccine. This survey will capture the views of the public through the Councils Talk Back Panel. The survey aims to capture people's views around the vaccine including why it's important to them, what would stop

them from receiving the vaccine. Each respondent will also be asked to complete an equality monitoring form. 424 questionnaires were returned.

- Understanding your views survey - Broader engagement activity to ensure we were reaching all people living in Calderdale from all demographics and protected groups. Communities that have been most impacted on by COVID, including those living in deprived areas, Black, Asian and Minority Ethnic (BAME) groups, shielding and vulnerable groups. Those with the highest occupational risk and people who may be socially excluded such as our homeless population, asylum seekers and people with learning disabilities**,** The survey aims to capture people's views around the vaccine including why it's important to them, what would stop them from receiving the vaccine. 482 responses in total over a period of approximately eight weeks.
- A large proportion of the insight we have received has been from voluntary and community organisations, including:
    - Temporary accommodation providers and support services for homeless people
    - Support services for asylum seekers, where pop-up vaccination clinics and Q&A sessions have also taken place
    - Forums of parents and carers of people with disabilities
    - Care providers facilitating respite for unpaid carers
    - Support groups for Asian women with mental health issues
    - Forums for people over 50, and organisations that support them
    - Organisations supporting Black and African communities
    - Organisations supporting older lesbians in Calderdale
    - Reference group of young people aged 0-25 with Special Educational Needs or Disabilities
    - Groups of college students through Healthy Futures (Public Health) project
    - Local youth workers
    - Organisations providing support, information, and advice to unpaid carers.
- Patient experience survey – over 500 responses to date
- Engagement predominantly through the Covid engagement champions and engagement champions through the voluntary community sector – through these routes there are approximately 148 engagement champions (43 engagement champions representing 23 organisation 105 COVID Champions)

We learned that people have concerns around having the vaccine that fell into the following themes: -

- Side effects
- Importance of the vaccine
- Mistrust of information
- Safety of the vaccine
- Effects on fertility
- Understanding how the vaccine works
- Additional needs
- Allergies

We are still learning, as the programme develops the emerging themes are:

- 2nd doses
- Waiting to make a decision about getting the vaccine
- Transport to sites
- Perceived risk of Covid to younger age cohort versus the benefit of having the vaccine
- Work being a potential barrier to getting the vaccine

Fortnightly insight reports are developed from all the feedback received which has informed and continues to inform the COVID vaccination programme and communication messages. The engagement started late January 2021 and continues, as we work through to the younger adult cohorts

More detailed information is provided in this report on how the CCG and partners (including local authority, voluntary and community sector and the providers that the CCG commission) have involved local people in the development, design and delivery of services

throughout the year. This report sets out who has been involved, what people have told us and what has happened as a result. Each section is a summary account with links to the published reports.

1. Introduction

NHS Calderdale Clinical Commissioning Group (CCG) was formally established in April 2013 and has the responsibility for ensuring that people living in Calderdale have access to high quality health services.

In 2006, Patient Involvement was strengthened by the NHS Act and Sections 242 and 244 of the Act placed a duty on NHS organisations to involve and consult local people and stakeholders in the planning and development of services. Also included was a duty for Primary Care Trusts (PCTs) to report on this activity in an annual 'statement of involvement'.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regards to how NHS commissioners will function. These amendments included two complementary duties for Clinical Commissioning Groups (CCGs) (as the organisations who replaced PCTs from 1 April 2013) with respect to patient and public participation and also a duty to promote the NHS Constitution which was refreshed in 2013. The legal duties in relation to Patient and Public Involvement are presented at Appendix 1.

This report provides an overview of the engagement and consultation activities that have taken place over the past year from 1 April 2020 until 31 March 2021 and includes a summary of what people told us, what the outcome was and where you can find further information. It also includes details of any engagement or consultation activities that are currently planned for 2021/22.

2. About Us

NHS Calderdale Clinical Commissioning Group (CCG) is the CCG covering 21 General Practices and a registered population of more than 222,000 patients. CCGs are groups of GPs that are responsible for planning and designing local health services in England. We do this by 'commissioning' or buying health and care services including:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

Clinical Commissioning Groups (CCGs) work with patients and health and social care partners (e.g. local hospitals, local authorities, local community groups etc.) to ensure services meet local needs. CCG governing bodies are made up of professionals from different backgrounds such as GPs from the local area and at least one registered nurse, one secondary care specialist doctor, senior managers and lay representatives, who are all working together to secure the best possible healthcare for local communities. Our aim is to improve the health and lives of local people by increasing life expectancy, making sure we commission and provide good quality services and to reduce health inequalities across the district.

Our vision and values

The CCG's vision is:

To achieve the best health and wellbeing for the people of Calderdale within our available resources

Our values are:

- Preserve and uphold the values set out in the NHS constitution
- Treat each other with dignity and respect
- Encourage innovation to inspire people to do great things

- Be ambassadors for the people of Calderdale
- Work with our partners for the benefit of local people
- Value individuality and diversity and promote equity of access based on need
- Commission high quality services that are evidence based and make the most of available resources
- Encourage and enable the development of care closer to home

Download a copy of the CCG Constitution here.

Our priorities

As an organisation we are working towards six key priorities. These are:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with a long-term condition (including work on urgent care pathways)
- Helping people to recover and maintain their independence (including work on intermediate tier)
- Ensuring people have a positive experience of care (including those in care homes, and those accessing primary care)
- Ensuring a safe environment and protecting people from harm
- Reducing inequalities in Calderdale

The CCG along with partners as a 'place' are also working towards the following priorities:

- New Relationship with our communities -harnessing the strengths of Calderdale's people and communities
- A shift to prevention and health outcomes- better wellbeing for all
- Relentless in reducing inequalities
- Seamless services for those that need help supporting integrated care services (Calderdale Cares)

Our finances

NHS Calderdale CCG is responsible for devolved healthcare budgets of approximately £343 million on behalf of our patients and people living across Calderdale.

We will make sure we use our available resources to deliver our priorities, fulfill our commissioning plans and improve outcomes for patients. We will regularly review our activities and where appropriate, take action to achieve financial balance in respect of provider costs, prescribing and management/running costs.

3. Our approach

Our approach to public engagement and consultation is to ensure that we use a variety of different mechanisms, methods and approaches to engage with people. We need to understand how we can best involve people, when they need to be engaged or indeed want to be engaged.

The Involving People Strategy is a joint strategy with a shared set of principles with our partners for involving people across Calderdale and ensures that we adopt a whole system approach to supporting this work.

The strategy enables us to meet our responsibilities under the Health and Social Care Act 2012:

- putting patients and the public at the heart of everything we do
- focusing on improving those things that really matter to the population of Calderdale
- empowering and liberating clinicians to innovate, with the freedom to focus on improving healthcare services and,

The strategy shows that we are committed to ensuring that we actively engage with patients, the public and other key stakeholders to ensure that the commissioning, design, development, delivery and monitoring of health and care in Calderdale meets the needs of

our population. By listening to patients and the public and learning from their experiences of health and care we can understand what really matters to people.

We want to make sure we hear from all the people and communities in Calderdale - everyone's opinions matter. We understand that the way we ask for people to share their views can make a big difference to who responds so we ensure we design our patient experience and engagement processes with this in mind. We also use equality monitoring to assess the representativeness of the views we have gathered and where there are gaps or we identify trends in opinion, these are looked into and plans made to address them.

Throughout the year, we actively promote any activities for people to become involved and this report is our opportunity to present the work undertaken, catalogue our activities and present any changes as a result of this work.

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

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

A. Governance;

B. Annual reporting;

C. Day-to-day practice;

D. Feedback and evaluation;

E. Equalities and health inequalities.

For 2019/20 we have been advised that our rating was 'Outstanding' with a score of 15 out of 15 Green Star.

This report will be published on our website and circulated to our member practices and key stakeholders. We also have a number of other mechanisms in place to manage our engagement activities and gather peoples views, these are highlighted below.

Involving People Network

A diverse network of people across Calderdale who share knowledge, skills and resources and provide peer to peer support to involve local people and our communities. Working together, with our communities to understand their needs and celebrate the great things that are happening in local areas.

Communication, Engagement and Equality (CEE) Collaboration

Communication, Engagement and Equality leads from key partner organisation who come together to facilitate system-wide projects, involvement, or campaigns – a do once approach, to ensure all expertise is considered in advance of any communications being published or involvement taking place, we do this by working together using our networks and our existing mechanisms by supporting our Calderdale Cares localities and the communities and people who live and work in them.

Patient Experience Group (PEG)

The purpose of the Patient Experience Group is to help shape and improve patient experience. The group do this by:

- Networking – developing and sustaining positive relationships across the group membership.
- Collaborating - working together with providers to identify areas of good practice, areas of concern and actions for improvement.
- Learning – sharing good practice across local providers as well as being mindful of the ongoing work of the West Yorkshire and Harrogate STP as new plans are developed across the region.
- Shaping – Setting, monitoring and driving the delivery of the patient experience priorities.

Calderdale Health Forum

Calderdale Health Forum (HF) provides patient input into key CCG priorities and potential service redesign. Members are also informed of additional engagement opportunities as they arise. Health Forum members are representatives of Calderdale GP practices who have a Patient Participation Group (PPG). The Network met on a bi-monthly basis, due to

the ongoing COVID-19 pandemic the Health Forum has been suspended. Regular communication with members of the Health Forum has continued throughout.

A PPG is a group of patients interested in health and care services and peoples experiences of those services who want to get involved with and support the running of their local GP Practice and contribute to the continuing improvement and development of your local GP practice.

Engagement Champions

Engagement Champions is an asset based approach to engagement and involves training members of the voluntary and community sector as engagement providers. The aim of the project is to support the third sector voice in commissioning and to use their communities to ensure we reach local people at a grass roots level.

Engagement Champions are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. Training is mandatroy and has five elements (below).

- Understanding how the NHS works
- Legal and statutory duties of the NHS
- Methods and approaches to engagement and consultation
- A practical task
- Equalities, safeguarding and review and evaluation

We currently have 43 Engagement Champions from 23 organisations who help support conversations with our diverse communities about healthcare services, and we are working in partnership with Voluntary and Communinty to recruit and train even more. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups by helping to give communities a voice.

Patient Stories

Patient stories help bring experiences to life and will encourage the CCGs to focus on the patient as a whole person rather than just a clinical condition or as an outcome. They have

the potential to inspire us to make successful changes, educate the workforce, to support learning about what works well and to promote excellence. We now have a system in place to collect stories as part of the CCGs approach to involving people.

Calderdale CCG website

Calderdale CCG has a website which provides information to the public including a section called 'Get Involved'. As a CCG we fully use our website to inform of our plans to engage, raise awareness of any consultation activity and also provide opportunities to become involved. This website is updated on a regular basis so we can regularly report on the outcomes of all consultations and what we have done as a result of our engagement activity.

NHS Calderdale CCG's Complaints Service

The Complaints Service helps the NHS to improve services by listening to what matters to patients and their families, and making changes when appropriate. It also provides the following functions to the population of Calderdale:

- It is responsible for receiving, handling and investigating complaints relating to the actions of Calderdale CCG and the NHS services it commissions.
- Providing information about the NHS complaints procedure and how to obtain independent help if the person decides they want to make a complaint
- Providing information and help for example: support groups outside the NHS
- Providing an early warning system for the CCG, NHS Trusts and monitoring bodies by identifying problems or gaps in services to prevent a recurrence.

More information can be found in our Complaints Policy on the Calderdale CCG website: www.calderdaleccg.nhs.uk/download/complaints-policy/

Healthwatch Calderdale

Healthwatch Calderdale is the consumer champion for both health and social care. It exists in two distinct forms – local Healthwatch and Healthwatch England. Local Healthwatch is an independent organisation and Calderdale CCG is working alongside the service to ensure that it forms part of our engagement of the local population. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Working in partnership

The CCG is committed to working in partnership with our partner organisations, providers, staff, public, patients and carers. We already have a good relationship with a number of key stakeholders including the third sector and we want to continually work with and invest in our partnerships to help us deliver the Involving People Strategy.

Care Opinion and NHS Choices

Care Opinion is a feedback platform for the public so they can share their story or experience of healthcare services. Anyone can post an opinion on the website. NHS Choices also provides a similar facility. Calderdale CCG will search these facilities by provider to listen to what patients are saying about NHS services.

National and Local surveys

National and Local surveys take place throughout the year from various providers and local GP practices. Patients are encouraged to contribute to these surveys. The public can use surveys to have their say on current services and Calderdale CCG is able to use such surveys to understand the patient's view of the service. In addition, surveys can be used collectively to inform commissioning decisions.

Service redesign activities

Throughout the year we actively promote any activities for people to become involved. Engagement as part of the development of our commissioning intentions will feed into the overall themes arising locally and support our decision making in respect of future actions. We will continuously cross reference the themes which arise from patient and public engagement to update and reflect on the intelligence we have to date.

4. Engagement and consultation activity

When there are decisions to be made which affect how local health and care services are commissioned, we make sure we talk to people who will be most affected and for those larger pieces of work we make sure the general public are made aware of any proposals so they too have the chance to have their say. We carry out one-off pieces of work as well as involving patients and the public on an on-going basis through the partnership arrangements we have in place with local people and communities.

The report includes all engagement and consultations that has been undertaken and completed during 2020/21, including any that started before 1 April 2020, or that started during the period of this report, but are not yet completed. It also includes details of engagement and consultations planned for 2021/222 and details of progress made on previous submissions of engagement and consultation that took place between 2016/19.

From all the work we have completed this year and in 6 previous years key emerging themes remain the same, which are below:

- Co-ordinated services working together to deliver integrated health and social care (from grass roots to community and hospital)
- Continuity of good care and treatment
- GP capacity to be increased
- Improve communication, information and sign posting including NHS 111
- Improved access to services with more flexibility and waiting times reduced
- Increase funding and support for services such as mental health and autism
- More involvement of 'Voluntary and Community Sector' in delivering services
- More on prevention and support to self-care
- More services closer to home and single point of contact
- Right staff in the right setting and training for staff including customer care and equality
- The theme of 'one size does not fit all' is further strengthened particularly for children and young people, frail elderly, diverse populations and mental health.
- Workforce who represent the communities they serve

Whilst the themes above remain the same, COVID-19 has affected everyone which has had a direct impact on peoples health and has further exposed wider inequalities. Communities have been disproportionately impacted directly and in directly by COVID-19. We know that many people appreciated the necessity for change during these unpresedented times but we also know also know that there has been a loss of trust in NHS and Care services. Emerging themes from recent engagement during the pandemic are below:

- Quality of care
- Access to services
- Digital access
- Communication between staff and patients

Feedback showed us that people have had mixed experiences accessing health and care services, both in-person and through digital means. The work undertaken also highlights issues in communication between healthcare staff and patients, and the quality of care delivered. In regard to respondents' mental health feedback also suggests that experiences have been mixed, with many people struggling due to the impacts of the Covid-19 pandemic, and others seeing an improvement in their emotional wellbeing during lockdown.

Intelligence gathered from all engagement is invaluable to every area of the CCG. We will continue to collaborate locally in planning and delivering action to address health inequalities, better listening to communities, and strengthening local accountability, deepening partnerships with local authorities and the voluntary and community sector.

5. Using insight to support commissioning decisions

Every engagement and consultation delivered throughout the year provides more rich information and intelligence to support service development and design. Prior to embarking on a piece of work to gather views, the CCG gather any existing patient experience and engagement information.

By working through existing intelligence the CCG can identify key emerging themes and also identify where there are gaps. In addition we can also identify through the Equality Impact Assessment (EQIA) the communities we have already reached and need to reach, in line with our equality duties. The information sources we use are:

- Patient Advice and Liaison (PALS) queries
- Reported Complaints
- Friends and family test
- Websites such as Patient Opinion and Patient Choices
- National and local surveys
- Findings from any engagement/consultation activity
- Calderdale Health Forum

The information we gather is saved in a format that allows for further interrogation. By looking at what we already know we can draw down information again and use it to support other service areas. The data we hold not only allows us to draw on a wealth of intelligence but further assures our local population that their views are an important source of business intelligence. The CCG also equality monitors all activity ensuring the insight we have can be used to represent the views of a range of protected groups.

Equality

How we involve our communities is a key consideration for any engagement or consultation. We work with equality colleagues who tell us, who we need to involve to ensure services meet the needs of the local population.

As part of a two year action plan informed by the Equality Delivery System (EDS) our aim has been to improve our reach with a particular focus on certain groups or people who are currently under-represented. The CCG continue to build on the work we started in 2017/18. Our objectives were to:

- Actively work with LGBTQ networks and encourage a stronger voice for this sector by engaging organisations and networks that can help us to do this.
- Actively involve young people aged between 12-25 years old to understand their experience of their local GP practice.
- Continue to deliver Engagement champions to our local community and to continually expand on the network of community experts to increase voice and representation.
- Actively work with unpaid carer and BME networks to encourage a stronger voice for these sectors by engaging organisations and networks that can help us to do this.

So far the work has helped us to improve our reach into the identified communities.

As an organisation the equality agenda is critical to our success and is reinforced by ourvisions and values. We work to understand the communities we serve and make betterdecisions ensuring the services we plan and buy meet the needs of the population of Calderdale. Calderdale Public Sector Equality Duty (PSED) 2021 provides evidence of our compliance and demonstrates our commitment to equality and inclusion.

Engagement and consultation activity April 2020 to March 2021

We ask our partners, providers and staff in the CCG to help and support the CCG to produce the Patient and Public Engagement Annual Statement of Involvement each year by gathering information so we can report on all engagement and consultation activity that has taken place across Calderdale. NHS Calderdale CCG is a partner of West Yorkshire and Harrogate Health and Care Partnership, some activity described in this report is carried out across the wider region including Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

NHS Calderdale CCG

COVID-19 Vaccination Engagement
January 2021 - ongoing

NHS Calderdale CCG is the lead organisation coordinating the COVID-19 vaccination programme for Calderdale. The purpose of the engagement is to gather views and experiences from people living in Calderdale about the COVID vaccine. We want to give people the opportunity to help influence how we shape the vaccine delivery model in Calderdale and the messages we share; through understanding and learning what the public views are of the COVID vaccine and understanding any concerns. This work is a collaborative approach with our partners including Healthwatch, Calderdale Council, and the voluntary and community sector.

Who did you consult with and what did you ask?

We want to understand the views and experiences of people living in Calderdale of the COVID Vaccine.

Key audiences, communities, partners, and stakeholders are:

- All people living in Calderdale from all demographics and protected groups
- Communities that have been most impacted on by COVID, including those living in deprived areas, Black, Asian, and Minority Ethnic (BAME) groups, shielding and vulnerable groups
- Those at highest occupational risk
- Voluntary and community groups

- Key partners and stakeholders
- Those socially excluded such as our homeless population, asylum seekers and people with learning disabilities

Utilising all the intelligence we can gather will help us identify gaps in our understanding and will help to influence our communication messages. There were four key areas that we needed to understand people's perspectives of, which are:

- How do people feel about the vaccine?
- What has the experience been like for people who have received the vaccine?
- What is the experience of our staff / professionals who are delivering the vaccine?
- Collecting lived experience stories of those receiving and administering the vaccine

The approach to engagement was to use existing services and mechanisms who can reach all target audiences. The engagement approach was multi-layered with different involvement options and took place during the systematic roll out of the COVID vaccine programme. The approach taken is below:

- Gather all the intelligence that we know has taken place from recent activity
- A short engagement activity to enable a 'temperature check' on how people are feeling about the vaccine
- A broader piece of engagement activity about how people are feeling about the vaccine to ensure we are reaching our diverse communities and protected groups within Calderdale
- Patient experience activity on peoples experience of receiving the vaccine
- To gather people's views and experiences we understand that a survey is not always an appropriate tool, so we also asked people to share their stories and experiences.

Number of responses we received from the different methods of involvement were:

- Talk back panel - A short engagement activity of two weeks to enable a 'temperature check' on how people are feeling about the vaccine. This survey will capture the views of the public through the Councils Talk Back Panel. The survey aims to capture people's views around the vaccine including why it's important to them, what would stop them from receiving the vaccine. Each respondent will also be asked to complete an equality monitoring form. 424 questionnaires were returned.

- Understanding your views survey **-** Broader engagement activity to ensure we were reaching all people living in Calderdale from all demographics and protected groups. Communities that have been most impacted on by COVID, including those living in deprived areas, Black, Asian and Minority Ethnic (BAME) groups, shielding and vulnerable groups. Those with the highest occupational risk and people who may be socially excluded such as our homeless population, asylum seekers and people with learning disabilities**,** The survey aims to capture people's views around the vaccine including why it's important to them, what would stop them from receiving the vaccine. 482 responses in total over a period of approximately eight weeks.
- A large proportion of the insight we have received has been from voluntary and community organisations, including:
    - Temporary accommodation providers and support services for homeless people
    - Support services for asylum seekers, where pop-up vaccination clinics and Q&A sessions have also taken place
    - Forums of parents and carers of people with disabilities
    - Care providers facilitating respite for unpaid carers
    - Support groups for Asian women with mental health issues
    - Forums for people over 50, and organisations that support them
    - Organisations supporting Black and African communities
    - Organisations supporting older lesbians in Calderdale
    - Reference group of young people aged 0-25 with Special Educational Needs or Disabilities
    - Groups of college students through Healthy Futures (Public Health) project
    - Local youth workers
    - Organisations providing support, information, and advice to unpaid carers.
- Patient experience survey – over 500 responses to date
- Engagement predominantly through the Covid engagement champions and engagement champions through the voluntary community sector – through these routes there are approximately 148 engagement champions (43 engagement champions representing 23 organisation 105 COVID Champions)

What did they tell you?

This engagement is ongoing due to the nature of the vaccination programme and focusses on different cohorts as the programme moves forward. Themes that we have heard so far include:

- Younger cohorts: more suspicion around the COVID pandemic and what some believe are ulterior motives behind the vaccine programme. Further concerns heard around fertility, and the barriers presented by work. Feedback from several different sources suggests that younger cohorts want to weigh up the potential risks of being vaccinated vs. not being vaccinated, as they perceive the risk of becoming seriously ill from COVID to be lower to them.
- Fertility and maternity - concerns around the long-term effect of the vaccine on fertility, on pregnant women and women who are breastfeeding, particularly from young Asian women. Several comments that guidance is confusing or difficult to access.
- Side effects – concerns around what common side effects and/or allergic reactions are, and how to find reliable information on this. Blood clots following the Oxford Astra Zeneca vaccine are one of the main concerns. Feedback that people feel more poorly than they expected to be following the vaccination.
- Validity of the vaccine – small groups of people who believe they do not need the vaccine as they are not at risk (people in their 20s/30s), or that the virus simply does not exist.
- Understanding the vaccine – many people do not know how the vaccine works or what is in the vaccine.
- Allergy clinic – some people at risk from anaphylaxis are struggling to access the allergy clinic, which is presenting further issues as shielding has lifted and the need for vaccination becomes more pressing.

What did you do?

The findings from the engagement were summarised in a fortnightly insight report, which was shared with the following groups:

- COVID-19 Community Engagement Task and Finish Group
- COVID-19 vaccination programme board
- Primary Care Network vaccine delivery meeting

- Calderdale COVID-19 Vaccination Communications, Engagement and Equality Group

In addition, the report was shared by partners to share within their own organisations.

Actions and targeted work arising from engagement includes:

- Pop-up clinics set up to better meet the needs of those who were more at risk of becoming seriously ill with COVID. These included:
    - The Gathering Place, for homeless or otherwise precariously housed
    - Madni Mosque
    - Elland mosque
    - Hopwood Lane mosque
    - St Augustine's, for asylum seekers, refugees, or others in contact with the service
    - The Basement Project, for those in recovery from substance use or alcohol dependency
- National campaign developed to promote vaccine through social media
- Fact sheets and resources developed by West Yorkshire and Calderdale CCG and made available to the public containing information on the vaccines, side effect advice, fertility, and lots more
- Q&A session planned in partnership with Women's Interfaith group, to provide information on vaccination and fertility/maternity
- Q&A session for St Augustine's to provide information in community languages – received feedback that this had changed several people's minds

A mapping exercise from all the intelligence we have gathered took place. All feedback will be used to further inform and shape the current model for the vaccine and inform consistent and accurate information on the vaccination programme moving into phase II of the programme. A public version of the mapping exercise 'you said, we listened' will be developed to share with the public who have taken the time to share their views and experiences.

Where can you find more information about this work?

This work is still ongoing, a report of the findings from the engagement will be produced at the end of this work. If you would like further information on this work please contact the CCG on CCG.FEEDBACK@calderdale.nhs.uk

NHS Calderdale Clinical Commissioning Group (CCG)

The impact of Coronavirus (COVID-19) on people's experiences of health and care services living and working in Calderdale

June – August 2020

In March 2020, Coronavirus (COVID-19) began to significantly impact everyday lives of people across the UK. There has been a significant impact in the way people live their lives and the way they access health and care services. In these times of unprecedented change, brought about by COVID-19, to the way people live their lives, and the way that health and care services are provided, it is essential for our health and care systems to understand how these changes are impacting the people of Calderdale.

Who did you engage or consult on and what did you ask?

We wanted to know what people's experiences of health and care services have been during this time and what the impact COVID-19 has had.

We need to understand people's experiences of using health and care services pre COVID-19, what worked well, what didn't and what were the challenges/difficulties people faced vs during covid-19, what being done differently now and what do people think of those changes? And understanding how we can plan for the future by learning from those experiences, what's working well, what do we need to keep, what do we need to expand or develop and what do we want to stop and why?

The key audiences and communities for this engagement were:

- All people living in Calderdale who are accessing health and care services
- Voluntary and community groups
- Staff from all health and care services including hospital, community, and primary care
- Key partners and stakeholders

The purpose of the engagement was to gather views, experiences and ideas from people living and working in Calderdale who have direct experiences of health and care services

during these unprecedented times and also the impact that COVID-19 may have had on them and their families and communities.

We also need to understand:

- How people are accessing, gathering, and using information about COVID-19 and the way health and care services are working
- Where people are facing difficulties or barriers in accessing both routine and urgent care, and how these could be overcome

This report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities and Black, Asian and Ethnic Minority (BAME) groups. The document also presents the views of health and care staff living and working in Calderdale.

What did they tell you?

This feedback will be used to inform and shape future health and care services which meet the needs of local people across Calderdale. We also want to enhance and develop our link with communities and support them to recognise the value that they are adding.

Four main key themes were identified below; feedback was mixed for all of these themes, with many people appreciating the necessity for change during the pandemic but feeling that their experience could have been improved.

- Access to services – covering limitations to face to face access, service closure and telephone access
    - People found access generally easier and more efficient during this period and some mentioned that they preferred telephone access with their GP practice, saying that it was quicker, less time-consuming and removed the risk of getting COVID
    - Many people had difficulties getting through to services by telephone which led to some frustration. For various reasons, some people struggled with telephone appointments, in particular if they couldn't explain their symptoms or if English was not their first language. With many people being asked to call rather than

visit, phone lines were often reported as engaged or unanswered. Telephone contact proved most difficult when people were trying to contact their GP practice.

- Some people felt they could have received better information about how services could be accessed earlier on in the lockdown, although it's recognised that the pace of change would have made this difficult. And people said they were confused by the changes and found the system difficult to navigate

- Digital access – covering the use of online booking systems and video call appointments
  - Most comments about digital access mentioned telephone calls, video calls and online appointments, most of these comments were about digital access to General Practitioners (GPs)
  - People appreciated the technology driven appointments but many experienced issues with the transition from face-to-face to online care, and sometimes this prevented them from accessing the services they needed

- Communication between staff and patients – covering the lack of information that has been made available about how services have changed, and missed opportunities to interact with people
  - Many of the comments about communication indicated that people struggled with communicating with health and care services during this period. People commented on communication challenges around arranging appointments, service changes, the absence of a real person with whom to communicate, anxiety, the fragmentation of services and barriers
  - People wanted to see improved communication from health and care services in general; this included better quality information being sent out to the public, some individual contact with people receiving routine care, and someone with whom they could discuss their queries.
  - People also wanted to be able to communicate with a real person. Some people would have been satisfied with speaking to a real person over the phone whilst others stated they wanted face-to-face contact.
  - People commented on the lack of integration between services and stated that services working together would have improved their situation greatly.

- Quality of care – covering person-centred and flexible support
    - Gratitude to health and care professionals trying to deliver good quality care and person-centred support in very challenging times.
    - Issues included delays in support for pregnant mums, difficulties getting medication or medical checks, lack of support for people needing support from carers at home, and problems accessing dental services.

The report shows that people have had mixed experiences accessing health and care services, both in-person and through digital means. The work undertaken by Healthwatch Calderdale also highlights issues in communication between healthcare staff and patients, and the quality of care delivered. Regarding respondents' mental health the report suggest that experiences have been mixed, with many people struggling due to the impacts of the COVID-19 pandemic, and others seeing an improvement in their emotional wellbeing during lockdown.

What did you do?

The intelligence gathered as part of this engagement process is invaluable to every area of the CCG, as describe in NHS Calderdale CCG's response to the health and care experiences of people living in Calderdale during Covid-19 outbreak thanked Healthwatch Calderdale for leading on the delivery of this report, while working in partnership with the CCG, Calderdale Council and voluntary and community organisations working across the area.

The health and wellbeing of the people of Calderdale is at the centre of everything we do as an organisation, and we are fully committed to listening and taking into consideration the views of the people we serve. We would like to thank everyone who has taken time to be part of this engagement and share. People's views really matter to us, and we will use the information put forward in this report to improve current health and care services in Calderdale, and to inform those planned and implemented in the future.

We have already begun conversations with GPs relating to phone accessibility. Although required at the time, we also recognise that restricting the number of settings in which face-to-face appointments with clinicians were available has been a barrier to some in accessing care. All Calderdale GP practices are now offering face to face appointments where clinically

required, at one or more of their sites. This means most patients will be seen at their normal practice building where appropriate, following a clinical assessment.

At the beginning of the Covid-19 pandemic, GP practices reviewed their processes for drug monitoring and administration of some medicines to reduce any non-essential face to face contacts. Changes were made in-line with national and local specialist advice, for example changing vitamin b12 injections to tablets for appropriate patients. Clinicians in practice moved to providing routine medication reviews and care via the telephone or video link.

We are committed to working in partnership with our providers, partner organisations, staff, public, patients and carers and by understanding and reflecting on all the responses received in the report we will ensure this work remains a priority for the CCG.

Where can you find more information about this work?

A report of the findings from the engagement was produced in August 2020. This report can be found on the CCG website www.calderdaleccg.nhs.uk/covidsurvey/

NHS Calderdale CCG

Enhanced Health in Care Homes (EHCH)
March 2020

Who did you engage or consult on and what did you ask?

The Framework for Enhanced Health in Care Homes (March 2020) sets out a framework, detailing practical guidance and best practice for CCGs, Primary Care Networks (PCNs) and other providers and stakeholders to work collaboratively to develop a mature EHCH service. As part of this work, Calderdale CCG and five PCNs held online engagement workshops with stakeholders to agree a model for multidisciplinary working and 'ward rounds' that would improve the health and wellbeing of people living in care homes, and how to best implement it across Calderdale.

The stakeholders involved in this engagement/dialogue were health and social care professionals from: care homes; the CCG; PCNs; Calderdale Council; CHFT and SWYPFT.

The aim was to ensure the model would help improve the physical health and wellbeing of people that live in Calderdale care homes. We asked them if they had comments/ideas on the proposed model, using their knowledge and experience

We presented new ways of working and new roles that would be there to support care homes, how they would envisage working with them and how to best approach this, for example working with the: care coordinators, PCN GP support, pharmacists; weekly ward rounds; Calderdale Council Business Relationship Managers, and ensuring they know who their identified support people would be (i.e. lead clinician, community nurse) to ensure there was swift access to clinical support and proactive care management.

Due to the COVID-19 pandemic, the workshops all took place online, and enabled staff from the various organisations involved in the care of people who live in care homes, to discuss the new multi-disciplinary ways of working, with the aim of improving quality of care for care home residents. Stakeholders could share their vast knowledge, experience and ideas to develop the model, and this also ensured they were involved in, and familiar with the new future ways of working.

What did they tell you?

Open dialogue with stakeholders took place to agree the model, new ways of working and to collaborate as a system for the benefit of care home residents. As part of the model, it was agreed that all care homes in Calderdale would have access to this service, so all older people's care homes (nursing and residential), learning disability, and mental health care homes would all have access to this new way of working

As outlined in the 'The Framework for Enhanced Health in Care Homes' (March 2020), the EHCH model has three principal aims:

a. delivering high-quality personalised care within care homes;
b. providing, wherever possible, for individuals who (temporarily or permanently), live in a care home access to the right care and the right health services in the place of their choosing; and
c. enabling effective use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes.

The engagement workshops with partners, were the initial vehicle for implementing the EHCH model in Calderdale, which will support working towards achieving the elements of the model:

1. Enhanced primary care support
2. Multi-disciplinary team (MDT) support including coordinated health and social care
3. Falls prevention, Reablement, and rehabilitation including strength and balance
4. High quality palliative and end-of-life care, Mental health, and dementia care
5. Joined-up commissioning and collaboration between health and social care
6. Workforce development Training and development for social care provider staff
7. Data, IT, and technology

What did you do?

Continuous dialogue between stakeholders to ensure the model is working and benefitting residents in care homes.

Daily communication between care homes, care coordinators and the Calderdale Councils business relationship managers. And working with the five Primary Care Networks on any challenges and successes to continually improve the model and new ways of working.

We will know the model is working by the health outcomes for residents in care homes, such as:

- reduced unplanned hospital attendances and improved health and wellbeing
- proactive and personalised care management of residents - health professionals getting to know the residents better
- personalised care plans being in place - residents and their families have had discussions and input to the care they receive, and their wishes are met

Where can you find more information about this work?

This work is still ongoing. If you would like further information on this work please contact the CCG on CCG.FEEDBACK@calderdale.nhs.uk

NHS Calderdale CCG

Hospital Reconfiguration (Right Care, Right Time, Right Place)
May – June 2020

Transformation of the current model of service delivery of hospital services in Calderdale and Greater Huddersfield in order to ensure the delivery of consistently safe, high quality care to all patients by meeting hospital standards and delivery of care in the most appropriate and cost effective setting to meet patients' clinical needs. Public Consultation was completed in 2016. In December 2018 the department of Health and Social Care awarded funding of £169.5m to support the transformation of care in Calderdale Royal Hospital and Huddersfield Royal Infirmary. The programme is currently developing the detailed design.

Who did you engage or consult with and what did you ask?
In May/June 2020, Calderdale and Huddersfield Foundation Trust (CHFT) engaged colleagues and the public to listen and learn about the transformational changes as a result of the Covid19 pandemic and to ask about their aspirations for future service delivery. These were held across all clinical and non-clinical CHFT services, with external partners (Primary Care Networks, Locala, Local Authorities, YAS, SWYPFT, CCGs) and the public. The engagement involved a series of digital Teams meetings and an email portal. A public and patient electronic survey was also undertaken. The survey questions were developed with advice provided by Healthwatch and the survey was distributed; by direct text and email to all patients that had been contacted during the pandemic; by email to Trust volunteers and members; via social media (Facebook and Twitter). A telephone number that people could call if they required support to complete the on-line survey was also provided. 185 Trust colleagues, 1,234 members of the public and 8 partner organisations, participated and contributed.

Following further work on the Design Brief, building on that engagement, members of the public across the communities of Calderdale and Greater Huddersfield are being invited to share their views on the new developments proposed in advance of planning applications being submitted to the local councils of Calderdale and Kirklees in May.

The following methods for involving local residents and stakeholders to comment on the design and building plans are being used:

- Provision of a dedicated website to view plans and comment;
- Leaflet drop to all resident households (provided in multiple languages) in proximity to CRH and HRI to provide information and ask for comments to be posted on website;
- Social media messages to provide information and provide link to website to comment;
- Information banners and posters in CRH and HRI providing information of website to access to find out more detail of plans and comment;
- Press releases to encourage people to comment with link to website;
- Internal CHFT communications via bulletin and website – recognising many people that work at CHFT live locally.
- Messages sent to all stakeholders and community groups including Healthwatch to encourage responses.

All the details for the new proposals for both hospitals are available on the CHFT Future plans website: www.chftfutureplans.co.uk

What did they tell you?

There is a shared appetite to sustain and further develop new integrated community models of care and to accelerate this through the use of digital technology across health and social care.

Across primary, community and hospital services digital or telephone appointments have been the first option during the pandemic for patient access with face to face appointments only available for urgent care. Generally, members of the public have found this a positive experience. In taking forward this model the risk of digital exclusion and the negative impact this could have on people already experiencing significant health inequalities has been identified

During the pandemic restrictions have been applied to limit hospital visitors. Digital options have been made available and there is support for these to continue in the future and potentially could have wider applicability in other care setting such as care homes. A number of benefits have been identified in relation to social distancing and also that friends

and family who may be geographically remote can keep in touch and support patients. Future plans for hospital reconfiguration will need to consider the provision of digital access points at each bedside to enable remote visiting.

Further themes in relation to: Direct assessment pathways; Workforce and organisational development; Working from home; Needs based prioritisation; Clinical communication; virtual multi-disciplinary team (MDT) meetings and education; Theatre productivity; Pathology; Estates and Facilities; and Preventative Care were also identified

What did you do?

The findings from the May/June engagement have been incorporated into an updated Design Brief for each site building on the Design Brief previously developed to incorporate opportunities for improvement and accelerated transformation in some areas. This will also ensure that further design elements that take account of best practice in building design regarding infection control and prevention are included.

The findings from the engagement in March 2021, will be considered alongside engagement with other partners/stakeholders and statutory consultees and will be used to inform the design development discussions at this stage of the process and will also play a key part in the detailed design development at future stages. Feedback on the design of the proposals will be used to inform the final designs in a ‘Design and Access Statement’, which will be submitted with the planning applications.

Where can they find out more info about this work?
The Updated Design Brief together with the report on Business better than Usual were published with the papers for the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee meeting on 19th March 2021.

The details for the new proposals for both hospitals are available at the CHFT future plans website: www.chftfutureplans.co.uk

NHS Calderdale CCG

Share and learn events – learning disabilities
May – June 2020

Who did you engage or consult with and what did you ask?
In recognition of the impacts of COVID-19 and to gain a wider understanding of how we can support people with a learning disability and those who work with them a "Share and Learn" event was held in January 2021. The events were a partnership approach between the CCG, local authority, the third sector and South West Yorkshire Partnership Foundation Trust (SWYPFT) along with organisations who provide services for people with a learning disability in Calderdale. This included 24hr care / day services and domiciliary care.
Over 40 people attended the event.

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

What did they tell you?
Some of the key themes from the feedback including questionnaires and workshops are below:

- Digital inclusion – Ensuring staff access to equipment and knowledge of how to use it. Using digital support to offer bespoke learning disability services. Guidance, training and policies of using social media

- Health Checks – Carrying out the health checks in peoples own environment so that they are relaxed and feel safe. Rolling out this way of working in other areas of the service. Working with other colleagues who can help with providing support in delivery health checks
- Supported decision making – Ensuring people have the tools they need to be able to make informed decisions. Ensuring the right people are involved such as families / carers, other professionals
- Wellbeing – Sharing and learning from the great work everyone is doing. Focused communication. Staff networks between different services

What did you do?

All feedback was collated and shared with those who attended at the workshop and an action plan developed and a further event was arranged to share feedback and agree next steps.

Informal share and learn sessions will continue and be arranged on a quarterly basis to ensure oversight and ownership of the action plan

All feedback has also been shared with Learning Disability partnership Group.

Where you can find out more info about this work?

If you would like further information about this work, please contact Sarah Antemes at sarah.antemes@nhs.net

Calderdale and Huddersfield Foundation Trust (CHFT)

Cancer - Quarterly Patient Focus Group

August 2020

Who did you consult with and what did you ask?

The Cancer Management Team with the support of the Macmillan Cancer Information Service engaged with the CHFT Cancer Patient Focus Group. Technical support was given to patients and carers over several days to enable the group to meet via Microsoft Teams.

In August 2020 one of the quarterly patient focus groups was used to discuss the impact COVID-19 on cancer patients.

What did they tell you?

Impact of COVID-19 on Cancer Patients

Some of the positive comments included:

- Little impact on cancer treatment in the Trust –those present, hadn't had any treatment delayed and some present had been diagnosed and started treatment during the pandemic.
- All spoke highly of the chemotherapy nurses and the dedicated, friendly support they had provided throughout the pandemic - 'absolutely brilliant, caring, lovely' and 'just got on with it'
- Felt very safe coming into both hospitals and reported that they felt safer at the hospital than in other environments, including home.
- Grateful to their consultants for keeping in contact via the phone / video appointments and face to face appointments over the last few months.
- Support groups run virtually from the Macmillan Information Service have been extremely useful, 'amazing' and have kept people going through lockdown and self-isolation, as well as helping people feel connected.

Some of the negative comments included:

- Not everybody has access to the technology needed for video calls and virtual support groups / courses.
- Very difficult not being allowed to take a family member onto the chemotherapy ward.

- Not being allowed to visit patients on ward 12 has also extremely difficult.
- Lack of information re cancer psychology services on diagnosis.
- More information required about the First Steps Cancer Programme for newly diagnosed patients - needs to be much more advertising, as well as staff signposting patients to it.
- Patients reported it is easy to feel forgotten if you are not currently receiving treatment.
- Patients feel odd and unsupported when cancer treatment comes to an end.
- Isolation due to the pandemic has been extremely difficult for patients and family members.
- Patients (and some consultants) are missing hugs – which are often needed when bad news is given.
- 'Communications during Covid have not been great, with just a letter postponing treatment and another postponing it again'

Specific Feedback about Appointments:

- Grateful to have received face to face appointments to receive bad news, rather than being given a phone call – this 'was done perfectly.'
- Considered video calls better than telephone calls, but not as good as face to face conversations in person (though they understood why these were reduced).
- Good experience reported with video calls and many felt that these were preferred to telephone calls, where patients felt as though staff had less time and a long list of other people to call.
- Some patients said they may not ask as many questions or open up as much on the phone, compared to a face to face conversation or a video call.
- People were happy to be able to have appointments in the comfort of their own home – felt more relaxed. Virtual appointments felt like the norm for newly diagnosed patients who were operating online for work/socialising etc.
- Some patients have liked the regular face to face contact with staff e.g. chemotherapy nurses.

What did you do?

Patient and Family Member Recommendations:

- All patients to be given a named Clinical Nurse Specialist on diagnosis / made aware of who this is (with contact details).
- More information and conversations to be provided early on in the cancer journey – not just a lot of booklets – including information about support services available.
- More video appointments should be offered where possible – these are preferred to telephone calls if patients have the technology.
- New diagnoses not to be given over the telephone – requires a video call or face to face appointment. To also include patients receiving scan results.
- Cater for patients who do not have the technology to join virtual courses / support groups / video calls etc
- Involve staff from other parts of the hospital in the cancer patient focus groups – e.g. a urologist / colorectal surgeon / ENT specialist (those dealing with cancer) not just oncology.
- Increase the advertising across the hospital of things like First Steps and support groups – on ward 12 at HRI, in outpatient departments, ENT, urology etc.
- Maintain contact with people no longer receiving treatment (or being treated elsewhere) e.g. with the Macmillan support groups.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in August 2020. This report can be found on the CHFT website in the Macmillan information section of the oncology page

Calderdale and Huddersfield Foundation Trust (CHFT)

Cancer - Patient Focus Group co-designing cancer support programmes
Summer and autumn 2020

Who did you consult with and what did you ask?

The Cancer Management Team with the support of the Macmillan Cancer Information Service engaged with the CHFT Cancer Patient Focus Group. Technical support was given to patients and carers over several days to enable the group to meet via Microsoft Teams.

During the summer and autumn of 2020 members of the CHFT Cancer Patient Focus Group participated in two events to co-design the strategy and content of the Virtual Cancer Health and Wellbeing Programme.

What did they tell you?

For the 'First Steps' – Newly Diagnosed Cancer Patient Health and Wellbeing Programme, the suggestions were:

- Videos to watch
- Information to read on website
- Chance to send questions in advance
- Online discussion group to talk through the content
- Option of 1:1 follow up call afterwards

For 'Thinking Ahead' – this is a Health and Wellbeing Course for people living with incurable cancer:

- Patient & Staff recommendations:
- Closed patient/family group via Microsoft Teams – no content to be viewed beforehand due to sensitive nature of content
- Mix of pre-recorded and live presentations on topics with presenters there for discussion/ questions on each topic
- All usual staff involved – hospice staff/ psychologist/exercise professional/dietician/ estates planner/chaplain/End of Life trainer/Macmillan Info team/OT for fatigue advice etc
- Usually held over three afternoons with 10 -12 topics – patients suggested one or two virtual sessions per week over a six week period – each approximately an hour

What did you do?

All of the above. The evidence of the output is available on the CHFT website: www.cht.nhs.uk/services/clinical-services/oncology/information-support/first-steps through the webpages patients and family members are able to book on to any of the virtual Health and wellbeing offerings.

Where can you find more information about this work?

No formal report was written. A presentation was written and presented at an NHS England showcase event (Shining a light on co-production) to highlight the virtual nature of the Health and Wellbeing Programme and more importantly the co-design of the strategy and delivery with CHFT Patient Focus Group. For further information please contact Christopher Button, Lead Cancer Nurse (Christopher.Button@cht.nhs.uk) or Helen Jones, Macmillan Cancer Information Manager - Cancer Support (Helen.Jones23@cht.nhs.uk)

Calderdale and Huddersfield Foundation Trust (CHFT)

Outpatients Transformation

April 2020 – March 2021

Outpatients transformation has an overview on a number of projects, but the engagement described has been in relation to remote appointments and to seek views from patients and wider stakeholders about how CHFT services could be delivered in the future.

Project 1: Experience of contact with CHFT during the early stages of the covid pandemic, including how services could be delivered in the future

Who did you consult with and what did you ask?

The stakeholders were patients, their families, staff, specific support groups (for example the BAME network at CHFT) and organisations/charities that support patients.

Due to covid restrictions it wasn't possible to attend clinics and speak to patients face to face, so an online survey was used. The survey covered the period 15th March to 15th June which covered the period of when the changes to services due to lockdown commenced. The survey was shared through social media channels, emailed to patients who had had a video appointment, sent by text message to circa 24,000 patients who had telephone or face to face appointments during the 3 month period, sent by email to CHFT members, volunteers and representative groups. It was also shared via Healthwatch and by the CCGs engagement teams.

The information sent out also included a telephone number that people could use to complete the survey over the phone if they were not able to or did not wish to complete it online.

The survey was split so that people who had used our services since 15th March 2020 could comment on their experience and they were also asked what had influenced their comments, for example travel, conditions in waiting rooms, ease of access, choice and parking. If people hadn't used our services, they were just asked questions about how they would like services to be delivered in the future.

What did they tell you?

- Appointment options
  - Patients liked being able to access / use remote patient appointments as they felt safe at home – felt these options should continue to be offered in the future
  - Important to take into account patient choice and need. Telephone or video might not always be the best option for the patient
  - 87% of those who received a telephone appointment said they would have one again
- Experience of Trust communications
  - Understood the reason for appointment delay or amendment
  - Felt it would be useful to be informed of situation and updated in relation to appointments in a timely manner
  - 88% reported the contact call as being handled well and sensitively

What did you do?

New Clinical Prioritisation Buddy roles have been introduced to support communications with patients. The Buddies are working directly with specialties in the hospital and their role is to keep patients informed and updated. They also provide a point of contact for patients with concerns.

Feedback on patient experience was shared with the Appointments Centre for them to include in training with their staff. The feedback as a whole was fed through the Outpatients Transformation Board to share with specialties. It has also informed projects that have started in the outpatient transformation since the survey was completed.

Continued to offer remote patient appointments, both telephone and video and dedicated clinics have been put in place for these appointment types so they will continue post covid. Views of the clinicians delivering the appointments have also been sought to find out if there are any issues for them that might impact on the offer to patients.

Where can you find more information about this work?

Further information about CHFT video appointments can be found on our website : www.cht.nhs.uk/patients-visitors/your-video-appointment

Project 2: Video appointment engagement

Who did you consult with and what did you ask?

Video appointments (2020)
The stakeholders for the video appointment engagement work were CHFT patients.
Two small pilots for video appointments at CHFT had already commenced prior to March 2020, however, because of the first lockdown the video appointment service had to be developed very rapidly. This required testing with patients and over the course of a week in March volunteer test patients were sought from CHFT staff, volunteers, the BAME network, patients who had previously been involved in testing and specific representatives including our Learning Disabilities Matron. The test patients were sent a draft information leaflet to guide them through how to participate in a video appointment and a test appointment was booked for them. The test patients were also given a contact number to ring if they had any issues or needed some support. Use of this number also formed part of the testing process.

'Andor' pilot (2021)
As with the previous video appointment engagement the stakeholders were CHFT patients.
The 'Andor' pilot, from a patient point of view, is testing sending out appointment information and links to join a video appointment via a text message as well as by email and to remove the need to download Microsoft Teams prior to the appointment if using a smart phone or tablet. This development is based on patient feedback asking for a text message option to invite them to their appointment instead of or as well as email. Prior to commencing the pilot engagement took place with test patient volunteers to try the process and provide their feedback before going live with 'real' patients for actual appointments.

For the testing process participants provided verbal feedback during their test appointment and also completed a survey. During the pilot, following each 'Andor' video appointment, the patients were sent a survey to complete to provide their feedback.

What did they tell you?

Video appointments (2020)

- Information leaflet
  - too many steps and didn't flow easily
  - Should be available in other languages
  - Device specific information would be helpful
- Email received when video appointment was booked
  - Would like contact details for the service / specialty that the patient would be accessing
  - To include a reminder of how to access video appointments
- A video to explain how to download Microsoft teams would be useful
- Needs to be ability to include both spoken language and sign language interpreters

'Andor' pilot (2021)

- Information
  - A lot of detail when logging into appointment but understood what to do
  - Not clear that this was from Calderdale and Huddersfield NHS Foundation Trust
- Email/Text message
  - Clear what message was about
  - Liked that they received a text message as well
  - Option to click for further information including a video was helpful
  - Did not include clinician name so if had multiple appointments wouldn't know which was which
- Inviting a family member/carer
  - Liked the ability to invite someone to join the appointment, as it meant they could invite relatives in other areas and could have support even in lockdown.
  - Not always clear how to invite people

What did you do?

Video appointments (2020)

Test patients provided feedback on their experience. Whether they understood the instructions, any issues they had ~~had~~ experienced and how they felt the experience could be improved. This feedback was then used to amend the process and provide more information that the test patients suggested would have improved their experience.

The information leaflet was changed and made much simpler, with easy read language and clear pictures. The information sent to patients via an email when the appointment was booked was amended to provide clear concise information, a link to the CHFT Friends and Family Test survey and a link to a dedicated webpage that included the information leaflet in the 6 most requested languages, but also and some short videos explaining how to access the appointments from different devices.

A process was developed and agreed with our interpreting providers to include both spoken and British Sign Language interpreters in the appointments.

The letters to patients who are offered a virtual appointment, give the advice on how to get in touch if they are unable to access an appointment virtually for any reason.

The comments and feedback received in relation to video appointments via the Friends and Family test is also reviewed and used to continually evaluate the processes.

'Andor' pilot (2021)

As a result of the testing the wording on the email and text message was amended to make it clearer that it was from CHFT. Working with 'Andor' to ensure the clinicians name is also included so patients know who their appointment is with and which condition it relates to if they have multiple appointments.

Where can you find more information about this work?

Further information about CHFT video appointments can be found on our website at www.cht.nhs.uk/patients-visitors/your-video-appointment

Calderdale and Huddersfield Foundation Trust

Children & Young People's service
February 2020

Co-designing d a vision for children and Young Persons Charter with input from the CHFT Youth Forum and nursing staff

Who did you consult with and what did you ask?
Around 20 children from a variety of different ethnic groups and ages were involved, they were asked to give their opinions openly and honestly.

The Youth Forum was already established, this was the 2nd meeting and it was felt that a relationship had been built within the group to start this conversation.
A simple question was used of "What is important to you?"

What did they tell you?
The feedback highlighted 3 key themes for the 'Charter':

Communication:

- Read my notes to know me
- Consider my needs other than my health
- Put yourself in my shoes
- Explain things to me in a way I understand taking into account my age and what I may already know about my condition
- Listen to me and my family
- Include me in my discharge planning and please don't rush it, especially if I need medicines.
- Keep me up to date and make sure I understand
- Get the message right the first time it is told
- I need to know where I am, where I am going and who I'm going with.
- Be informative and introduce yourself - this may help my anxieties (mental health)
- Consider that I matter in planning my care

Environment:

- Please keep it quiet at night
- Please make sure I have enough to eat and drink, and have snacks available considering my dietary needs
- Even as I get older, I get bored, make sure there are things for me to do. TV Nintendo, books etc.
- Make my room more 'homely' not plain walls, blinds etc comfy chairs and blankets would be good
- Drop-in sessions from CYP support groups e.g. Asthma, Diabetes
- Group activities and social activity events
- A quiet space
- Information boards and use of videos/games to explain things to me
- Try and make sure my appointment runs on time
- Pet therapy dog
- Comfy parent beds

Staff

- Try and keep some continuity of staff
- Tell me who my key contacts are
- Be visible- I may be frightened
- Try to get things done in a timely manner
- Clear name badges with job roles are helpful
- Like rainbow/child friendly lanyards
- Prefer staff uniforms as they are
- Regular contact until I feel confident with what I'm doing
- Good staff that know you and build up 'friendships'
- Trust in staff

What did you do?

Feedback received from the engagement was used to design the charter to create a new vision for Children's Services at CHFT, in a language that Children and Young People understand: 'We will look after you and your family, making sure you are treated well, kept informed and reassured, so you can trust and rely on us'. This has been approved by the

Trust's Paediatric Forum, shared via the Children's Directorate and across the wider Paediatric team.

The Trust has appointed a Lead Nurse for Children and Young People, with a portfolio for the Voice of the Child across the Trust and uses the messages directly from the Children & Young People to promote this.

There have been various developments, that have been undertaken in response to the priorities within the Charter:

- Introduction of child friendly name badges
- Purchase of new parent beds
- Increased focus on mental health: including improved risk assessment / care plans and daily professionals' meetings between CAMHS and the Children's ward to support young person's pathway
- Young person's input on behalf of the Trust in the National Confidential Enquiry into Patient Outcome and Death (CEPOD) study 'Transition
- from child to adult healthcare services. Includes involvement in focus groups to help determine what patters to young people in the process of transition
- Introduced ward-based sleep champions including the promotion of 'QUIET TIME' to help rest, sleep and heal

Further opportunities will be taken during 2021/22 to monitor feedback against the priorities and to work with the Forum members to evaluate the impact of the changes to date.

Where can you find more information about this work?

No formal report was written. The plan was to share face to face at the following Youth Forum, due to the pandemic the meetings were put on hold. As such the findings were shared with the young people via the email contacts.

For further information please contact Julie Mellor, Head Nurse - Children and Young People: julie.mellor@cht.nhs.uk or Louise Riby, Matron – Paediatrics Louise.Riby@cht.nhs.uk

South West Yorkshire Partnership Foundation Trust (SWYPFT)

Reform of Mental Health Act (MHA) engagement
March 2021

The Government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme for the transformation of mental health care England has ever known. This reform has been described as a central in the delivery of the NHS Long Term Plan. The aim is to ensure two million more people receive high quality mental health services by 2023 to 2024. The reforms are set to make changes from primary care to specialist community teams, in some schools and colleges, in accident and emergency departments, and in crisis and in inpatient settings. This work builds on the Five-Year Forward View for Mental Health which will deliver services to one million more people by April 2021.

Who did you consult with and what did you ask?

To raise awareness of the national consultation a presentation and paper were circulated at several internal groups and committees. Staff attending were asked to respond directly to the consultation or await tools which could be shared with both staff and those using or volunteering in our services including families, friends and carers. The aim of the engagement was to provide an opportunity to collate a Trust wide rather than individual response. The Trust wanted to ensure that as many people as possible had awareness of the consultation and an opportunity to respond.
The tools created were:

- An information sheet on the reforms
- A presentation to promote the purpose of the reforms
- 5 short videos produced by the legal team to simplify and explain the proposed reforms

For each reform a specific set of questions were asked. The engagement team acted as a central point for feedback. Once all feedback was gathered an insight report captured the responses.

What did they tell you?

The summary of findings under each reform heading are set out below:

Change in criteria for detention:

- Recording the therapeutic benefit was felt to be the right way forward but there is a need to understand who determines the level of what is significant, serious, likely harm and how it is recorded.
- Use of term ‘substantial risk of harm to person or other individuals may mean the MHA is used less frequently. As a result, there will need to be clear and precise guidelines in place to be able to gauge ‘substantial risk of harm’. This will necessitate replacement strategies to ensure the safety and welfare of those involved who do not meet the new definitions in the MHA.
- The subsequent safety net will need to be strengthened and defined as a result.
- Concern that the change might make it harder to get help and be hospitalised when the service user or family/carer felt they were unwell to the point of hospitalisation.
- None felt that discharges would happen sooner and stated there should be much more provision in the community, to be detained seems too severe.
- Some felt this change would make it more difficult to get help and may encourage people to go to the extremes of trying to take their own lives as that is deemed a way to get help.

Nominated person:

- A nominated person was a good change and felt a much better approach than an Approved Mental Health Professional (AMPH) decided nearest relative.
- A nominated person would enable service user choice, would help combat family/cultural/gender ID/sexuality/religious belief/etc. issues and would enable the service user to ensure they trusted their nominated person to act in their best interest
- All felt that the extra powers of the nominated person were a good thing and were in fact key to the role.
- The nominated person needs information and understanding as to the importance of their proposed role before undertaking the responsibility.
- To be able to work closely with the Approved Practitioner when looking for guidance/advice and they have the capacity to make that decision.

- Concern that the person who the service user would deem good, might not be the best person for them and it would be better to have someone with whom the service user has regular contact with.
- Questions around how this would work if a person is homeless and they don't have a nominated person, or they are in a crisis.
- It was asked if there will be appropriate resources be made available to finance this?

Advance choice document:

- Advance choice document was thought to be a good idea, questions around at what stage it would be expected to be done and whether everyone would be expected to have one.
- Some had experience of having a WRAP (Wellness, Recovery Action Plan) and saw many similarities between this and what is intended to be in an advanced choice document.
- Some felt that it would be useful to incorporate more areas of a WRAP and professionals behind any decision making.
- It was felt that regular reviews of the document would ideally be done with the input of the nominated person and should also be available to complete with a GP (if patient gave consent), to help with an all-round care package.

- Areas to be included in the document alongside those suggested were:
  - Anything the service user and nominated person feel should be in it and was important to them.
  - Where their preference of inpatient location would be should they be hospitalised
  - Dietary preferences.
  - Early warning signs to becoming unwell.
  - Measures that they find useful to remaining well (not only medications, but coping strategies and other wellness tools).
  - What they would like to be known by
  - Which ward they would rather be placed on if transgender
  - Cultural and religious preferences

- Need to consider if the person would prefer community outreach instead but concerns around waiting times in community.

- Consideration also needs to be given to gaining two Drs opinion to act in best interest, rather than waiting for court process.
- Clarity was needed, if this document is the same as a DNAR (do not attempt resuscitation) and ensuring that the person has the capacity to make decisions at the time it is written.
- It was suggested that where possibly to choose a member of staff where you can, e.g. someone you feel comfortable with. As an example, a female who has suffered domestic abuse might feel better with a female member of staff than a male.
- Concerns raised about extra time for nurses to complete it and will staff refer to it or override the decisions contained in it.

Statutory care plan:

- The statutory care plan is a good change, especially the co-production.
- A suggestion of a mandatory review with the service user (and ideally nominated person) after a further 7 days, with regular reviews after this should take place.
- Need to be clear that discharge timelines, can be subject to change.
- Some felt that 7 days was too long, a 24-hour plan was suggested to prevent increase in suicides.
- A timeline to acknowledge a way out of the immediate situation and to provide reasoning for the chosen interventions was recommended.
- Consideration to be given to someone who was homeless at point of admission, where would they be discharged to.
- Concern that not all care plans work now and if content will be copied and pasted.
- Suggestion of a one-page profile that people can see immediately rather than expecting people to read a huge document for each person
- Questions raised were will the care plans be available for viewing of the patient and their appropriate nominee, or will it be something that is locked away from view?

Change to tribunal arrangements:

- The automatic tribunal referral after 4 months, 12 months and then every 12 months was a good change.
- Section 2 appeal being extended to 21 days was also a good change.

- Some people were not comfortable with removing the managers review but all felt that if the service user did not wish to go to a manager's review, only a tribunal, then this should still be their choice.
- All were extremely wary of the tribunal panel not meeting the service user and only conducting a paper review/report review.
- All believed that the nominated person should be present also, as this person should know the service user best and therefore know whether they are still presenting as unwell.
- A video-link tribunal was seen as acceptable, if this was the preference of the service user (or time was sensitive, or there was too much of a risk posed to be able to meet the service user/conduct the tribunal face to face).
- To reduce the number of meetings required the better for efficiency, time, and energy for all concerned.
- Meetings to go ahead without service user or nominated person if they have had their say prior to the meeting and have therefore felt they have contributed effectively to their ongoing plan of care and support.

What did you do?

The findings from all the engagement which has taken place will form part of a Trust wide response to the reform consultation. In addition, the insight will be used to support the roll out of reforms and help to identify areas of concern that may require further planned co-development or engagement.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in March 2021.

You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at Home | South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

Capturing patient views of services during the pandemic
February 2021

The Trust response to the pandemic resulted in temporary changes to the way existing services were provided and delivered. In addition, the inpatient service response required some additional demands to working practice, all of which had implications for those using services, carers, families, friends, and staff. A Trust wide approach to capturing feedback during this time was developed to understand the impact of these temporary arrangements.

Who did you consult with and what did you ask?

A trust wide survey tool was developed in partnership with both the patient experience and engagement team. The tool was used to support services to capture feedback from people using services during the pandemic. The participating services were reflective of the Trust. The surveys were aimed at,

- People who use services
- Carers, families, and friends
- Partners and stakeholders

Surveys took place over an 8-month period and included services such as community and inpatient services, services for people with a learning disability and CAMHS. People were asked a range of questions relating to their care including questions on:

- Access to services
- Information and communication
- Digital approaches
- The care and treatment received, and
- Supported self-care

What did they tell you?

The response received from all the survey findings were collated together and a Trust wide approach to identifying the key areas of success and improvement were identified. Each

service area received an individual report of findings. The Trust received over 775 responses during this time. The key overarching themes were:

- Staff had put people at ease and had been very reassuring during this time
- Some people would still have preferred a face to face appointment
- Some people found it easier to communicate by video than phone
- For some digital appointments proved difficulties to see/hear due to the quality of the phone/video call
- There were instances were staff had not listened or communicated as well
- On wards the pandemic had resulted in staff being too busy

Overall, feedback received indicated that service users and carers were satisfied with the service being provided during the pandemic. The Trust received several comments praising staff and the services, including the use of digital solutions.

Key successes:

- Overall, respondents rated communication highly during the pandemic. These include staff introducing themselves, explaining the reason for their contact and making contact at the agreed time.
- Most respondents were happy to receive contact by phone during the pandemic and thought that staff communicated well and gave them enough time to answer questions. Respondents also felt safe, that their privacy and dignity was maintained and that they felt involved in their care and treatment.
- Those respondents that were discharged from services were happy with their discharge.
- Several comments acknowledged the difficult circumstances that staff are working under and showed their appreciation for the care and treatment that they have received.

Key areas from improvement:

- Information provided to respondents in mental health inpatient and Forensic settings scored low
- The support following discharge in Barnsley Community services including care whilst at home and contact from clinicians
- Respondents also rate the explanation following an assessment or outcome as low

What did you do?

There have been 4 Key outcomes so far from the use of this insight. These are as follows:

- Feedback relating to technology has been used to support the revised digital strategy.
- Results have been shared with the Trust internal 'Recovery Group' and are being used to help the Trust restore services following the pandemic.
- The results have been fed into the Trust internal 'Health Intelligence Group' to support ongoing planning and developing of more accessible, sensitive, and responsive health services and health initiatives to meet the needs of the local population.

Individual survey data has been shared with each service and actions so far include:

- Attention Deficit Hyperactive Disorder (ADHD) / Autism Spectrum Disorder (ASD) Service are looking at how remote contact may be used going forward to support service users. They have also adjusted their service user's satisfaction survey to review/ monitor if remote contact is useful for service users and clinicians in the future.
- The Mental Health Act Team have reviewed their results of their survey and considering the responses received have adjusted some of the questions. This survey will continue outside of the scope of this work.
- Due to the number of responses received from CAMHS a project group has been setup to look at how we collect feedback from service users, their families, and carers. The group commenced in November and attendance has grown.
- The Trust Recovery Colleges are using their results to adapt their services going forward to support online learning in the future.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in February 2021. You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

Digital Strategy engagement
November 2020

The new digital strategy takes into account not just the technology required but also the mindset, culture, organisational values, and guiding principles. Traditionally, digital has tended to be the domain of the Informatics function within the Trust. The report presents the findings from all the conversations, events, focus groups and surveys which took place during November and December 2020 on this strategy. The engagement report marks the start of the development of an approach to continued digital engagement, consultation, and inclusion with equality for all at the centre.

Who did you consult with and what did you ask?

The report describes in more detail the engagement activity, including the approach, feedback, and themes for all the insight and feedback. The report sets out what we already know as a starting point with the aim of the approach to add value rather than to repeat conversations. The learning from Covid19 provided a range of feedback on both digital inclusion and exclusion.

The engagement used the following insight and feedback:

- Existing intelligence captured via West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS and Healthwatch colleagues
- Staff feedback
- Feedback from people who use services including the learning from Covid19 across a broad range of services

People were asked to consider:

- What would support digital inclusion
- What exclusions we should consider
- Barriers and solutions to accessing technology
- A review of existing technology and service improvements

What did they tell you?

The key findings below include what we already found out as part of our existing review and the findings from the most recent engagement approach. The findings from both have been considered and this is what people have told us;

What works well for people:

- To use technology for services to be more efficient
- Prescriptions to order online
- Appointments to book online
- Blood pressure monitoring results online
- Information online about conditions/medication/treatment
- Online consultations
- Online conversations could involve more than one health care professional to support complex health needs and integrated working
- Use of Skype, Microsoft Teams, WhatsApp
- Easier to communicate via video than telephone
- Some people prefer face to face appointments, due to quality of call or video
- Access to services digitally when shielding or self-isolating
- Not missing appointments as can access service at home
- Reduced anxiety – not having to travel, being in a clinical setting, taking time off work
- Most people would like the NHS to continue to offer telephone and video appointments after coronavirus restrictions are lifted
- GPs most trusted professionals in using personal data

What needs to be further developed for people:

- People feel frustrated by slow developments to NHS online systems. They'd like it to be easier to access their notes, make all types of appointments, and see their test results online.
- Few people offered video and text messaging support as an option
- People would like to be able to check real-time A&E waiting times online, and to have access to apps that provide support whilst they're on waiting lists.
- Health care providers should continue to give clear and consistent messages to ensure that people know how and when to contact services.

- Some people do not have the confidence to use a smartphone
- Most people were happy to use technology but like the option to phone and speak to someone
- Health professionals need to know about community groups – what they are and what they can do. They can help with technology
- People were not sure how well it works with an urgent care issue and when you need to see someone
- Technology needs to be simplified to support everyone to use
- People worry about the legitimacy of advice on the internet
- Websites are daunting for some and for those who have grown up with visiting the GP they like the fact a GP touches and feels and you which is more reassuring
- Using everything online could make you more isolated and sedentary than a visit to see someone
- People are worried about how secure information was and having conversations in settings that were not private
- Online appointments should cater for joined up assessments too

Key equality and diversity themes are:

- Individuals for whom **English isn't their first language** said they'd benefit from digital access to translated materials and interpretation, too.
- **Vulnerable groups** would appreciate proactive communication rather than feeling that they are having to chase information themselves.
- Additional consideration needs to be given to the needs of the **deaf community**, particularly when thinking about telephone and online appointments.
- Information about support available for people who are struggling with their **mental health** must be made clear and consistent, so people do not feel that they are struggling alone.
- People with **sight loss** need support, help and training to use technology and there we need to link to support groups who can help with this
- APPS offer limited support for people with **sight loss** and the **elderly** including people with **dementia** and those who have a **first language that is not English** including **deaf people**
- Technology can add more pressure on to a **carer**

- People are worried that everybody will be expected to use technology to engage with the NHS and that groups who can't do so or find it difficult will lose out. These groups include people with a **learning disability**, some **older people**, those with **additional** communication needs, those with **reduced dexterity**, those whose **first language isn't English**,
- Those on **low incomes** and rural communities with poor broadband connections will find accessing the NHS using technology as a barrier

What did you do?

The findings from all the engagement have been used to inform the development of the Trust wide 'Digital Strategy' and accompanying action plan. In addition, the Trust is using the insight to inform the Digital Strategy Equality Impact Assessment (EIA). As part of the Trust recovery of services post Covid19, the insight will ensure that digital inclusion and consideration for the impacts of digital exclusion form part of the Trust approach.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in December 2020.

You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

Equality, Involvement, Communication and Membership Strategy engagement September 2020

The Trust had several existing strategies to support involvement, equality and membership which were all due to expire in December 2019. There is a requirement for the Trust to have a published strategy in place. Following an internal reconfiguration of staff and structures, marketing communication, engagement, equality, and volunteering were moved into one directorate. A strategy refresh provided the Trust with an opportunity to strengthen its commitment to developing a more inclusive and integrated approach to involving people

by aligning the Trust approach into one strategy. The membership approach was also included in the same strategy to further strengthen the Trust commitment.

Who did you consult with and what did you ask?

The approach to delivering the strategy refresh was to ensure that it reflected the alignment of the three functions of communication, engagement, and inclusion. The engagement was delivered using several methods and approaches including online and paper survey, focus groups, peer led conversations, a send us a postcard and talks with presentations. A plan was put in place to support this work. The initial steps taken were to:

- Map existing approaches to engagement, communication and inclusion and identify any gaps
- To review the Trust approach to involving external stakeholders using the findings from a previous insight report
- To utilise the staff survey to ensure that the views of staff were captured
- To identify a process which will help the Trust meet its legal obligations.

To better understand how involvement has been delivered across the Trust we ask staff, patients, stakeholders, and people in the local communities we serve to tell us

- What we did well?
- What we could improve?
- Please tell us what we need to think about when we want to involve and include you?
- Please tell us what we need to think about to inform and communicate with you?
- How will we know we have got this right?

The Trust received 720 responses which were used along with the existing insight and intelligence from the Trust.

What did they tell you?

From the responses we received and the existing insight there were several key overarching themes from all the findings. Each of these themes and a summary of the key points raised are set out below:

Delivering on our values

- People want the Trust to be more visible and to describe who we are and what we do

- People want an honest, trusting, reciprocal relationship with us
- People want to help us get this right and value the opportunity to create a relationship based on ongoing communication and information
- People told us we should ‘listen before we talk’ and to not just come when there is a set agenda
- People wanted a human to human relationship built on dignity and respect. A point was made that any one of us could be the service user. We all need to get our services right
- People want to feel valued when they work with us

Our approach

- People want us to communicate in plain jargon free language appropriate to the target audience
- Images and pictures were welcome with accompanying clear, short to the point text
- We need to go where people are and not ask people to come to us where possible
- We need to use our assets and networks to involve and include people
- People want us to reimburse any out of pocket expenses on the day and think about other support requirements for carers and parents
- People want us to provide feedback on what we have done with the information we have gathered
- People want us to be accountable and demonstrate real improvements through involvement and inclusive approaches

Equality and Diversity considerations

- People who do not have English as a first language feel they are not treated equally, often getting the wrong information and not being asked to contribute because people do not support the right access to conversations
- The use of internet and computers as the main source of information is seen as isolating people more and needs to be part of an offer not the whole
- Use large print in posters and ‘Talking Newspapers’
- Bilingual speaking staff are needed
- The Trust need to demonstrate they understand the culture of the community before working with it

- People want contact through the local mosque and support for mental health comes through the Imam whom we should work with
- People who do not have English as a first language do not use social media for local information
- Posters and leaflets need to also be in Urdu and other community languages
- Use community images to reflect the audience in printed material
- Use symbols and images more than the written word as it is easier to understand
- Help break the mental health taboo and barriers in Asian communities so we can help you help us. Working with communities will help to 'reduce fear, ignorance and misunderstanding'

What did you do?

The findings from the engagement were collated and a final report of findings was produced. These findings informed the development of the Trust wide strategy, with a particular focus on the principles set out in the strategy.

In addition, some of the feedback was also used to support the development of Trust wide action plans. An action plan for involvement and a separate one for equality were developed to support the delivery of the strategy.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in September 2020 and the final strategy developed and signed off by the Trust Board was in December 2020. Both documents will be published on the Trust website alongside an easy read version and animation. You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

Staff Carer Network
July 2020

The Trust wants to create an inclusive environment for staff; this in turn ensures that those people who use our services feel included as they are supported by people who reflect the local population. The Trust has a number of successfully established staff networks.

As part of the Trust commitment to carers an engagement event took place to engage staff who are carers in the Summer of 2020. The Trust describe 'carers' as 'anyone who provides unpaid care and support to a family member or friend due to their disability, health condition, frailty, mental health problem, addiction or other health and care needs'.

Who did you consult with and what did you ask?

The Trust acknowledges that work is required if we are to ensure our commitment to carers is upheld. This means that we need to continually work to ensure the needs of family, friends and carers are addressed by embedding an approach to support and involve family, friends, and carers across the organisation. There is already some great work taking place throughout West Yorkshire and Harrogate to support carers including work by the Health Care Partnership in which SWYPFT are a partner.

To build on this great work the Trust held a 'Carers Matter' Event on Tuesday 7th July 2020. The event was aimed at staff who identified as a carer, and who work in the Trust. The aim was to further support the development of 3 objectives.
The objectives were:

- To engage with carers and find out what more we should do as a Trust to support them
- To gather opinions and views on the carer's passport
- To identify opportunities for a 'Staff Carers Network'

What did they tell you?

The report of findings from the event provided a detailed account of the engagement. From this report several common themes were identified. These themes are set out below:

Caring for the carer:

- Identify carers via recruitment
- Support access to a carer need assessment
- Implement the carers passport – not a paperwork exercise
- Flexible working patterns offered
- Leave arrangements for carers need strengthening

Resources and support:

- Ensure all carers have access to support – Occupational Health
- Signpost carers to additional support and information – website/ via a network or Human Resources (HR)
- Set up a dedicated carers section on the intranet

Creating the right conditions:

- Culture of the organisation needs to actively demonstrate the value of carers – carer stories at Board level
- Support and awareness raising for all staff on the implications of caring – through a communications campaign
- Specific training for Managers on supporting a carer

Making carers visible and supporting each other:

- Identify the right approach to create a network – inclusive approach
- Ensure those who do not have access to technology feel included – involve them in what would work
- Staff network in place to support carers – frequency and format to be determined

What did you do?

As a direct result of the event the Trust now have a thriving staff carers network. The network has a voice in several forums and have a nominated chair. HR resources to support staff who are carers have been refreshed and a dedicated intranet page has been set up.

Staff who are carers have also done work alongside carers of people who use our services and with organisations who represent carers. This work has resulted in the development of a joint carers passport and supported resources.

In addition, following a successful application to 'Charitable Funds' the Trust has secured 2 years funding to employ a part time dedicated project worker for carers. This post will support all carers including staff, carers of people who use services and continue to strengthen the work the Trust are doing with the local communities we serve.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in August 2020.

You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

South West Yorkshire Partnership Foundation Trust (SWPFT)

'Virtual Visitor'
April 2020

During the pandemic and to help prevent the spread of COVID-19, visiting across SWYPFT inpatient areas was impacted and restrictions in place. To ensure the people in our care did not become socially isolated, virtual visitor was set up to ensure continued contact with their families and loved ones. The Virtual Visitor Scheme had two aims.

- To combat service user isolation and enhance contact with family; and
- To combat service user isolation and enable contact with services and initiatives to support wellbeing.

The development of the proposal was tested through community engagement and the findings were used to initiate the project.

Who did you consult with and what did you ask?

The initial idea for the project was to respond to the coronavirus pandemic. The pandemic had restricted visiting in all Trust inpatient areas. The project aim was to put in place a scheme to combat this and to make sure people in our care did not become socially isolated.

We asked several people to share their thoughts on the idea by asking the following questions:

- What are your thoughts on a 'Virtual Visitor Scheme' whist we are in lockdown, is this a good idea?
- What are the main things we need to consider as part of this work?
- If this is success, what else could we use it for?
- Do you have any other ideas and suggestions?
- Would you like to be part of this work?

The engagement was aimed at staff, carers, and community representatives.

What did they tell you?

The 'Engagement and Equality' team did some research with staff, service users, carers, families and third sector partners to test the concept of the Virtual Visitor scheme. The findings from this work are set out below. People told us:

- The scheme should be in place anyway but essential and very beneficial now
- A connection to the outside world for the in-patient would be good/advantageous
- If a befriender – might take a little while for service user to feel comfortable talking to a stranger – but worth trying. Consistency – same befriender
- Could also send email notelets to individuals to read
- Private space if patients are having private conversations with the loved ones
- Will also need a member of staff assisting the patient to use this chat forum if they are new to this
- An allowance needs to be made with people who do not have access to a computer. Therefore, the traditional methods of a phone call or text, WhatsApp should be used.
- Additionally, a contingency plan needs to be in place in all IT and phone systems don't work

- You will need to look at who is going to monitor this (staff level) do they have the capacity and enough equipment?
- Some hospitals are offering “skype appointments” where wards according to their availability of staff offer various appointments e.g. Weds Morning 9-12 or Friday evenings 6-9pm where carers can book a 15 min slot to be contacted via the ward and person they support
- They should be able to choose their one time slot on a first come first basis. This can be done using the internet, website, or email
- Appropriate training for Carers/staff/Volunteers
- Equipment or an app that patients download themselves (zoom?). Equipment to be thoroughly cleaned after each person has used it Internet connection needs to be good (some hospitals already have such poor connectivity, so it is already so isolating for patients)
- Virtual visiting will allow volunteers to support people in any geographical location. Would give more flexible 'working' for Family members& staff. Family or carers as first choice for someone close to the individual.
- A befriender ideally needs to have related insight – either because they have “walked in those shoes” themselves or have spent time either visiting, working, or volunteering on a ward
- The Trust’s Recovery Colleges have volunteers who already provide peer support to learners and who would be ideally placed to be virtual visitors
- There would need to be some flexibility around the time that a telephone call will take place – option for it to be within 2-hour s of the appointed time
- A staff member should make the outgoing call in case the individual is too unwell to talk and reschedule if needed
- A limit of 30 minutes maximum per telephone call – this is the limit that schemes like ‘The Silver Line’ has, it can help to mention when say only 5 minutes are left.
- In other befriending roles a person is matched with someone of the same sex - in the same (or older) age group with similar interests – this is often the key to establishing a link
- All telephone befriending charities have protocols in place relating to the service that their volunteers deliver

- Not everyone has a smartphone or Internet access and even where they do have those facilities available to them, they may not be proficient in their use – so the method of contact means one size will not fit all.

Questions people raised:

- How would this impact visiting 'hours'?
- Would we need GDPR/confidentiality/safeguarding training for volunteers and family members?
- Will the carers/loved ones also have the necessary IT equipment to access it?
- Will have to be prepared for IT issues as is always the case with computers/laptops
- Could the ward point of contact between patient and volunteer be the ward occupational therapy team?
- Would there be clear routes of expressing concerns about patients that may arise?

Comments:

‘Virtual visiting could also be a more practical and a safer way of providing support to people in hospital. I have been both an in-patient and a visitor in relation to psychiatric wards and taking into account how unwell some of the patients can be, then from a visitor’s perspective, the environment can be unpredictable, challenging and distressing, on occasions.

‘We are all discovering new ways of working in this new situation we are experiencing. Drs are doing more phone consults, so of course follow ups etc. could be easier like this?’

‘As a carer I will be happy to help out with the trial’

‘It is important that we are in touch with our loved one as we know it can have a detrimental impact on their health and wellbeing’

What did you do?

The Trust used the findings from the engagement and set up a working group to mobilise the initiative with partners who were identified through the engagement. Equipment and data cards were purchased for every Trust ward. The virtual visitor equipment along with clear guidance for staff and instructions were distributed in a timely manner throughout April and May 2020.

The scheme has since received additional funding in 2021 and support to continue for a further 2 years. The Trust are now looking at wider uses for devices which include patient engagement, advocacy support and online patient experience surveys.

Where can you find more information about this work?

A report of the findings from the engagement process was produced in April 2020.

You can find out more information about this work by emailing the following inbox and requesting a copy involvingpeople@swyt.nhs.uk or visiting our website at South West Yorkshire Partnership NHS Foundation Trust or call us on 01924 316000 and ask for the engagement team.

Calderdale Voluntary and Community (CVAC)

Engagement Champions - COVID Vaccine Engagement
February and March 2021

Who did you consult with and what did you ask?

In February and March this year, Calderdale CCG asked VAC for the support of the Engagement Champions to understand people's views on the COVID vaccine such as any concerns that they might have had, and what might have stopped them from having the vaccine. Engagement Champions had open conversations about the vaccine and listened to people's views and recorded them on the survey form. They were also able to direct people to trusted sources of information if people were hesitant about having the vaccine. This helped support people to make informed decisions about being vaccinated against COVID-19, and to ensure that accurate information was accessible to everyone in Calderdale.

Supported conversations were held with people from the groups that the Engagement Champions normally support, and these included:

- People living in deprivation / most impacted by health inequalities
- People experiencing homelessness
- People with learning disabilities
- Carers
- People classed as clinically extremely vulnerable
- Black, Asian and minority ethnic (BAME) communities

What did they tell you?

Survey responses were fed into the overall CCG survey analysis.

What did you do?

Engagement Champions carried out supported conversations using the survey as the basis for the conversations and collected in-depth qualitative information on how the people they support felt about the vaccine. They also provided links to trusted information or talked

through the information where people were hesitant to enable them to make a more informed choice.

Where can you find more information about this work?

This work is still ongoing, a report of the findings from the engagement will be produced by the CCG at the end of this work.

Calderdale Voluntary and Community (CVAC)

Engagement Champions – understanding peoples experiences of health and social care during COVID-19
July – August 2019

NHS Calderdale CCG asked VAC for the support of the Engagement Champions to ensure a survey led by Healthwatch achieved a representative level of responses amongst need to hear groups. The survey was about people's experiences of health and social care during the pandemic. The Engagement Champions circulated the survey to all their members and then responses CCG analysed by protected characteristic. The percentage of responses received from BAME communities and people with a range of disabilities was not representative, and at this point, VAC approached Engagement Champions who work directly with these groups to carry out supported conversations with their members to improve the level of qualitative feedback included in the survey responses. This resulted in an improvement in the representation of the survey with added valuable insights into the thoughts and needs of under-represented groups.

Who did you engage or consult on and what did you ask?

Supported conversations were held with people from BAME communities and people with a range of disabilities as analysis showed that their views were under-represented in the survey responses received. The same survey questions were asked but people were supported in the completion of the surveys with Engagement Champions inputting their responses onto the online survey whilst talking to the participants by phone or Zoom call.

What did they tell you?

Survey responses were fed directly into the overall Healthwatch survey analysis.

What did you do?

Supported the engagement champions to deliver the engagement and contribute the report of findings.

Where can you find more information about this work?

Analysis of the Healthwatch surveys can be found on the Healthwatch website at the following link below:

The experiences of people working in health and care services during the Covid-19 outbreak - Calderdale | Healthwatch

Healthwatch

Experiences of medication during Covid-19
March 2021 - ongoing

Who did you consult with and what did you ask?

As part of Healthwatch Calderdale and Healthwatch Kirklees Covid-19 feedback we heard from over 200 people about their experiences of medication.

Many had positive feedback about their experience, but we heard that some things may have been difficult, they were:

- We wanted to delve deeper into this issue and thus we began in March 2021 via a survey to talk to people about their experiences of medication during Covid-19. This work was carried out across Calderdale and Kirklees. We wanted to know if access to medication is impacting the health and wellbeing of the public in Kirklees and Calderdale. We worked with several Calderdale pharmacies, leaving surveys at the premises for people to complete when they visited the pharmacies; we did some engagement with a school wellbeing workshop about general pharmacy views. Other engagement was via social media as well as a discussion with a pharmacist about their experience.

Who did they tell you?

This work is not yet complete. The survey has now closed, and we are currently analysing the data.

What did you do?

The final report exploring people's experience of medication during Covid-19 is currently being produced and will be shared with medicine management leads at the CCGs, Community Pharmacy West Yorkshire, and leaders in Primary Care.

Where can you find more information about this work?

The report should be available on the Healthwatch Calderdale website in June/July 2021.

Healthwatch

The health and care experiences of people living in Calderdale during the Covid-19 outbreak

May – August 2020

Who did you consult with and what did you ask?

Over a period over of 12 weeks (end of May to end of August 2020) Healthwatch Calderdale and partners used a variety of different engagement approaches and tools including a survey and virtual focus groups to talk to people:

- Who lived in Calderdale about their health and/or care experiences during Covid-19.
- Who worked in Calderdale in health or care settings about their experiences of working and delivering a service during Covid-19

We asked people to tell us their experiences of accessing health and care during the covid-19 outbreak, if they experienced any change/s to the service/s that they would normally receive and what those changes were. We also asked people to tell us what was good about the service they received, what didn't work so well and what would have made their experience better.
We also asked people to share their experiences with us in creative ways such as stories, pictures, poems and word clouds. We received feedback in the form of stories, drawings and poems.

The survey can be found in the appendices from the reports at the link below:
www.healthwatchcalderdale.co.uk/report/the-health-and-care-experiences-of-people-living-in-kirklees-during-the-covid-19-outbreak/

Alongside the survey, we provided a list of creative ways in which people could share their COVID-19 health and care experiences. Staff designed specific tools to provide ideas for how people could share their stories in different ways. Some specific resources were designed for children and young people, such as designing their own emoji, or sharing a lyric or sentence with us that was significant in the pandemic. We also shared a more traditional case study template, in case people wanted to tell a fuller version of their experience, rather than putting it in to the survey.

We conducted virtual focus groups with St Augustine's, who support asylum seekers and refugees. We undertook conference calls with people with learning disabilities. We worked with one of the local mosques to ask people to share 1 line of their experience with us, in a format of their choice for example, audio recording, in their preferred language. We also experimented with different digital tools for engagement, notably using Snapchat, email and zoom to talk to young people. We talked with young people about their thoughts and feelings on Covid-19 official messages. They felt that many of the NHS messages were not aimed at them and what they wanted to know about (e.g. impact on education and well-being) wasn't clearly in the messaging they were exposed to. Young people created a playlist of songs they felt reflected their views on lockdown.

What did they tell you?

The key themes that are mentioned repeatedly throughout our survey responses and other engagement tools are:

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

Feedback was mixed for all these themes, with many people appreciating the necessity for change during the pandemic but feeling that their experience could have been improved. Some respondents have made suggestions for how their experience could have been improved. There were discrepancies in experience for Asian/Asian British respondents, people who were shielding due to age or disability, and people with caring responsibilities. It was also clear that for almost all respondents, there was a mental health impact of Covid-19. For some, that impact was positive, with people finding life easier in lockdown, and for others the impact was negative, with a struggle to adapt to the changes in our way of life.

What did you do?

The report was published in August 2020 and was shared with partners involved in the project as well as the following local NHS and social care organisations

- Calderdale & Huddersfield NHS Foundation Trust
- Calderdale Clinical Commissioning Group
- South West Yorkshire Partnership NHS Foundation Trust
- Locala
- Yorkshire Ambulance Service
- Pennine GP Alliance
- Calderdale Local Medical Committee
- West Yorkshire and Harrogate Health and Care Partnership
- Local Dental Committee
- Calderdale Health and Wellbeing Board
- Members of Parliament for Halifax and Calder Valley
- Local councillors
- Calderdale Council including social care, care homes etc.

We asked NHS and social care organisations to respond in writing to several questions regarding the findings of this piece of work within 20 working days of receipt of the reports as per the timeframe set by the Health and Social Care Act 2012 and The Arrangements to be made by Relevant Bodies in respect of Local Healthwatch Organisations Directions 2013.

There were some themes that emerged from the work that we felt required additional work, which we are now undertaking specifically around medications, delays to routine care and dentistry.

Where can you find more information about this work?

A report of the findings from the engagement was produced in August 2020. This report can be found on the website below:

www.healthwatchcalderdale.co.uk/report/the-health-and-care-experiences-of-people-living-in-kirklees-during-the-covid-19-outbreak/

Healthwatch

Partnership working
April 2020 - ongoing

Although 2020/21 has been a year of unprecedented challenges, it has also been a year of unprecedented opportunities; one of the best opportunities for Healthwatch Calderdale has been working more closely with partners across Calderdale to develop a joined up approach to involving people in how the health and care system takes its decisions and works to provide good quality public services. The CCG and Council's work to develop an Involving People strategy that sets expectations for how people's voices should be gathered, considered and utilised in Calderdale has been welcomed by Senior Management staff in all partner organisations, and we have been really pleased to work closely with those partners to start work implementing that strategy. With the Involving People Network now up and running, and two significant pieces of partnership work under our belts, we are evidencing how closer working enhances the opportunities for the public to get involved, and for that involvement to really mean something. There is still some work to do to pull together a Communications, Engagement and Equality Collaborative that will take a strategic lead in setting the Calderdale approach to embedding the public's involvement, but starting with real tangible examples of how working together has enhanced our offer feels like a great way to connect. Healthwatch in Calderdale is committed to this programme of work and is excited to see what the future holds for inclusive involvement that pulls together all organisations in amplifying the public's voice.

Locala

Doing things differently

October 2020

Covid-19 has resulted in changes to how some patients receive their healthcare. To enable us to learn from their experiences we created a survey, ‘Doing things Differently’.

Who did you consult with and what did you ask?

A survey was created and shared with our patients, carers and families. The survey asked if service users had received care in a different way and how they found that experience, both good and not so good. We asked questions based on:

- Accessing services in a pandemic
- Digital/Virtual appointments

The survey was texted, sent via email, shared on social media, hard copies were available, and an Easy Read version created.

It was also shared with our members and partners.

What did they tell you?

A total of 591 responses were received from users of 44 different services. All responses were from Patients and carers.
Most of the feedback came from services who traditionally respond to text surveys, Sexual Health, Health Visiting (Calderdale and Kirklees), MSK, Podiatry and Dermatology however we did receive comments from the majority of our services.

Key themes are below:
Access to service

- 88% contacted by telephone gave positive feedback
- 70% contacted using a digital method gave positive feedback

Digital and Virtual appointments

- Video contacts: 94% positive experience 6% negative
- Telephone contacts: 92% positive experience 8% negative

We also heard that 15% of patients stated that they would like the virtual option to remain once services are able to resume normal delivery. The survey contains many comments that demonstrate that although face to face is preferred patients understand the need to adapt service delivery in the future.

What did you do?

The responses were shared with services and the service managers, the feedback is being used in the transformation teams' projects to address virtual contacts going forward into 2021. The feedback is also being used in other quality improvement pieces of work across our organisation.

Where can you find more information about this work?

If you would like more information about this work or a copy of the engagement report please email emma.boyes@locala.org.uk

West Yorkshire and Harrogate Health and Care Partnership

Further engagement about Assessment and Treatment Units
October to December 2020

Over the past few years the Assessment Treatment Unit (ATU) Steering Group has looked at the way in which care is provided across the three ATUs in West Yorkshire and how as an area we make the best collective use of our services to ensure people can access support when they need it, that our services are designed to be resilient and responsive to people's needs, and that we work towards eliminating our of area placements.

The number of specialist hospital beds in West Yorkshire has already reduced because of the improvement in support that people with learning disabilities are receiving in their local community and processes and procedures that have been put in place to identify people at risk of admission. This was the final stage of engagement about ATUs in West Yorkshire

Who did we consult with and what did we ask?

The engagement was with people (including families/carers) with lived experience of ATU, at risk of admission to ATU and staff who are involved in their care. Inclusion North helped to develop easy read documents and were available to help with engagement. After being postponed due to the COVID-19 pandemic the engagement took place during October and November 2020 with staff engagement taking place in November and December 2020. The report highlights the methods used and the limitations faced. 51 completed questionnaires were received in response to this final stage of engagement.

This further engagement process was about how moving from three to two units might impact on people. Previous engagement had already informed the decision to move from three units in 2019.

What did they tell us?

The key findings from this last stage of a long engagement journey are:

We found out from the engagement with people who access care, carers and family members that:

- It is challenging to engage with people with lived experience of the ATUs because of the small numbers, how poorly they were, the fact that visiting was not allowed during the pandemic and that staff were dealing with all of these stresses on top of COVID-19.
- Most people who responded felt that we had given them enough information
- The majority of those that responded felt that the change would either be a good idea or not affect them
- Those who felt it would affect them in a negative way were mainly concerned about having to travel further.

We found out from the engagement with professionals and staff that:

- The staff and colleagues in Leeds are concerned about the loss of a unit at Leeds. This was mainly from local authority commissioning colleagues responding to the questionnaire for people who access care from these units, their carers and families. 15 out of 20 felt it would not be a good idea and had LS postcodes.
- Those responding to the staff survey gave equal positive and negative comments to the change
- Staff felt that the model would bring better coordination and sharing of good practice and training.
- Staff who were concerned felt that carers of Leeds service users might have to travel further or not visit leaving service users isolated.
- They had lots of ideas for how to help the implementation of plans. Good communication was key to this and this feedback will be shared.
- Some staff wanted to be involved more in the future.

In both surveys of people with experience of services, their carers and family and professionals and staff, we were very successful at collecting equality information as part of the engagement.

What did we do?

The final report went to the West Yorkshire Joint Health Overview and Scrutiny Board, the Joint Committee of CCGs, the Mental Health, Learning Disabilities and Autism Board as well as the ATU Steering Group. The proposal to close

Parkside Lodge and develop the other two sites as one centre of excellence was agreed with further communication taking place with colleagues from Leeds

Service users, carers, professionals, and staff are being informed about the next steps. People we have engaged with and those involved in the change will receive communication/briefing about the findings. This will conclude the public engagement.

Where can you find more information about this work?

A report of the findings from the engagement was produced in November 2020 and is also available as a summary in easy read format. The full report can be found on the West Yorkshire and Harrogate Health and Care Partnership website

West Yorkshire and Harrogate Health and Care Partnership

In-depth engagement with people in long-term restrictive complex rehabilitation inpatient settings

November 2020

Who did we consult with and what did we ask?

The Complex Rehabilitation Project's aim is to use co-production techniques to provide consistent models of care. The intention is to provide clear complex rehabilitation pathways for people currently using predominantly independent; out of area locked rehabilitation beds, which are often placed far from home. The project includes patients being considered for complex rehabilitation (previously known as locked rehabilitation) and their carers, not those currently using forensic or open rehabilitation services.

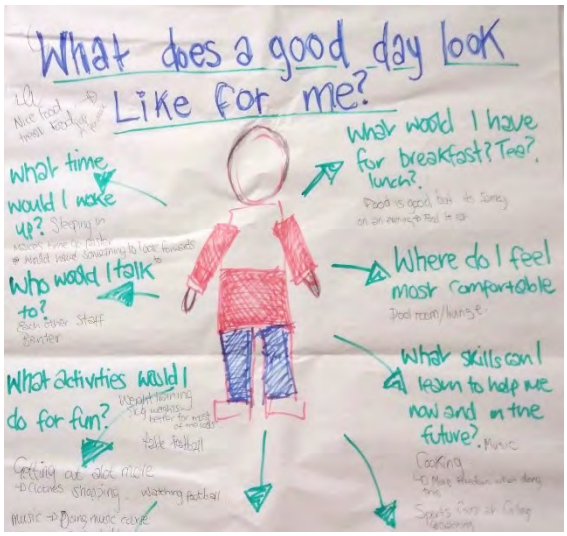
This project will help to consider how better to support of people who are currently cared for in long-term, restrictive rehabilitation inpatient settings and their carers and how they might be better supported closer to home and were possible in the community.

What did service users tell us?

A lot of rich insightful information was gained through this co-production exercise; below is some of the recommendations made:

- Better understanding of patient's needs to improve care and quality of life.
- Enable more effective use of resources.

- Improve consistency of intervention outcomes.
- Provide effective rehabilitation pathways.
- Reduce inequalities in the care system.
- Analyse effects of out-of-area care.
- Co-production to be utilised in future projects at an earlier stage, where possible, so that Service Users are involved in decision making which impacts them with project planners and service design right at the very outset.
- To continue to work towards new and creative ways to communicate with all service users to optimise the levels of inclusivity and capture the authentic service user voice.



What did we do?

The process of acting upon the recommendations and implementing the service user and carer voice has already begun. This is visible throughout the project in a number of ways some of them are below:

- Service user and carer voice has directly informed decisions made around the recruitment, induction, and training of staff for the Regional Intensive Complex Rehabilitation Team.
- Co-produced development of user & carer experience within valued based questions to inform and support a new recruitment process, for new services.
- Service user and carer voice has now been integrated into the business proposals for four new service proposals.

- Service user and carer voice has shaped the roles, interventions and training requirements needed, to deliver recovery and co-production focused services.

What did carers tell us?

Below are some of the things that carers told us:

- Advocacy support for carers to enable their voices to be heard.
- Where possible service users to be placed in hospitals closer to their families to help maintain connections with loved ones.
- Staff to continually liaise with the family of service users to help build up a fuller picture of the client to help improve the overall outcomes for service users.
- Professionals to be mindful that clinical language and terminology is difficult to understand to people outside of the clinical setting. A glossary of terms and acronyms to be given to loved ones/carers prior to meetings so that they are “in the know” about what is being discussed.
- Single point of contact for family members/carers whose loved ones have left rehabilitation services and have transitioned back into the community.

What did we do?

- Service user and carer voice has directly informed decisions made around the recruitment, induction and training of staff for the Regional Intensive Complex Rehabilitation Team.
- Co-produced development of user & carer experience within valued based questions to inform and support a new recruitment process, for new services.
- Service user and carer voice has now been integrated into the business proposals for four new service proposals.
- Service user and carer voice has shaped the roles, interventions and training requirements needed, to deliver recovery and co-production focused services.
- Peer support roles have been embedded within each proposal.

We will continue to work alongside service users and carers to ensure that:

- their voice about interventions that improve quality of life, hope and optimism are embedded within new service proposals;
- specific areas of concern raised about cultural needs and support around loss are followed up and addressed;
- the outcomes of the project and how their voice has supported the development of new service proposals are fed back;
- we continue to promote co-production; its value, the service user and carer voice within ICS work.

Where can you find more information about this work?

A report of the findings from the engagement was produced in November 2020. The service user report and the carer report can be found on the West Yorkshire and Harrogate Health and Care Partnership website: www.wyhpartnership.co.uk/

West Yorkshire and Harrogate Health and Care Partnership

Green social prescribing survey
November 2020

Who did we consult with and what did we ask?

The online survey was created in order to gain insight to bid for funds develop green social prescribing in the West Yorkshire and Harrogate area. It was promoted to all stakeholders and the public.

What did they tell us?

We asked about access and barriers to using green space. 81% of those who responded said that they had easy access to a private garden with 83% having access to park, woodland or other green space.

When asked what barriers they faced in accessing green space 44% said they did not have barriers, 29% said a lack of facilities such as toilets or changing facilities and 24 % said fear

of getting or spreading coronavirus. 92% said they would be interested in accessing green space activities. Thoughts on those activities were:

- Activities that encourage a connection with nature, such as nature trails or foraging - 58%
- Local walking groups - 56%
- Outdoor wellbeing activities, such as yoga or mindfulness
- 56.02%
- Outdoor learning or creative projects, such as art classes, poetry writing and history walks -51%
- Trips to areas of natural beauty - 50%

What did we do?

This information was included in the bid, from which funds were received to support innovative projects, which help connect people to nature, improve physical and mental health and reduce health inequalities. It asked for projects that:

- enabled people to access nature-based activities e.g. outdoor arts, outdoor education, conservation projects, walking groups, community food growing projects
- involved creating new greenspaces e.g. pocket parks, spaces to grow food
- did a combination of the two

Where can you find more information about this work?

A report of the findings from the engagement was produced in December 2020. This report can be found on the West Yorkshire and Harrogate Health and Care Partnership website

West Yorkshire and Harrogate Health and Care Partnership

Maternity services community action insight
September 2020 & February 2021

Who did we consult with and what did we ask?

In phase one (September 2020) health professionals who work in maternity services were engaged to gain their insight into services. This second phase (February 2021)of the

Maternity Services project – created a community action network with the public, supported by co-production work.

The network needed expertise or to be working with the following groups:

- Teen mums
- Refugees and asylum seekers
- Poverty and deprivation (including homeless)
- English not a first language
- BAME population groups
- Women in prison or detention centres
- Addiction

Below are some of the questions they were asked:

- Why people did/did not enjoy their pregnancy?
- What makes it more difficult for people to go to appointments about their pregnancy and what would make it easier?
- What makes a good midwife in terms of how they treat people and involve them in their care?
- What sort of relationship they want to have with their midwife and how that relationship affects them?
- What makes it more difficult to follow the advice the midwife gives and what would make it easier?

What did they tell us?

Similarities across all women, some of what they told us is below:

- Listen to me and treat me with respect. Don't judge me. I'm more likely to follow your advice if you do.
- I want the midwives to be friendly and professional. I differ in how much I want them to feel like a friend.
- Involve me in decisions about my care.
- Don't rush through appointments and give me time to think. Take the time to answer my questions fully.
- Even if I need a different approach or specialist services, don't think of me as a problem.

- When appointments are by phone or video, I don't get the chance to build a good relationship with you.
- Make sure you know about the support that might be useful for me.

There was specific feedback from the groups previously mentioned e.g. Teen mums which can be seen in the report.

What did we do?

- Development of local volunteer buddy group – meet weekly online or face to face (*when safe to do so).
- Development of a series of support videos (up to 4) to have real-life mums speaking about their pregnancy journey and how they received support.
- Development of a step-by-step financial support guide or information tool.
- Explaining financial support available in an accessible way.

Development of a simple support tool to support expectant mums through their pregnancy and what support is available to them, including:

- Step-by-step pregnancy support at the NHS
- Key terms
- Who is who (key healthcare roles in pregnancy support)
- Translation support
- Financial support

Where can you find more information about this work?

A report of the findings from the engagement was produced early in 2021. This report can be found on the West Yorkshire and Harrogate Health and Care Partnership website

West Yorkshire and Harrogate Health and Care Partnership

Ongoing engagement mechanisms

We are committed to meaningful conversations with people, on the right issues at the right time. We believe that this approach informs the ambitions of our partnership - to work in an open and transparent way with communities. This includes many ongoing engagement mechanisms such as panels etc. These can be found on our Get Involved webpage.

West Yorkshire and Harrogate Health and Care Partnership

Engagement and Consultation mapping report 2020/21

This engagement and consultation mapping report presents the findings from all relevant engagement and consultation activity which has taken place during April 2020 to April 2021, across Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The past year has been an exceptional one for the NHS and care organisations and especially our communities due to the Coronavirus pandemic. This report too is different to previous mapping reports to reflect the situation. The purpose of this report is to refresh the previous engagement and consultation mapping exercise that took place in May 2020. A review has taken place of all relevant engagement and consultation that has taken place between April 2020 and March 2021 in the West Yorkshire and Harrogate area from partners. This work supports the work of Partnership priority programmes and each of the place mentioned above when planning engagement or services. West Yorkshire and Harrogate Consultation and Engagement Mapping (insight) Report.

8. Progress update on previous engagement and / or consultation activity

We recognise that it can take several months or even years before any outcomes or changes can be reported on from any engagement and/or consultation activity that takes place. With this is mind we have asked our partners if they can provide an update or progress of any previous submissions of engagement and/or consultation activity that took place between 2016 and 2018.

Previous submissions can be found under the header patient and public engagement / communications on our website: www.calderdaleccg.nhs.uk/key-documents/

NHS Calderdale Clinical Commissioning Group (CCG)

Hospital Reconfiguration - Right Care, Right Time, Right Place

The findings from engagement in 2019/20 were used to inform the initial Design Brief
The Design Brief Public Involvement Report was published with the papers for the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee meeting on 19th March.

Improving Access to Psychological Services (IAPT)

A particular theme of the engagement was exploring the use of digital technology to support managing mental wellbeing. Findings were mixed.

- Some people told us they were aware of online apps our courses to support their mental wellbeing and others said they weren't aware.
- Of those that were aware some told us that digital support such as apps, online courses; webchats were not a preferred method of managing their mental wellbeing.
- However, people who told us they were aware and were happy with the digital support they received said they like to use them for mindfulness, mediation to ease / help with anxiety, help with OCD/depression and sleep. And that they liked the accessibility of being able to use them when they need them
- Others said that they don't use apps for reasons such as they didn't use apps were because they struggled with technology, they don't like using apps, or because of their conditions or their reasons were too complex / complicated

In response to COVID-19 the IAPT offer quickly adapted and switched to a digital offer using various social platforms, to deliver both one to one and group sessions. Feedback has been varied, with people expressing individual preferences however the consistent message is people want a choice in how they access support for their emotional health and wellbeing. Both IAPT providers have proactively promoted their offers alongside a range of alternative apps, helplines and online tools developed over the past 12 months to provide a range of support options available for individuals to choose from. IAPT services are actively planning how to begin to deliver 1:1 session's when it is safe to do so, which will complement the range of digital options available.

Out of hospital care

Following the event that took place work has continued to progress. Trusted and single assessment is now used to support hospital discharge and onward referral. This is fully implemented and continues to be refined. Work has continued around out of hospital/community beds, and transition from step down to step up. This is part of Urgent Community Response work and step up is clearly embedded as part of the work.

COVID-19 provided us with revised discharge guidance which promotes home first and discharge to assess; using a trusted assessor, people are being discharged more quickly and assessment is taking place outside of hospital.

In relation to workforce and skill mix – there is a limited number of staff – work is therefore ongoing looking at blurred boundary working to ensure we are making the best use of workforce. There are, however, several new roles that are in place within the Primary Care Networks.

In relation to intermediate care beds and stroke rehabilitation - work is continuing to provide evidence for the re-procurement of intermediate care beds/stroke rehabilitation and other work previously part of the integrated living model, for example improving rapid response to keep people at home for longer.

Finally, the outcomes from the event in relation to dementia and mental health have been used to inform future work with regards to the development of future services for people with dementia/mental health.

Next steps following the Children and Young People's Autism Spectrum Disorder Summit 2020: "Find Your Brave"

In February 2020 Young People with Autism Spectrum Disorder (ASD) organised and led Calderdale's second Autism summit, 'Find Your Brave'. During the Summit, our Young People told participants their personal stories and what their dreams for Calderdale are. System leaders gave an update on the pledges made in January 2019 and partners celebrated the progress made since then.

Participants identified together how we all can continue the autism journey together in transforming the way we think, organise, and operate in Calderdale.

During spring 2021, the Calderdale ASD Steering Group held two virtual workshops to explore and build on the ideas and actions generated by Young People and other stakeholders at the Summit. The members of the Steering Group include young people, parent carer representatives, the voluntary and community sector, health, and local authority representatives.

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

In October 2021, NHS Calderdale CCG Governing Body members were delighted to have a full and frank conversation with the Young People who designed the Find Your Brave Summit. They reminded the Governing Body of their expectations and urged them and other partners to maintain the momentum on delivering the Calderdale autism agenda.

Despite the challenges brought by the COVID-19 pandemic, Calderdale remains committed to working with Children and Young People and families to continue making progress and delivering the improved outcomes they say they need.

NHS Calderdale CCG Governing Body papers are available on the About our Governing Body page of the Calderdale CCG web site:

Calderdale and Huddersfield Foundation Trust (CHFT)

Transforming hospital services in Halifax and Huddersfield design principles engagement phase

The findings from the Public Involvement and Colleague involvement sessions were used to inform the final Design Principles which were approved by the Transformation Programme Board, presented at JHSC and shared with NHSE/I. The reports can be seen on the CHFT website:www.cht.nhs.uk/about-us/chft-transformation-updates

As work progresses, members of the public across the communities of Calderdale and Greater Huddersfield are being invited to share their views on the new developments proposed in advance of planning applications being submitted to the local councils of Calderdale and Kirklees in May. The deadline to do so is Monday March 29.

All the details for the new proposals for both hospitals are available at the CHFT Future plans website: www.chftfutureplans.co.uk

Cancer – Macmillan Prehabilitation Project

The Macmillan Prehabilitation Project is constantly evaluating the offer of support that patients receive from the point of diagnosis and pre-treatment to support and improve their health and wellbeing. This is informing the way we develop and deliver services in that same period. For example, smoking cessation support is evolving through developing training to all our CNS groups. The importance of physical activity and embedding this into routine conversations with all cancer team staff is supporting personalised and tailored support in this area. Providing an individual prehab support offer to lung cancer patients and more recently upper GI cancer patients has seen positive outcomes for patients in respect to tolerating treatment, recovery and quality of life. Further engagement with the cancer patient focus groups and individual patient evaluation will continue to support developments and support improvements in access to Prehabilitation.

Further information about the programme is available on the Trust website: www.cht.nhs.uk/services/clinical-services/oncology/information-support/prehabilitation

Healthwatch

Hypermobility Syndromes 2016-2018

We continue our work on hypermobility syndromes, though meetings have been delayed due to Covid-19. All information relating to this project can be found on the Healthwatch Calderdale website: www.healthwatchcalderdale.co.uk/report/hypermobility-syndromes/

On 10 January 2021, Healthwatch Calderdale presented at on online event, broadcast globally, entitled 'Paediatric Ehlers Danlos syndrome and Hypermobility Spectrum Disorder: Exploring The Impact of Misdiagnosis'. This was hosted by the Ehlers Danlos Society. Following the publication of our main hypermobility syndromes report in July 2019, we received feedback nationally from people with hypermobility syndromes. We are currently in the process of writing up this information.

Healthwatch Calderdale submitted additional feedback to Calderdale and Huddersfield NHS Foundation Trust (CHFT) regarding the secondary care experiences from people with hypermobility syndromes in Kirklees and Calderdale. CHFT is now (as of April 2021) drawing up an action plan with regard to improving care for individuals with hypermobility syndromes within the Trust. CHFT and Healthwatch Calderdale will continue to work together in this regard.

Adult Autism

Since the publication of the original report in May 2017 and our last involvement submission, Healthwatch Calderdale has continued to work in this area specifically in the following ways:

- Providing support during the development and implementation of the 'Keeping Neurodivergent People Connected' project run by the Society for Neurodiversity. This project supported people with neurodivergent conditions in Calderdale during the covid-19 pandemic, providing them with information about the support that was available for them, helping to tackle loneliness and isolation and keeping them connected to their community.

- Submitting a submission for the NICE autism guidance consultation in November 2020 using intelligence from feedback gathered from previous engagement, as well as from clients being supported by Healthwatch Calderdale
- Discussing the issue of patient choice in relation to attention deficit hyperactivity disorder (ADHD) and autism with Calderdale Clinical Commissioning Group and other stakeholders

All information relating to this project can be found on the Healthwatch Calderdale website:

www.healthwatchcalderdale.co.uk/report/adult-autism-in-kirklees/

Access to health services for Syrian refugees/asylum seekers and refugees

In 2020 Healthwatch Calderdale ran online focus groups meeting with asylum seekers and refugees as part of its covid-19 engagement work. Healthwatch Calderdale is involved with the Valley of Sanctuary specifically in relation to access to health services for asylum seekers and refugees.

Healthwatch Calderdale is also contributing to work concerning the current Welcome Pack asylum seekers and refugees are provided with, and we are working to revise the section on Healthcare Services so that it tells people what they need to know when they first arrive in Calderdale, and to ensure it is an up-to-date resource which is easy to understand.

In the last year we have contacted GP practices to make them aware of the issues asylum seekers and refugees are experiencing when trying to register as patients (notably surrounding proof of ID/address, interpreting support for remote appointments and staff in GP practices not having an understanding of the languages their patients use and need support with. We have also asked GP practices how they plan to resolve these issues. In response we have been assured that practice staff will be receiving the training they need to allow them to deal with these issues in a more informed and professional way. Practice staff are now liaising with St Augustine's Centre to make sure they are better informed about the communities the practices serve and languages they use.

In addition, we have raised the issue of the importance of making three-way interpretation available for all patients who need it, especially during the pandemic when patients have to have remote appointments. After a slow start this now appears to be happening in most

cases. We have also given NHS England Dental Commissioners detailed feedback on the issues faced by refugees, asylum seekers and migrants trying to access both emergency and routine dental care, and this information will be used to inform their service planning.

Children and adolescent mental health services (CAMHS)

Healthwatch Calderdale continues to meet with the Open Minds Partnership and will attend future meetings with this partnership to work together to improve the service. Healthwatch Calderdale continues to support parents experiencing issues with CAMHS via its NHS Complaints Advocacy Service.

South West Yorkshire Partnership NHS Foundation Trust

Staff Networks

SWYPFT have continue to develop staff networks in 2019/2020 and the networks have been actively involved in shaping the response to the pandemic by supporting our approach and response. Networks have been engaged in the development of online resources for staff during the pandemic, organised peer to peer conversations to support aspects such as the vaccine roll out and in the development of proposals to address inequalities highted during the pandemic with a particular focus on BAME staff, resulting in a co-designed staff resource, appointment of a BAME WRES Lead for the Trust and a dedicated online resource. A Carers network was also established during 2019/2020 which was highlighted as one of our next steps, we have included an update on this work in this report.

Carers Charter

The Trust carers charter has now been reviewed as part of a wider offer to carers. The original charter was co-designed with carers and families. This charter has now used as a framework to co-design and develop a 'carers passport'. The carers passport which is available on the Trust website under Carers' passport | South West Yorkshire Partnership NHS Foundation Trust can be used to identify and provide support to all carers including carers and families of people who use our services and by managers to support staff who are carers. In addition, the Trust have now established a staff carer network and a partner carer network. These groups help to drive improvements for carers by having a voice in the planning and development of services.

Dales inpatient wards

No update is available on this work due to the pandemic.

Single Point of Access

The SPA service have continued to improve the service offer following extensive engagement with local people. This work has taken place has been in partnership with Healthwatch colleagues. Healthwatch have worked together with the SPA to improve the support to frontline staff which has involved development sessions. In addition the choose well for mental health leaflet which has been co-designed with people who use services and can be found using this link: Choose well for mental health | South West Yorkshire Partnership NHS Foundation Trust now clearly articulates the SPA offer and provides guidance for people so they can access the right support.

Suicide Bereavement Support Services

All updates on the suicide prevention service can be found on the West Yorkshire and Harrogate Health Care Partnership website by following the link: West Yorkshire and Harrogate Partnership / West Yorkshire and Harrogate health care partners tackle suicide prevention Organisations from across West Yorkshire and Harrogate are joining forces to adopt a 'zero' suicide approach, where every death by suicide is viewed as preventable following the development and launch of a collaborative strategy to support this work.

West Yorkshire & Harrogate Health and Care Partnership

West Yorkshire Healthy Hearts Project

Following the patient engagement activities around phase two of the WYH Healthy Hearts project, we produced a report available on the West Yorkshire Health Hearts website. On the back of this, we also created some letters for GP practices to use to inform patients about why their medication was changed or why they needed to start using statin medication and produced Easy Read version as well.

We worked with a patient reader group to revise the changes made to patient letters to ensure these were in line with the feedback received. We created a FAQ document to accompany each letter to address patients' concerns and answer any question about what cholesterol is, how to keep it under control, what statin medications are and what side effects they might have. We created an Easy Read version for the FAQ documents as well.

We also revised the content on our web page dedicated to cholesterol management including some useful animations created by BHF and signposting to other trusted resources such as the NHS, Heart UK, BHF, Blood Pressure UK and Stroke Association.

Health and Care Learning Disability Champions

We want people with learning disabilities in West Yorkshire and Harrogate to receive the best possible care. We also want people with learning disabilities to feel supported to have their say as they are the experts when it comes to knowing what help, support and personalised care they need.

We work with a group of people we call our Learning Disability Health and Care Champions, facilitated by our partners BTM. The group meets weekly and works on projects and issues that support the work of our priority programmes. We involve them in future conversations about improvement and ask them about their experience of care for people with learning disabilities. This is an approach supported by councils and NHS organisations.

The Champions have recently been discussing their views, experiences, and concerns about the Covid19 vaccine.

- Cancer Awareness – the Champions have worked on booklets about breast and bowel cancer screening. The booklets have audio too. They have helped us to create a "Top Tips" leaflet to help colleagues in the health care system promote uptake of cancer screening and annual health checks.
- They have told us that it is important for people with learning disabilities to be able to make their own decisions - Why it's important for people with Learning Disabilities to make their own decisions - film
- They have told us that people with learning disabilities may or may not suffer from mental health problems – just like the general population. They have created a presentation about Mental Health.
- Planned Care (this means things that you might do, go into hospital, have an appointment about a condition you have with a doctor or specialist or if you are having a baby). The Champions have helped us to create a "Top Tips" leaflet to help our colleagues in secondary care to help them have the best experience should they have to attend hospital.

- Promoting the needs of people with learning disabilities (speaking to health and care organisations and people who work for them to make sure they understand what you need). Supported by their project worker, the Champions prepared for and made a presentation at two of our priority programme boards, sharing their views on how our programmes can work with them and be supported by them as the develop projects that impact upon them and their care.

You can find out more about this work by visiting West Yorkshire and Harrogate Health Care Partnership website www.wyhpartnership.co.uk/get-involved/health-and-care-champions

9. Planned work for 2021-22

Hospital services:

To continue to support the delivery of Right Care, Right Time, Right Place programme to provide advice and support as requested and develop and deliver an action plan for communication, engagement and equality.

West Yorkshire and Harrogate Health Care Partnership:

Continue to provide advice and support to the programme office on all aspects of engagement and consultation. Develop a strategy for engagement and liaise with partners across the local footprint. To continue to support the development of composite reports for all work streams in partnership with Healthwatch to ensure the local voice continues to be reflected.

Primary care engagement and consultation:

To work with GP practices to support the delivery of engagement and consultation processes to inform any future service developments or changes.

Equality Objectives 2021/22:

To continue to deliver our two-year action plan for equality which will help to identify methods and approaches to reaching groups or individuals covered by the Equality Act 2010 and ensure the CCG increase reach into these communities by 2021/22.

Community Services:

We will continue to engage where needed on the specific requirements of some services that are closer to home and supporting work around the current model for, out of hospital care and care homes.

Primary Care Networks (PCNs) and localities:

To provide advice and support to our five PCNs and localities on all aspects of involvement, engagement and consultation and continue to ensure the voice of our local communities is embedded in the work of Calderdale Cares.

Transformation programmes:

Focus will be given to future transformation programme's such as Community Mental Health, Older People Mental Health Inpatient service and Care Homes. Should formal consultation take place previous engagement will inform the consultation. Consultation will facilitate genuine and meaningful involvement to ensure we reach, inform, communicate, and formally consult with the public, patients, carers, our partners, and stakeholders.

COVID-19 Pandemic:

All future planned work and any additional projects identified will be influenced by any learning from COVID-19 to understand the wider impact on health inequalities that COVID-19 has had on our communities, our different population groups including Black and Ethnic Minority Groups (BAME), Learning Disabilities, Carers, Mental Health and other vulnerable groups. We need to understand people's experiences of accessing services and those of our workforce during this time; and beyond to support service change and build a more effective health and care system within Calderdale.

White Paper Integration and Innovation: working together to improve health and social care for all:

Support the future direction of travel and implementation of the West Yorkshire Integrated Care System.

10. Contact details for NHS Calderdale CCG

If you are interested in finding out more about getting involved in the work of NHS Calderdale CCG or would like to share your views on local health services, please contact us via the following contact details.

Address:

NHS Calderdale Clinical Commissioning Group

5th floor F Mill

Dean Clough

Halifax

HX3 5AX

Tel: 01422 281300

Email: CCG.FEEDBACK@calderdale.nhs.uk

Please note that this email address should NOT be used if your message contains patient/personal information.

Facebook: NHS Calderdale CCG

Twitter: @calderdaleccg

Website: www.calderdaleccg.nhs.uk

Care Opinion

Care Opinion is an independent website about your experiences of UK health services, good or bad. They pass your stories to the right people to make a difference.

You can share your views and experiences of the healthcare you have received locally by visiting the Patient Opinion Website (patientopinion.org.uk)

Appendix 1

Legal duties for CCGs in relation to Patient and Public Engagement

Section 14P - Duty to promote NHS Constitution

(1) Each clinical commissioning group must, in the exercise of its functions—

(a) Act with a view to securing that health services are provided in a way which promotes the NHS Constitution

Section 14U - Duty to promote involvement of each patient

(1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to:

(a) The prevention or diagnosis of illness in the patients, or

(b) Their care or treatment.

Section 14Z2 - Public involvement and consultation by clinical commissioning groups

(1)This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) In the planning of the commissioning arrangements by the group,

(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

NHS Constitution (Refreshed March 2013)

The NHS Constitution produced by the Department of Health establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

A copy of the refreshed NHS Constitution and supporting handbook can be accessed via the gov.uk website (**gov.uk/government/publications/the-nhs-constitution-for-england)**

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. Principle Four focuses around patient engagement and involvement and is emphasised through the Patient's Rights Section.

Principle Four

The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services

Patient Rights - Involvement in your healthcare and in the NHS:

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:

- To provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- To work in partnership with you, your family, carers and representatives (pledge);
- To involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- To encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Workforce Report**	**Agenda Item No.**	10
Report Author	Tazeem Hanif, HR Business Partner	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby, Clinical Chair	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary
This paper presents an overview of the CCG's workforce data as part of the bi-annual update between the periods of 01 January to 30 June 2021. It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce. The paper includes the following workforce metrics: • Workforce composition • Staff turnover • Sickness absence • Equality and diversity data • Workforce headlines relating to the CCG's workforce.

Previous Considerations

Name of meeting	Senior Management Meeting	**Meeting Date**	07/07/2021

Recommendations
It is recommended that the Governing Body: 1. **RECEIVES** and **NOTES** the content of the CCG workforce report update.

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	All information in this report is presented in such a way that individuals cannot be identified from the data, in line with information governance requirements.

	Diversity information is reported to Governing Body separately as part of the Public Sector Equality Duty reporting. At the request of Governing Body, this report includes information about the Equality and Diversity of the CCG's workforce, to facilitate discussion.
Resources / Financial Implications (including Staffing/Workforce considerations)	The report provides the Governing Body with an overview of staff resource available to the CCG.
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	**Risk (include risk number and a brief description of the risk)**	None identified.
Legal / CCG Constitutional Implications	This paper provides the Governing Body with assurance that the CCG is operating in line with legal requirements, best practice and within agreed CCG policies and procedures.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts arising from this report will be managed in line with the CCG's Management of Conflicts of Interest policy.

1. Introduction

1.1 This paper presents an overview of the CCG's workforce data as part of the bi-annual update between the periods of 01 January to 30 June 2021. It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce.

1.2 The quarterly workforce reports are presented to the CCG's Senior Management Team (SMT) by Human Resources (HR). The information provided enables SMT to identify any patterns or trends to enable the identification of any actions that need to be taken at an operational level. It also provides a vehicle for advising SMT about any key developments in employment law, best practice or other matters that may affect the CCG's workforce.

1.3 The Governing Body report complements the reporting to SMT, providing assurance in relation to the effective management of the CCG's workforce. The recommendation to Governing Body is that it receives and notes the content of the CCG workforce report update.

1.4 Please note that this document is in an accessible format except for data within tables 1-7. The information can be supplied in accessible format on request.

2. Workforce Composition

2.1 The workforce composition of CCG employed staff as at 30 June 2021 was 86 equating to 76.12 Full Time Equivalent (FTE). The CCG also has arrangements in place to share staff resource with other local CCGs, particularly, NHS Kirklees CCG which accounts for roughly 20 staff.

2.2 The majority of the CCG's staff are employed under Agenda for Change terms and conditions which represent job bandings 1 to 9. The other category refers to the Very Senior Managers (VSMs).

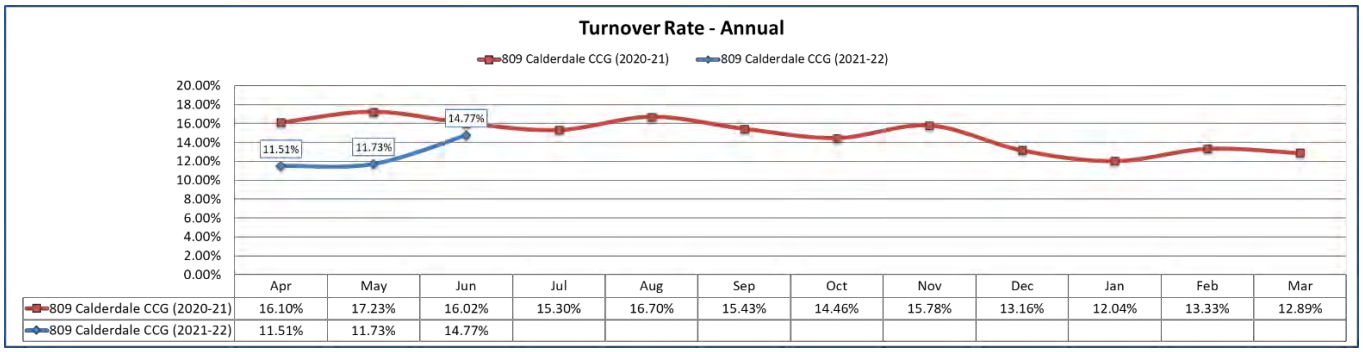
3. Staff Turnover

3.1 Staff turnover refers to the proportion of employees who leave an organisation over a set period and is expressed as a percentage of the total workforce average. The CCG calculates turnover on a rolling annual basis. The formula which is used to calculate annual employee turnover is:

$$\frac{\text{Leavers over a rolling 12 months}}{\text{Average total number employed over a rolling 12 months}} \times 100$$

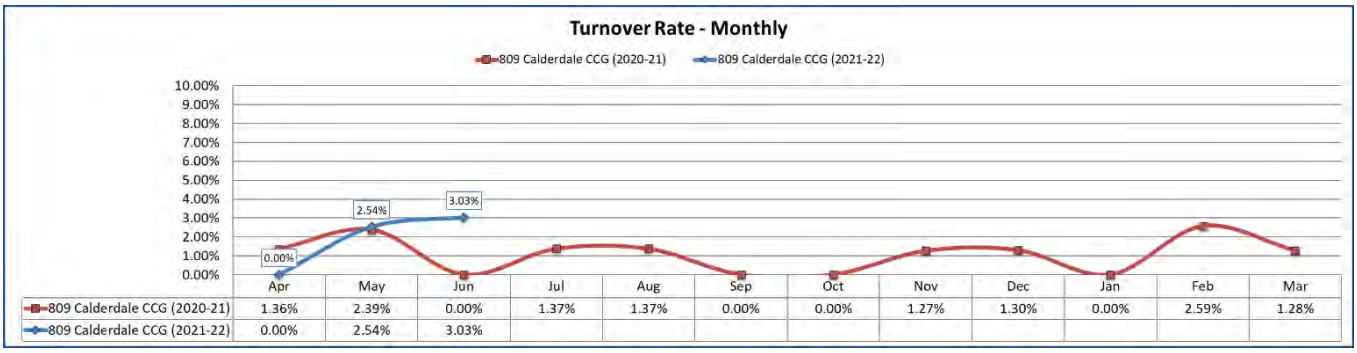
3.2 The data set out in Table 1 and 2 includes the CCG's annual and monthly staff turnover rates from 01 January to 30 June 2021 and a comparison with turnover for the previous financial year.

Table 1 – CCG Rolling Annual Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	16.10%	17.23%	16.02%	15.30%	16.70%	15.43%	14.46%	15.78%	13.16%	12.04%	13.33%	12.89%
809 Calderdale CCG (2021-22)	11.51%	11.73%	14.77%									

Table 2 – CCG Monthly Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	1.36%	2.39%	0.00%	1.37%	1.37%	0.00%	0.00%	1.27%	1.30%	0.00%	2.59%	1.28%
809 Calderdale CCG (2021-22)	0.00%	2.54%	3.03%									

3.3 It is important to note that the small number of employees means that any leavers have a significant impact on the overall percentages. Rolling annual turnover reflects the total number of leavers over the past 12 months, as a percentage of the workforce. Annual turnover has increased; however, the rate is much lower than the previous year which reflects 8 leavers between January to June 2021. A level of turnover is to be expected and is appropriate in any organisation.

3.4 Where individuals have left the organisation, this has been a combination of the following reasons: -

- Retirement
- Voluntary resignation for reasons of promotion, work life balance and relocation.
- Return to front line clinical practice
- End of fixed term contract
- Retire and return

3.5 All line managers are provided with a leaver's pack that includes a manager's checklist as guidance and although the completion of exit interviews is optional; conversations are taking place with line managers in understanding the reasons for leaving. One exit questionnaire has been received which referred to feedback on work life balance and this was discussed with the service lead. If there are any areas of concern or risk related – these are discussed between the HR lead and the relevant service lead for that area in terms of organisational learning.

4. Sickness Absence

4.1 Sickness absence figures are calculated based on a percentage of total time available, using the following calculation:

$$\frac{\text{Total absence (hours or days) in the period x100}}{\text{Possible total (hours or days) in the period}}$$

4.2 The overall sickness absence percentages can be found in table 3, 4 and 5 which is the overall sickness absence including both short and long-term sickness. Long term sickness is defined as any single instance of sickness absence, which lasts for 28 days or more.

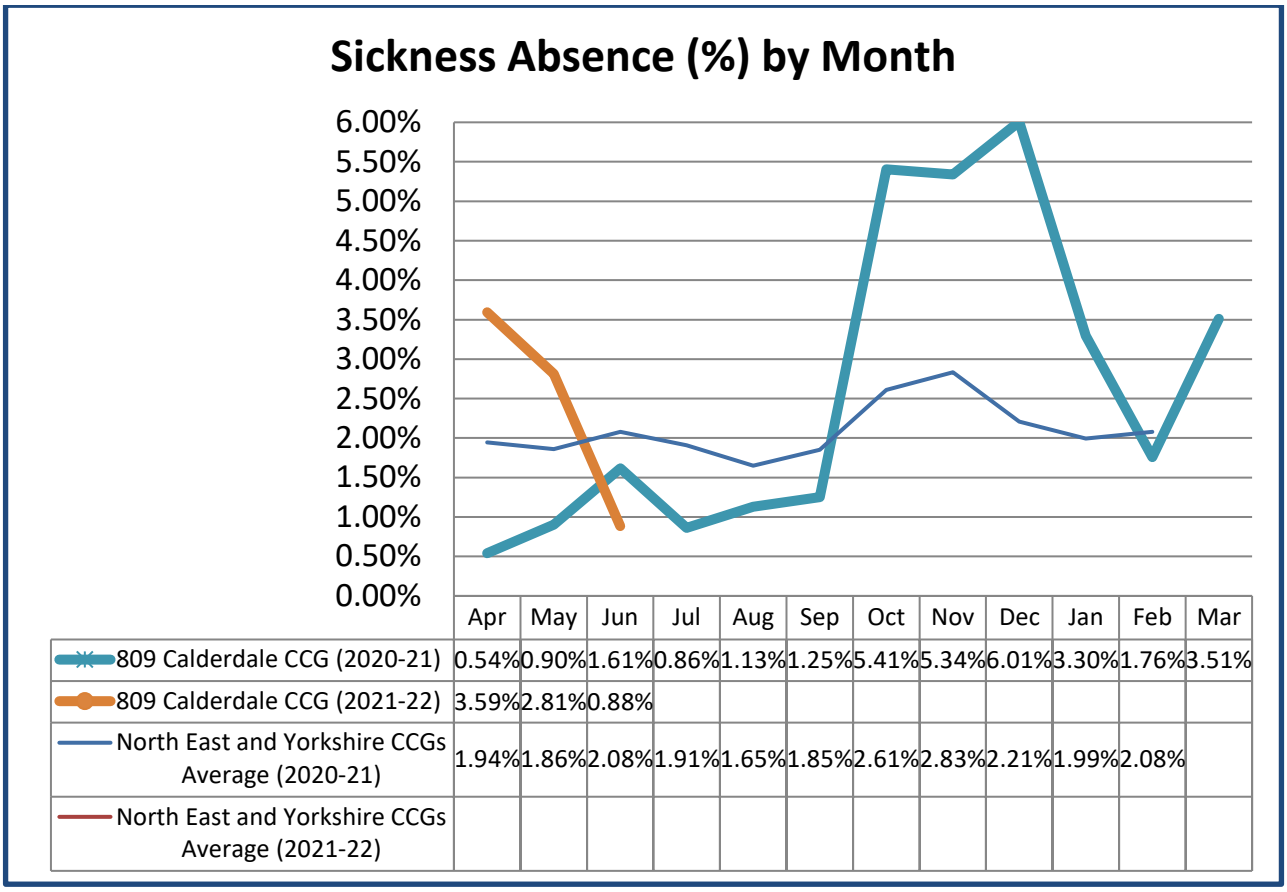
4.3 Sickness benchmarking information is available nationally from NHS Digital as a comparator against other NHS organisations. However, any available national data does not break sickness down to short or long term and therefore the comparisons are difficult to make. Previously, the North East and Yorkshire CCGs have been used as a comparator

and the only available current national data is up to February 2021 – March and April data being available in late July 2021.

4.4 Sickness absence levels continue to fluctuate, though for much of the first quarter of 2021 it has been higher than the same period in the previous year. Most of the sickness absence continues to be driven by long term sickness which peaked from January to May 2021 and managed carefully on an individual basis, in line with the CCG's policies. Anxiety and stress are the top reason for absence which to date in most cases has been related to a combination of personal and work-related issues. There are no themes in relation to the reasons for short- and long-term sickness, which are deemed to be of organisational concern. Table 6 highlights the top three sickness reasons.

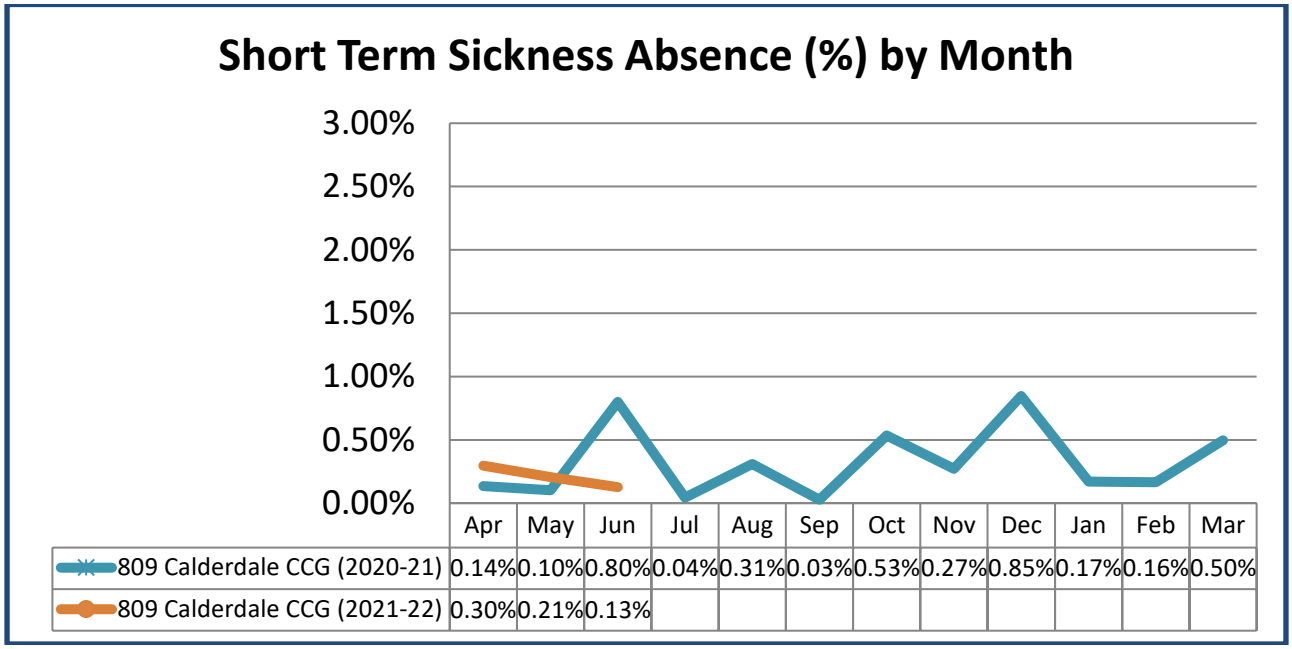
4.5 The CCG has several support mechanisms in place such the Employee Assistance Programme, additional Mental Health First Aiders, and access to Occupational Health advice. Staff feedback through recent surveys and sickness management meetings has been positive about the benefits of these services in supporting them to remain at work and to return to work more quickly. Where an individual requires additional support – this will be identified, or they will seek specialist support/referral via their GP.

Table 3 – Overall Sickness Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	0.54%	0.90%	1.61%	0.86%	1.13%	1.25%	5.41%	5.34%	6.01%	3.30%	1.76%	3.51%
809 Calderdale CCG (2021-22)	3.59%	2.81%	0.88%									
North East and Yorkshire CCGs Average (2020-21)	1.94%	1.86%	2.08%	1.91%	1.65%	1.85%	2.61%	2.83%	2.21%	1.99%	2.08%	
North East and Yorkshire CCGs Average (2021-22)												

Table 4 – Short Term Sickness Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	0.14%	0.10%	0.80%	0.04%	0.31%	0.03%	0.53%	0.27%	0.85%	0.17%	0.16%	0.50%
809 Calderdale CCG (2021-22)	0.30%	0.21%	0.13%									

Table 5 – Long Term Sickness Absence

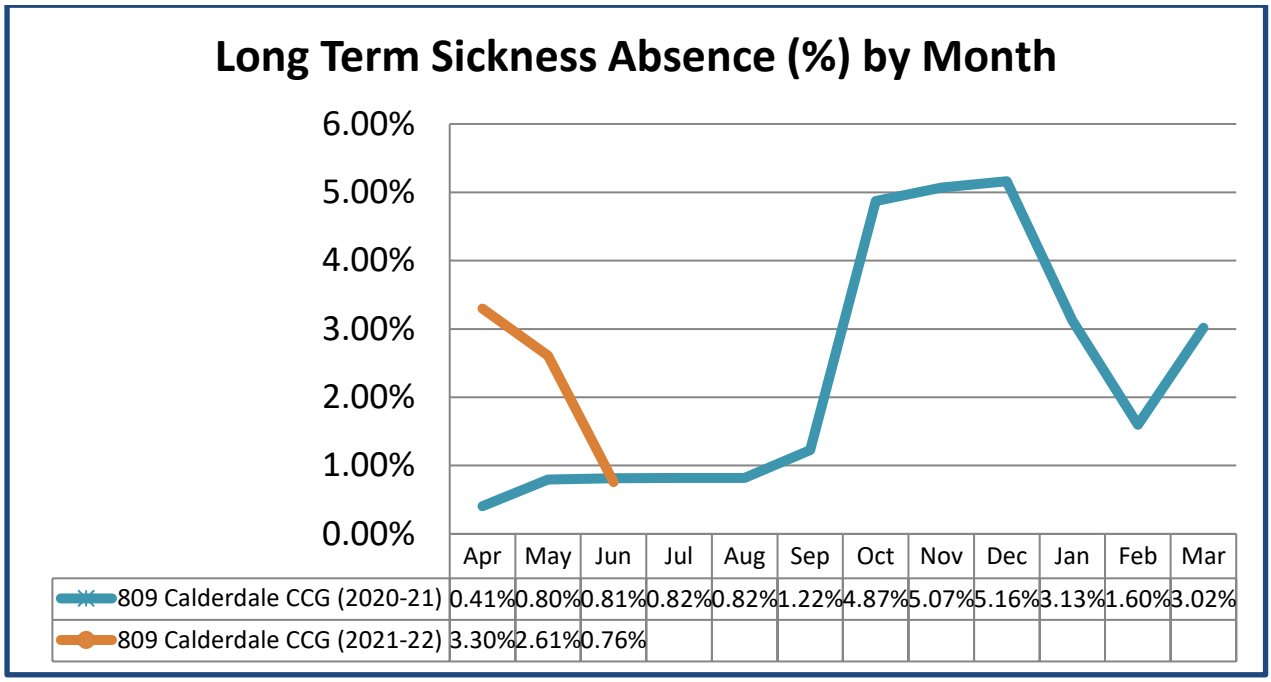
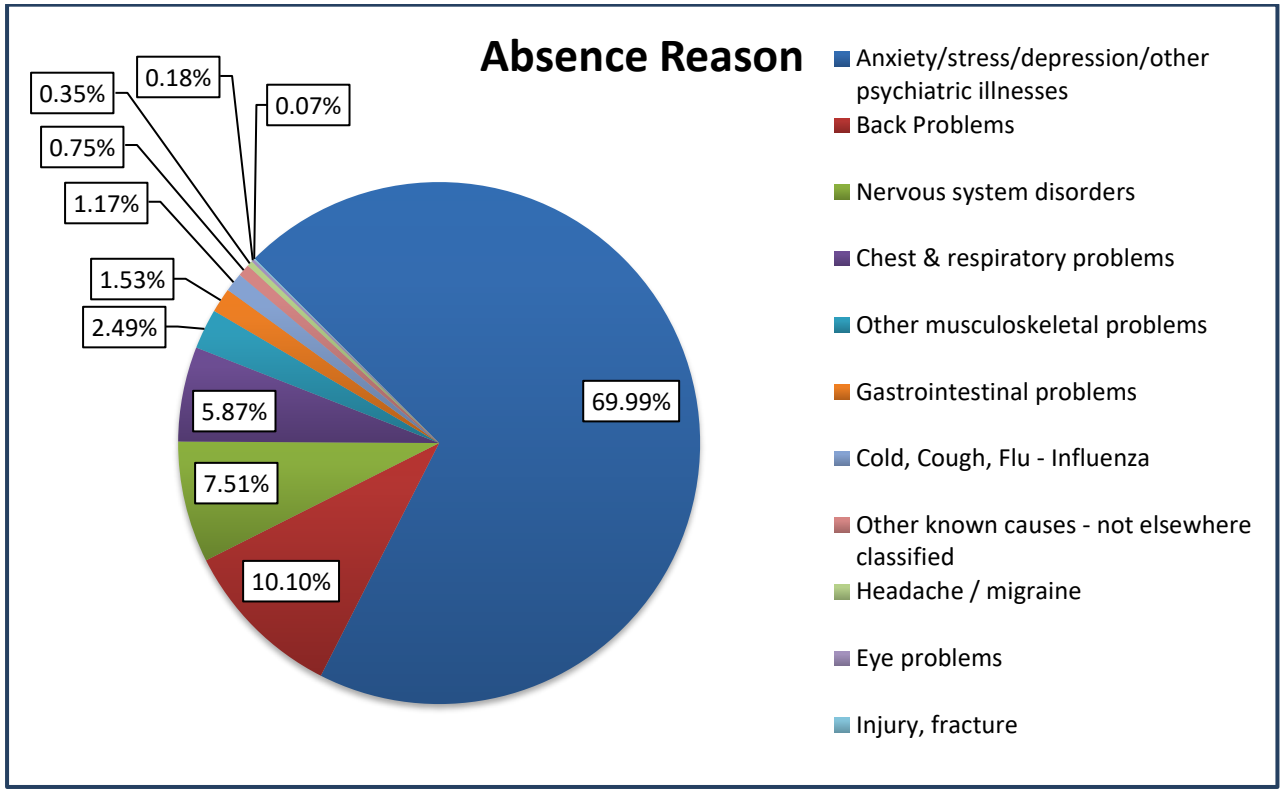


Table 6 – Absence Reason - Top 3



4.6 Sickness absence levels are discussed at SMT and the Human Resources (HR) team works with line managers to ensure that appropriate support is provided to individuals. The updated Managing Sickness Absence policy includes a clearer process for identifying when

individual sickness levels need further exploration. Line managers are now able to review real-time sickness absence information for their teams, so that any patterns or concerns can be identified more quickly through the Electronic Staff Records (ESR).

4.7 Compliance via ESR on return to work sickness meetings is regularly checked and HR actively chases line managers to ensure that these meetings are taking place and any risks being managed. The current compliance rate for return to work interviews as at 30 June 2021 was 100%.

5. Equality & Diversity

5.1 The CCG is committed to equality and diversity in all areas of its work. The equality and diversity information are included in table 7 and is reported in a way that ensures that data is not personally identifiable. The data demonstrates that:

- The workforce is predominantly female.
- Several staff have declared that they have a disability.
- Most of the workforce declared their sexual orientation as heterosexual.
- Most of the workforce declared their religion.
- Most staff have declared their ethnic origin.
- A large percentage of the workforce is aged 41 or over.

Table 7 – Equality and Diversity Information

Disability	Headcount
No	77
Not Declared	≤5
Yes	7
Gender	**Headcount**
Female	69
Male	18
Sexual Orientation	**Headcount**
Gay or Lesbian	6
Heterosexual or Straight	66
Not Declared	13
Other sexual orientation not listed	≤5
Undecided	≤5

Religious Belief	Headcount
Atheism	15
Buddhism	≤5
Christianity	48
Islam	≤5
Not Disclosed	18
Other	≤5
Sikhism	≤5
Ethnic Origin	**Headcount**
Asian or Asian British	≤5
Black or Black British	≤5
Mixed	≤5
White	75
Not Disclosed	≤5
Age Profile	**Headcount**
20-25	≤5
26-30	0
31-35	≤5
36-40	10
41-45	10
46-50	24
51-55	20
56-60	12
61-65	≤5
66-70	0

5.2 The CCG takes a number of actions to promote equality and diversity amongst its workforce and this is particularly important in the context of a small organisation, made up of long-serving staff, and with limited recruitment, which means that opportunities to fundamentally change the demographic make-up of the workforce are limited and take place over time.

5.3 The CCG has signed up to the Integrated Care System (ICS) BAME Review action plan mirroring its focus on areas such as recruitment and selection, succession planning, talent, retention, and culture. This aligns to the CCG workforce equality action plans derived from the analysis and reporting of the Workplace Race Equality Standard (WRES), Workplace Disability Equality Standard (WDES), internal facing goal of the Equality Delivery System and the staff survey. The action plan describes the CCG actions to improve the representation, experience, and outcomes for CCG staff as a whole and particularly those staff from protected groups.

5.4 The WRES and WDES report and data for 2020-21 will be presented to SMT in autumn supported by an action plan for approval.

6. Workforce Headlines

This section provides a summary of other key activities, which have taken place in relation to the workforce.

6.1 Employee relations

The CCG has low levels of employee relations issues and currently there are no formal or informal grievances, disciplinary or performance cases. The policies promote the informal resolution of any issues where appropriate, and HR colleagues provide professional advice and support to line managers and individuals on an informal level in line with this approach.

6.2 HR policy review

The suite of all 25 HR policies were reviewed in 2020/21 and approved by the Remuneration and Nomination Committee. These have now been made available to staff in an accessible format including a summary of changes made to key policies.

6.3 Supporting Working Carers

The CCG has been working in partnership with several organisations to build awareness of the growing need to identify and support working carers with the aim of promoting: -

- A carer-friendly workplace.
- Enabling staff to continue working while caring for someone.
- Preventing the loss of valuable talent for the CCG.
- Understanding carers' needs and issues in the workplace.
- Developing carer-friendly policies and creating a supportive work environment.
- Implementing staff awareness and line manager training.
- Helping carers to identify themselves as carers and to understand what support is available locally.

A comprehensive project plan was developed to support this work which included a phased approach of implementation and an update to Governing Body on the following key deliverables –

- Staff awareness raised at staff workshops.
- CCG now operating a Carer Passport scheme, as part of the CCG's approach to supporting staff who look after family or friends who have a disability, illness or who need support in later life. This is an important ongoing tool for conversations to take place between an employee and their line manager.

- ESR recording guidance developed so staff can confirm in ESR that they are a working carer. To date 1 person has completed a carers Passport and have identified themselves in ESR as a carer.
- Manager's guidance developed with training identified to support them.
- Communication sent out to staff to join the Wakefield CCG Carers' Network.
- Changes to the HR policy made to allow for carers provision for a week's paid leave. The policy has been agreed by SMT, Trade Unions and approved by the Remuneration and Nomination Committee.
- Appraisal document, induction checklist updated to reflect carers support
- Disclaimer added to NHS Jobs re CCG as carer friendly organisation.
- The CCG has a carers' champion in place for advice and support.

6.4 **Employee Assistance Programme (EAP)**

The Employee Assistance Programmes (EAP) is an employee benefit programme offered by the CCG to all employees. The contract with Health Assured has been extended for a further 12 months.

An EAP staff survey was developed and sent out to all staff for a three-week period ending on 22 February 2021. The purpose of the survey was to gain an understanding of EAP awareness, usage, and access to other support services. A total of 16 respondents completed the survey of which 93% had heard of the EAP service through staff workshops, word of mouth, and intranet/MS teams followed by line manager brief. In terms of access to the service – 25% accessed this during the pandemic and 50% before the pandemic. Reasons for accessing the service varied from personal life, work related concerns, finances, and other reasons such as bereavement.

Overall experience was good and over 69%% said they would recommend the service to colleagues and family members. When asked about access to other support services – over 46% said they had accessed other services and over 53% said they hadn't. Details of other support services ranged from own GP, Union, Mental Health First Aiders, managers, colleagues, and friend's network.

6.5 **Accommodation Update**

The accommodation consultation with respect to the contractual change of base was launched on 1 April 2021 and ended on 31 May 2021. Feedback from the 1-1 meetings included car parking, agile ways of working, IT equipment and other team related queries.

The feedback has been incorporated as FAQ's and made available to staff. Reasonable adjustments have also been identified and discussions taken place with those individuals regarding specific support.

An equality impact assessment was also completed which reviewed if there would be any negative impacts on staff in relation to the move. There were no issues of concern that were not already being addressed through individual staff conversations or workplace adaptations being considered.

All staff (including those on contracts for service) will be issued letters in late July/early August regarding the effective date of change of base once this has been confirmed.

6.6 **Health and Wellbeing**

In partnership with the 5 west Yorkshire CCGs – Calderdale CCG will be sending out a wellbeing gift to all directly employed staff in August to thank them for all their hard work and dedication through this challenging time. This will be sent out via HALSA Wellbeing who deliver wellbeing solutions to restore and protect the mind and body. They have created a bespoke wellbeing gift which has been categorised into 4 key areas: Feel Well, Think Well, Sleep Well, Eat Well.

6.7 **Learning and Development**

The current statutory mandatory training dashboards provided to SMT this month (table 8) show that overall compliance remains relatively high averaging at 90% with an expectation that compliance needs to be 95%.

Table 8

Corporate Induction	91.40%
Fire Safety	90.32%
Health, Safety and Welfare	91.40%
Infection Control	91.40%
Manual Handling	90.32%
Safeguarding Children	88.17%
Safeguarding Adults	89.25%
Equality & Diversity	94.62%
Data Security Awareness (IG)	92.47%
Fraud Awareness	91.40%
Managing Conflicts of Interest - Module 1	87.10%
Managing Conflicts of Interest - Module 2	74.29%
Managing Conflicts of Interest - Module 3	100%

ACAS Managing Challenging Behaviours	100%
Unconscious Bias	86.02%

Staff excluded from reporting figures are those who are on long term sick leave or maternity leave. New members of staff are required to complete all their statutory and mandatory training within 2 months of joining the CCG. Heads of Service are actively encouraging staff to review their compliance through various staff communication methods and team meetings.

Line managers are aware of the need to confirm to the Learning and Development team of any additional modules that need to be assigned to the post on ESR in line with the statutory and mandatory training matrix for staff. This includes modules that have differing levels of learning for example Conflict of Interest, Safeguarding or other modules and apply to any members of staff appointed to the new roles that would require higher level of training.

The statutory and mandatory training matrix is reviewed annually by the subject matter experts involved in the delivery of modules and this has recently been approved by SMT for 2021-22.

The Unconscious Bias training commissioned externally by the CCG, was rolled out in December 2020, and ran until 24 February 2021. A small number of staff were not able to attend, however arrangements are being made for them to attend a session later in July delivered by the Equality and Diversity team.

We are currently in the appraisal season which ends 31 July 2021 and appraisal meetings are currently taking place. The intention is to report back on these figures in the next Governing Body workforce report.

6.8 **Social Partnership Forum**

The CCG Partnership Forum is held quarterly with the purpose of facilitating and promoting partnership working between all CCGs and Trade Unions across the Calderdale and Kirklees footprint. The meeting provides a platform to enable meaningful consultation, negotiation, and communication. Trade Union representation at meetings is regularly attended by Unison, RCN, PDA and Unite and the CCGs continue to work in partnership with them.

Items of discussion to date have focused on horizon scanning, the ICS and CCGs, Greater Huddersfield and North Kirklees CCGs merger, accommodation update, Trade Union regional and national updates and Trade Union time recording activity.

6.9 **ICS Transition**

On a regional west Yorkshire level, the CCGs are working closely together to ensure staff are fully briefed on communications and that these are consistent across the regional patch. To date the employment commitment, design framework documents and a set of FAQs have been published and shared with staff.

7. Recommendations

7.1 It is recommended that the Governing Body:

1. **RECEIVES** and **NOTES** the content of the CCG workforce report update.

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Update on 22/22 Planning Round**	**Agenda Item No.**	11
Report Author	Debbie Graham, Director of Improvement (Strategic Planning and Acute Care)	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby, Clinical Chair	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary
Calderdale approached its 2021/22 planning round as a place-based system, and made submissions in both narrative and numerical form, which were collectively agreed with partners. West Yorkshire Integrated Care System (WY ICS) confirmed they were assured by the content of our Calderdale submission, and aggregated the work into the full West Yorkshire narrative submitted to NHS England/Improvement. Our place-based narrative is also being used in the development of place-based operational priorities for 2021/22. A full version of the narrative is attached, as well as a summary of key expectations. The aim of this report is to ensure the Governing Body is sighted on the work and next steps.

Previous Considerations

Name of meeting	Senior Management Team	**Meeting Date**	Standing weekly item
Name of meeting	Quality Finance and Performance Committee	**Meeting Date**	Monthly as part of Performance report

Recommendations
Members are asked to: i. **CONSIDER** the update on the process which has taken place for the completion of a place-based planning submission for 2021/22, ii. **CONSIDER** the full version of the narrative, which is attached as Appendix A, iii. **SEEK** further updates on progress, particularly in relation to the development and delivery of operational priorities for 2021/22.

Decision ☐	Assurance ☒	Discussion ☐	Other:

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Ensuring the quality and safety of service provision is a key element of the planning submission. The Calderdale contribution forms part of the aggregated plan submitted by West Yorkshire Integrated Care System (ICS). A QIA was not a requirement of the submission
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	A key strand of the narrative is its description of work already undertaken and work planned to reduce inequalities. Engagement activities are described in the relevant sections. The Calderdale submission forms part of the aggregated plan submitted by West Yorkshire Integrated Care System (ICS). An EQIA was not a requirement of the submission
Resources / Financial Implications (including Staffing/Workforce considerations)	A key element of the submission is the narrative on workforce; wellbeing, recruitment, retention and risk. A separate financial submission was made as part of the planning round by system finance teams
Sustainability Implications	Our submission is underpinned by; the outcomes in the Calderdale Inclusive Economy Strategy, ambitions for Calderdale to tackle the climate emergency, and Calderdale's aims related to increasing social value.

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

Strategic Objectives (which of the CCG objectives does this relate to?)	The narrative touches on all of the organisations' strategic objectives	**Risk (include risk number and a brief description of the risk)**	The narrative covers a wide breadth of areas, and as such, individual risks are included on the Corporate Risk Register as appropriate
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.

1. Introduction

1.1 The purpose of this paper is to update the Governing Body on the operational plans which have been developed to support the latest national planning round, and how this work is being used to describe place-based priorities for 2021/22.

1.2 On 25 March 2021, NHS England and NHS Improvement (NHSE/I) issued priorities and operational planning guidance for the NHS. This set out a range of specific requirements to be addressed through our partnership planning process and covered the first half of 2021/22.

1.3 The NHS planning guidance set out priorities in the following areas:

a) Supporting the health and wellbeing of staff, and taking action on recruitment and retention
b) Delivering the NHS Covid-19 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 and local health outcomes and address health inequalities
e) Transforming community and urgent and emergency care to prevent inappropriate admissions to hospital, improve flow and reduce length of stay
f) Working collaboratively across systems to deliver on these priorities

2. Approach

2.1 The West Yorkshire Integrated Care System (WY ICS) used ‘place’ (emerging Integrated Care Partnerships) as the primary unit of planning. To support this, Calderdale held regular weekly meetings throughout the planning period involving senior representatives from commissioners, providers, local authority and Voluntary and Community Sector (VCS) partners. This ensured; the development a shared narrative about the transformation of local services, a common set of assumptions about service changes, clarity on activity

requirements, and a place-level financial plan built from an open book approach to organisational planning.

2.2 Calderdale submitted its first draft of a joint plan on 28 April 2021. This included several elements:

- a narrative setting out the assumptions made and actions to be taken to address each of the planning priority themes
- activity and performance trajectories for each of the first six months of 2021/22
- workforce planning trajectories (including detailed mental health workforce
- a final version of the place financial plan

2.3 The plans from each place were aggregated to form the first draft WY ICS submission to NHSE/I on 5 May 2021.

2.4 Feedback was provided by NHSE/I to places and WY ICS programme teams to support the further development of the draft plans. Two ‘world café’ workshops were held between to bring further alignment and improvement between place and WY ICS programmes.

2.5 Checkpoint meetings were also held with the senior planning leads and NHSE/I in each place to review progress, prior to final plans being submitted on 28 May 2021.

2.6 The final, aggregated WY ICS plan was submitted on 3 June 2021 - a copy of the Calderdale plan is attached as Appendix A. The focus now is already on implementation of the plan, to ensure the maximum possible recovery of health and care services in line with the principles and priorities we have agreed.

2.7 NHS England confirmed that they were assured about the content and approach of our place submissions.

2.8 The table in Appendix B below provides a summary of planning guidance expectations.

3. Risks

3.1 The narrative includes a clear set of risk within each individual section. In addition, a summary of high-level risk was shared at the final place checkpoint meeting;

a) Scale of elective recovery
b) The growth in demand in Emergency Departments and in non-elective activity
c) Impact of the pandemic and recovery on the workforce
d) Impact of the pandemic and recovery on finances
e) Continuing to manage COVID-19 demand, including the implementation of new services to support long-covid
f) The White Paper, particularly the multiplicity of priorities, and impact on a finite workforce

4. Next Steps

4.1 As the detailed plan covers only the first half of 2021/22 it is expected that an additional planning process will be required over the summer in preparation for the autumn and winter period.

4.2 We are developing an approach to describing our priorities for 21/22 as a place, which includes the following:

a) Outcomes from Calderdale's Wellbeing Strategy (with a greater emphasis on inequalities)
b) The 10 Big ambitions agreed by the WY ICS
c) The expectations in the planning guidance

A more comprehensive view of the final version of this approach will be shared with the Governing Body at their next meeting for consideration.

4.3 Clarity on our place priorities is critical to ensure we focus on what is important in Calderdale during the period of organisational change driven by the White Paper. It is also important that our ICP development is underpinned by clarity on our local vision and priorities.

4.4 We will therefore use the WY ICS Development Framework to guide our approach to delivery of our priorities. The Framework has three areas, which underpin a self-assessment, in terms of the strength of our:

a) Vison, purpose, outcomes, alignment
b) Leadership, culture, style relationships, behaviours
c) Infrastructure, governance, financial frameworks, risks, data

4.5 The self- assessment is intended to identify the current maturity of each place, and support movement to greater maturity and delivery, based on four levels:

a) An emerging ICP which has just begun the journey to working together in partnership in place
b) A developing ICP which has set up the foundations needed for the partnership and has identified steps needed to become an effective ICP
c) A maturing ICP, with the right components in place to be effective in delivery at place and delivery within the wider ICS
d) A thriving ICP which seeks to go beyond the minimum and has an ambition to excel for its population

4.6 The ICP Development Programme in Calderdale will be leading the self-assessment. We are working closely with partners to ensure alignment of approaches.

5. Recommendations

Members are asked to:

i. **CONSIDER** the update on the process which has taken place for the completion of a place-based planning submission for 2021/22,

ii. **CONSIDER** the full version of the narrative, which is attached as Appendix A,

iii. **SEEK** further updates on progress, particularly in relation to the development and delivery of operational priorities for 2021/22.

6. Appendices

Appendix A - Copy of the full narrative document

Appendix B - Summary of planning guidance expectations

Item 11, Appendix A

2021/22 Priorities and Operational Planning: Narrative Submission Template for Calderdale

29 March 2021 Calderdale V7

1. Summary of sections

Ref	Section of 2021/22 priorities and operational planning guidance	Response Required Against: Numerical Plan	Response Required Against: Priorities A-F
A	Supporting the health and wellbeing of staff and taking action on recruitment and retention	Yes	Yes
B	Continuing to meet the needs of patients with Covid-19	No	Yes
C1	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service	Yes	No
C2	Restore full operation of all cancer services	Yes	No
C3a	*Expand and improve mental health services [incorporated in section A.]*	No	No
C3b	Expand and improve services for people with a learning disability and/or autism	Yes	Yes
C4	Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review	No	Yes
D1	Restoring and increasing access to primary care services	No	Yes
D2	Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities	Yes	Yes
E1	Transforming community services and improve discharge	Yes	Yes
E2	Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	Yes	Yes
F	*Working collaboratively across systems to deliver on these priorities [no requirement for narrative submission]*	No	No
	Other areas outlined within implementation guidance		
	Elective Recovery Framework: Gateway Criteria		
	Health Inequalities: 5 priority areas		

System name:	Calderdale

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
A1 Looking after our people and helping them to recover	Calderdale's Wellbeing Strategy confirms the long-standing commitment of our system to its ''enterprising and talented staff''. We have an Integrated People Plan for Calderdale, based on the 4 key areas of the NHS People Plan released in July 2020 but we are clear for Calderdale it covers all areas of our health and care system not just NHS. There is a monthly group that oversees development and implementation of the plan - with representatives from all providers. The deliverables within each programme are still being shaped, it is currently divided into 1-12 months and 1-3 year and we propose to use this work around the planning guidance to reframe and refresh so it aligns with the narrative expectations of the 'next 6 months' time period. As a system we recognise the central role staff in all our health and care, and broader set of partners have played in the pandemic, supporting and caring for our patients and population. We also recognise that our staff require that same support and care from our system in order to give them the resilience to continue on the next stage of our journey. We know that our staff are fatigued from their efforts, and we have a range of intervention in place at all levels, in all organisations to enable them to recover – many of which have been in place through the three waves of the pandemic. *We believe the following examples provide a sense of the work ongoing in Calderdale to* deliver on the key lines of enquiry which are: particularly *a) Ensuring provisions are in place to support our people to recover and promote proactive health and wellbeing:* *b) To ensure organisations are ensuring people have time off to recover in Q1 and Q2* *c) Designed process for Individual HWB conversations and wellbeing plans to be undertaken, which include staff safety and protection, risk assessment, flexible working and access to preventative HWB support.* *d) We have enhanced occupational health and wellbeing across our partnership* *e) We have ensure rapid access to psychological and specialist support* • As a Calderdale place we were successful in securing funding for 2 Enhanced Occupational Health projects: o Health and wellbeing boosts – working with Halsa Health and Wellbeing to provide a range of sessions for

	all our staff around the 4 areas of 'Eat Well, Sleep Well, Feel Well and Think Well'. We have 22 sessions planned across 8 days in May during Mental Health Awareness Week which will be part of our spring boost week offer. There are also 11 video links provided for staff to access on a more flexible basis. o Sessions for staff experiencing more complex mental health symptoms - Socrates, an external clinical psychology company are providing up to 6 sessions per referral for those staff who would benefit from this more specialist service. o We continue to focus a significant amount of attention on the 'Looking after our People' programme of work, recognising that it is essential for the recovery and restoration of our people over the coming months. We are currently in the process of planning a shared health and well- being group across Calderdale and Kirklees that will report into our respective integrated workforce groups. This will enable us to maximise available resources, share good practice, reduce duplication of effort and work more effectively with the WY & HP Mental Health Resilience Hub. • CHFT developed a clear approach to supporting 'colleague' health and wellbeing during the pandemic and this approach will continue through the next 6 months and beyond. Examples include; o Regular and visible leadership and listening events, supported by Managers guides o Annual Health and Wellbeing Risk Assessments, supported by the roll out of physical risk assessment 'lite' and a 24/7 helpline with triage to psychological support o Dedicated Schwartz rounds o Wellbeing Ambassadors supporting teams to deliver the basics of health and wellbeing: Nutrition/hydration/Facilities/sleep o Deployed staff induction packs for new areas o Recommunicate and encourage The Wellbeing Hour – managers training sessions rolled out o Delivered a series of 'Team to Team' events to support effective relationships o Accelerated the 'thank you' campaign to encourage colleagues to share positive stories about each other o Facilitated 'Soft' Working Together to Get Results events to focus on the future o Delivered events to reconnect those colleagues who have been working from home for a year – inc those who are clinically vulnerable and pregnant colleagues with those who have been working on site o Continued free parking for staff who will be issued with new access cards. • SWYPFT enhanced its long-standing commitment to workplace wellbeing, and has its own specialist in house accredited Occupational Health and wellbeing service and in-house staff counselling service, as well as an

	active pastoral and spiritual care team providing staff retreats, mindfulness and spiritual services. This approach will continue well into the future, and examples include; o Increased its wellbeing support, including an initial 7-day a week psychological advice line, occupational health advice, improved access to wellbeing resources, risk assessments, fast track access to support for stress-related illness, and dedicated Coronavirus Psychological Support line. o Built on its formal BAME and vulnerable staff risk assessment process, created a self-assessment process for all staff, and an MSK risk assessment process (recognising that many people were working differently including remote/home working o Encouraged regular individual and team conversations about wellbeing, and cascaded regular messaging through the Trust's Team Brief communication and other communication channels. o Encouraged staff to take their annual leave and to look after their wellbeing prior to and during the pandemic. o Conducted a well-being at Working Survey with over 2000 responses, with wellbeing at work was a key theme used in our appraisal process prior to the pandemic and this has been strengthened this year. • Calderdale Council's workplace wellbeing programme offers a wide range of support for employees impacted directly or indirectly by Covid-19: o Commissioned Healthy Minds, a voluntary and community sector mental health promotion and support organisation to develop and deliver a peer led mental health support programme to the workforce particularly impacted by responding to Covid-19, with a focus on care home, Calderdale Council and voluntary and community sector staff and volunteers. The service will also support access of mental health services where this is appropriate. o We have established a Employee Resilience Group open to all staff and including members of the staff networks (BAME, LGBTQ, Carers, Disabled staff, etc). The group is involved in shaping decisions about future ways of working, recovery of council services and employee resilience. o Support through Peer 2 Peer – Listening Ear (P2PLE) – a confidential support line, run by employees, for employees of Calderdale set up as a direct response to Covid and the challenges employees were facing. Enabled access to information and relevant local resources for differing issues. Self-Referral was set up in order to support easier access to Occupational Health for all employees. o Reviewed communication and engagement with a continued focus on wellbeing – including Wellbeing Surveys. o Ensuring wellbeing conversations are at the heart of Shared Conversations) and webinars led by senior leaders covering key topics identified from the workforce. Wellbeing Wednesday E-call was set up to focus

	specifically on Wellbeing and this ecall specifically highlights different opportunities and initiatives to support wellbeing. o Improved / Enhanced Learning and Development Opportunities – these include Mindfulness, understanding sleep, financial support with delivery from Calderdale Credit Union and development of Mental Health Awareness. o Enhanced Equality and Diversity training that focuses on inclusion and the impact of micro aggressions on health and wellbeing. Calderdale Adult Learning offers covering adult learning/hobbies/sewing cooking etc. is actively promoted. o Staff Networks and Forums – have developed and grown over the last year, Black and Asian Minority Ethnic Network; Staff Disability Forum; Lesbian, Gay, Bi & Trans (LGBT) Network; Employee Reference Group; Shielding Support Network and a newly formed Parent and Carer Together Network. All these networks support wellbeing and engagement across the organisation and wider in some cases across a West Yorkshire footprint. o Wellbeing Week – covered five days of interactive activities, resources, and Zoom events and workshops. Some events were live, but many were recorded so employees were able to view later. The week was opened by our Chief Executive Robin Tuddenham, Council Deputy Leader Councillor Jane Scullion, and Keynote speaker Jason Anker. o Active Calderdale - this has been continually promoted for active engagement of various activities and initiatives to support physical activity and wellbeing. This is a borough wide initiative. o Wellbeing Champions - a network of enthusiastic volunteers, helping to raise health and wellbeing awareness throughout the Council. • In primary care we have; o An Employee Assist Programme has been made available for General Practices across Calderdale for 20/21 and to date 8 practices have indicated a desire to continue to offer that benefit to their employees. o Created access to Supporting our NHS People which includes a bespoke online resource package for General Practice Staff to Access o Benefitted from funding to offer staff across the system Specialist Psychological Support acknowledging the effects of working through the pandemic which enhances the occupational health offer. This is open to General Practice staff o Invested in Practice Management Coaching and Mentoring Support for 2021/22 recognising the pressure that practice management staff are feeling at the present time. • In the Voluntary and Community Sector we have;

	o An Integrated Workforce programme, being led by Maureen Goddard for Calderdale, includes VCSE representation and input through VAC CEO in order to integrate priorities/actions across our wider Health & Care Workforce. We are also exploring opportunities to have a workforce health and wellbeing representative on our emerging Calderdale and Kirklees group from the VCSE o Bi-monthly VCSE Peer support webinars led by VAC /VSI Alliance including a focus on promoting dialogue and action on sector needs linked to health & wellbeing o Supporting over 500 volunteers registered with the Volunteer Hub, supported by VSI Alliance through offering access to online training and range of support (including wellbeing linked to VCSE workforce wellbeing plans) o VSI Alliance organisational development team and Volunteer Team available to provide advice and signposting where support required to VCSE sector/ volunteers o Communications and social media campaigns promoting messages linked to sector workforce wellbeing, access to support and engaging in regional campaigns i.e. #movethecalderdaleway #calderdalecommunityresponse #calderdalefireflies (linked to lockdown resilience) and promoting West Yorkshire and Harrogate Partnership campaign across the workforce i.e. #WYHcheckinVCSE mutual aid groups linking in with Active Calderdale to improve access to physical activity and wellbeing for community response volunteers • At Overgate Hospice we have; o Continued to support system wide colleagues via Mutual Aid in the short term and are committed to doing so. o Explored the potential to re-establish the CCCG funded place Hear for You telephone support line recognising that staff may now need support. We could also expand our counselling provision to system wide staff, expand our bereavement support services to include those bereaved through covid. Like Kirkwood Hospice we are committed to exploring rotational staffing posts across the system which may act as an attractive employment proposition which could have positive effects on recruitment and retention. o The CCG has; o A long-standing staff wellbeing agenda, which has been amplified during the pandemic, and include; o Self and line management risk assessment, and access to a range of support mechanisms, including physical and mental health support o Increased levels of communications, messaging, one-to-one support from managers at all levels in the organisation.

	o Building on our successful Staff Forum, ensuring staff have a strong voice in developing support mechanisms, including a new Staff Resilience Programme
A2 Belonging in the NHS and addressing inequalities	As a system, we recognise that the pandemic has created a new sense of belonging, not just in the NHS, but across caring organisations more broadly, with local communities recognising, now more than ever, the value of the people who care for them. Our Vision 2024 has an aspiration for Kindness and Resilience. Our Calderdale Wellbeing Strategy commits to continue that journey by learning from the pandemic and changing the nature of the relationship between our staff and the people they serve. Our organisations have found new and innovative ways of staying connected to staff, ensuring they feel valued and have a voice. *We believe the examples we have provided as a system demonstrate an inclusive and compassionate culture, and once which addresses health inequalities. There are clear examples of; improved diversity through recruitment and local practices, developed WREs and WDES improvement plans, and accelerated delivery of the model employer goals. There are clear examples about actions to develop a more diverse leadership, and improve workplace experiences for those from ethnic minority back grounds* • As a Place we were successful in securing funding through the Support Staff Development Fund (SSWDF) with Calderdale College as our lead provider, to explore, co-design and co-produce the content of a programme that will focus specifically upon engaging with and developing support staff from ethnic minority groups early in their careers (bands 1-4) with a view to ascertaining what learning interventions would be most helpful in maximising their potential and developing them as future sector leaders. The programme builds on the existing aspiring leader's programme. The first focus group took place in April to establish a framework for the pilot. Leading members of the BAME business community in Calderdale are involved and have agreed to act as critical friends at the beginning stage of the project as well as expressing interest in becoming mentors under the programme. • We were also successful in gaining Place funding through the SSWDF, again with Calderdale College as our lead provider, to develop 'Digital Inclusion Specialists' to assist those staff members furthest away from meeting the Level 1 competencies of Health Education England's Digital Capabilities Competencies Framework. We will build on the work already undertaken on developing an outline of course content for the Specialists to use and the outline of the course content to train the trainers with plans to deliver a series of employer/individual-led workshops to test training content and delivery methods. • Building leadership for Inclusion activities and executive development programmes as well as continuing to encourage applicants and the provision of Calderdale wide placements for the WY&HP Fellowship programme. Our priority is the High Potential 2 Programme which is currently being recruited to. We will also continue to develop our leaders through our shared Future Leaders Programme.

	• Creating WRES OD development roles and talent pools, along with a programme to develop capabilities and confidence, whilst offering opportunities to support career aspirations. In SWYPFT Talent Pool members have priority access to learning programmes, including Crucial Conversations training, Shadow board, Reciprocal Mentoring and Peer Coaching. • SWYFT is also supporting the WY&H Care Partnership in their leadership development programme by hosting a Fellow and providing Peer Coaching, and continues to work with The Tavistock Institute in further developing our Framework for a Conversation into Team-Talk. • Reviewing recruitment processes to increase diversity and supporting everyone to access employment opportunities. • SWYPFT have also developed a Race Forward network and will implement an Equity Guardian model which has a clinical path for service users that behave in racially inappropriate manner and support for staff that experience racist abuse from service users. • CHFT remain instrumental in delivering a health service where equality, diversity and inclusion are embraced and communicated in our everyday. The Trust's 5 year Inclusion strategy sets out how the organisation strives towards delivering change and our policy ensures that employment matters adhere to best practice and legislation. Performance is monitored by the workforce committee, a sub-committee of the Trust Board. When considering performance outcomes, the Committee will seek to ensure the outcomes align with overall business performance. • In the last 12 months, CHFT developed a LGBTQ+ forum. Over 2500 colleagues wear their NHS Rainbow Lanyard with pride and they have all pledged to take action to support inclusion and accessibility to services. They flew their LGBTQ flag during LGBT History month and the network chair developed a LGBTQ History video. Their LGBTQ colleague network plays an important role in ensuring we value and celebrate diversity, sharing their experiences and highlighting important events. • CHFT have formed a Colleague Disability Action Group and are working on a Workforce Disability Equality Plan. Their disabled colleagues contribute to proposals around service and policy changes through our Equality Impact Assessments. • Through 'Project Search, CHFT offers young adults with learning difficulties, disabilities or autism, opportunities to support them on their employability journey through a blend of work experience and classroom learning. • The CHFT BAME network has over 100 members and during the pandemic they continued to meet quarterly via Microsoft teams. Members are actively involved in Equality Impact Assessments and Reconfiguration Plans. They We developed a 'Step in Our Shoes' 'Unconscious Bias' module in their Leadership Development Programme and produced a range of materials during Anti-Bullying Week. Plus a poster campaign during black history month. The Trust offers an Inclusive Mentoring programme for BAME colleagues and is working

	with the network to ensure the Trust has BAME representatives on interview panels. • Overgate Hospice is committed to addressing inequalities and this forms one of their four clinical priorities in their clinical strategy.
A3 Embed new ways of working and delivering care	As a system we have committed ourselves to leaning as much as possible from the pandemic, and creating and embedding new ways of working and delivering care to our population. We view our staff are the most vital component of these changes. We have seen innovative ways of working across our place to reach some of our most vulnerable populations and we will continue with this work over the coming months as well as using it as a springboard for new ways of working. Our Calderdale Collaborative Community Programme (3CP) is a key driver for this change. *We believe the examples below provide a clear view of our systems actions to; develop and embed new and creative ways of working, changed pathways and worked extensively across organisational boundaries, implemented E-rostering, supported each other across organisational boundaries and have embraced digital advances;* • Our Roving Vaccine Team, a shared initiative across CHFT and PCNs to deliver vaccines to our housebound populations and in pop up clinics in mosques and other community venues. Our approach to ensuring the supply of a flexible workforce during the pandemic has seen the development of an MoU, mutual aid and PCNs being supported to recruit staff through a GP Federation. This model and the availability of a flexible staff pool for primary care will be an asset going forward. • In July 2020, following the first wave of the COVID-19 pandemic, Calderdale Partners came together to take stock. The rationale was to help stabilise the system and show how our communities and services came together to address challenges and adapt. It also enabled us to learn from doing things differently, understand what has worked well and allowed us to work differently. The aim of the review was to capture that learning for the benefit of all. • By working together our aim is to transform the experience of people who use services as well as the experience of those who deliver them. The outcome from the review has helped us to understand and: learn from our mistakes and restore services, create a place based system that promotes wellbeing, and work together to develop a workforce that is adaptable to new care needs /demands and challenges as they arise across the whole community (locality and/or place based). The 3CPB has developed a delivery plan to improve care and wellbeing outcomes, enable timely access and seamless patient journey. • At the end of July 2020, Calderdale had some of the highest Covid-19 rates in the country and was placed under local restrictions which we have been under ever since. Taking a community centred approach to

	talking and listening to communities with enduring Covid-19 transmission was effective at reducing case rates. It provides a platform for a new way of working with communities on improving health and wellbeing that has empowerment at the heart of it. • WYAAT will be leading on re digital passports (and other initiatives to support staff movement. *We have identified some of the key changes we have planned and also some of the key challenges as they relate to our workforce;* In CHFT, an overarching workforce redesign programme has been developed that allows local flexibility to deliver design at pace, whilst ensuring good workforce governance. • This programme has also identified 3 initial themes to test out the approach and directly support the recovery; Advanced Clinical Practitioners, Multiskilled Health Care Worker in AED and Clinical Administration support within Divisions • The initial key areas of risk in relation to recovery are wards, Endoscopy and theatres and for these areas new clinical workforce models need to be explored at pace. This will involve a task-based approach to understanding the need, a review of professional groups to maximise the opportunity where there is more opportunity to secure capacity and a blurring of professional boundaries to maximise the capacity available. • Where new roles have already been defined for example Ward Based Pharmacists, recruitment will be expedited. In addition, where opportunities have been identified for team developments that increase resilience e.g. HOOP & Outreach these will be explored at pace. • There will need a high level of risk appetite to maximise this opportunity, moving away from nationally recommended ratios and skill mix into something that better meets the needs of patients within each clinical area. This will widen the access for colleagues to contribute to safe and effective care. • Colleagues who have been redeployed will be retained or moved back to home areas in accordance with the priorities of the recovery framework. During this review of redeployed colleagues we will ensure that a skills passport is developed for all colleagues who may be asked to work in areas outside their normal working environment. • Where staff return to their Pre-Covid-19 workplace there will be a formal 're-boarding' which will include 1:1 with line manager, assessment of any skills refresh required and the offer of pastoral support. • We will continue to encourage staff to take their Annual leave as a key element of their personal resilience. We recognise there has been a significant volume of carry over and we will ensure that rostering of all leave is well structured and does not impact on the delivery of care to patients • There is a requirement to ensure we remain responsive to patient need linking back to our principles of health

	inequality guided and needs base. This will require a flexible approach to workforce planning including flexibility in Consultant job plans. We will work with clinical colleagues to agree the least bureaucratic approach to this including team job plans and annualised activity. This will be an approach for the period of recovery and will not replace the previously agreed framework once recovery is complete. This will include agreement on both patient facing activity and arrangements for associated clinical admin for planned and unplanned activity. • There will be a number of key challenges to this work. The key challenge is the availability of workforce due to a combination of: o Gaps pre Covid o Absence as a result of covid either through isolation or shielding o New models in response to Covid either volume, acuity or segregation driven o Increased sickness absence due to fatigue o Increased absence or resignation as a result of changes implemented to manage the pandemic. o These may be positive opportunities or from a position of dissatisfaction Without due regard to the health and wellbeing of staff there is the potential for these gaps to be exacerbated. SWYPFT continues to develop an already recognised and well-established workforce planning cycle within the Trust, which supports the wider annual planning process, workforce and OD strategy and L&D delivery in line with financial plans and apprenticeship levy spend. It has delivered on the cycle again this year, albeit as a light touch approach as it continued to concentrate on Covid response and recovery. It has; • Rolled out E-rostering across all inpatient units and has plans to roll out further across the Trust in the next 12 months. It has also implemented the Safe Care module in inpatient units, and is working together with services and professions to ensure they have appropriate staffing levels and workforce capacity to meet the needs of service users. Support and training will be provided to managers on how to maximise the use of e-rostering and promote visibility and flexibility for staff. • Signed ICS-wide MOUs to support flexibility and the movement of staff, which has been positive in supporting the vaccine programme, and is leading on developing a collaborative bank across the MH/LD providers across WY&H ICS which will support the option of digital passports. It has agile and remote working policies and processes which are being reviewed considering the increase in home and remote working over the last 12 months and this will also inform recovery and estates plans. It has successfully used remote learning for our welcome events and other training courses and plan to embed this further through more digitalised learning spaces and options.

	• Built on its 6th year of its clinical support workforce strategy, including continued delivery of its band 2 apprenticeship model which is supported by our care certificate delivery. It is into the 3rd year of TNA into nursing assistant rollout. Take up has been high and we currently have 92 staff in different stages of the programme. We are now looking toward diversification of support roles into other professional need such as AHP, psychology and pharmacy. • Recently appointed to a lead Peer Support Worker role which will work with workforce planning to develop a wider integration of PSW roles across the Trust. We already employ 17 PSW's in various service settings, but our intention is to widen this participation over the next 12-18 months within operational workforce plans. Whilst it has ACP roles embedded into the Trust already, it continues to develop role availability and widen its placement. It has a number of ACP's graduating this year who await placement into the Trust • Developing its our own peripatetic workforce to support primarily our clinical support workforce and also offer even greater flexibility to staff hours worked. In Calderdale Council, throughout Covid 19 the pace and extent of collaboration with CHFT and CCG partners has been unprecedented, providing the opportunity to create a range of initiatives in a significantly shorter period than would have been the case prior to the pandemic. • The Council has a small public health team that has been leading the prevention and management of Covid-19 outbreaks and transmission. The team is embarking on a process in May 2021 to develop a vision for the future of the public health function and to recover public health programmes and services • Job profiles have been redesigned to ensure integrated multi-disciplinary approaches are at the forefront of community-based practice • The new model has been designed with an emphasis on a Hospital Discharge to Assess/Home First approach and a revised First Contact function within Gateway to Care to manage community demand more effectively. The clear focus will be to address immediate concerns in the first instance, including safeguarding responses, provide advice, guidance/information, sign posting and undertake assessments, depending on need and circumstance. Calderdale Council practitioners will be trained to have a greater focus on an asset and strength-based approach by enabling people to live as independently as possible, utilising their own strengths and abilities, linked to resources in their communities. As part of a system wide competency framework, Calderdale Council practitioners with health colleagues will receive Trusted Assessor training to assess a person's essential health and Calderdale Council needs and be empowered to prescribe the use of simple to use technologies that people can access to further enable independence, encourage self-service and reduce isolation and improve health and well-being. • The Prevention and Early Help Hubs will host a newly established 24/7 integrated Community Rapid Response

	Team, an extension to the current Reablement Service, focusing on the immediate delivery of short-term support to an individual in crisis in their own home within 2 hours, as part of an integrated UCR model, jointly developed with CHFT community services. The service will provide, personal, therapeutic, and clinical care support to avoid hospital and care home re/admissions. The clinical element will be introduced as part of a wider system proposal to establish an integrated Rapid Response service incorporating CHFT community services. The service will also provide a sitting service where identified to enable a person to return home and avoid hospital re/admission for social reasons. A Covid recovery and resilience programme focusing on VCSE is being led by VAC (as part of VSI Alliance) workforce wellbeing is delivering the following outcomes: • Dedicated VCSE lead as part of VSI Alliance in place to focus on workforce wellbeing and resilience developments with a focus on sustainable outcomes/solutions. • Clear understanding of the mental health & emotional resilience needs across Calderdale VCS workforce including volunteers. • Increased access to the range of mental health and wellbeing support for VCS workforce to ensure wellbeing and resilience i.e online toolkits to support mental health and wellbeing including access to online support (wellbeing apps such as Headspace, etc) • MH First Aiders trained/developed across the sector to encourage organisational and sector resilience. • Focus on mental health and wellbeing through wellbeing champions network driving peer support networks at all levels of VCS (Conversations actively taking place about Wellbeing Champions, linked into CMBC Mental Wellbeing and Suicide Prevention programme led by Richard Porter, Public Health) • Greater engagement and participation by VCS workforce and service users in a range of targeted campaigns led and championed by the VSI Alliance. • VCSE leading on / supporting wellbeing campaigns in partnership with on Active Calderdale and Public Health i.e.#movethecalderdaleway and #stepoutchallenge to promote greater VCS and volunteer engagement into wellbeing campaigns /activities/ opportunities links into physical activity to raise awareness and wellbeing of staff and volunteers. Investment made into VSI Alliance (VSIA) will fund an organisational development role focusing on embedding physical activity (PA)/wellbeing across VCSE sector/workforce from April 2021 to ensure the following: • Physical activity/wellbeing is embedded into the core business for the VSIA through changes to the VSIA's processes and infrastructure • Physical activity is part of the VSIA diagnostic and becomes part of core support for organisations supported

	through the VSIA • Through communications support the profile of physical activity/wellbeing across the sector will be increased, enhanced and maintained • An increased number of VCSE organisations are hosting, delivering or promoting Activity and embedding activity/wellbeing (this will be further enhanced for organisations who are taking up or undertaking Quality for Health & Wellbeing Standard) • Organisations signed up as Active Ambassadors/ Signed up to an active charter • Annual survey results demonstrate increased awareness and cultural changes across the sector increasing the level of activity within organisations • Facilitate story gathering and sharing across VCSE to promote engagement and benefits into sector workforce wellbeing and create movement linked to wellbeing linked to above.
A4 Grow for the future	Our System has recognised the need to maximise learning from the pandemic, refresh its strategic direction and grow its future workforce. *We believe the examples below provide a sense of our local approach;* • We have developed a variety of workforce supply pipelines across our place in response to the pandemic including local recruitment into a flexible workforce for our PCNs, people working across organisational boundaries facilitated by an MoU and a large pool of recruits to the CHFT staff banks through the national NHSP pipeline. We are working over the coming weeks to ensure we continue to engage with these people as a potential talent pool, beyond the life of the vaccine programme, where we can utilise their skills in other areas. As well as a Well-being Strategy, we have also agreed an Inclusive Economy Strategy which promotes practices to target recruitment at our most deprived communities, and promote social value through investment in local businesses. We will continue to attract new people to our health and care sector by widening participation and supporting economic recovery through programmes such as Kickstart. Across Calderdale (all sectors) we have secured 200 vacancies with people currently starting placements. • CHFT are key partners in the Community Collaborative, and; o Are currently appointing to an employability post within the Trust to ensure widening participation is embedded o There have already been changes made across the Operational Leadership team, and over the next few weeks there will be similar levels of change in clinical leadership across the Divisions. o They recognise that for corporate, operational and clinical leaders this has been a challenging 12 months with little opportunity for recuperation, as they moved between planning and delivery across all 3 waves.

	o The Trust launched an online leadership programme which will be reviewed with colleagues to inform future developments. We will also deliver a new CD programme reflecting over 50% of CDs will be newly appointed and continue with monthly leadership sessions using external providers such as 'The Art of Brilliance' o Leadership Communications will continue through the weekly leadership briefings as well as the Medical and Nursing forums. Divisions will be expected to have forums for their leadership teams and wider staff groups. • SWYPFT are key partners in the community collaborative, and have; o Workforce development initiatives are aligned with priorities across MH partner trusts, the geographical places in which the Trust delivers services, and at ICS level. o A strong relationship with HEE and local universities to build future workforce capacity needs, and existing strategies are being reviewed in response to Covid o A Recruitment and Retention Task Force has developed marketing approaches with flexible working and internal transfer options. The Trust has implemented local and community BAME workforce initiatives. . o Career pathways are developed specifically for the nursing and AHP workforce o The HR and OD approach is to provide professional leadership in supporting service reconfigurations and emergent skills mix needs as a response to COVID now more influenced by digital solutions, new ways of working, and a new forming cultural norm for staff and service users. o Lead Trust within 2 separate recruitment initiatives. Firstly as a direct response to the People Plan and the need to reduce nurse vacancies, Secondly a collaborative MH Virtual Recruitment hub and virtual platform for recruitment fairs. o Employed into a specific role which concentrates on increasing marketing, footfall and communication within various social media platforms and fields. o Workforce planning representation continues to be maintained on all ICS led workforce strategy and development boards with both workforce and education leads at the forefront of the decision making and operational delivery/liaison. o Its current workforce strategy is being refreshed based on its organisational priority of making the Trust a great place to work and aligns with the NHS People Plan. • Calderdale Council are key partner in the Calderdale Community Collaborative Partnership and have; o The restructure of Adult Calderdale Council assessment services will place a clear emphasis on workforce development. Team Managers, Team Leaders and Advanced Practitioners will be recruited to posts with

	skills and experience to support the current and future needs, functions of the service. A workforce needs analysis will be undertaken following the restructure and all colleagues will each have a workforce development profile that will support their immediate and longer term professional development to ensure they are able to confidently discharge their new duties and maximise their potential for future career opportunities. The above will inform a service wide workforce development programme to ensure a highly skilled workforce. o Development of progression pathways for both qualified Social Work and unqualified assessment staff. o A range of staff forums to improve workforce engagement. o Assessments will take a strength/asset-based approach, providing first contact information at the right time and place to maximise independence. o Developed opportunities to support the care home sector • In our Voluntary and Community Sector are a key partner in our collaborative, and have; o Develop ways to support retaining and recruiting people into VCSE workforce. To counter this: o Calderdale college has a programme linking employers to students, including apprenticeship opportunities which need to harnessed to promote a pipeline for VCSE workforce o WY & H Partnership Harnessing Power of communities Local Workforce Action Board funding allocated to VAC to promote second careers in VCSE health and care and supporting local recruitment drives for hospital trust based vacancies from diverse communities o Work experience for volunteers giving opportunities to review the variety of careers available in VCSE including moving into apprenticeships and/or take on paid employment. o VSI Alliance are part of a West Yorkshire infrastructure group (Big Lottery funded) who share volunteering good practice and have trialled engaging with NHS and VCSE colleagues to enable increased capacity across the workforce o Calderdale College have a programme linking employers to students, including apprenticeship opportunities. WY&H Partnership Harnessing Power of communities/LWAB funding focused on promoting second careers in health and care and local recruitment drives for hospital trust based vacancies Primary Care are a key partner in the community alliance, and actions associated with additional roles in primary care are identified in the primary care workforce section

Please summarise the key assumptions that underpin the numerical workforce plan submissions listed below, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned workforce levels where these are not set out above, including recruitment and retention, use of bank and agency, redesign of teams and roles, deployment across sectors and/or organisations and sickness absence.	
Primary Care	
Assumptions	• Workforce data source is from published data – Dec 2020. Publication of data providing March 2021 is due May 6th 2021 therefore likely to change slightly on second submission • GP numbers based on the same rationale as last year; Based on Mckinsey findings that increased the number of generalist GPs at 2023 by 7 • Nursing numbers based on same rationale as last year; Mckinsey says reduction in nursing by 40% by 2023 Assumption made this will not be in primary care. Have built in ANP roles and therefore left it static throughout • ARRS funded roles - Outturn and establishment at March 2021 are actuals with data source being PCN submissions and claims at March 2021 made to the CCG • Non ARRS funded clinical roles – data source is from published data – Dec 2020. The roles listed in this data do not differentiate as to ARRS or not therefore the submission figure has been reached through subtracting the ARRS funded roles • ARRS forecast is placed on current PCN plans
Actions	• CCG to continue to work closely with the PCNs to ensure ARRS recruitment plans are shared • CCG to continue to promote the value of ARRS in delivering high quality general practice, and work with partners to encourage collaboration around ARRS roles to improve recruitment and retention • PCNs to develop workforce strategies and use workforce planning tools to assist with this • PCNs to access West Yorks and Harrogate Primary Care School offers due to come on stream in 2021/22 - Clinical Supervision programme, GP fellowship, GP mentoring programme, pre –registration nursing placements
Risks and issues	• Recruitment and retention issues • PCN maturity regarding management and supervision of the Additional Roles, particularly in recognising the importance of professional development. • PCN level of expertise to develop clear workforce strategies along with other partners within the system • Risk that the ARRS funding will not be fully utilised due to the above.

Acute, Community and Ambulance	
Assumptions	• Planned numbers do not assume a further wave of COVID. • Staff temporarily re-deployed due to the COVID pandemic will return to their normal base work areas – excluding those who may chose to remain in the deployed areas on a permanent basis. • The Trust will be able to recruit to planned posts, including expectations around appointments of trainees into medical posts. • Bank and agency usage levels have been reduced proportionally to the level of recruitment to substantive vacancies and with the assumption that levels of usage will decrease through the year compared to March 21 - pending no further COVID waves. • The workforce plan includes recovery planning and long term COVID planning e.g. increased respiratory posts. • Appointment of Registered Nursing/Healthcare Assistants/Healthcare Support Workers/Nursing Associate posts are based on modelling as of April 2021 for expected numbers. • The intensive recruitment of Healthcare support workers (HCSW) has been extremely successful with an envisaged zero vacancy rate by end of April 2021. There is continued recruitment of this workforce to establish succession planning at a rate of approximately 10 new HCSW per month. • Recruitment of International Nurses continues to strive for the ambitious employment of 70 nurses by Dec 2021. • It is estimated around 60 students will choose to work for CHFT when they qualify in the summer. Recruitment of this final year cohort is well underway. • CHFT continues to support the apprenticeship RN Degree programme and the Nursing Associate programme, with 13 Nursing Associates expected to qualify in June 2021. A further cohort of 13 trainee nurse associates hs been recruited internally from the substantive HCSW workforce to commence June 21. • Radiology Global Fellow posts – Which are temporary posts, have been delayed significantly due to COVID. Start dates have been assumed based on predicted dates but are not guaranteed.
Actions	• Potential future COVID waves may require changes to workforce models and reprioritise current workforce. • Potential for increased loss of workforce through leaving the NHS or retirements post COVID. • Challenges with regard to the changing of home office regulations post Brexit and the issuing of Certificates of Sponsorship and Work Visas, as well as the changing quarantine laws as a result of COVID-19, which have resulted in delays to recruits being able to start work at CHFT. • Current consideration of 7 day working for Band 7 Ward Managers – this may increase the WFM required. • Deployed staff who have moved on a permanent basis have contributed to a vacancy gap in Outpatients, this vacancy gap is higher than in previous years as recruitment was also halted during the COVID period.

	• Recruitment of experienced ED Registrar level doctors remains a challenge. A number have been appointed; however, vacancies remain. • As a system we will work towards identifying any particular medical/Dental staffing risks where training plans could mitigate those risks.
Risks and issues	The following risks and issues have been identified related to the activity submissions for acute, community services • Potential future COVID waves may require changes to workforce models and reprioritise current workforce. • Potential for increased loss of workforce through leaving the NHS or retirements post COVID. • Challenges with regard to the changing of home office regulations post Brexit and the issuing of Certificates of Sponsorship and Work Visas, as well as the changing quarantine laws as a result of COVID-19, which have resulted in delays to recruits being able to start work at CHFT. • Current consideration of 7 day working for Band 7 Ward Managers – this may increase the WFM required. • Deployed staff who have moved on a permanent basis have contributed to a vacancy gap in Outpatients, this vacancy gap is higher than in previous years as recruitment was also halted during the COVID period. • Recruitment of experienced ED Registrar level doctors remains a challenge. A number have been appointed; however, vacancies remain. • High demand for inpatient beds continues to increase as lock down restrictions ease, alongside continued challenges expected when cohorting necessary. • Maintaining patient flow and facilitating sufficient ward capacity expected to continue to be challenging • Concerted work on optimising CHFT patient flow continues to embed following 20/21 investments. Service fully recruited, provides weekend cover and moving to a full 7 day a week service. • Patient flow work to date has been critical in maximising the existing inpatient bed usage and avoiding out of area placements. • Robust cohorting framework to remain in place for all wards and patient areas alongside inpatient clinical pathway for covid-19 positive patients. • Staff resilience and fatigue (YAS will provide a narrative/submission directly to NHSE)
Mental Health	
Assumptions; [Please outline how systems have considered their	• Mainstreaming of crisis alternatives and individual placement support schemes previously NHSE funded pilots (the CCG have confirmed substantive funding of the Band 4 IPS worker)

Mental Health LTP strategy and commitments to complete this workforce collection, and summarise how the workforce assumptions made as part of the Mental Health Workforce submission	• Utilising non-recurrent and additional recurrent investment 21/22 to address the current psychology backlog/waiting list and review sustainable service provision model (workforce model to be developed) • EIP – No specific additional investment or workforce changes but to be kept under review in year in relation to any emerging pressures e.g. impact increased referrals upper age limit and impact of expansion of timescale with services for those with at risk mental state (ARMS). • Additional workforce in relation to CMHT Transformation- project management and mental health practitioner roles(1 band 8a project manager – 5 x band 6 mental health practitioners – very possibly 5 x band 6 or 7 Children and young people mental health practitioners awaiting meeting with PCN and CCG) • Additional roles in relation to the CAMHs Neurodevelopmental pathway – addressing backlog and sustainable model (plans have not yet been formally agreed but likely workforce impact is 1wte Band 6 SALT, 1 wte Band 7 Psychologist) • Adult ASD – expansion of services to sustainable annual demand level
Actions	• We will implement and evaluate the effectiveness of redesigned, new, physical, or virtual Neighbourhood Mental Health (MH) Hubs. These will be integrated multidisciplinary, partnership-based (MDT) teams and Community Health & Wellbeing (CHWB) Workers, aligned to the specific, identified population health needs of each PCN, delivered initially in 3 Calderdale PCNs. This model will be rolled out across the remaining 2 PCNs over the three-year transformation. Over the three years, the Calderdale system will move away from concepts of 'primary' and 'secondary' services, of discharge and referral, towards providing flexible, place based mental health and wellbeing support from the system as a whole. • Enhanced Care Home Support Team extended to cover complex needs for people with a learning disability in care homes for people with a Learning Disability. Delivery model designed by PCNs in partnership with CHFT and SWYPFT. 21/22 12-month investments with plans to sustain dependent on outcomes.
Risks and issues	• Increasing difficulty in recruiting particularly certain staff groups: medical staff, clinical psychologists, qualified nurses, MH Practitioners. There is likely to be increasing difficulty in recruiting B6 MHP roles due to the expected increased number of new posts through PCN additional roles and CMH transformation. SWYPFT are also expecting staff will be lost to Red Kite View (Tier 4 CAMHS) facility as an example. • Staff Wellbeing particularly in relation Covid related challenges. • Need to increase capacity and leadership across its systems to support care closer to home, treatment interventions and dementia services. • Age of workforce- level of expected departures via retirement in next three years. A decrease in workforce is expected through retirement and turnover. Recruitment in a timely manner and retention of staff is a priority to offset this. • Increasing turnover rates in specific areas of service – psychology, MH nursing of higher banded staff,

	although band 5 and band 6 nursing across SWYPFT has seen a reduction over the last 2 years progressively. • New roles in primary mental health - at this time it is unclear if this will deplete or increase the WTE as funding for the new roles hasn't be clarified • Expansion of Primary care offer through CMHT transformation roles and MH practitioners within PCNs • Development of ACP and ANP roles within services to enhance clinical leadership. • Review of Medical workforce in the community to explore options for recruitment and reduction of agency spend. • Training of nurse prescribers in core to increase efficacy of core clinic offer • Investment in IHBT for additional posts. • Expansion of the Perinatal service to enable increased national targets to be met. • Investment opportunities will be explored to expand our EIP workforce and increase specific roles to meet workforce gaps e.g. psychology provision in OPS community & inpatients, Kirklees OPS community medical staff, physiotherapy, ANP on OPS inpatient wards & a senior ACP for Kirklees OPS community • Peer support workers - 2 - TIPD and 1 in EIP • International nurse recruitment programme underway on a high-profile collaborative basis with 4 neighbouring WY&H (+ 1 other SY&B) MH Trusts. Delivery of 140 MH & LD nurses over the next 12 months across the collaborative - SWYPFT committing to 40. • Virtual recruitment hub agreed again on a collaborative basis with 2 other WY&H MH Trusts (L&YFT & BDCT). Delivery of multi provider (including social care, primary care, third party, voluntary and education provider sector University and FE). National funding via NHSE agreed and virtual platform agreed. Roll out Q3 2021. • Kirklees and Calderdale have progressed the MHST's and have continued to focus on areas of need such as the pathways for Children in Care and reducing the waits for Neurodevelopmental assessments. Additional funding has been received to support this work. • Partnership working with a number of entry level workforce solutions including Kickstarter programme, The Kings Fund and Indeed are currently being developed. The aim to target 16-24 starters currently out of work looking to begin a career in health. • Development of a competency framework for ACP & ANP roles to evidence continued learning and competency

System name:	Calderdale

B. Continuing to meet the needs of patients with Covid-19

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
Preparations for any future potential surge requirements for Covid patients *[Please include commentary on the use of home oximetry and 'virtual wards']*	(a) Planning for Further Surges Oversight of preparations for any potential future surges is overseen by the Calderdale Health Protection & Advisory Group (CHPAG), which has representation for across the system, and is chaired by our DPH. This provides a vehicle for; escalation monitoring, assurance and includes scenario planning and future planning. This links to the tactical and operational teams in each organisation , who have a role to continually review their status and identify mitigating actions for their own or other organisations (b) Support As from 01/04/21 Calderdale Council, in collaboration with CHFT have ensured that Gateway to Care has been the designated referral point for post COVID triage and assessments. This function will also collect the level and type of post covid related data that will enable the system to measure demand and inform the future development of services to manage the longer-term impact. In relation to Pulse Oximetry and Virtual Wards • Pulse oximeters are being provided to patients in Calderdale in response to COVID-19. This service supports people at home who have been diagnosed with coronavirus and are most at risk of becoming seriously unwell. • The pathway has been developed in partnership across the Calderdale and Greater Huddersfield footprint, in line with NHS Guidance and locally determined to meet the needs of our population • The service is offered by general practice working alongside community teams. People are provided with a pulse oximeter and supporting information to monitor their oxygen saturation levels at home for up to 14 days, supported by carers and/or family members where appropriate. • The GP assesses the patient as needing the pulse oximeter and 'on boards' them explaining the process, what to do if their symptoms worsen • A Virtual Ward/Team has been established to support and manage this cohort of patients once on-boarded by their GP. • There is an In hours and Out of hours agreement to manage this cohort of patients. In hours – this has been commissioned through the Calderdale Gateway to Care (Single Point of Contact) and; out of hours: through Local Care Direct/111/999 • To ensure an integrated approach, the Gateway to Care Nurses input the information into clinical records when

	they have had patient contact. • The Calderdale pathway also includes links with the Specialist Community Respiratory Team should the GP and/or the Gateway to Care nurses require any further advice. • In addition, pulse oximeters are offered by Specialist Community Respiratory Team for people being discharged from hospital. This cohort of people are being supported by the community team at home to ensure a more intensive oversight • In terms of risk associated with this service; Calderdale data does not provide a true reflection as practices are using the pulse oximeters, but are not formally 'on-boarding' patients (data is picked up via on-boarding process) In relation to other system working; • Our VCSE is closely linked into vaccination programme through JCVI working group – linked via VSI Alliance/ VCSE based Community Response Coordinator who plays a key role in coordination in terms of connecting up community based support, enabling engagement and also communication across the sector and within/between communities. Engagement with communities that do not engage or experience inequality is key to this work. • Expansion of covid champion programmes to support take up of vaccine and get key messages out into communities as part of local campaigns or drives – this will include promoting messages linked to wellbeing and accessing support for covid recovery. • CSE can offer peer support and wellbeing support for long covid patients through Staying Well Service and Social Prescribing link workers signposting people into VCSE services/support and enabling a focus on wellbeing. • Overgate Hospice will continue to mobilise clinical and volunteer capacity to help support system priorities in the future, including supporting the vaccination hubs / centres. If required Overgate could act as a delivery site for vaccines to patients, families, and workforce (including volunteers) • The planned changes to the reconfiguration of hospital services across CRH and HRI will incorporate improvements and accelerated transformation and ensure that best practice in building design regarding infection control and prevention are included.
Provision of timely and equitable access to Post Covid Syndrome ('Long Covid') assessment services.	Our Systems came together to commit itself to the formulation of plans for the development and implementation of Post Covid Syndrome Assessment Services. We have led workshops, had strong clinical leadership, and a good interface with the work being drive by the ICS. The resulting Long Covid pathways describe the local determined models for primary community, and secondary care services needed to meet the immediate and longer-term care needs of patients discharged following an acute episode of COVID-19 In preparation of implantation of the Long Covid Pathway, two webinars were held in February across all local stakeholders; attended by Voluntary Sector

	Organisations, GPs, Community staff from health and Calderdale Council, hospital consultants and staff (i.e. frailty, respiratory etc), CCG, Local Authority, and public health, to inform provide an insight into: • the needs of patients with ongoing-symptoms of COVID-19 • the long term effects • National management of long term effects • how we evolve to help people recover from Covid/Long Covid • the Long Covid pathways developed (<12 weeks and + 12 weeks) and proposed referral process • factors where patients can be referred to ongoing support across the system (as per <12 weeks pathway, and; • MDT approach for the +12 weeks pathway, the team and referral criteria The Post COVID syndrome pathway was introduced in Calderdale on the 12th April 2021 to support the co-ordination of patients who are post covid (12 weeks plus). Following an initial triage, those patients who meet the criteria are reviewed at the MDT clinic, where a holistic approach is taken to improving patient access to existing services. During the implementation period, patients will be reviewed to identify any gaps within existing service offers, with the likelihood of a post covid service required to support patients. A business case is in development to further support roll out of the pathway. Our assumption is that there will be a long-term need for this service going forward. The MDT team comprises of specialists: Clinical Lead,, Rehabilitation (physio, occupational and vocational therapies), IAPT (clinical psychology will be via escalation from the MDT), and Social Worker In terms of Progress; the Covid-19 Yorkshire Rehabilitation Screening Tool (C19-YRS) is being used and was developed especially to screen individuals recovering from Covid-19 symptoms using a telephone consultation. It enables scoring the severity of the symptoms and its impact on functioning. Outcome measures will be reported at various service entry and exit points to capture change in health condition and effect of the interventions. A Calderdale and Huddersfield Quality Impact, Equality & Engagement checklist has been completed to assess the local delivery methodology and how this adjusts to meet local needs and reasonable adjustments. This will be reviewed at 3 and 6 month periods In terms of risk; there is little surveillance of Long Covid therefore numbers on population need is still being gathered. The demand on community services is unknown and funding has only been allocated nationally for Covid clinics. As this continues in 2021/22 and demand impacts on services provided in the community, it has been identified locally that additional monies may need to be allocated to compensate these services.

System name:	Calderdale

C1. Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service

Please summarise the key assumptions that underpin the activity plan submission, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.

Elective Spells	
Assumptions	• That the focus will not be on patients waiting over 52 weeks • That there may be a change to Royal College approach to priority ratings, given we are into recovery • During Q1, delivery of expectations are likely to be met, however delivery in Q2 is tighter, and is constrained by our ability to maximise IS capacity • We have not applied demographic growth • We are assuming there are no further surges in covid related activity
Actions,	We have developed a set of principles to underpin recovery of our elective care. The principles are owned by colleagues and clinicians within and outside the hospital; • Patient safety & colleague health, wellbeing and safety a priority • Resilience for surge & winter • All de-escalation to have a rapid escalation plan • PPE, equipment & consumable availability • Estate & workforce redesign essential • Understand interdependencies including financial balance • Ensure learning reviewed & embedded • Needs based and health inequality guided • Ensure a positive training environment with appropriate opportunities to learn • Incorporation of priority action plans (flow & outpatients) • Maximise all available capacity to meet system demand 1. We have clarity on how we are prioritising patients: • Patients are prioritised using, where available, college guidance, and where not, CHFT prioritisation criteria agreed through Clinical Reference Group (CRG) which will remain in place for the duration of recovery and

	will be supplemented by further subject specific CRGs widening clinical input into planning. Also agreed through with our primary care colleagues through the Elective Improvement Group. • Urgent patients are classified as P1&2. Initially priority access for people with a learning disability then further identification of other higher risk groups. There is equity of waiting times for BAME & non BAME. We take account of the risk of deterioration with an impact on post-operative outcomes, reduced their independence. P3 patients treated within 3 months of listing. • We are committed to having *no patients waiting over 104 weeks by September 2021*. The Acute Trust has set a target to reduce the average RTT by 12 weeks by September 2021, and a further 12 weeks by March 2022 *There are no patients waiting over 104 weeks in the* IS, and they are supportive of a synchronous recovery for our local system and are working with CHFT deliver the above targets. Providers are working collaboratively to maximise system capacity. P1 and P2 are the first priority for any theatre capacity and all partners are prioritising patients in these categories. Datix, complaints and litigation have been reviewed *retrospectively in providers to highlight any areas where patients may have come to harm*, and would indicate attention is required. None have been highlighted. • Administration support Increased into Clinical Assessment services, waiting list validation, booking and alternative risk stratification models e.g. FIT testing • Prioritising of services includes; endoscopy - where increased capacity will reduce potential delayed cancer diagnosis, theatres - where there is no alternative treatment option, outpatients where there is no alternative but face to face (or where virtual activity is taking place but a cohort of patients require face to face(, and Radiology, where alternative pathways may support pathway/demand reduction • All patients on the waiting list must have a priority assigned • All patients on the follow up overdue list must have a priority assigned • All new referrals will be reviewed through a CAS type service and be prioritised • Referrals for diagnostics will be vetted on receipt and prioritised accordingly reflective of information on the referral • Audits will be undertaken to ensure consistency of priority scores • Patients awaiting a procedure on the 'Evidenced Based Interventions' list of exclusions should be reviewed jointly by GP & responsible consultant • We have recruited a number of buddies to support patients on waiting lists to guide them through their journey, and identify any need for escalation of their case for an urgent clinical review. • Undertaken joint review of patients on waiting lists between primary and secondary care colleagues to identify any patients who could receive a different intervention.

	• We have strengthened our approach to the gathering, triangulation and reporting of quality assurance data to ensure that we are effectively identifying any harm to patients as a result of their time waiting. • Both wave 1 and 2 of the *Evidence Based Interventions* are being implemented. Primary Care have been advised of the new wave, and reminded of the process to follow prior to referral. A letter has been shared with providers for Consultants refreshing awareness of the list and how to identify where prior approval has been granted, or patients currently waiting for something where the guidance has changed following referral, a process has been designed which will review them against the EBI criteria. As a system we do not feel it is appropriate to have patients waiting for lengthy periods when a more effective treatment may be available. If appropriate a conversation will take place which may result in them being directed to the most up to date evidence based treatment. 2. We have clarified how our theatres will operate • Only list patients who are fit and ready to proceed to theatre • Only use theatres for procedures where there are no alternative locations • Only list patients who require a procedure that's included on the 'Evidence Based Interventions' (EBI) list if this has prior approval • A review of all patients on the waiting list who are listed for a procedure on the EBI list by an MDT panel to determine if they should remain • For all pathway changes internally and across the system we will identify any opportunities to circumnavigate the pathway into different specialties, monitor and agree any corrective actions. 3. Confirmed our support for our staff; • One Culture of Care - health and wellbeing of colleagues and the link to patient care made explicit • Colleagues must be safe to practice • Focus on mental AND physical health – adopt the basics of health and wellbeing: hydration, nutrition, sleep, facilities, breaks • Compassionate leadership behaviours • Concise, clear compassionate communication via a variety of channels • Any additionality will be voluntary with regular wellbeing assessment of those regularly undertaking additional work. • We will widen access to recruitment to ensure that we fill as many vacancies as possible, including reviewing clinical workforce models to maximise skill of AHPs, HCSWs and PAs • Our communication strategy will focus on honest, transparent, and clear messaging through a variety of

	different channels 4. Worked with our Partners • Weekly meetings take place *with all Independent sector* and CHFT. We focus on 3 priorities o Transfer of patients between providers to meet sub contract volumes and facilitate synchronous recovery across all partners o Review TCI dates for transferred patients so patients in the correct P categories are transferred in a timely manner and will meet the deadlines associated with the P category o Review total activity delivered in the IS providers to assure access to ERF • Ensuring a connection with Calderdale Council colleagues for support and discharge • Ensure we have clear communications across our partnership and with our population • Maximising the impact of collaboration; particularly on community services redesign • Exploring the value of the Voluntary and Community Sector who can add value to existing services; offering wrap around support and ensuring key communities requiring treatment can be targeted and supported to take up services, can be supported by the VCSE Engagement teams, part of the VSI Alliance team who can play a role in engaging with patient groups where required to support planning of elective care options particularly from groups who do not engage or those experiencing inequality, and can support recruitment of volunteers through Volunteering Hub for any additional activity / capacity needed in system
Risks and issues	• Moving forward in appropriate timescales • Colleague availability and fatigue • Variation in Covid demand • Reversal of some efficiency improvements e.g. move back from non face to face • A two site model that does not facilitate fully 'green' pathways with associated risk appetite • Increased acuity and dependency impacting on length of stay and outcomes • Potential lack of broader partner support to the plans • Patient demands/expectations inconsistent with the priorities • Clinician demands/expectations inconsistent with the priorities • National directives not aligned with priorities • Lack of volunteers for any additional activity as people re prioritise work:life balance • Increased retirement and resignations • Maximising access to IS capacity, and lack of access to external capacity • Surge in demand for planned care

Outpatients	
Assumptions	• That there may be a change to Royal College approach to priority ratings, given we are into recovery • During Q1, delivery of expectations are likely to be met, however delivery in Q2 is tighter, and is constrained by our ability to maximise IS capacity • We have not applied demographic growth • We are assuming there are no further surges in covid related activity
Actions	1. Working with our Partners • Our system has had a multi-agency Out-Patient Transformation Board, which has been supporting our out-patient redesign for a number of years. This has been key to our recovery planning, as many of the actions in our recovery plans, amplified those that were already in place, or were proposed. • To ensure a sustainable and effective recovery programme, we continue to work closely with partners in health and Calderdale Council both locally across the CHFT footprint, as well as with both WYAAT and the ICS. • CHFT opened to routine referrals in May 2020, learning from the initial closure in wave 1, when, as a system, we lost visibility of the patients waiting. This opening, with the knowledge that patients would not receive an appointment, was agreed with the principle that the outpatient waiting list would be jointly owned by primary & secondary care. This will be tested in the next stage of recovery to ensure this principle is visible in the work we do together. • We will continue to maximise the impact of collaboration; particularly; working with our IS colleagues and community collaborative, maximising the value of the Voluntary and Community Sector to existing services offering wrap around support, and, ensuring key communities requiring treatment can be targeted and supported to take up services, ensuring a connection with Calderdale Council colleagues for support and discharge, ensuring we have clear communications across our partnership and with our population 2. Managing Demand in Primary Care • Weekly meetings continue with both CCGs and representative GPs, and clinicians and managers within CHFT to support demand management • Successful movement of the majority of specialties to a Clinical Assessment Service (CAS), and increasing the use of Advice & Guidance. This work will continue to mature, ensuring that referrals into these services meet the correct clinical criteria, and maximise their benefit • Worked with primary care (both elective out-patients and cancer) to implement; o Use of Arden's for all routine referrals

	o Use of fasttrack proformas for all cancer referrals o Implement effective feedback loops for inappropriate referrals o Ensuring advice and guidance is used appropriately and implement a system that retains the referral with CHFT if the advice is that they need Consultant review without the need for the GP to write a new referral (which is currently required) o A joint review of patients on a waiting list where they may require a procedure listed as not have an Evidence base. o Developing options for increased number of patients categorised as Priority 4 follow up being either o For planned and urgent referrals work with diagnostic teams to implement appropriate straight to test and test to clinician pathways that reduce waiting times o Patient initiated Follow up or primary care follow up 3. Strengthening processes in hospital • Internal CHFT demand management changes are being implemented whilst we continue to reduce backlogs, as more patients are being referred requiring outpatient, diagnostic and theatre capacity. • Developing a Clinical Assessment type service in each specialty so that all referrals will be reviewed , which will also allow informed prioritisation • Implement an electronic internal referral system with clear expected response times • Implement pathways that support early diagnosis within minimal outpatient appointments • Continue to increase the use of virtual appointments • Continue the 'buddy' system that facilitates patients safely waiting at home and moves towards Patient Initiated Follow Up (PIFU) 4. Maximising digital opportunities • Ensure all patients are clinically prioritised, within EPR and, that patients who can be managed within primary care are discharged back to GPs. • Explore opportunities to build on the systems we have to develop digital links between patients and services. This will enable patients to upload their outcomes for a clinical review, and the clinician could remotely advise the patient or, potentially, discharge the patient without the need for an appointment.
Risks and issues	• Moving forward in appropriate timescales • Colleague availability and fatigue • Variation in Covid demand • Reversal of some efficiency improvements e.g. move back from non face to face

	• A two site model that does not facilitate fully 'green' pathways with associated risk appetite • Increased acuity and dependency impacting on length of stay and outcomes • Potential lack of broader partner support to the plans • Patient demands/expectations inconsistent with the priorities • Clinician demands/expectations inconsistent with the priorities • National directives not aligned with priorities • Lack of volunteers for any additional activity as people re prioritise work:life balance • Increased retirement and resignations • Lack of access to external capacity • Surge in demand for planned care
Diagnostic Activity	
Assumptions	• That there may be a change to Royal College approach to priority ratings, given we are into recovery • During Q1, delivery of expectations are likely to be met, however delivery in Q2 is tighter, and is constrained by our ability to maximise IS capacity • We have not applied demographic growth • We are assuming there are no further surges in covid related activity
Actions	Our System has been proactively involved in diagnostic redesign across the ICS and WYAAT. CHFT have been proactive in redesigning its internal services and processes, linked to the wider partnership through; the Out Patient Transformation Board, Elective Improvement Group and Cancer Board. The following are the actions being taken: • Ensure referrals are appropriately prioritised by the requester • Only request diagnostics where this is essential for diagnosis • Avoid mass suites of tests for individual patients, unless essential to secure diagnosis • Review the frequency and types of blood tests required, and ensure tests requested are reviewed • Review all request for appropriateness, and electronically return to requester as required, so they are aware of the return and can safely action accordingly. • Implement a system that enables requests for diagnostics to be cancelled • Ensure todays request is actioned today for inpatients including access to Endoscopy • Continue to maximise capacity held by our IS partners

Risks and issues	• Moving forward in appropriate timescales • Colleague availability and fatigue • Variation in Covid demand • Potential lack of broader partner support to the plans • Patient demands/expectations inconsistent with the priorities • Clinician demands/expectations inconsistent with the priorities • National directives not aligned with priorities • Lack of volunteers for any additional activity as people re prioritise work: life balance • Increased retirement and resignations • Lack of access to external capacity • Surge in demand for planned and unplanned care

System name:	Calderdale

C2. Restore full operation of all cancer services

Please summarise the key assumptions that underpin the activity plan submission, highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels. (Note: this submission is not designed to replace the single comprehensive delivery plan for cancer that Cancer Alliances have been asked to develop on behalf of their respective ICSs. Systems will want to engage with their Cancer Alliance to inform this submission).

Urgent cancer referrals	
Assumptions	• Additional funding will be accessed to support prioritisation of urgent cancer surgery • Recent spike in fastrack cancer referrals will return to pre-covid levels • The system will work together to fully and effectively implement the identified improvements
Actions	Calderdale has been proactively involved in cancer redesign and recovery work, across the CHFT footprint and with the ICS Cancer Alliance. This has been key to developing our system recovery plans, and planning delivery of key priorities in the NHSE Operating Guidance; particularly tackling inequalities, and improving access, experience and outcomes. Throughout the pandemic CHFT have continued to deliver on important cancer targets, and this is something our system is very proud of. The following actions are being taken to support cancer recovery; 1. Improved Performance • Support delivery of QOF early cancer diagnosis targets • Management and oversight of cancer fastrack referrals responding to demand and quality of referrals 2. Recovered Screening; • Recover breast screening backlog • Extend bowel screening to 50-60 year olds; 56 year olds April 2021 • Getting patients to come forward and reaching out to hard to reach groups 3. Transformed Diagnostics: • Implementation of approved diagnostic tools including: Colon capsule endoscopy, Cytosponge, Targeted Lung Health Check and Pinpoint testing

	• Rapid Diagnostic Centres – project planning in place and engagement with PCNs 4. Redesigned Treatment • Centralised clinical triage – plans in place to expand beyond current tumour sites • Centralised surgical hubs are in place with super green areas and designated wards for cancer patients • Person Stratification Follow Up – identified in 3 additional tumour sites and 1 implemented by March 2022 (in addition to breast, prostate, colorectal). 5. Supported Demand Management • Oversight and management of current waiting list will continue • Understand historic demand and plan future capacity for clinics 6. Worked with our partners • Maximising support and opportunities from Cancer Research UK and Macmillan Cancer Research and including the Macmillan Information Centre as a resource and support for cancer patients and their families • Maximising support and opportunities from with Overgate Hospice • Maximising support and opportunities with our Voluntary and Community Sector; o Offering wrap around support and ensuring key communities requiring treatment can be targeted and supported to take up services i.e. Hospices play an important role in supporting cancer care priorities o Integration with VCSE organisations across provision to add value to existing pathways in terms of engagement and support o VCSE provide access to alternative therapies, yoga, exercise groups, arts craft activities for creative outlets to emotions to promote wellbeing of patients and carers/families i.e. Carers groups and national cancer charities e.g. MacMillan as a support to patients and families, including emotional and financial support, CAB ensuring all benefits and entitlements are in place. Also connections into peer support particularly where people are on waiting lists for treatment. o Engagement team as part of VSI Alliance can support engagement with patient cohorts and carers to enable engagement in services and support/ aftercare • Overgate Hospice can support cancer patients with non-curative disease earlier in their disease trajectory. They will work with partners to ensure they are aware of the services that are available and respond to local demand. It is the intention that Overgate Hospice's specialist palliative care capacity needs to be maintained and potentially increased to manage even more people successfully in the future.

Risks and issues	• Referrals do not reduce, and demand continues to exceed capacity • Reduced effectiveness of clinical triage if poor quality referrals are received including an absence of pre-referral checks or diagnostics • People referred do not attend owing to continued nervousness about covid or lack of understanding about why they have been referred • Workforce/staffing • Increased demand in Endoscopy impacting on capacity and an inability to recruit • Increased demand in Radiology impacting on capacity, CHFT have the fewest Radiologists in Region • Many Cancer Nurse Specialists are reaching retirement age so succession planning is in place but may not materialise and leave gaps in staffing and knowledge • Lack of remote monitoring for Person Stratified Follow-Up
Cancer treatment volumes	
Assumptions	• Faster Diagnosis Standard – Q3 at 75%. (current target 70% current actual 80+%) • Achievement of all CWT standards – perform well, only issue is 62 day screening • No clarity on the Calderdale % of the STP – previously 8%/ - will need cross referencing to actual numbers at CHFT
Actions	1. We have worked to restore services and recovery backlogs: • Prioritised urgent P1/P2 surgery • Tackled long waits (understanding ethnicity and deprivation within that) • Undertaken patient focussed reviews • Assessed clinical risk across primary and secondary care 2. Improved Performance • Achievement of the Faster Diagnosis Standard • Achievement of all CWT standards 3. Supported Demand Management • Implement recovery plans currently in place to reduce all waiting lists • Oversight and management of current waiting list will continue • Understand historic demand and plan future capacity for clinics

	7. Improving Diagnostics: • Implementation of approved diagnostic tools including: Colon capsule endoscopy, Cytosponge, Targeted Lung Health Check and Pinpoint testing • Rapid Diagnostic Centres – project planning in place and engagement with PCNs 8. Improving Treatment • Centralised clinical triage – plans in place to expand beyond current tumour sites • Centralised surgical hubs are in place with super green areas and designated wards for cancer patients • Person Stratification Follow Up – identified in 3 additional tumour sites and 1 implemented by March 2022 (in addition to breast, prostate, colorectal). Centralised clinical triage
Risks and issues	• Ability to recover breast screening backlog • Extension of bowel screening to 50-60 year olds; 56 year olds in April 2021 • Workforce/staffing o Increased demand in Endoscopy impacting on capacity and an inability to recruit o Increased demand in Radiology impacting on capacity, CHFT have the fewest Radiologists in Region
Patients waiting 63 or more days	
Assumptions	• Additional funding received • PTL for waits >62 days; restore to Feb 2020 figures/national average in Feb 2020 if lower. CURRENT: 2 people >104 days
Actions	The following actions have been identified; 1. We have worked to restore services and recovery backlogs: • Successful prioritisation of urgent P1/P2 surgical patients • Tackled long waits (understanding ethnicity and deprivation within that) • Undertaken patient focussed reviews 2. Supported Demand Management • Implement recovery plans currently in place to reduce all waiting lists • Oversight and management of current waiting list will continue

	3. Improving Treatment • Centralised surgical hubs are in place with super green areas and designated wards for cancer patients • Person Stratification Follow Up – identified in 3 additional tumour sites and 1 implemented by March 2022 (in addition to breast, prostate, colorectal). Centralised clinical triage
Risks and issues	The following risks and issues have been identified • Surge in fastrack referrals in Q3 and Q1 result in higher conversion rate and more people requiring treatment and demand exceeds capacity • People do not attend or defer treatment owing to continued nervousness about covid • Workforce/staffing o Increased demand in Endoscopy impacting on capacity and an inability to recruit o Increased demand in Radiology impacting on capacity, CHFT have the fewest Radiologists in Region o Many Cancer Nurse Specialists are reaching retirement age so succession planning is in place but may not materialise and leave gaps in staffing and knowledge o Lack of remote monitoring for Person Stratified Follow-Up

System name:	Calderdale

C3b Expand and improve services for people with a learning disability and/or autism

Please set out the specific actions that, as a system, you will prioritise over the next 12 months to address the objectives below

Make progress on the delivery of annual health checks and improve the accuracy of GP Learning Disability Registers	As a system, Calderdale has confirmed its commitment to improving outcomes for people with a learning disability. The following provide a view of our current position and actions: • Calderdale exceeded the ambition for % *annual health checks* of 67% and as at the 22nd March 2021, and the latest position is 75%. For 2021/22, the aim is to increase the number of people with a learning disability receiving a health check, and plans are in place to work with partners, including local Voluntary and Community Sector organisations, to ensure good quality health checks and action plans are in place to improve health outcomes for people, enable them to live a wider life and reduce inequalities. • Whilst we achieved the standard this year, we want to ensure the practise embedded. We will agree the trajectory for achievement over the quarters. Practices are encouraged to spread the reviews out across the year and offer face to face where appropriate. Clover Leaf Advocacy and Inclusion North have 3 workshops planned for May/June with carers, service providers (including day care) and people with lived experience to discuss with them the importance of the health check and what to expect. • Funded a post of a strategic health facilitator whose role will be to support practices in achieving high quality health checks through sharing and developing resource packs and working directly with practices and patients who may need additional support and preparation to participate in the health check • Funded the role for a person with lived experience to support individuals who do not want to attend healthchecks through sharing their experience – this again can be utilised by practices (is it in North at the moment Sarah) • Work has taken place with GP practices to align registration of LD patients, and to facilitate annual health checks (AHCs). Our locality community nursing teams support this activity for anyone that is open to the team. In addition to this, GP Practice LD awareness raising training has been rolled out to the majority of practices to support completion of Annual Health Checks for people with a learning disability. Nurses in community teams provide regular reasonable adjustment advice to practices and will attend AHCs to support where needed (for service users that are open to SWYPFT). • Next steps are: o Practices to validate the register and ensure that people on the register have a learning disability

	o Practices to case find and ensure that people who should be on the register are. o Working in collaboration CHFT to align data o Establish a small task and finish group to work through specific actions and what support is required for the ambition to be achieved and sustained
Reduce reliance on inpatient care for both adults and children with a learning disability	Within Calderdale, there is a partnership approach to improving outcomes and *reducing reliance on in patient* care. This brings together the broad partnership, including the community and Voluntary and Community Sector, and is aligned to the work taking place in the ICS. One element of the Thrive model commissioned in to avoid, as far as possible, admissions to in-patient services. *The following provides an overview of actions;* • In 21/22 we agreed investment into the Enhanced Care Home Support Team, to extended cover to people with a learning disability. A delivery model has been designed by PCNs in partnership with CHFT and SWYPFT. There are plans to sustain this dependent on outcomes. • A Strategic Health Facilitator role (12 months) is also to be embedded in the SWYPFT LD team to provide additional capacity to support health needs of people with learning disabilities including supporting GP's to undertake annual health checks and develop action plans. • Plans to improve the update, quality, and resulting actions plans from health checks will support delivery, as identified in the previous section • A 7-day crisis service has recently been implemented for CYP to avoid escalation to hospital and/o Tier 4 beds out of hours and/or at weekends. A national 24-hour crisis line is being implemented across West Yorkshire • Our Voluntary and Community Sector in Calderdale can; o Promote greater integration with VCSE organisations supporting people with LD/Autism for pathway improvements i.e. Calderdale Disability Partnership, Visits Unlimited, Parents & Carers Council & Magpie could all support care pathways o Provide wrap around care and services as part of integrated models including support for carers including Young Carers support o Engagement teams/programmes can support insight building to enable improvements in engagement, care and support o Young people focussed VCSE organisations can provide added impact and capacity where required. • CHFT has a flag on the Electronic Patient record that identifies all adult patients with a Learning Disability and have undertaken work to improve access for patients with a learning disability which includes: • The Board of Directors have agreed a principle within the Recovery Framework that prioritises patients who also have a Learning Disability, regardless of their clinical prioritisation

	• Priority access to theatre for patients currently on the waiting list with specific operating lists that best meet their needs • Exploring options with Locala to rapidly treat the backlog of patients awaiting access to dental care under a general Anaesthetic • The development of a FastTrack pathway for all patients referred to CHFT who also have a Learning Disability with deployment of care navigators to support their journey • Raising awareness of the needs of people with a Learning Disability • Building capacity and therefore resilience in the team involved in the care of patients with a Learning Disability • Community CETRs, led by the CCG, are focussed on those who either have been, or may be about to be admitted to a specialist mental health / learning disability hospital either in the NHS or in the independent sector. Prior to Covid 19; CETR's in Calderdale were held face to face; due to the pandemic this approach was amended to enable the CETR's to be delivered virtually during 2020; using MS Teams or in one situation via teleconference. • Activity data for CETRs 2019 to 2020 *Year* — *Number of New CETR's* — *Outcomes* July – December 19 — 6 — 2 admissions (now adult) January – Nov 20 — 10 — 0 Admissions
Implement 100% of the actions coming out of LeDeR reviews within 6 months of notification *Please set out details of your local LeDeR governance system for monitoring the completion of LeDeR reviews and implement actions from learning from LeDeR reviews]*	Calderdale has committed itself to ensuring implementation of *LeDeR Review actions,* and a view of our current position is set out below: • Under the current processes the CCG is notified via the electronic platform Learning Disability Mortality Reviews of individuals who have died with a Learning Disability. The CCG Local Area Contact (LAC) then allocates each case to a trained Local Reviewer locally who has capacity to complete the review within their substantive roles. The current LeDeR reviewers are recruited from within the CCG, from the local Authority, from main health providers in the area and from a NHSE funded small West Yorkshire Team. • The LAC monitors the progress of the review, supporting the reviewer to complete within the timeframes. Once the review is completed the LAC (which is a shared role in Calderdale and Kirklees between 2) complete a Quality Assurance process for each submitted report. • Each LeDeR review requires relevant service provider records accessed directly by the Reviewers along with relevant conversations with professionals involved to identify if there are any concerns of local learning. • Organisations are asked to take forward any learning that is pertinent to them, and any learning that is

	recognised as a systemic is shared with transforming care and LD commissioners for inclusion in planning and commissioning service activity. • A new NHSE policy for the LeDeR programme published at the end of March 2021, sees a change to the programme, with requirements a change to delivery of the programme on an ics Level. This includes that LeDeR reviewers to be a dedicated funded resource (at least 0.5 wte for the role), a new quality assurance process for completed reviews, for one LAC per ICS to sing off the reviews, and for there to be an ICS/Place based process for implementing learning and that the programme must be integral to a Quality Improvement approach. Currently the LAC's are working with the ICS Transforming Care lead to identify and describe how the new approach will be taken forward (dates have been set for different stages of the new approach throughout the year) and be fully in place by April 2022.
Please summarise any additional key assumptions that underpin the activity and performance plan submission, highlighting any key risks and issues.	
AHCs delivered by GPs for patients on the Learning Disability Register	Calderdale continues to maintain or increase the % based on its the latest position of 75%.
Reliance on Inpatient Care for Adults with a learning disability, autism or both	• Success of Strategic Health Facilitator role pilot and resulting recurrent funding
Reliance on Inpatient Care for Children with a learning disability, autism or both	• CYP Crisis Team has seen an increase in complex referrals (inc ASD) since wave 2 of COVID-19 into the crisis team, and acuity of referrals at point of referral. • Accessing appropriate specialist inpatient placement is extremely challenging. To avoid a hospital placement for these, CYP system needs more skilled crisis medics

System name:	Calderdale

C3c Expand and improve mental health Services

Please set out the specific actions that, as a system, you will prioritise over the next 12 months to address the objectives below	
Overall Position and Actions	We have seen increasing demand across the whole mental health system in Calderdale, numbers and complexity of referrals- all age, primary & secondary care, VCSE, local authority (20/30%). *A number of actions are therefore taking place* • Working in partnership across Calderdale, to enhance/improve provision, drawing on the strengths of all providers including the VCSE, strengthen voice of VCSE in system

	• Maximising and embedding learning from Covid, including increased digital opportunities to deliver a blended offer promoting choice, and ensuring accessibility for all • Working as a system to maximise best use of financial envelope to have most impact on the emotional health & wellbeing of Calderdale's population addressing health inequalities, and promoting access and inclusion. • Supporting the emotional health and wellbeing of the workforce across the system, staff retention and exploring new roles e.g peer support workers, PCN roles etc to address the wider social determinants of emotional health & wellbeing • SWYPFT have maintain transformations and beneficial changes made as part of COVID-19, where clinically appropriate, including 24/7 open access, freephone all age crisis lines and staff wellbeing hubs • All Age Liaison has gone live with positive outcomes in all areas. • Implementing a dementia steering group to increase diagnostic rates, evaluating current support offer, for Calderdale to be a dementia friendly borough • We have seen an increase in demand which is leading to delays in time taken to assess people (recent data shows a 10% increase in referrals). • Teams within SWYPFT have put additional staff on shift including weekend work to keep on top of referrals, though feedback shows still a very high proportion are referred on to primary care. • Outcome of full impact of 20/21 SPA investments by Kirklees and Calderdale CCG's
Actions; Community mental health services	• SWYPFT – investing fully in community mental health, including funding for new integrated models for Serious Mental Illness (adult and older adult) and SDF funding to expand and transform services. To support this, a new metric will measure those accessing community mental health services. • The Calderdale Primary and Community Mental Health Transformation Programme will be a new way of delivering services for adults and older adults with serious mental illnesses (including eating disorders, complex rehabilitation and personality disorders – these areas will be led by the WY ICS) People will be assessed in their own communities and have a trusted individual who supports them in all aspects of their lives. The aim is to identify, engage with and address people's needs before they become significant. • The approach is to ensure parity of esteem in how people's physical and mental health needs are met, addressing barriers to healthcare, and enabling adults and older adults with the most complex mental health needs to easily access appropriate, integrated, holistic care, close to home in their PCN. • We will implement and evaluate the effectiveness of redesigned, new, physical, or virtual Neighbourhood Mental Health (MH) Hubs. These will be integrated multidisciplinary, partnership-based (MDT) teams and Community Health & Wellbeing (CHWB) Workers, aligned to the specific, identified population health needs of each PCN, delivered initially in 3 Calderdale PCNs. This model will be rolled out across the remaining 2

	PCNs over the three-year transformation. Over the three years, the Calderdale system will move away from concepts of 'primary' and 'secondary' services, of discharge and referral, towards providing flexible, place based mental health and wellbeing support from the system as a whole.
Actions; C&YP	• Enhancing support for children and young people through implementation of MHSTs, focus on areas of need e.g. Children in Care pathways and ED, reducing waits for Additional funding has been received to support this work. Has applied for future rounds of MHST's and working within localities to connect the work its work with the Voluntary and Community Sector and other partners to ensure good outcomes for CYP. Neurodevelopmental assessments, and improved crisis alternatives e.g. 24/7 helpline • Through SWYPFT continue to strengthen crisis and IHBT pathways for all CAMHS and, 7- day working is now in place with extended hours in Calderdale. • Continued to operate during COVID-19 and has made use of new ways of working, digital solutions such as telephone and video link sessions, as well as delivering face to face to face care to children most in need. • Relationships with the planned new CAMHS inpatient building have been established and it is working well with regional colleagues to seek and offer support and share best practice. A pilot for an out of hours crisis support line has been funded for 2021, and services have helped to shape the offer. • Ensured staff recruitment, retention and development has been a key focus and a training plan for staff has been developed service wide, the main priority to move towards trauma informed care and treatment that is responsive to risks and risk management. • Developed future priorities for all areas are managing eating disorders, preventing hospital admission and reducing waits for Neurodevelopmental assessments. • Continued to increase children and young people's access to NHS-funded community mental health services, noting the revised metric and importance of continued focus on quality of care • Volunteer passports at national and WY&H level. Discussions linked to integrated teams and working with VCSE on a range of community based and wider offers through Calderdale Community Collaborative Programme Board (Care closer to Home)
Digital	SWYPFTs Digital Mental Health Strategy will ensure; • Close alignment with ICS digital strategies and place-based digital plans, provides clear line of sight from which to actively engage, collaborate, shape, and influence moving forward both our own priorities and the wider collective digital agendas with support of our partners across health and Calderdale Council. • Use of increased digital approaches e.g. video conferencing - we would look to retain this for those with lower levels of risk and where it is indicated for the therapeutic modality and are conducting a pilot in terms of impact of this approach to scope reach, applicability and outcomes • Continued use of technology to reduce unnecessary travel.

	• Introduction of a virtual visitor scheme using zoom. This involves having a stand -lone tablet on each inpatient area which can be used to connect by a service user with their family & friends. • Increased digital approaches e.g. video conferencing for those with lower levels of risk and where it is indicated for the therapeutic modality and are conducting a pilot in terms of impact of this approach to scope reach, applicability and outcome • Better sharing of information (digitally) between all health & care partners (e.g. leveraged and underpinned via Yorkshire & Humber Care Record). • Improving ability to share/access information digitally, where clinically appropriate/legitimate need • Improving the digital skills and competencies of our staff - focussing on our workforce becoming digitally excellent, fully conversant, competent, capable, and confident in their use of digital solutions with digital literacy at the core.
Risk and Issues	• High demand for inpatient beds continues and expected to increase as lock down restrictions ease, alongside continued challenges expected when cohorting necessary. Maintaining patient flow and facilitating sufficient ward capacity expected to continue to be challenging • Concerted work on optimising patient flow continues to embed following 20/21 investments. Service fully recruited, provides weekend cover and moving to a full 7 day a week service. Patient flow work to date has been critical in maximising the existing inpatient bed usage and avoiding out of area placements. • Robust cohorting framework to remain in place for all wards and patient areas alongside inpatient clinical pathway for covid-19 positive patients. • Continued weekly meetings with mental health partners across the integrated care system enabling strengthening of collaborative approaches, shared learning and innovative practice developments • EIP – No specific additional investment planned but to be kept under review in year in relation to any emerging pressures e.g. impact increased referrals upper age limit and impact of expansion of timescale with services for those with at risk mental state (ARMS). Full impact from additional CBT therapy and peer support posts from 20/21 investments to be realised in 21/22 Q1. • CAMHs – Neurodevelopmental pathway – addressing backlog and sustainable model • Transfer of Mental Health Support Team (CAMHs 0-19 services) to SWYPFT Lead Provider to support better integration services across full 0-19 CAMHs pathway. • CAMHS LD ASD service piloted 20/21. Mainstream 21/22. • Development of community rehabilitation and recovery services through reconfiguration of existing services. • Trauma Informed Personality Disorder Pathway – full impact of additional career and peer support worker roles from 20/21 investments to be realised 21/22 Q1.

System name:	Calderdale

C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objectives below	
Pandemic recovery - recovering the full maternity care pathway	Following publication of the *Ockenden Report* in December 2020 providers of maternity services have had to submit a number of self-assessments to provide assurance on quality, leadership and oversight against specified requirements. The LMS have a key role in oversight of quality and safety measures and CCG's are required to be involved and attend local Quality Surveillance meetings. The *following actions have been taken;* • At a Trust level there are six requirements to strengthen and optimise board oversight for maternity and neonatal safety: • To appoint a non-executive director to work alongside the board level perinatal safety champion to provide objective external challenge and enquiry • That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board • That all maternity serious incidents are shared with Trust boards and the LMS, in addition to reporting as required to HSIB • To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings. • In collaboration with the LMS lead and the regional chief midwife, formalise how Trust level intelligence will be shared to ensure early action and support for areas of concern or need • Review available guidance to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model. • Create an independent senior advocate role which reports to both trust and LMS boards. The role of the advocate is to be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed. • Providers will monitor action plans arising from the Ockenden Report assurance templates internally and the LMS will maintain overall oversight. In term of *implementing maternity care pathways* - continuity of carer (CoC), CHFT has a specific programme related to Continuity of Carer, and have maintained focus on this throughout the Covid-19 pandemic: • In January 2021, 22% of all women were booked on to a CoC pathway and 40% of BAME women were booked onto this pathway. We know that, from CHFT data on health inequalities, there is a greater percentage of

	pregnant BAME women in the most 2 deprived groups. • We are currently analysing our position at the end of Quarter 4 and are confident we have exceeded the required targets. However, this workstream remains a priority in 2021/22, with clear plans in place to continue to grow this pathway offer. • The CCG have funded a MVP Chair post, and are involved in the recruitment process, as are CHFT. Interviews are scheduled for end April. • Further expansion of the perinatal hub and spoke model covering Kirklees, Calderdale, Wakefield and Barnsley, is taking place in line with 21/22 target for 8.6% (2016 ONS birth rate), and provision of services for mothers for babies up to 24 months old. • Huddersfield Birth Centre unfortunately remains closed with an options appraisal paper being reviewed at the end of April as part of recovery plans. However, the interim CHFT model ensures a continued high level of quality and experience for women receiving maternity care. • The ICS now have a Programme Lead for PNMH to chair and progress required actions via the PNMH Steering Group. Calderdale be proactive in the work of the group. • Closer working with our Voluntary and Community Sector will support; o Promote greater integration with VCSE organisations supporting family's inc crisis pregnancy care for pathway improvements. o VCSE provide wrap around care and services as part of integrated models including support pre & post partum. Additionally, Children's Centre's have a key role especially in family and community support groups i.e. mums on a mission, 'light up bach'
Confirmation that Local Maternity Systems have a plan in place, agreed with their ICS to deliver the maternity transformation priorities for 2021/22 in line with the timings set out in section 5 of the implementation guidance	• The CCG attends the LMS hosted ICS Implementation meeting where progress against delivery of the maternity transformation plan by each provider and as a system is reviewed. • The CCG and the LMS meet regularly and the CCG Head of Quality is supporting the LMS progression of the quality agenda and contributing to the development of an LMS dashboard. • *Development of the plan*, is part of the work identified above
How Local Maternity Systems will improve their governance and how ICSs	• The CCG meets regularly with the Head of Midwifery at CHFT to discuss the dashboard, progress against the Maternity Safety Improvement plan and any other issues. • The CCG are working with CHFT to develop this into a formal Quality Surveillance meeting with clear terms of

will strengthen their oversight of Local Maternity Systems	reference, identified roles and responsibilities, plus escalation mechanisms. • The LMS will attend on a rotating basis. These meetings commence in May 21. • The Head of Midwifery presented a recent update against the Ockenden recommendations at the CCG-led Clinical Quality Board. • The CCG also attend HSIB Quarterly Review Meetings where progress against recommendations from HSIB investigations and the CHFT Maternity Safety plan are discussed, and issues are identified

System name:	Calderdale

D1 Restoring and increasing access to primary care services

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below	
Getting practice appointment levels to appropriate pre-pandemic levels[Please include a summary of the key assumptions that underpin the activity plan submission, highlighting any key risks and issues.]	During 2020 General Practice rapidly changed the way services were delivered highlighting that not all clinical interactions with patients are recorded as appointments and it is not always easy to identify what type of appointment is carried out. This has resulted in an under-recording of the activity in practices and probably under-reporting in the NHS Digital GPAD data publication. *The following is an overview of progress;* • The CCG is working collaboratively with the LMC to support practices to capture accurately the full scale of scale of what general practice is providing for patients this includes activity provided at scale by staff working on behalf of PCNs. • We await the outcome of the revised national appointment data mapping exercise and will use this to inform subsequent actions. • In the meantime, we have previously embedded a minimum standard 70 appointments per 1000 patients per week and will use this as a benchmark. This has been in place for 2 years prior to the pandemic. This would equate to 70, 865 appointments per month (4 wks.) with a prescribing clinicians. There are two key risks; • Ensuring the data is of sufficient quality to be useful and comparable remains technically and operationally challenging and does not enable an effective and useful trajectory to be set. • The CCG does not have access to practice level GPAD to enable effective practice and PCN level interventions. • We will continue to invest in additional GP capacity through the retention of the Covid Clinical Assessment Centre until the end of June 2021 • We intend to explore the potential for increased uptake of Electronic repeat dispensing and the

	implementation of the Community pharmacy Consultation Service in Calderdale. • We intend to support practices and PCNs to effectively implement and utilise the Apex Insight tool to support comprehensive workload analysis and workforce planning capability an enable the to make informed decisions about the future. • Alongside the use of the Apex Insight Tool we will utilise a population health management approach in order to ensure that the right type of appointment is accessible to meet the patient's needs, thinking particularly of flexing appointment type and time for groups such as minority ethnic, people with a learning disability and asylum seekers, refugees and homeless. This will assist in ensuring General Practice delivers an offer that reduces health inequalities in practice populations and will be particularly useful in assisting prioritisation of long term condition reviews for those at most risk. • We intend to engage in the Access Improvement Programme and will work with the regional team to focus on supporting areas where potential issues have been identified by national activity data • We will support the development of a WY collaborative plan and initially focus on areas where access is proving more challenging including areas of greater inequalities. • Resources will be used to support a Deep Dive approach – Focussing on Practices/PCN with wider access challenges. • Key themes and lessons learnt will be analysed and shared to inform future access developments and support PCN access plans for 2022 onwards. • The Medical Director at Overgate Hospice is working with Primary Care Networks (PCNs) to ensure that palliative and end of life patients are identified and referred to specialist palliative and end of life services at an earlier opportunity. The hospice has through the pandemic has introduced a community outreach service and will continue to expand this to meet place based needs.
Maximising clinically appropriate dental activity	In relation *to dental care*; • Managing patient expectation/demand both in terms of urgent and routine care: • Significant drop in access to primary and community care during 2020-21 due to closure of practices, followed by national SOP, significantly reducing the levels of face to face treatment that could be safely provided. National targets seen as a maximum expectation (by some providers) rather than minimum threshold to secure income protection with no real incentives to go beyond this. • Data shows that demand for urgent care continues to be above that for 2019-20. Local initiatives introduced to manage urgent care remotely, where possible, to increase urgent care capacity to cope with the demand generated as a consequence of the lockdown and, in Q4, to incentivise practices to prioritise urgent care patients. Initiatives will need to be extended/enhanced into 2021-22 if the activity target is less than the full

	commissioned capacity. • Demand for dental services is likely to increase significant once lockdown is lifted - ability to meet the demand and address backlog will be severely impacted unless targets are significantly increased to as near as possible to the full contracted activity. • GAs and in particular GAs for children is a national concern, which is mirrored in the region • Majority of dental patients are low priority within Trusts, which causes issues with access to theatre lists, increasing waiting lists/times for special care dentistry and paediatrics. • Secondary care RTT at Month 10 – block contracts in place, activity targets suspended - improving position: • Y&H: average 59% of the activity in the same timeline last year. 7 Trusts (out of 15) above average. Range in NYH 46-82%, SYB 50-71% and WY 53-77%. Whilst performance is generally improving, this does not take into account the growing backlog and waiting lists. The RTT data at month 10 shows a Y&H average (against the 92% target) of 54.4%. • Key priorities 21/22: o Q1 and Q2 – support practices to meet the national contractual framework expectations (60%). Aim to maximise face to face clinical treatment capacity that can be delivered safely – within the constraints of the SOP and IPC measures - to facilitate addressing the backlog and to increase access to routine and preventative care. o Review the additional investment initiatives already in place (but extended to Q3) which incentivises practices to increase capacity whilst noting the impact the reduced treatment has had on PCR and therefore available resources o Once commissioned capacity for dental access is restored to pre-Covid levels, explore opportunities to develop/implement initiatives to address inequalities and target areas of highest need – the opportunities around flexible commissioning will be reviewed and local plans re-introduced, alongside the option of using enablers like the national commissioning framework. o By end of Q1 have a complete restoration profile which includes all pathways and has an agreed trajectory for reaching pre- covid levels. o Work with Trusts to support their resumption of secondary and community care dental services to pre-Covid levels including increasing access to theatre space for GAs.

System name:	Calderdale

D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the LTP objectives below	
Expansion of smoking cessation services	Our Public Health teams continue to work towards services integrating smoking cessations services into the community model, to increase their effectiveness and value for money. • There is clear evidence that people living in the most deprived areas are more likely to have multiple unhealthy behaviours. Existing services that support people to change a single specific behaviour (smoking, being active, eating well, etc) are therefore less effective at enabling those with the greatest needs to stay well. Integrating services that support behaviour change into integrated wellbeing services can ensure that personalised support is provided tailored to the individual's needs • Healthy behaviours are also more likely to be sustained where core determinant of poor health such as low income, poor housing, fear of crime are addressed, and where people are connected to opportunities an assets in their local community. We therefore plan to *integrate adult public health services that support healthy behaviours into the integrated community model,* so that they are joined up with other community services, primary care and voluntary and community sector support, to achieve the population health outcomes we have set ourselves through Calderdale Cares. This will also integrate action to improve mental and physical wellbeing Through this approach we will be well placed to deliver the expansion of stop smoking services, weight management services and other key public health prevention services and interventions into healthcare pathways in line with the NHS planning guidance • The Yorkshire Smoke Free Calderdale service has adapted due to Covid-19 and support has been delivered via different methods during COVID-19 offering support via phone, email, text and video calling. Clients also had access to stop smoking medication through an e-voucher that was sent direct to their mobile phone. This helped clients get faster access to their stop smoking medication at a time when they would have had to rely on the postal system to deliver their paper medication voucher. We intend to carry on using these methods and increase our Social media presence to make the service more accessible to more people. • The Stop Smoking Contract has been extended to 2023 • The website has been updated and a 'client zone' has been developed to give them took and resources to

<table>
<tr><td></td><td>enhance the support they receive from the adviser.
• YSFC works in partnership with The Brunswick Centre (subcontracted by Yorkshire Smokefree) to help reduce the smoking prevalence within the LGBT community. Research shows that specifically tailored smoking cessation programmes are likely to be effective for those who identify as LGBT and those that are HIV positive by addressing reasons for smoking, such as homophobia, biphobia & transphobia and stigmatisation. To ensure the needs of this community are met, The Brunswick Centre, a charitable organisation working across Kirklees and Calderdale, ensure the needs of this community are met by providing a suite of services, including HIV prevention, testing and support and services for people identifying as LGBT. They also provide an in-house stop smoking service to Calderdale residents who they come into contact with through their own services and via referral from Yorkshire Smokefree.
• The service is planning to do some targeted engagement work in Park Ward and North Halifax to help to reduce health inequalities</td></tr>
<tr><td>Improved uptake of the NHS diabetes prevention programme</td><td>• GP Practices in Calderdale have participated in the mail-out to patients who would benefit from this programme. Early indications are that this has increased the number of referrals made to the NDPP. This mail out has been extended throughout May 2021
• One of the PCNs is taking a PHM approach to a cohort of 48 patients from a minority ethnic background with rising risk, and working alongside them to improve health outcomes and improve diabetes management. This is a collaborative approach across partners and sectors and has involved developing a new offer, aligning the metrics in the SPLW template so Person Activation Measures can be identified. A clinical leader has been identified so that this learning can be shared with other PCNs</td></tr>
<tr><td>Progress on CVD prevention</td><td>Two of our PCNs have identified patients at rising risk of diabetes and CVD and are defining the opportunities within the cohort for targeted intervention. A PHM approach will be adopted as described above to improve outcomes and reduce risk for these patients</td></tr>
<tr><td>Progress against the LTP high impact actions to support stroke, cardiac and respiratory care</td><td>GPs across Calderdale have delivered the WY led programme "Healthy Hearts". This has had a positive impact on deaths, stroke and heart attacks (data below for April 2020) (https://www.westyorkshireandharrogatehealthyhearts.co.uk/). See data below;

Hypertension – Jan 19 – Jan 21
<table>
<tr><td colspan="3">Calderdale Hypertension Register</td><td colspan="3">BP Controlled</td><td></td></tr>
<tr><td>Jan-19</td><td>Jan-21</td><td></td><td>Jan-19</td><td>Jan-21</td><td></td><td>CVD</td></tr>
</table></td></tr>
</table>

	Hypt. Register	Hypt. Register	Patient Increase/ Decrease	Controlled BP	Controlled BP	BP Controlled Patient Increase	Events Potential prevented over next 5 years
	29,263	30,999	1,736	17,237	20,590	3,353	65
	• We are moving into phase 3 of the programme which focusses on the impact of diabetes and heart disease. • Our local Acute Trust delivers HASU and thrombolysis to appropriate patients, and an early supported discharge service is commissioned to facilitate discharge and rehab. • The WY respiratory programme is about to recommence as we exit the COVID pandemic, during which respiratory services have been responding to urgent and acute challenges.						
Expansion of NHS digital weight management services	• Digital weight management support for people who are obese, and have diabetes or hypertension, is due to be rolled out across the NHS this summer (we currently do not have digital weight management service in Calderdale). This will integrate with our other tier 2 weight management provision, with referral from primary care. • We are currently looking at our local authority commissioned tier 2 weight management services. Meetings are planned to discuss options. An local implementation group will be pulled together to look at how the NHS digital service fits alongside existing face to face and remote provision and an excess weight pathway for Calderdale or for each PCN will be produced. • Links are being made and embedded in the Diabetes and CVD/Healthy Hearts programme						
Please summarise the key assumptions that underpin the personalised care activity plan submission (personal health budgets, personalised care and support planning, social prescribing unique patient referrals), highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.							
Assumptions	• PCNs will actively engage in population health management to target the groups outlined; including hard to reach • The people identified will be responsive to the interventions suggested and actively engage in the support offered • PCNs will be able to recruit and retain staff within the identified roles to deliver personalised care						
Actions	• NAPC commissioned to support PCNs understand and utilise population health management techniques • Oversight of the implementation of personalised care tools e.g. shared decision making, patient activation						

	and care and support planning • Share developments in personalised care with the PCNs for delivery
Risks and issues	• Hard to reach groups do not actively engage in personalised care interventions • PCNs are unable to recruit or retain the workforce to proactively deliver personalised care • Primary care clinicians do not refer to the personalised care support team • Changes to the PAM tool at national level

System name:	Calderdale

E1 Transforming community services and improving discharge

Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objective below	
Deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days	In August 2020, the Government published the Hospital Discharge Service The policy sits within broader ambitions to support people to live at home independently for longer. The Reason to Reside tool is widely used to determine whether a person can be discharged from hospital. Our governance and delivery models are aligned to this national approach, which is supported by a new assurance process within the ICS. We recognised the clear impact delays have in the ability of CHFT to recover, as part of the overall set of recovery assumptions; • Optimise the changes implemented both for winter and Covid in relation to admission avoidance, maximised use of all SDECs. • A step change reduction in the number of patients who do not meet the criteria to reside, an agreed maximum number of patients on the Transfer of care list and full deployment of Estimated Date of Discharge (EDD) • Proactive management of discharge on the day planned with 50% of patients moved to the discharge lounge, or discharged by 12midday. • Retention of the Virtual Frailty service and the development of a system frailty service supported by the National Frailty Collaborative Reductions in the number of delayed transfers of care, and lengths of stay have been long standing priorities for the Calderdale system and the Health & Wellbeing Board. Delivery of improvements has also been a priority for the allocation of BCF funding. Our system is actively managing the delivery of reductions in LOS at 14 and

	21 days. *We making good progress related to 14 days, but have further actions planned in relation to patients waiting over 21 days*: • A team of additional staff were recruited to support patients with their rapid discharge into the community. Discharge to assess beds were commissioned by the Local Authority to ensure assessments for long term needs took place away from acute settings, bed coordinators were put in place to support timely access and flow onwards. • All referrals for discharge are received via the twice daily integrated discharge hub and are triaged either by health and Calderdale Council discharge teams with timely and proportionate assessments being completed to commence people onto the right pathway where long term needs can be better understood and arranged away from an acute setting. • The Home first principle is maintained through work with housing partners including the introduction of a palliative care pathway for housing adaptations. • The Trusted Assessment referral tool is used to support safe, effective discharges. • Health and Calderdale Council services also maintain a focus on hospital avoidance and will support an individual at home, where it is safe to do so, using the services available within the rapid response teams and Gateway to Care as a single point of contact and support for the SDEC Frailty Unit and Hospital Avoidance Team activity • The ongoing pressures from the Covid outbreak have amplified what are now year round pressures, as what was once primarily a winter demand problem now extends into the summer months. Short term funding solutions aimed at meeting seasonal demand have been effective in the past, however our more efficient and effective planning and delivery ensures a consistent model throughout the year. • The system has a live dashboard which provides an overview of delays and lengths of stay, and identifies barrier to discharge. • The A&EDB has monthly oversight of progress, and a clear governance structure which supports delivery of improvements. • Within the Calderdale system, a Senior System Coordinator for discharge (a new nationally required post) has recently been appointed, and this will support the continued focus on discharge delays and a maximum level of Transfer of Care inpatients will be agreed with clear actions in response to any escalations. There is a direct impact on elective activity from bed availability and this is a key dependency. CHFT are awaiting confirmation of the position of this post within Kirklees. • Current Risks: o Number of patients on the TOC list exceed the optimum number needed to support recover

	o 7 day discharge not fully implemented o Impact of level if instability in the Calderdale Council market (services and workforce)
Please summarise the key assumptions that underpin the 2-hour crisis community health 12 month activity plan submission highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.	
Assumptions	• Work continues in Calderdale to develop a community model that delivers on urgent community response expectorations • We are in the planning stage, with a planned implementation timeline for 2022 • Whilst we have some elements of the service, they have not yet been integrated (including mental health services) • We are currently in the process of defining a go live date • There remains a capacity gap for reablement in Calderdale which will require addressing prior to winter 21/22 and will be a priority
Actions	The Calderdale Cares programme sets out a set of clear system outcomes that require new approaches to integration and ways of working to achieve are consistent with those set out in the recent White Paper. Calderdale Cares commits itself to; staff working across organisational boundaries, in teams without walls, with the person or patient at the centre. One of the key drivers for change is our Community Collaborative, which brings together a broad set of partners to integrate community services to help keep the population well and independent, ultimately leading to a more sustainable health, care and wellbeing system in Calderdale. These are the mechanisms for driving forward development of a UCR model in Calderdale; • In July 2020, following the first wave of the COVID-19 pandemic, Calderdale Partners came together to take stock. The rationale was to help stabilise the system and show how our communities and services came together to address challenges and adapt. It also enabled us to learn from doing things differently, understand what has worked well and allowed us to work differently. The aim of the review was to capture that learning for the benefit of all. • By working together our aim is to transform the experience of people who use services as well as the experience of those who deliver them. The outcome from the review has helped us to understand and: learn from our mistakes and restore services, create a place based system that promotes wellbeing, and work together to develop a workforce that is adaptable to new care needs /demands and challenges as they arise across the whole community (locality and/or place based). The 3CPB has developed a delivery plan to improve care and wellbeing outcomes, enable timely access and seamless patient journey

	• Calderdale Council have already started to pilot the move towards this model using non-recurrent BCF funding. • *Calderdale is developing a Crisis/Community Response Service.* It is an MDT made up of nursing, PT, OT and HCA's/TA's that will respond to primarily step-down urgent 2 hour response needs (within hours), and provide that 0-72 hour transition to independence and/or longer term IMC services, packages of care. They work closely with our reablement services to provide that holistic response. • These 2 services (with their single point of access LCD or Gateway TBC) will provide the foundation for the Urgent Community Response within Calderdale. Our plan is to deliver this as per our annual plans by April 2022. • They key gaps here are hours of cover (none are 24/7 services), capacity (their current size and workforce models limits ability at the moment to meet the step up demand alongside existing step down) and agreed processes though an unplanned care single point of access. *All of these gaps are outline activities in our plans to deliver by April 2022.* • The output from the pilot will be used to determine recurrent investment • Calderdale is working closely with partners in Kirklees who are a national UCR pilot to ensure that are able to pick up learning as their work progresses. • Working with Primary care Network (PCN) Clinical Directors (CDs) we will look to develop sustainable workforce models that support the patient pathway reducing admissions and enabling early supported discharge. The Quest team will continue to input to care homes but with a renewed focus on prevention rather than reactive interventions • Upon completion of a service restructure in 2021, underpinned by close collaboration with CHFT and CCG partners, Gateway to Care Plus will be the Single Point of Contact for a range of community health and Calderdale Council services. This will incorporate 4 early intervention and prevention hubs with clear areas of responsibility designed to proactively manage hospital discharge and community contacts, enabling people to remain independent and live at or closer to home for longer. • Our Voluntary and Community Sector will continue to promote greater integration with VCSE organisations supporting pathway improvements. It can provide wrap-around care and services as part of integrated models including avoidance of hospital admissions through crisis care in areas of mental health, substance misuse service and wider preventative provision – including helpline services, online support and peer support groups and networks. • Our general practices are taking a number of actions to support improvements in community services; and support delivery of new interventions; o Enabled direct, digital appointment booking from AED to GP slots

	o Implemented the model of in and out of hours streaming from AED that demonstrates the most effective patient pathway o Facilitated direct booking to SDEC across all specialties o Implemented a rapid Consultant/GP phone line in all specialties o Implemented virtual ED models that reduce patient conveyance to hospital o Supported GPs to identify 'at risk patients' proactively and avoid deterioration and attendance o Implemented the agreed changes from the Frailty collaborative
Risks and issues	• Data development issues, ability to demonstrate progress given complexity of matrix system, and confirming accountable provider • Workforce availability and funding • Access to Reablement services • A move to a 24/7 service offer

System name:	Calderdale
E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	
Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the objective below	
Continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes	• We are continuing to divert activity to the West Yorkshire Local CAS service provided by LCD via two cohorts – Under 11s and GP 1 and 2-hour dispositions. • Outcomes seen show significant proportion able to be closed remotely without further intervention. • Audit checks confirm safe and no follow up attendance across system. • Work now underway for WYUC local CAS to carry out validation of ED dispositions reached by people using the NHS111 Online tool – anticipated go live during Q1. • Currently offering 20 EDDI appointments at each CHFT ED each day between 9am and 5pm with plans to expand this to 48 appointments at each ED between 9am and 9pm

Roll out of the Emergency Care Data Set (ECDS) to all services	ECDS is rolled out to all applicable services. Currently we are submitting version 2. We are working towards (in conjunction with XML middleware * and EPR suppliers) submitting version 3's file specification, with an intention to do this from end May/beginning June 2021, this being dependant on the XML middleware supplier delivering against their advised timeline. There are no concerns regarding readiness and ability to capture 'Ready to Proceed' or ability to monitor time to initial assessment and 12 hours from time of arrival. *company contracted to submit our ECDS
Please summarise the key assumptions that underpin the UEC activity plan submission highlighting any key risks and issues. Please also set out any system actions that are critical to the delivery of the planned activity levels.	
A&E attendances excluding planned follow ups	
Assumptions	• That Covid NEL levels assumed at just below 5% as per the planning guidance. • The success of local targeted communications on the appropriate use of A&E and other services. • The offers from other partners, as part of development of our UTC model for 2024
Actions	• Continued targeted communications work focused on areas with the highest usage. • Continued work with primary care on the opportunities to support reductions in demand • Maximise opportunities to encourage the use of other services (111, GP out of hours) • Maximising the uptake of A&E Streaming Services
Risks and issues	• Significant Increase in A&E attendances – up 15% from February 21 to March 21 • Increase in proportion of patients who could have potentially received their care from a primary care clinician
NHS 111 referrals to SDEC	
Assumptions	The very low trajectory for SDEC takes account of the fact that the 111 provider has only been capturing the data since December 2020 and to date the numbers recorded are very low.
Actions	As monitoring of this measure develops and there is greater clarity on what should be counted in the first half of the year, we'll be in a better place as a system to understand the current performance position more accurately and develop the trajectories with more confidence.
Risks and issues	Further clarification is needed on what can be captured under the SDEC heading as a direct referral from 111 into SDEC.

System name:	Calderdale

Elective Recovery Framework: Gateway Criteria

To qualify for ERF funding, systems are required to demonstrate their elective recovery plan supports the requirements in sections C1 and C2 of the planning guidance and the five objectives listed in the accompanying implementation guidance. Please set out the specific actions that, as a system, you will take to meet the 'gateway criteria' below:

Addressing health inequalities (Plans should take due regard of the need to reduce pre-pandemic and pandemic related health inequalities using related waiting list data that is embedded within system performance frameworks to measure access, outcome and experience for BAME populations (and those in the bottom 20% of IMD scores)	We recognise the importance of Health Inequalities in relation to our current service models, the recovery plan, and the strategic case for change that is guiding the reconfiguration planning in this footprint. We are building capacity and capability to ensure we fully understand the health inequality agenda, we make truly informed decisions by being able to accurately analyse data and interpret feedback in a meaningful way. In terms of delivery of the criteria;
	
	• 4 programmes of work in relation to health inequalities, overseen by a Steering group and reporting directly into key organisational and system forums
	• *Significant work on Health inequalities with all waiting lists analysed* by IMD, LD, Frailty and Ethnicity and outcomes incorporated into prioritisation and planning
	• Priorities specifically include health inequalities
	• A priority work programme for *LD patients* and developing a fast-track pathway for all new referrals as well as priority access for those currently on the waiting list
	• A specific work programme on the 'Lived Experience' in place as a stream of the HI work with a second workstream on engagement into communities and digital inclusion
	• Restore NHS service inclusivity
	  o We have the data that will support the analysis of referral trends
	  o We have already picked some areas where action will be required as levels appear disproportionate to population and pre covid levels. We have joint clinical and operational forums that will allow improvements to be agreed
	  o All data is available at IMD and ethnicity with priorities set for recovery that reflect the outputs of the analysis. The data is live so refreshed real-time
	
	The Health inequalities agenda has had an increased profile internally and nationally since the onset of Covid 19 with a national focus and the identification of 8 urgent actions included in the national stabilisation and reset priorities letter in July 2020 reinforced in December 2020.
	Internally, CHFT recognise the importance of this in relation to our current service models, the recovery plan, and the strategic case for change that is guiding our reconfiguration planning. We are building capacity and capability to

	ensure we fully understand the health inequality agenda, we make truly informed decisions by being able to accurately analyse data and interpret feedback in a meaningful way. n terms of delivery of the criteria; Reflecting the complexities of this and the need to learn at pace the agenda has been split into three themes with a director lead for each them who will then bring this together to help shape our response and disseminate this learning across the organisation and wider Health & Calderdale Council system. However, the Chief Nurse/Deputy Chief Executive is the Executive with overall Board responsibilities for Health Equality. The three themes are: 1. The external environment, how we connect with our communities and use this to inform our business as usual planning and includes digital inclusion [Anna Basford, Director of Transformation & Partnerships] 2. The lived experience, with initial focus on families accessing our maternity service [Ellen Armistead, Chief Nurse/Deputy Chief Executive and Executive lead for Health Inequalities] 3. Health inequalities data and how we use this to compliment clinical prioritisation and our post Covid-19 delivery model for both planned and unplanned care. [Helen Barker, Chief Operating Officer] In addition to the 3 patient focussed themes there is also a workforce related programme around Health inequalities, diversity and inclusion. A single overarching programme will be launched for all four elements. To support this key agenda we have built on the excellent data capture of ethnicity and other Health inequalities data with an ever evolving section in Knowledge Portal+. Through this we can identify the patients who require access in line with the agreed priorities and monitor delivery of these. A small Clinical Reference Group has been established to work through any potential health inequality issues in relation to the backlogs and overall waiting lists. This will include developing models that better align with the needs of patients where health inequalities are identified or start to emerge and will include: • Dedicated capacity for patients who also have a learning disability • Reviewing isolation and swabbing pathways for patients who are unable to adhere to the guidance to ensure they also receive timely access • Ensuring communications and models of care can respond to the heightened concerns of BAME patients in relation to their increased risk profile A Learning Disabilities improvement programme has commenced, building on the agreement to prioritise thee patients. This includes: • Ensuring all patients with a Learning Disability have a flag on EPR, including children & Young people • Developing a FastTrack pathway from referral to treatment with a patient support navigator

	• Working with Locala to support patients with dental needs access CHFT services more promptly • Raising awareness of the needs of people with a Learning Disability • Building capacity and therefore resilience in the team involved in the care of patients with a Learning Disability As part of the Business Better than Usual programme, work has been taken forward to develop new ways to involve local communities and listen to their needs and co-produce responses to reduce inequalities. The aim of this work is to build relationships and listen to the views of local groups and communities in relation to their experience of accessing healthcare and to develop with them actions that can be taken to meet their specific needs and improve experience. To shape and guide this work, we are seeking advice from the West Yorkshire ICS Programme Lead and are currently meeting with local stakeholders to collaboratively agree specific groups of people to work with. One example that is being progressed is to better understand the needs of refugees, asylum seekers and homeless people – the Trust has had discussion with Huddersfield Mission with the aim of joining an action group to listen and co-produce responses to offer improved access and support. We continue to work in partnership across the system for example, in Calderdale, to support and contribute to actions agreed that have been informed by Calderdale Council Public Health team engaging with people living or working in Park ward and surrounding areas to address the disproportionate impact of Coronavirus on Black Asian and Minority Ethnic (BAME) communities. Our long-term ambition is to develop strong links with our diverse range of communities, giving voice to those groups who are seldom heard, to overcome barriers together and facilitate the necessary conversations about health, wellbeing, prevention and services, finding ways to enable all individuals and carers to take advantage of new ways of accessing health care support and information using digital technologies (e.g. remote consultations, patient portal) – ensuring offers of using technology to access services are culturally competent
Transforming outpatient services Plans	The *Out-patient Transformation Board, a system forum* across the hospital footprint, has been in place for 3 years as a system group, is leading on increased transformation OP activity and avoid unnecessary referrals. Key improvements are; • *Advice & Guidance utilisation has increased by 199%* since March 2020 81% of these were responded to within 48hrs • Clinical validation of all waiting lists in place, including outpatients. Proactive patient contact system developed and being rolled out with good patient feedback and early identification of need • Non face to face (remote/virtual) *outpatients is at 32%* with plans in place to increase number of patients accessing

	non face to face appointments • *PIFU in* place across cancer pathways and programme for non-cancer pathways. • F/U clinical validation and prioritisation in progress across all specialties to inform roll-out, this includes assessment of face to face or virtual. 2000 patients already discharged from the initial cohort of clinical validation (10%) • Locally we have a PTL that we track and reporting that is reflective of our agreed priorities. • We are using the IS for both CHFT and ERS patients and this is overseen by a weekly system meeting • Dashboard in place and reported into weekly system forum • A small Clinical Reference Group for modelling has been formed in CHFT with operational, clinical and THIS colleagues who will meet regularly to continually review the modelling, learning from the experience of delivery weekly & monthly and advise on any changes to parameters. This group will also validate the outcomes of models to ensure they are sensitive to agreed specialty variation.
System led recovery Plans should ensure that Patient Tracking List (PTL) management is undertaken at a system level and that all capacity (including IS) is being used to the benefit of the whole-system population	• Locally we have a PTL that we track and reporting that is reflective of our agreed priorities. • We are using the IS for both CHFT and ERS patients and this is overseen by a weekly system meeting. We are proactively engaged with the Planned Care Board to develop thinking on an ICS PTL
Clinical validation, waiting list data quality and reducing long waits Plans should ensure ongoing clinical validation and shared	1. Key Messages • We are currently reviewing the gap between the modelled number and our capacity plan which will be confirmed by final submission • Activity & threshold position in submission is core and based on staffing as is currently. It does not include any further recruitment or additional activity through WLI etc, and we are confident there will be an increase in the final submission) • The modelling will be constantly reviewed to ensure it takes account of demand changes • We have a Clinical Reference Group with 6 Consultants across the specialties supporting this so really good engagement in the planning • There is a step change in additions at P2 that we are exploring but also aware that the Royal Colleges are changing

decision making between patients and clinicians as well as maintain a continuous focus on waiting list data quality	their guidance on P values reflecting they were originally established when there was very limited access 2. Clinical validation A small Clinical Reference Group for modelling has been formed in CHFT with operational, clinical and THIS colleagues who will meet regularly to continually review the modelling, learning from the experience of delivery weekly & monthly and advise on any changes to parameters. This group will also validate the outcomes of models to ensure they are sensitive to agreed specialty variation: • 100% of the admitted waiting list has a P value assigned • Where anomalies are identified, e.g step change in volume of P2 additions this is reviewed for consistency by Clinical Directors • A P value criteria for overdue Follow ups has been developed internally as no national guidance. Patients undergo admin then clinical validation which is tracked at consultant level weekly. Through this exercise over 1800 follow up patients have already been discharged on clinical validation alone • The majority of services have a Clinical Assessment service (CAS) for new referrals with the aim for 100% coverage as part of the Recovery Framework. this allows clinical prioritisation of urgent patients but also avoids a large % of actual appointments. For example of 13000 referrals, 2500 were discharged via the CAS CHFT have a Data Quality Board which oversees; • Waiting list data review and validation takes place weekly • Clinical Reference group in place • Weekly submission and data quality sign off process in place 3. Prioritisation We have agreed priorities at CHFT Board for waiting lists which are: • P1 & P2 • Patients with a Learning disability • Equity of waiting time for BAME & Non BAME • No 104weeks • Patients whose outcomes will be significantly impacted by excessive waits • Patients at significant risk of losing their independence This means that we will be taking a combination of the P value and the patients holistic need to determine access and we have another Clinical Reference Group for scheduling

	4. Balancing waiting list • Clinical Reference Group for modelling established and meeting weekly to constantly review all waiting lists, assess demand & prioritisation changes remodelling as required. Expected to run for length of recovery • Weekly Exec Board overseeing delivery of recovery • Recovery specific section of the Integrated Performance Report developed overseen by Executive Board and Finance & Performance Committee 5. Activity modelling <u>Admitted Patients:</u> *By 30th September 21* • All P2s within 4 weeks of listing • All P3s within 12weeks of listing • A 12 week average RTT waiting time reduction for P4s (? Need to also look from date on waiting list to consider best approach) • No over 104 week waiters from RTT *By 31st March 22* • P2 & P3 as above • A further 12week average waiting time reduction <u>Non admitted Patients:</u> *By 30th September 21* • No urgent referrals waiting longer than 6weeks for first appointment • No routine referral waiting over 22 weeks *31st March 22* • Maintain 6 week maximum wait for urgent referrals • No routine referral waiting longer than 12 weeks <u>Follow up</u> • Patients with a Priority 1, 2 & 3 will be seen within the relevant timescales

	Endoscopy: All routine waiting lists to be no longer than 6weeks by the end of June 21 and sustained All surveillance waiting lists to have no patients waiting longer than 13weeks past their due date by 30th September 21 reducing to 6weeks by March 22 All other diagnostics we are aiming to be back to 6weeks maximum by end of June with several already at this level
People recovery Plans should demonstrate how the health and wellbeing of staff will be monitored, including through an appropriate set of measures	• Each organisation will monitor at board level delivery of recovery, including recovery of its staff wellbeing and capacity through current and or strengthened metrics, including ; KPIS on sickness absence rates going up and particular reasons for absence (stress, etc), LTO increasing, themes from HWB conversations etc. • We are looking at a system approach to oversight of this intelligence through the new ICP architecture, including a System Oversight and Assurance Group to provide quality, finance and performance system oversight.

System name:	Calderdale

Health Inequalities: 5 priority areas

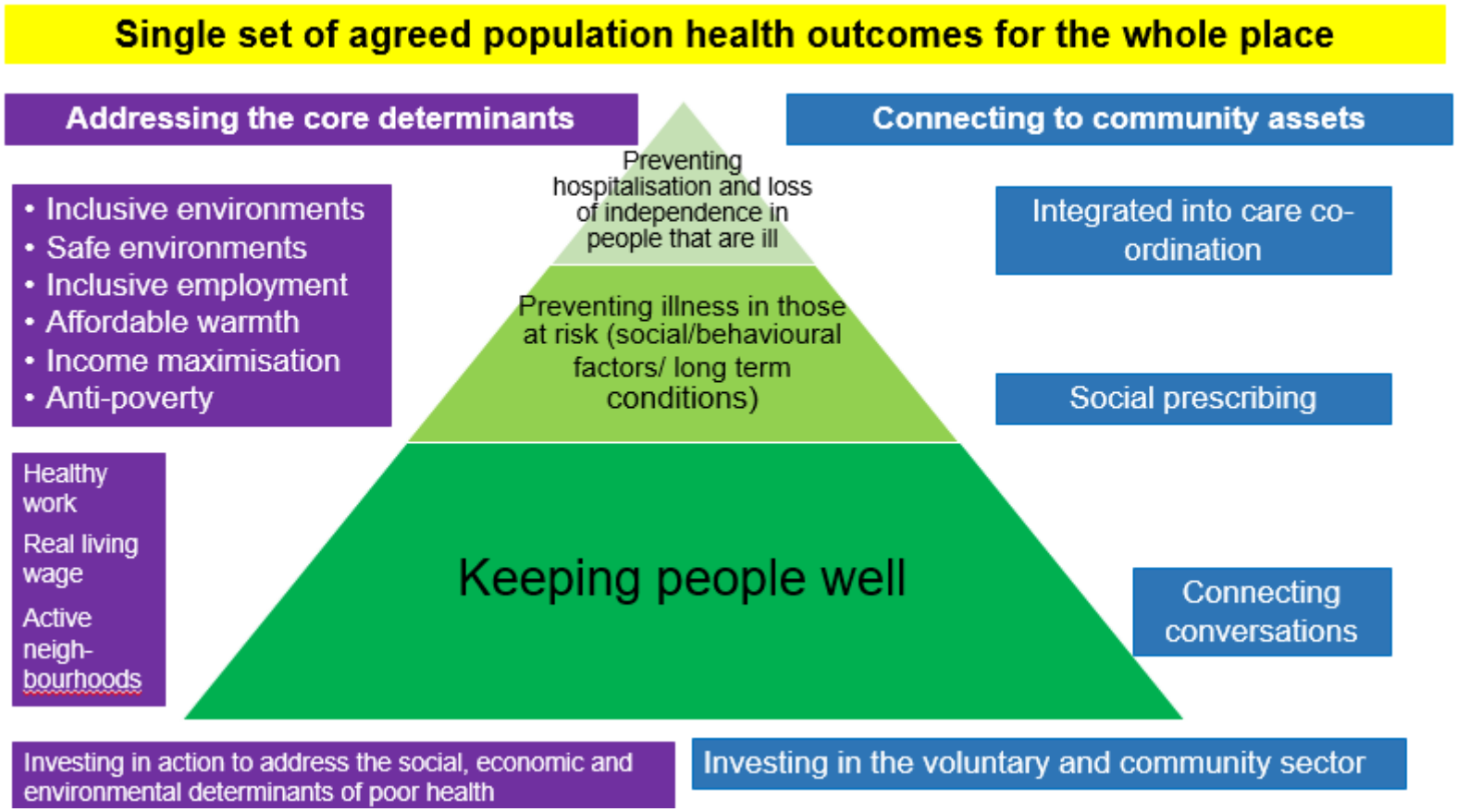
Please set out the specific actions that, as a system, you will prioritise over the next 6 months to address the priorities below	
Restore NHS services inclusively	As a system, Calderdale identified the importance of improving outcomes for people with a learning disability. This has been further reinforced in recovery as part of our local approach to health inequalities. The recent letter to NHSE from our system (5 April) provides a strong overview of the work that is on-going. This was also a feature of a recent HWB focused sessions when our plans were well received. *In terms of progress; during the Pandemic, 78% of pre-pandemic planned outpatient activity was delivered in 2020/21*. This was delivered via 51% Face to Face and 49% digital appointments (telephone and video). As a system we were already rolling out new pathways via our Outpatient Transformation Board however, there was a rapid acceleration in use of digital appointments through the pandemic. • 14 Clinical Assessment Services (CAS) have been implemented in 2020 – these new pathways provide more streamlined review of patients and reduce the need to attend hospital • Over 3,000 video appointments in the community have been delivered • We are currently progressing, and aim to see, rapid expansion of Patient Initiated Follow-Up (PIFU) models of care in 2021-22 – this will aim to optimise use of the Patient Portal to enable more self-care. In relation to next steps; • We have the data that will support the analysis of referral trends • We have already picked some areas where action will be required as levels appear disproportionate to population and pre covid levels. We have joint clinical and operational forums that will allow improvements to be agreed • All data is available at IMD and ethnicity with priorities set for recovery that reflect the outputs of the analysis. The data is live so refreshed real-time The Outpatient Transformation Programme Board (that includes representation from Healthwatch, Patients, CCGs, LMCs and the Trust) has reassessed priorities considering the feedback received through the Business Better than Usual engagement feedback, the Covid-19 recovery phase and the increased use of digital health. The board agreed 5 key areas of work including the Digital Inclusion workstream to mitigate against the risk of any patient or carer being disadvantaged by any digital options for care. Work is ongoing with partners within each Local Authority and voluntary sector and community leaders to gain a collective understanding of need and coordinated focused response. We are active participants in four system programmes ensuring feedback to programme teams on learning and await the

	publication of the system reviews from which we will build any local actions into our Recovery framework and overarching Health Inequalities programme. In particular, we are sharing our learning on the Health Inequalities analysis of our planned care backlogs with the planned care programme helping to shape prioritisation planning and ensuring region wide plans take the risk of widening Health Inequalities into account. A small Clinical Reference Group has been established to work through any potential health inequality issues in relation to the backlogs and overall waiting lists. This will include developing models that better align with the needs of patients where health inequalities are identified or start to emerge and will include: • Dedicated capacity for patients who also have a learning disability • Talking directly to those patients in the lower IMD groups to understand their pathway and needs • Reviewing isolation and swabbing pathways for patients who are unable to adhere to the guidance to ensure they also receive timely access • Ensuring communications and models of care can respond to the heightened concerns of BAME patients in relation to their increased risk profile The focus on our vaccine programme on pop up clinics in; mosques, homeless shelters, recovery services, refugee services and women's shelter, is part of a Health Inequalities Plan that has been delivered to underpin vaccine roll-out Our Voluntary and Community Sector is a key player in this work through; • Integrated care key to collaborative working. Calderdale Community Collaborative is key to address this priority linking in VCSE organisations to transform and address gaps, inequalities and improve wellbeing. VCSE is able to effectively engage with communities experiencing poorest health outcomes/inequalities to understand their experiences of the health and care system pre-COVID, during COVID and how their needs may have changed. • Their ability to engage with those who currently experience exclusion using asset-based community engagement, through the Engagement Champions project. This has proven crucial in understanding reasons behind vaccine hesitancy for different communities. • Their working in partnership with existing health and care services to coordinate engagement with communities that experience barriers to accessing care. This will enable communities to co-design new services, and shape services re-opening to ensure that key support is prioritised. • Strengthening their part in pathways to address local need with accessible, holistic ways to improve wellbeing. Many VCSE organisations, including those outside of the traditional health and care sector, promote preventative measures against health issues and in turn reduce the demand on statutory services. This will also enable priorities to be met and delivered including addressing digital poverty and structural exclusion which can create barriers to access and

	effective progress in health improvements • Focus on ensuring pathways enable priorities to be met and delivered including addressing digital poverty and structural exclusion which can create barriers to access and effective progress in health improvements • Structures such as anti-poverty partnership group and Equalities Forums, (CMBC & CCG) Calderdale Recovery Board can play a role here. • Resource allocated to VCSE from vaccination programme to tackle vaccine take-up/access inequalities using existing covid champions programme and other creative community engagement means. • Partnership working with VCS and health partners with co-produced initiatives to address health inequalities in communities with endemic covid19
Mitigate against digital exclusion	Calderdale and Kirklees Healthwatch undertook specific engagement with service users that have protected characteristics regarding *their experience of new ways of digital access to services*. In 2020, CHFT undertook a further public survey on patients' views in relation to digital access. Responding to this feedback the CHFT has implemented • Continuous testing and feedback on new pathways with over 100 patient volunteers • Improved access to interpretation services including the use of British sign language during video consultations • Undertaken specific work with Learning Disabilities Teams and Safeguarding regarding access • Provided an option for Patient feedback on all video appointments that we can use to inform and adapt delivery models • Remote appointment instructions have been translated into 6 most requested languages • Carers, relatives and interpreters can be dialled into remote appointment • Working on new ways of involving local communities to listen and understand their needs and co-produce responses to reduce inequalities; currently meeting with local stakeholders to collaboratively agree specific groups of people to work with initially. • Survey of patients completed to understand their views and experience of accessing services and in particular the use of digital technology and remote consultations. The feedback from this, along with the findings of a review undertaken by Healthwatch that asked people with protected characteristics about their views in relation to the use of telephone and video healthcare appointments, is being used to inform the programme of outpatient transformation and ensure that adaptations to support the use of digital technology are made (e.g. provision of British Sign Language and translation options in digital consultations). • Digital exclusion is also a work-stream in our Out Patient Transformation Board. Improving the digital capabilities of service users and carers is a priority within SWYPFT - providing service users/carers with access to services and care that has digital embedded within the service offer that is more in keeping with how they

	prefer to engage with other services digitally in everyday life. Focus on championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve. Addressing barriers to digital inclusion and digital inequalities through working with partners
Ensure datasets are complete and timely	CHFT collect data on *ethnicity for all activity and can report on this through any service specification*. The Trust has always ensured focus on the collection of data in relation to ethnicity and has developed a comprehensive data-base within its Knowledge Portal that allows this to be used actively for the planning, delivery and monitoring of services. This database includes ethnicity, IMD data and specific flags, e.g., Learning Disability and Frailty. The current completion rate of ethnicity capture is approximately 94%, however, there is a slight variation dependent on which pathway the patient is on, for example, it is slightly lower in Outpatients and AED, but higher for admitted patients with the higher proportion of missing data appearing to relate to 'not stated' rather than 'not captured' which is being explored. On investigating the position there are 2 areas of concern that are currently the focus of activity. • A deteriorating position in outpatient which we believe is linked to the increase in non-face to face appointments. Previously the data was asked at reception when the patient booked in, but this is now all done by the clinician and we have not been explicit with this requirement. A standing Operating Procedure has been developed and will be implemented. • Whilst the overall data capture gap is approximately 6%, this rises to 20% when applying it to non-local CCG activity. This indicates good compliance to data capture by both local CCGs that tracks through on referral but necessitates further investigation for non-local referrals which we have commenced.
Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes	• Early in the pandemic, Calderdale Council engaged with the local Asian community in Halifax to hear about the impact that the pandemic and lockdown was having on the lives of local people. The insight gathered from this engagement informed the development of an action plan to mitigate disproportionate impacts of Covid-19 on local Black, Asian and Minority ethnic communities and to address the underlying inequalities that led to these unequal impacts. This has been adopted by the Health and Wellbeing Board and has informed our approach to tackling enduring Covid-19 transmission which affected these communities during 2020. The system-wide action plan is led by a CHFT Director • Our work on an integrated community model will join up services and programmes to achieve outcomes, including an outcome to narrow the gap in healthy life expectancy. Ultimately this will require the local system to deliver prevention

and early intervention targeting those at greatest risk of poor health outcomes. The approach will integrate interventions within health, care and wellbeing services to keep people well, prevent ill health and keep people out of hospital and independent for as long as possible; and will address core determinants of poor health and connect people to assets in their local communities. This is summarised below.



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

	inequalities. It is central in helping the CCG embed the voice of patients, carers, families, staff and the public everything we do. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback. The duty to involve local people is set out in sections 242 and 244 of the Health and Calderdale Council Act 2012, The NHS Constitution and the Equality Act 2010. The strategy helps us to build place based engagement and communication - and the principles of strategy are the foundation by which local people can expect to be involved by organisations in Calderdale. Working in partnership with our partner organisations, providers, staff, public, patients and carers is a key principle. We have good relationships our key stakeholders including the Voluntary and Community Sector and we want to continually work with and invest in our partnerships to help us deliver the Involving People Strategy. CHFT has a flag on the Electronic Patient record that identifies all adult patients with a Learning Disability and have undertaken work to improve access for patients with a learning disability which includes: • The Board of Directors have agreed a principle within the Recovery Framework that prioritises patients who also have a Learning Disability, regardless of their clinical prioritisation • Priority access to theatre for patients currently on the waiting list with specific operating lists that best meet their needs • Exploring options with Locala to rapidly treat the backlog of patients awaiting access to dental care under a general Anaesthetic • The development of a FastTrack pathway for all patients referred to CHFT who also have a Learning Disability with deployment of care navigators to support their journey • Raising awareness of the needs of people with a Learning Disability • Building capacity and therefore resilience in the team involved in the care of patients with a Learning Disability
Strengthen leadership and accountability	Within our system we have; • Identified senior health inequalities leads in each organisation • Created a place based Health Inequalities partnership to oversee planning and implementation • Developed a place based inequalities plan which is clear about leadership and accountability • Created links to the WY ICS Inequalities Action Plan, and Tackling Inequalities for Black, Asian and Minority Ethnic (BAME) communities and staff agenda • Built the agenda clearly into our Recovery plans • Held a system of system workshops led by the CO of CHFT, sharing data and insights to support our plans • Strengthened listening to communities; through the agreed Involving People Strategy • Co-produced an action plan to reduce the Impact of Covid 19 on our BAME communities.

END

Overview of Planning Guidance Expectations

No	Expectation
1	**Community health services** Full access to digital mobile services for community workforce. Delivery of crisis response services, providing an agreed number of guaranteed two-hour home response appointment (Urgent Community Response)
2	**Primary care**; support PCN Development (workforce redesign and team development, including recruitment to additional roles and extra doctors to work in general practice), improving patient access and waiting times, implementation of online consultation and information about A&E attendances, building operational relationships with community providers (including pharmacies), primary care network contract for direct enhanced service.
3	**Mental health**; bolster community mental health provision for adults and older adults, increase investment and staffing in core and dedicated community mental health services, inc IAPT trainees. All deliverables in NHS long term All providers/PCNs to organise and deliver integrated services
4	**Learning disabilities and autism**; ensuring the right range of support and care services for individuals with learning disabilities and/or autism are available in the community, rather than in hospital, inc increased use of personal health budgets, discharge pathways and community alternatives to admission.
5	**Urgent and emergency care**; deliver material improvement in A&E performance, reduce general and acute bed occupancy to a maximum of 92%. (no longer expected that bed numbers will be reduced). Increase patients seen and treated on same day, or within 12 hours. Providers are required to deliver acute frailty services for 70 hours per week. Same day emergency care (SDEC) activity must be recorded.

No	Expectation
6	**Referral to treatment time (RTT)** including 26-weekchoice; waiting lists on 31 January 2021 should be lower than that on 31 January 2020. Financial sanctions remain in place if patient breaches a 52 week wait. All providers and systems to implement supplementary choice at 26 weeks, offering a meaningful choice of an alternative provider.
7	**Outpatient transformation**; reduction in unnecessary activity, commissioners and providers to agree blended payments including advice and guidance and uptake of non-face to face consultations. Implementation of video consultation in major specialties..
8	**Cancer**; roll-out of rapid diagnostic centres, targeted lung health checks programme, delivery of the ambitions set out in the NHS long term plan, increased funding for children's hospices and end of life care services
9	**Prevention;** alcohol care teams and smoking cessation support expanded in selected sites, and low calorie diets piloted in ten systems to support type 2 diabetes remission, delivery of screening and vaccination programmes, possible flu vaccination mandatory for NHS staff. All systems should have a green (or sustainable development management plan)
10	Hospital and community **workforce**; actions to improve retention and release time to care and improve productivity. Primary care workforce plan that considers local multi-disciplinary workforce needs. Looking after the wellbeing of staff.

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Director of Finance Report**	**Agenda Item No.**	12
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 report outlines the CCGs forecast financial position against the plan submitted to NHS England for the period April 2021 to September 2021.

The report highlights the key financial variances and also the key risks and potential mitigations in relation to the CCGs financial plan for the next 6 months.

Contracting

The update provides key messages relating to main areas of contracting activity presented to Committee.

Performance

The report highlights the progress and challenges associated with the achievement of the standards set out in the NHS Constitution and the impact of Covid 19 on access and performance to NHS services.

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 finance update
2. **NOTES** the content of the contracting update
3. **NOTES** 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.

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.

Contents

1. Introduction

1.1 This report to the Governing Body in relation to the CCG's latest finance, contracting and performance updates.

2. Finance

2.1 Finance Key Messages

This report updates the financial position as at month 3, 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 – this period is referred to as H1 by NHS England. The plan submitted is to achieve a balanced position for 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.
- The CCG is still awaiting allocation notification and planning guidance for the period October 2021 to March 2022 (H2). NHS England briefings have indicated that guidance and allocations may be issued in September 2021. It is expected that there will be a much more challenging efficiency requirement to deliver in H2.
- The CCG has developed plans to deliver the Mental Health Investment Standard in 2021/22.

2.2 2020/21 Final Financial Position Update.

The CCG submitted draft accounts to NHS England on the 27th April 2021. Audit Committee approved the accounts on the 10th of June and the final submission to NHS England was on the 15th June 2021. The CCG delivered its financial plan for the year and these accounts were unqualified by our auditors Grant Thornton.

2.3 2021/22 Financial Plan

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 was approved by Governing Body on 29th April 2021.

The CCG is still awaiting allocation notification and planning guidance for the period October 2021 to March 2022 (H2). NHS England briefings have indicated that guidance and allocations may be issued in September 2021. It is expected that there will be a much more challenging efficiency requirement to deliver in H2.

2.4 Financial Forecast April 2021 to September 2021 (H1)

The CCG is forecasting to meet the financial plan however there are a number of variances to note. The makeup of these variances can be seen in **appendices A-C** and summarised below: -

- **Acute**: Currently forecasting a small underspend. The CCG has block contract arrangements in place with NHS providers and payments are in line with expectations.
- **Mental Health**: This is showing a small underspend due to the IAPT budget being set too high. Plans are in place to meet the MHIS, these plans will need refreshing once the national Agenda for Change Pay uplift has been agreed.
- **Prescribing**: Currently forecasting online with budget due to limited activity information available at this early stage in the financial year. 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**) : Showing a small underspend due to budget alignment issues.
- **Primary Care** : Delegated : Currently forecasting on line with budget. It is expected that we will show an overspend in the future as Additional Roles are fully recruited to and 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 a small overspend. The forecast will continue to be refined with the most up to date activity information.
- **Other / Reserves**: Showing an overspend due COVID-19 related hospital discharge costs which will be matched by additional allocations. Included here is a forecast of £0.9m of costs which is expected to be matched by additional allocations from NHS England on a retrospective allocation basis.

- **BCF**: Forecasting online and includes the increase in the planned 21/22 BCF contribution.
- **Contingency**: currently showing an underspend on contingency which is being used to balance against unidentified QIPP.
- **Running Costs:** The CCG plan for running cost has a requirement for £50k savings to meet the running cost allocation of £2,058k for H1. There are several vacant posts in the structure, and it is forecast that the planned savings target will be met through vacancy savings. Agenda for change uplift costs are currently excluded in the forecast and will be included once national guidance has been issued.

2.5 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 M3 QIPP forecast position.

Calderdale CCG H1 QIPP Target as at 30th June 2021

QIPP		Target £'m	Risk Adjustment %	Projected Delivery £'m	Risk £'m
Prescribing	R	0.25	100%	0.25	0.00
CHC	R	0.25	100%	0.30	0.05
Other	NR	0.71	100%	0.71	0.00
Unidentified	NR	0.80	0%	0.00	(0.80)
Total		**2.01**		**1.26**	**(0.75)**

The forecast risk on delivery of QIPP for H1 if £0.75m. The CCG is utilising the contingency to mitigate against QIPP under delivery whilst further QIPP plans and mitigations are being developed.

2.6 Public Sector Payment Policy

The CCG has a target of 95%, and performance is currently between 94.15% and 99.9% across NHS and Non-NHS invoices.

Appendix D shows the public sector payment policy in more detail.

2.7 Risks and Mitigations

The CCG has several 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.

3. Contracting

3.1 Acute and Independent Sector providers

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place until September 2021, therefore no 2021/22 contracts are in place and contracted NHS acute providers are paid on a nationally set block amount under 2021/22 National Contract Terms and Conditions.

Activity reporting indicates that a more stable level of elective activity is now taking place across acute providers. Increased demand is experienced at A&E departments causing pressures in the system on both acute footprints.

Further to the expiry of national contracts with independent sector providers, new contracts have been put in place from April for a period of 6 months by calling off from the Framework for Increasing Capacity in Independent Sector providers.

3.2 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place for the SWYPFT contract. The national target (95%) for follow up on CPA

within 7 days of discharge was met in Month 1 (100%). The national target (60%) for EIP-NICE approved care package within 2 weeks was also achieved in Month 1 (100%).

3.3 Yorkshire Ambulance Service (YAS) 999 Ambulance

Initial performance information for Month 1 for Calderdale shows that the 999 service responded to 2,936 calls. Of this number, 88.5% were responded to on the scene. 11.5% were 'Hear and Treat' responses. YAS overall responded to 85,435 calls in Month 1, which is 12.2% higher than Month 1 of 2020/21.

3.4 Integrated Urgent Care (IUC, formerly NHS 111) and West Yorkshire Urgent Care (WYUC)

IUC overall in Month 1 showed 154,708 answered calls in April, which was 0.3% above the Annual Business Plan baseline volume. Calls answered in April was 8.4% above the volume in March, and higher than any month over the past year. Validated overall WYUC activity shows 22,713 cases for Month 1, an increase of 12.5% from Month 1 of 2020/21. Of this activity, Calderdale CCG had 1,997 cases in Month 1.

Yorkshire Ambulance Service (YAS) Patient Transport Services (PTS)

In March 2021 NHS England and Improvement national guidance was received 'Financial and Contracting arrangements for H1 2021/22' which advised that the block payment financial arrangements will remain in place for the first six months of the current financial year commencing 1 April 2021 to 30 September 2021. For NHS Calderdale CCG Month 1 activity was 2,562 which is a 78.9% increase in patient journeys compared to the same period in 2020-21. The number of patient journeys during April 21 compared to March 21 has seen a decrease of 134 (0.5%) patient journeys.

3.5 Posture and Mobility (Wheelchairs) Service (Ross Care)

Total new referrals increased to 234 in April. For Calderdale there were 69 adult referrals with 28 of these being re-referrals. There were 13 paediatric referrals for Calderdale with

all 3 being a re-referral. Performance is showing that overall referrals screened within 2 working days maintained 100% against the 95% target. Referral to assessment for urgent clients within 5 working days also maintained 100% in the month and relates to 38 requests collectively (12 for Calderdale). Handovers of equipment within 7 days (using held or recycled stock) achieved 100% for Calderdale and relates to 11 requests. Handovers within 28 days (using manufacturer's equipment) was just below the 95% target at 93% for Calderdale with breaches relating to 3 out of 40 clients.

3.6 Procurement Update

Service description	Status	Contract start date	CCG Annual / Indicative contract value
The Provision of a Pre-School Children's ASD	**Completed** - Contract awarded to Oakdale Centre	01.06.2021	Circa £153,000
West Yorkshire Patient Transport Service (Acting as Coordinating Commissioner)	**Completed -** Voluntary Ex-Ante Transparency (VEAT) Notice published; no challenges received contract awarded	01.04.2021	£30,000,000 across all CCGs (West Yorkshire)
Community Phlebotomy	**Ongoing –** Market testing exercise underway	To be confirmed	To be confirmed: Potential providers asked to submit a cost per venepuncture
Community Ophthalmology Service	**Ongoing –** AQP process underway; for new providers only to apply for reaccreditation	01.08.2021	Zero value contract (i.e. no commitment, payment based on activity)
Designated Beds (COVID-19): Calderdale / Kirklees /Wakefield	**Completed –** Contract awarded to Croft Care Homes	21.06.21	£1,165 per bed x 6 (potential to rise to 12)
Intermediate Care Beds (Bracken Bed View)	**Ongoing –** Market engagement completed, 4 responses received, next steps under discussion	To be confirmed	To be confirmed
Continuing Healthcare Domiciliary Care	**Ongoing –** Re-opening of process in May 2021 and quarterly until March 2025	01.04.2021	Approximately £1m (multiple providers) £0 value contracts, payment per package of care

4. Performance

This section of the report will provide an update on progress against the NHS constitutional standards including the impact of Covid 19 on the restoration of access levels to NHS services

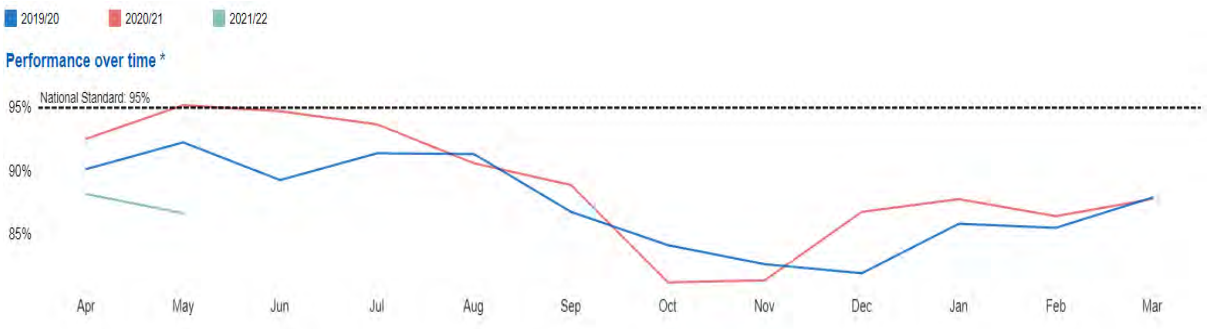
4.1 Urgent and Emergency Care

Indicator Details	Latest Period	Target	Value	Change
A&E - % waiting under 4 hours	May 2021	95% and above	86.7%	⇓ -1.5%
A&E - No. waiting 12+ hours from DTA	May 2021	0	0	⇔

4.1.1 A&E - % waiting under 4 hours

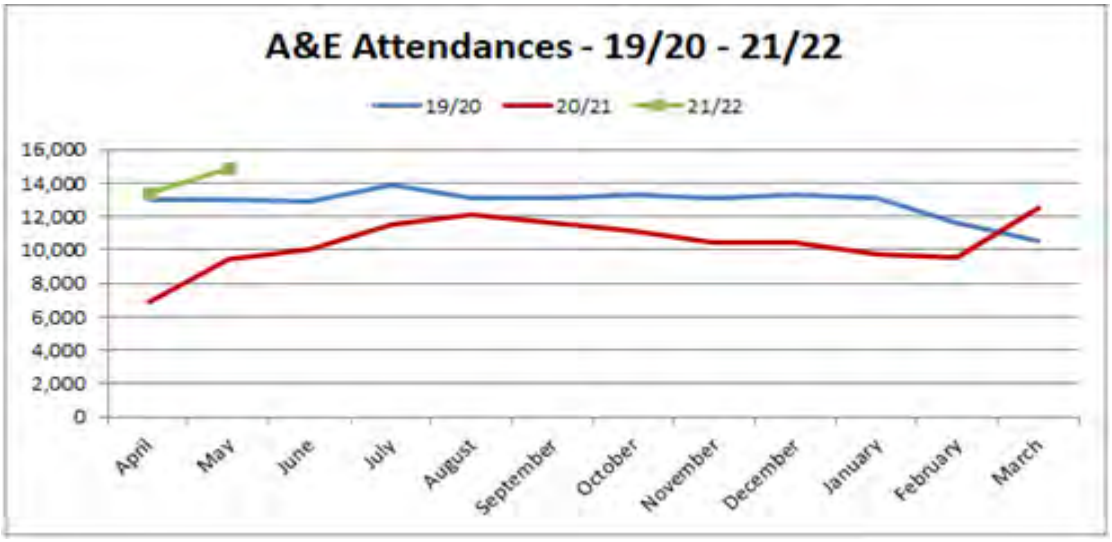
A&E performance refers to the percentage of patients discharged, admitted or transferred within 4 hours of arrival at the A&E Department. Calderdale performance is aligned with the performance achieved by the local acute provider CHFT.

A&E performance achieved 86.7% in May 2021. This is below the national standard (95%) however this level of performance is stronger than the national average (84.1%) and ranks 4th in the region (North and Yorkshire) and 19th nationally.



4.1.2 **Attendance**

The chart below compares the volume of A&E attendances to CHFT by month during the last 2 years. The impact of the pandemic on the volume of attendances can be noted during throughout 2020/21.



More recently there has been a significant increase in attendance to A&E during the latter part of the Q4 2020/21 and Q1 2021/22. Further analysis of A&E demand has been undertaken and reviewed at the Urgent and Emergency Care Board to inform its priorities for action (see section 1.4 - Priorities).

4.1.3 **Impact of Covid 19**

The number of covid admissions at CHFT reported during the second and third waves of the pandemic reached volumes greater than those reported during wave 1 – see chart below.

Activity levels associated with covid are now receding and at the time of reporting the impact of the delta variant remains negligible. As a consequence, the bed base (and theatre capacity) available is increasing to support the recovery of support non covid activity levels.

4.1.4 **Calderdale and Greater Huddersfield Urgent and Emergency Care Board**

In order to ensure the A&E Delivery Board is in the best shape to support the system, a workshop was held to confirm; vision, priorities, links with the WY ICS, implications of White Paper, new planning guidance and name. As a result the Board has been renamed the Calderdale and Huddersfield Urgent and Emergency Care Board (UEC Board). This reflects the architecture at WY and also the geography, in that the Board only covers one half of Kirklees. The Mid Yorkshire A&EDB covers the remainder.

We confirmed our role and strategic aims, which are aligned to those of the WY ICS UEC Board. The role of the Board is to hold the system to account for delivery of the following vision:

- To ensure our system provides high quality, appropriate, and responsive rapid and urgent care services that deliver care as close to home as possible for our population
- Ensuring those people with more serious or life-threatening emergency care needs have access to specialist care to maximise a good recovery

Strategic Aims:

- Enabling effective access to, and navigation through, rapid, unplanned care through integrated urgent and emergency care pathways
- Enabling provision and equity of local rapid and urgent and emergency care services
- Ensuring agreed standards of quality, safety and patient experience
- Ensuring clear communications to develop confidence of our population and partners of our offers
- Addressing health inequalities associated with access to rapid, urgent and emergency care services

- Encouraging collaboration, and creating relationships across pathways and providers, particularly focusing on the important role of our third sector.
- Ensuring we support the health and wellbeing of our staff
- Maximising opportunities for innovation and covid learning, including digital opportunities

Priorities

The following provides an overview of priorities

1. Accelerating the implementation of Urgent Community Response offers in line with the expectations in the planning guidance for 7 days, 8am to 8pm, 2-hour health response. This acceleration is in response to the increasing number of high acuity patients being seen across all our services, which is due in part to a combination late presentation and deconditioning due to the pandemic.
2. Taking forward at pace the work to develop interim Integrated ED and Primary Care offers, in line with the model consulted on as part of RCRTRP. This is in response to the significant numbers of patients attending EDs with minor illnesses, ailments and injuries. We are currently also exploring the increase in children's ED attendances.
3. Looking at opportunities to support general practice to deal with the significantly increase same day demand

4.2 Elective Care

Indicator Details	Latest Period	Target	Value	Change
Diagnostics - % waiting over 6 weeks	April 2021	1% and below	23.7%	⇓ -3.6%
RTT - % waiting over 18 weeks	April 2021	92% and above	N/A	
RTT - No. waiting over 52 weeks	April 2021	0	1795	⇓ 6.4%
RTT - Total Incomplete Waiting List	April 2021	0% growth at March 2019	20480	⇑ 8.7%

4.2.1 Referral to Treatment

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.

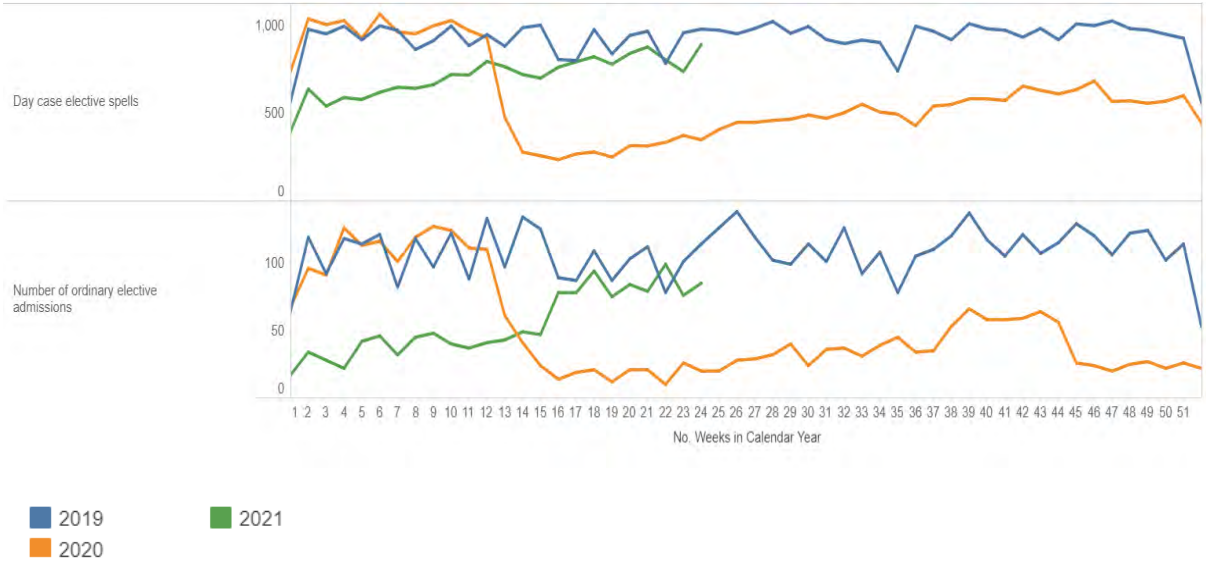
4.2.2 **System Recovery Post Covid**

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 during Q2 2021.
A further planning round is expected to support delivery during the latter half (Q3/Q4) of 2021/22.

Provisional data (from NHSE) up to mid June 2021 (week 24) – see charts below - illustrates the increasing volume of elective activity being undertaken since the initial lockdown was introduced in March 2020:

Inpatient Recovery

- Daycases - currently reporting activity at 91% of pre-covid levels reported in June 2019
- Inpatient electives - currently reporting activity at 75% of pre-covid levels reported in June 2019



Outpatient Recovery

- First OP appointments - currently reporting activity at 87% of pre-covid levels reported in June 2019
- Follow up OP appointments - currently reporting activity at 102% of pre-covid levels reported in June 2019

4.2.3 Long Waiters

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.

In terms of the scale, the volume of patients waiting at CHFT includes:

- 11,000 people are waiting for a first appointment including 150 who are currently waiting more than 52 weeks. The main specialties in terms of volume are ENT, MSK and Ophthalmology
- This is the in the context of continuous demand with an additional 2,000 new referrals arriving each week and 1800 patients being removed (followed their appointment/ treatment)
- 71,000 people are waiting a follow-up appointment, of which 19,000 are overdue for their first follow up appointment.
- 5,600 people are waiting to be added to the list for surgery (inpatient admissions and day cases)

To manage the backlog, the Elective Care Improvement Group are focusing on the out of hospital transformation in the four specialties which have the highest demand and the largest backlog (ENT, Ophthalmology, MSK/Pain/Orthopaedic, Rheumatology).

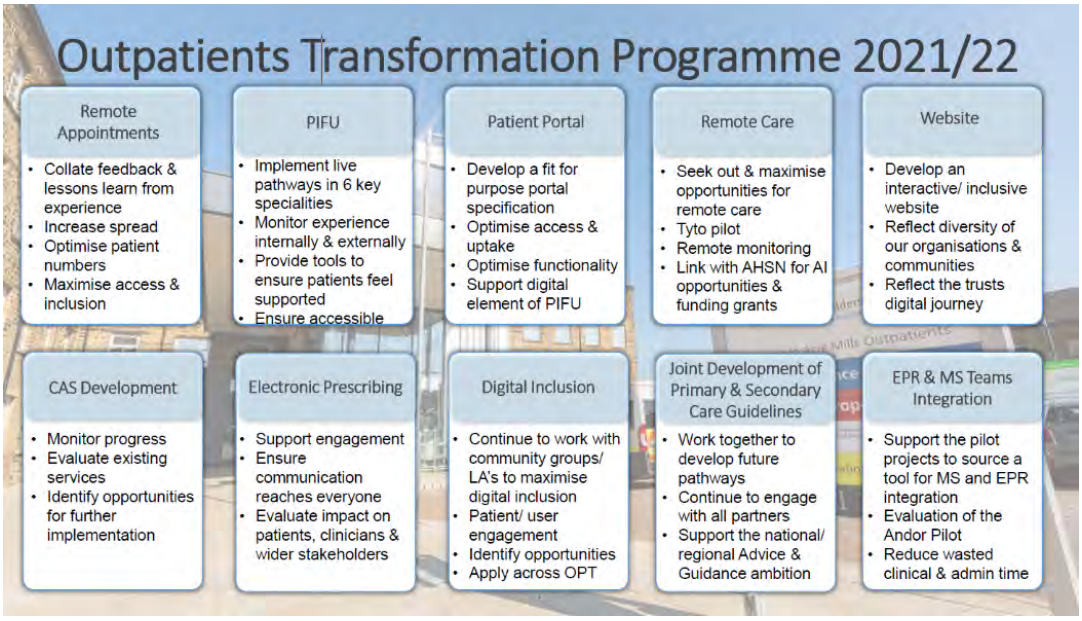
The transformation is aimed at accelerating access, refining demand and identifying additional capacity in the system. Clinically led work-streams have been established, and as key themes emerge, they will be tested with PCNs and LMCs to support their implementation. We will also be reviewing the workforce and financial resources involved and how this can be deployed differently to support the recovery programme. Whilst examples are included below, there has been agreement to accelerate the pace and scale of the work given the continually growing backlog:

- Increase the use of Arden's software to ensure the quality and appropriateness of referrals
- Increasing clinical assessment services (CAS) across specialties, in order to more effectively review referrals.
- Maximise the use of Advice and Guidance, which will support more appropriate referrals and identify out of hospital alternatives to support individuals with the management of their condition and wellbeing
- Looking at the potential for AQP and GPIS providers to deliver care previously delivered in hospital
- Maximising the activity available in the independent sector, particularly Spire and BMI

- Implementing processes to reduce the number of referrals for procedures of are not considered to be clinically effective (Evidenced Based Interventions)
- Collaborate with high street optometrists to provide more capacity for follow-up care

We are using existing quality assurance process to assess any issues relating to patient harm.

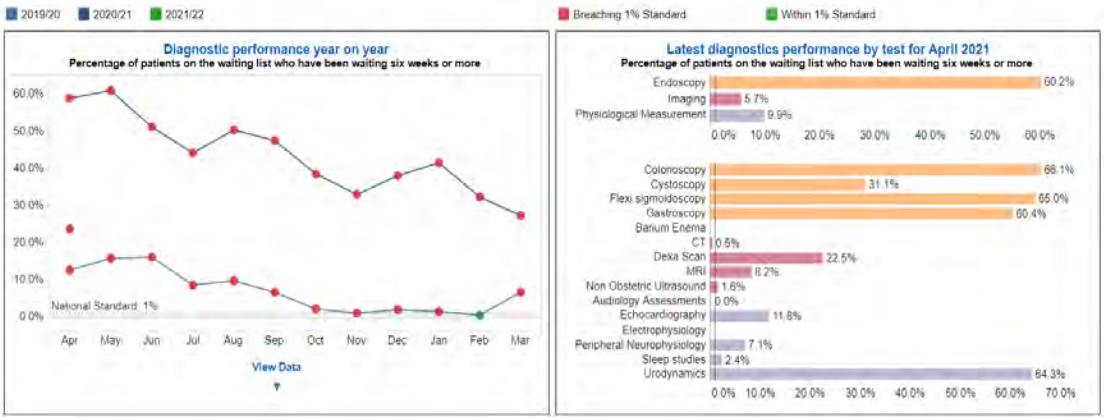
In addition the Out-Patient Transformation Board has several workstreams seeking to embed new ways of working, including digital opportunities, outlined in the graphic below.



4.2.4 **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 April 2021, 27.3% of patients experienced waits greater than 6 weeks across the spectrum of diagnostic tests. The national average is 24%.



As with elective care, access to diagnostic testing capacity has been restricted due to the impact of covid. The latest planning round with NHS England focussed on maximising the volume of diagnostic capacity that can be made available across the system to treat patients in safe and timely manner. System plans have been developed that will see diagnostic activity increase during Q1 and Q2 of 2021/22. A further national planning round is expected to support Q3 and Q4.

The transformation work coordinated by the Elective Care Improvement Group informs these plans which includes an increase in the capacity for MRI and CT scans and more theatre capacity to support endoscopy.

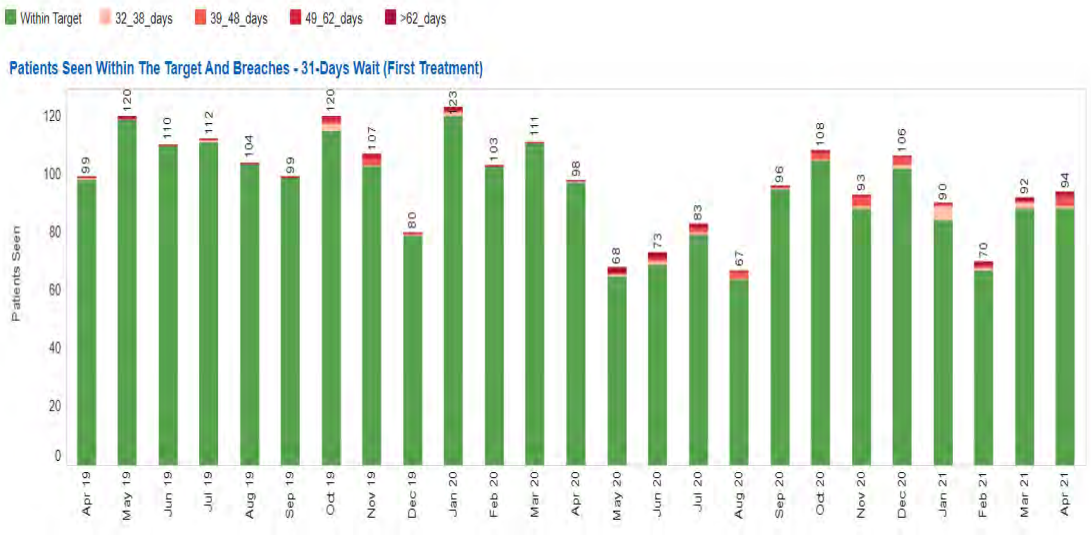
4.3 Cancer Waiting Times

In April, Calderdale continues to sustain strong levels of performance across the majority of the cancer waiting times standards – see table below.

Indicator Details	Latest Period	Target	Value	Change
Cancer - % seen within 2 weeks (breast symptoms)	April 2021	93% and above	97.3%	⇑ 0.7%
Cancer - % seen within 2 weeks	April 2021	93% and above	93.5%	⇓ 0.0%
Cancer - % treated within 31 days	April 2021	96% and above	93.6%	⇓ -2.0%
Cancer - % treated within 31 days (Drugs)	April 2021	98% and above	100.0%	⇑ 2.4%
Cancer - % treated within 31 days (Radiotherapy)	April 2021	94% and above	100.0%	⇔ 0.0%
Cancer - % treated within 31 days (Surgery)	April 2021	94% and above	77.8%	⇓ -19.1%
Cancer - % treated within 62 days (Consultant Upgrade)	April 2021	No target	100.0%	
Cancer - % treated within 62 days (Screening)	April 2021	90% and above	85.7%	⇑ 19.0%
Cancer - % treated within 62 days	April 2021	85% and above	89.8%	⇑ 1.3%

4.3.1 **31 Day First Treatment**

Patients who require treatment for their cancer should receive this within 31-days. The standard to achieve is >96%.

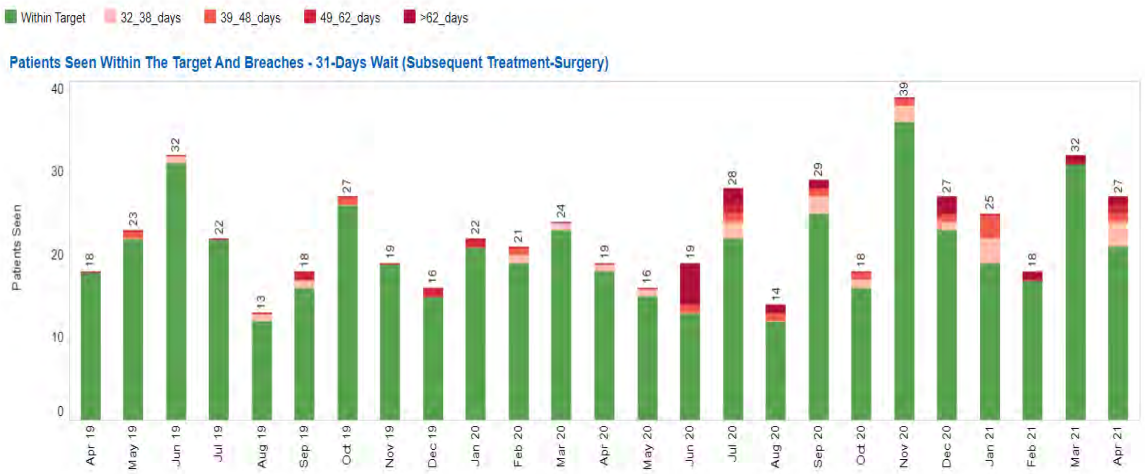


In April, 88 patients received their first treatment within 31 days. There were 6 patients who breached the waiting time standard. Each breach of the waiting time was associated with provider capacity issues. Each patient has now received their treatment.

4.3.2 31 Days to Subsequent Treatment (Surgery)

Patients who require subsequent surgery for their cancer should receive this treatment within 31-days. The standard to achieve is >94%.

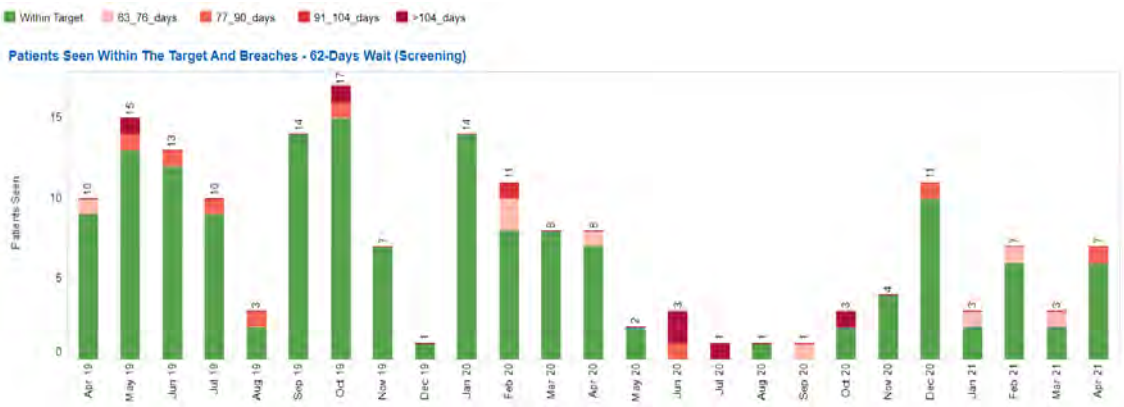
In April, 21 patients received their subsequent surgical treatment within 31 days. There were an additional 6 patients who breached the standard. Five of these breaches were associated with provider capacity issues and the remainder involved a complex diagnostic pathway. Each patient has now received their treatment.



4.3.3 62 Days Wait - Screening

Following their referral from a screening programme, patients should receive their first definitive treatment within 62 days. The standard to achieve is >94%.

In April, 6 patients received their treatment within 62 days. There was 1 breach of the waiting time standard that involved a complex diagnostic pathway.



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.

Calderdale has submitted compliant activity/ performance plans to NHS England as part of the latest planning round and was acknowledged as one of few systems to have sustained high levels of performance throughout the pandemic.

Performance against all the cancer waiting times continues to be reviewed by the Cancer Locality Group and Cancer Network across WY&H.

4.4 Mental Health

The latest position for the core mental health indicators is captured in the summary table. Overall, services continue to achieve the majority of the performance targets. They key areas of variance are outlined below.

	Standard	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
CYP Eating Disorder Waiting Time - Urgent	95%			50.0%			50.0%			50.0%			71.4%	
CYP Eating Disorder Waiting Time - Routine	95%			95.2%			96.0%			90.3%			91.4%	
IAPT Access Activity		830.0	960.0	900.0	1,185.0	1,050.0	1,075.0	1,175.0	1,205.0	1,240.0	1,165.0	1,210.0		
IAPT Access Rate	6.25%	3.19%	3.69%	3.46%	4.56%	4.04%	4.14%	4.52%	4.64%	4.77%	4.48%	4.66%		
IAPT Recovery Rate	50%	53.8%	50.7%	48.3%	50.6%	50.5%	50.0%	49.2%	50.0%	50.0%	52.2%	57.0%		
IAPT Waiting Times 6 Weeks	75%	91.0%	94.0%	95.0%	89.0%	79.0%	97.0%	93.0%	97.0%	98.0%	100.0%	99.0%		
IAPT Waiting Times 18 Weeks	95%	100.0%	100.0%	99.0%	99.0%	100.0%	100.0%	100.0%	99.0%	99.0%	100.0%	100.0%		
EIP Waiting Times - MHSDS	60%	91.0%	71.0%	77.0%	83.0%	70.0%	82.0%	90.0%	96.0%	96.0%	96.0%	95.0%		
SMI % Achievement	60%			16.9%			13.7%			11.7%			10.7%	
OAP Bed Days (Inappropriate Only)		215.0	160.0	155.0	245.0	270.0	245.0	125.0	90.0	65.0	45.0	65.0		
Dementia Diagnosis Rate	66.7%	62.9%	61.2%	61.0%	59.9%	59.5%	58.5%	58.3%	58.1%	57.8%	58.3%	58.5%	58.6%	58.6%
Perinatal Access		100.00	105.00	105.00	110.00	110.00	115.00	120.00	115.00	120.00	125.00	130.00		
Perinatal access rate	7.1%	4.0%	4.3%	4.3%	4.5%	4.5%	4.7%	4.9%	4.7%	4.9%	5.1%	5.3%		

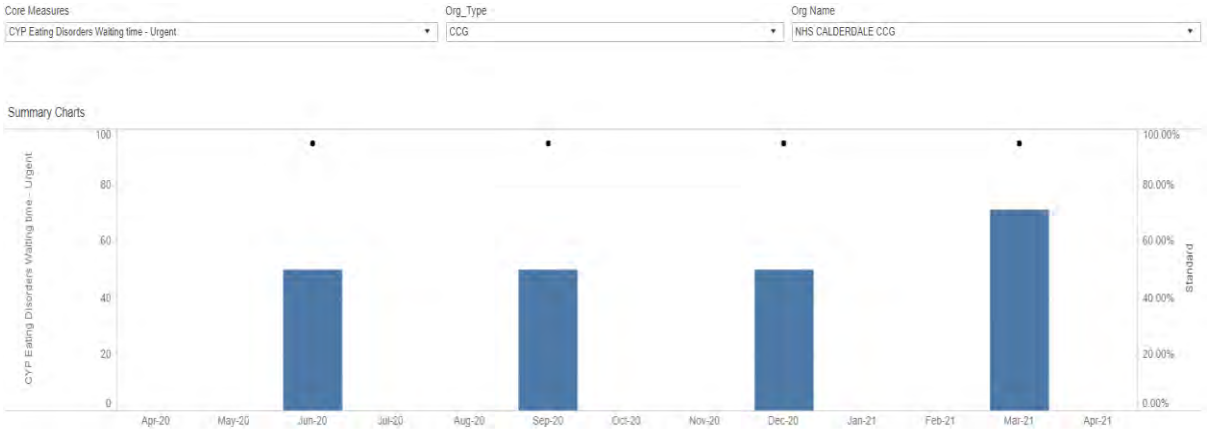
4.4.1 Children and Young People Eating Disorder Waiting Times

Work continues both at ICS level and in place to address the waiting times for both urgent and routine treatment. This includes:

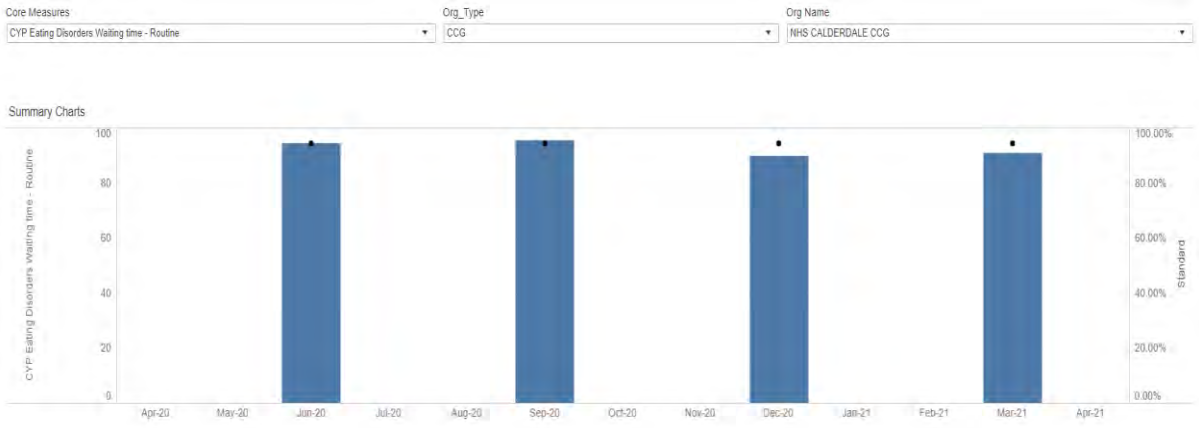
- using non recurrent money from the spending review to enhance the current service

- address the increased waiting list the developed during the pandemic
- intervene at an earlier opportunity
- extend the offer to 25 years

Urgent



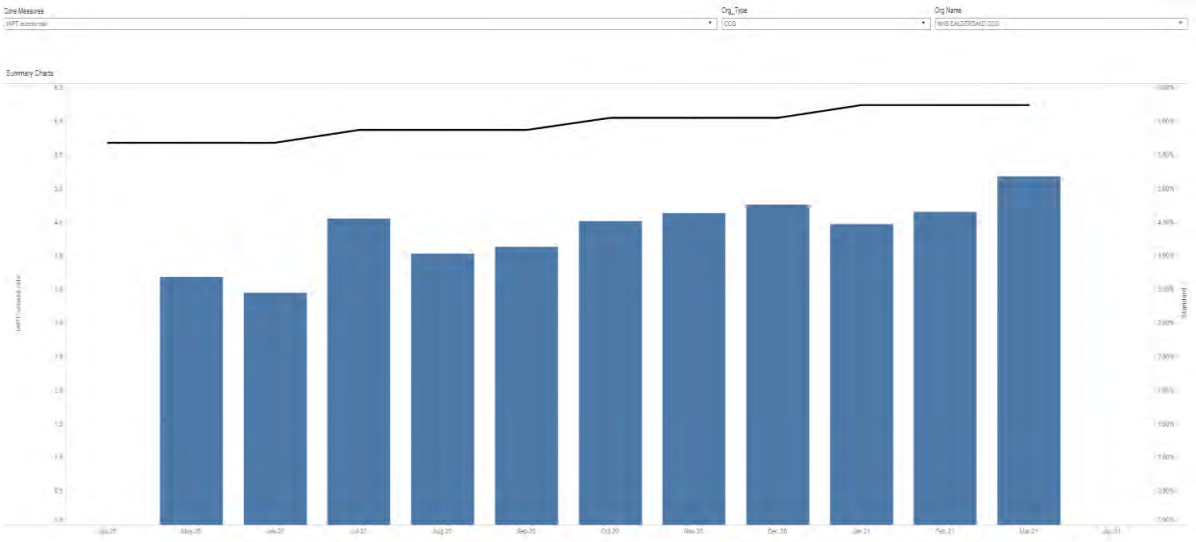
Routine



4.4.2 IAPT – Access Rate

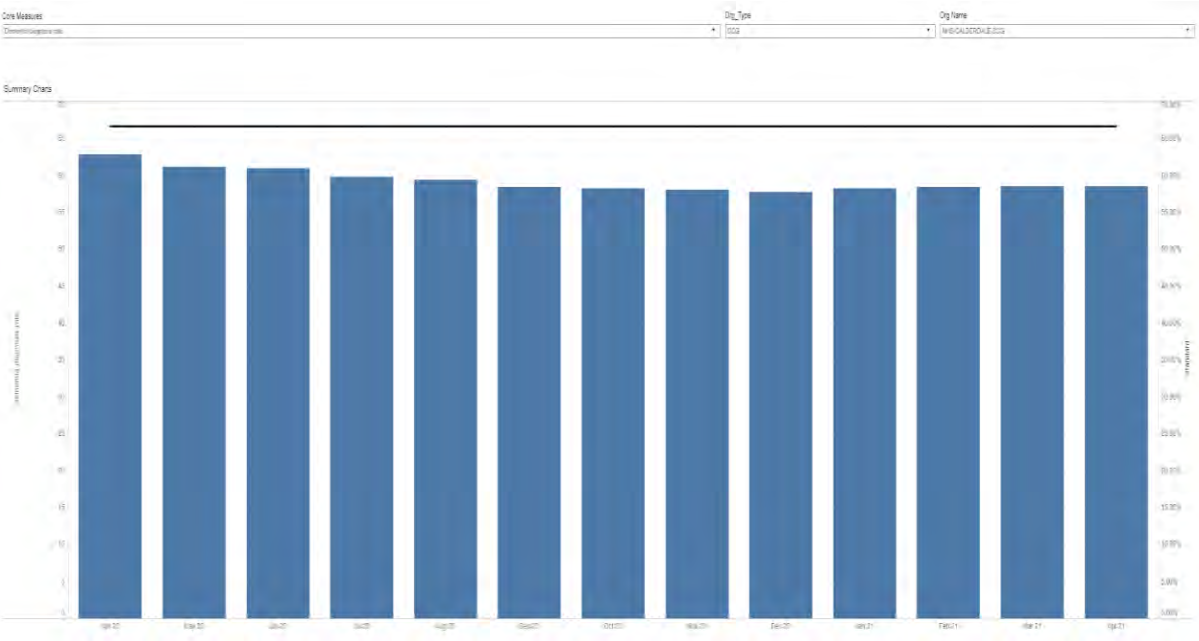
Whilst overall waiting times and recovery rates are being achieved, access rates for IAPT have demonstrated a marginal increase which continues to mirror the national position.

VitaMinds is exploring opportunities to locate IAPT staff in the community including the potential of having IAPT staff in practices. This would enable PCN staff to directly book into these clinics and support more people to enter the service.



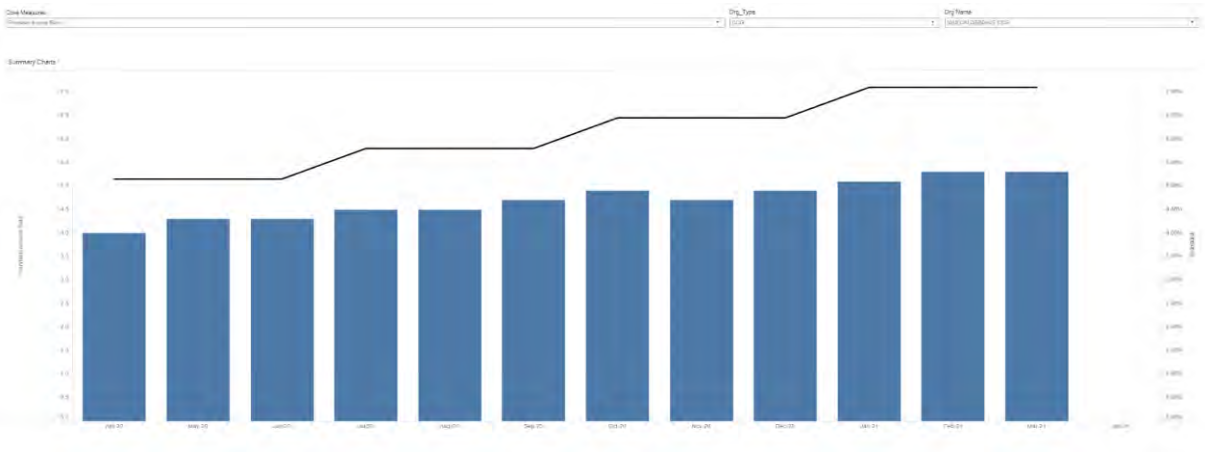
4.4.3 Dementia Diagnosis Rate

The dementia diagnostic guidelines are being updated and will be recirculated across the system. Spending review money will fund additional memory clinics which will have a positive impact on both the waiting list and diagnostic rate.



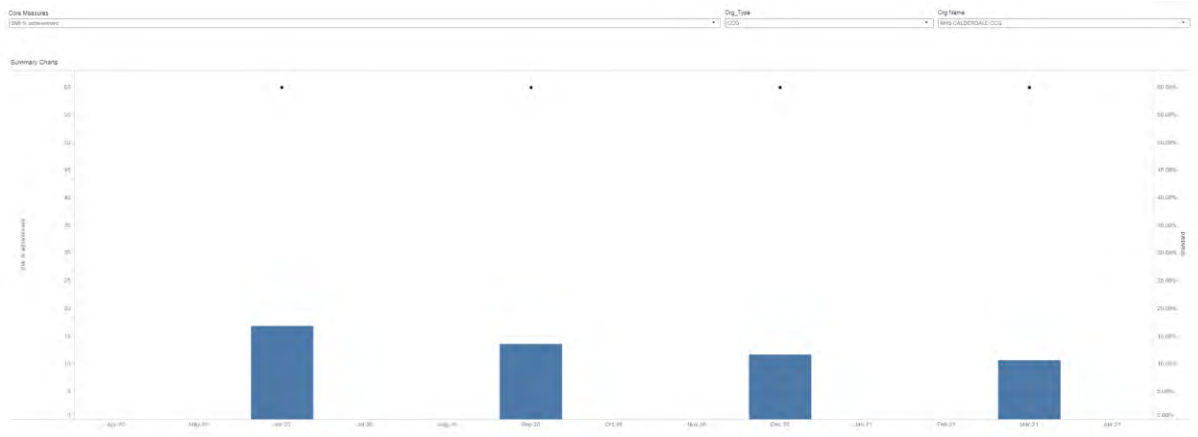
4.4.4 Perinatal Access Rate

Performance against the access rate remains below target and was impacted by COVID. A recovery plan is now in place to achieve the access rate by Q3 2021.



4.4.5 **Severe Mental Illness (SMI) - physical health checks**

The overall position remains challenging and a workstream recently 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.



5. Recommendations

It is recommended that the Governing Body:

1. **NOTES** the content of the finance update
2. **NOTES** the content of the contracting update
3. **NOTES** 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.

6. Appendices

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.

Calderdale CCG Resource Allocation Summary as at 30th June 2021 — Appendix A

Centre Code	Annual	In Month (£)			Year To Date (£)			Forecast (£)		Mth 2 Forecast	
Name	Budget (£)	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS IN YEAR	(176,300)	(29,465)	(29,465)	0	(87,906)	(87,906)	0	(176,300)	0	(175,341)	(959)
ACUTE	95,431	15,705	16,291	586	47,715	47,348	(367)	95,417	(14)	96,031	(614)
MENTAL HEALTH	20,448	3,450	3,660	210	10,097	10,182	85	20,221	(227)	19,942	280
CONTINUING CARE	11,900	1,983	3,456	1,473	5,950	6,012	62	12,006	106	11,900	107
PRESCRIBING	18,229	3,038	3,107	68	9,115	9,121	6	18,243	13	18,238	5
PRIMARY CARE	3,402	570	622	52	1,693	1,719	26	3,423	21	3,339	84
DELEGATED CO-COMMISSIONING	16,787	2,798	2,797	(0)	8,393	8,393	(0)	16,787	0	16,787	0
COMMUNITY HEALTH SERVICES	1,419	236	338	101	709	678	(31)	1,330	(89)	1,320	10
OTHER	1,213	202	218	16	606	598	(8)	1,184	(30)	1,165	19
BCF	7,079	1,214	1,203	(11)	3,437	3,539	103	7,079	(0)	6,669	410
COMMISSIONING RESERVE	425	273	(2,025)	(2,298)	206	682	476	1,493	1,068	442	1,051
UNIDENTIFITED QIPP	(798)	(133)	0	133	(399)	0	399	0	798	0	0
CONTINGENCY	765	128	0	(128)	383	0	(383)	0	(765)	0	0
Grand Total	**(0)**	**(0)**	**203**	**203**	**0**	**366**	**366**	**883**	**883**	**490**	**393**
Anticipated HDP costs reclaim	0	0	(197)	(197)	0	(360)	(360)	(870)	(870)	(490)	(380)
Anticipated ERF costs reclaim	0	0	(6)	(6)	0	(6)	(6)	(13)	(13)	0	(13)
Expected year end surplus	**(0)**	**(0)**	**(0)**	**0**	**0**	**0**	**(0)**	**(0)**	**0**	**0**	**(0)**

Calderdale CCG Running Cost Allocation Summary at 30th June 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 02 Outturn	Month 02 Movement
ADMINISTRATION & BUSINESS SUPPORT	20	3	1	(3)	10	6	(4)	10	(10)	15	(4)
CEO/ BOARD OFFICE	312	52	37	(15)	156	148	(8)	297	(15)	307	(10)
IM&T	42	7	2	(5)	21	15	(6)	35	(8)	39	(4)
CORPORATE COSTS & SERVICES	84	14	18	4	42	43	1	88	5	75	13
EQUALITY AND DIVERSITY	20	3	3	(1)	10	8	(2)	17	(3)	17	0
PATIENT AND PUBLIC INVOLVEMENT	41	7	5	(2)	20	13	(7)	28	(13)	28	0
CONTRACT MANAGEMENT	180	30	30	1	90	96	6	189	10	196	(6)
MEDICAL DIRECTORATE	203	34	35	1	101	87	(14)	175	(28)	161	13
HUMAN RESOURCES	18	3	3	0	9	9	(0)	17	(1)	16	0
STRATEGY & DEVELOPMENT	316	53	51	(2)	158	147	(11)	299	(17)	294	5
BUSINESS INFORMATICS	180	30	20	(10)	90	52	(38)	111	(69)	111	0
QUALITY ASSURANCE	188	31	21	(10)	94	81	(13)	159	(30)	181	(22)
ESTATES AND FACILITIES	82	14	(3)	(17)	41	35	(6)	107	25	133	(26)
FINANCE	248	41	21	(20)	124	84	(40)	193	(55)	211	(18)
GENERAL RESERVE - ADMIN	(50)	(8)	86	94	(25)	154	179	242	292	167	75
CORPORATE GOVERNANCE	174	29	15	(14)	87	50	(37)	92	(83)	107	(15)
Grand Total	**2,058**	**343**	**343**	**0**	**1,029**	**1,029**	**0**	**2,058**	**0**	**2,058**	**0**

Calderdale CCG Delegated Primary Medical Services Summary at 30th June 2021 **Appendix C**

PRIMARY CARE SERVICES: 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 02 Forecast Outturn	Mth 02 Forecast Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	9,585	1,597	1,597	(0)	4,792	4,792	(0)	9,585	0	9,585	0
PMS	1,237	206	206	0	619	619	0	1,237	0	1,237	0
APMS	381	63	63	0	190	190	0	381	0	381	0
QOF	1,540	257	257	0	770	770	0	1,540	0	1,540	0
Enhanced Services	158	26	26	(0)	79	79	(0)	158	0	158	0
Premises - Reimbursed Costs	1,644	274	274	(0)	822	822	(0)	1,644	0	1,644	0
Premises - Other	117	19	19	0	58	58	0	117	0	117	0
Prof Fees Prescribing & Dispensing	90	15	15	0	45	45	0	90	0	90	0
Other GP Services (inc. PCO)	161	27	27	0	81	81	0	161	0	161	0
Other Non GP Services	392	65	78	13	196	218	22	392	0	392	0
PCN	1,398	233	234	1	699	719	20	1,398	0	1,398	0
Reserves - Contingency (91811060)	84	14	0	(14)	42	0	(42)	84	0	84	0
Total Primary Care Medical	**16,787**	**2,798**	**2,797**	**(0)**	**8,393**	**8,393**	**(0)**	**16,787**	**0**	**16,787**	**0**

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 30th June 2021

Supplier	In Month: Number of invoices paid within target	In Month: % within target	In Month: Value of invoices paid within target	In Month: % within target	Year To Date: Number of invoices paid within target	Year To Date: % within target	Year To Date: Value of invoices paid within target	Year To Date: % within target
NHS	50	98.04%	£17,369,533.01	99.94%	118	97.52%	£51,906,973.47	99.98%
Non NHS	834	97.89%	£9,074,949.57	97.64%	2,054	97.53%	£28,173,970.36	94.15%
Total	884	97.90%	£26,444,482.58	99.14%	2,172	97.53%	£80,080,943.83	97.84%

Appendix E

Calderdale CCG Resource Allocation Summary at 30th June 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: Improving Access to Psychological Therapies - adult and older adult (IAPT)	(62)		
Mental Health: SR: 18-25 young adults (18-25)	(25)		
Mental Health: SR: Memory assessment services and recovery of the dementia diagnosis rate	(31)		
Mental Health: SR: Discharge	(168)		
Mental Health: SR: Physical health outreach and remote delivery of checks	(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 - reversed for system level allocation	51		
PCT SUPPORTING MENTORS SCHEME - reversed for system level allocation	7		
Grand Total	**(159,513)**	**(16,787)**	**(2,058)**

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Quality and Safety Report and Quality Dashboard**	**Agenda Item No.**	13
Report Author	Sam Parkinson, Project Support Officer Debbie Winder, Head of Quality	**Public / Private Item**	Public
Clinical Lead	Dr Farrukh Javid, GP GB Member	**Responsible Officer**	Penny Woodhead, Chief Quality and 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 high level information taken from the Quality Dashboard for May 2021, providing a quality and safety update for our main providers plus the following information:

- Learning Disabilities Mortality Review (LeDeR) programme Annual Report
- West Yorkshire Urgent Care/Local Care Direct Care Quality Commission (CQC) inspection report
- National Quality Board Position Statement – Managing Risks and Improving Quality through Integrated Care Systems

Previous Considerations

Name of meeting	Quality Committee	**Meeting Date**	24/06/2021
Name of meeting		**Meeting Date**	

Recommendations

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 updates:

- Learning Disabilities Mortality Review (LeDeR) programme Annual Report
- West Yorkshire Urgent Care/Local Care Direct Care Quality Commission (CQC) inspection report
- National Quality Board Position Statement – Managing Risks and Improving Quality through Integrated Care Systems

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)**	1635 – IPC 1361 – LCD 1565 – Covid 19 impact on Quality Team capacity
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.

3. Learning Disabilities Mortality Review (LeDeR) programme Annual Report

3.1 In June 2021 the CCG's annual report of the Learning Disabilities Mortality Review (LeDeR) Programme was presented to the Quality, Finance and Performance Committee, where it was approved for publication on to the CCG Website – an NHS England (NHSE) requirement articulated in the new national policy for the LeDeR Programme published in March 2021.

3.2 The annual report provides an overview of the programme delivery between 1st April 2020 and 31st March 2021 and includes information on the current LeDeR program and the delivery in Calderdale as well as key learning from the reviews. It also presents an overview of the work of Learning Disability Commissioning Leads to transform care for people with a Learning Disability who live in the area.

3.3 Key highlights from the report included:

- The recognition that behind every LeDeR review is a human story, so this year the report included 4 patient stories from the LeDeR cases.
- This year more detailed analysis of the local findings was included such as gender and age details, causes of death and co-morbidities alongside the grading of case for each case and any learning themes (recognising examples of both good practice and areas for improvement).
- The continued challenges to delivery of the programme caused by a backlog cases waiting a reviewer and due to the Pandemic. In July 2020 NHSE required all cases waiting a LeDeR review were required to catch-up and complete reviews on all cases by December 2020. This was achieved with the support and thanks to staff in the CCG, the support of staff from our providers and from social care.
- An overview of the key findings from a national report analysing of the deaths of 206 people with a Learning Disability (LD) who died of Covid that was undertaken and the actions taken by the CCG LD Commissioner and Primary Care Leads to address the 4 overarching themes that had been identified in the national report.
- An overview of the other work of the CCG Learning Disability (LD) commissioner and the CCG Transforming Care Partnership Board Lead have continued to deliver actions to address inequalities for people with LD, the overall goal of the LeDeR programme.

3.4 An overview of the marked changes to the future of the programme required under the new NHSE LeDeR Policy, to be fully implemented by April 2022, was also received, that will also then include the commencement of reviews for people with Autism as part of the programme later in the year.

Implications for the key changes in Calderdale:

- A dedicated Reviewer resource that will be delivered on an Integrated Care System (ICS) basis. The CCG Local Area contact for the programme is working with the other

CCG's to deliver a team of dedicated reviewers on an ICS basis to undertake all reviews.

- The future programme will be seen as a 'quality improvement' process to be embedded – local place-based panels to address learning: This will need a local panel of key people from commissioning to quality, to identify actions to address learning.
- Work to address learning from LeDeR cases will need to be embedded into Quality Monitoring processes.
- Future LeDeR annual reports will be delivered on an annual basis: but local place-based work will need some inclusion.

3.5 The joint annual report has now been published on the CCG website in an accessible version.
An Easy Read version of the report is in development for those people with a Learning Disability and will also be published when completed.

4. West Yorkshire Urgent Care/Local Care Direct Care Quality Commission (CQC) inspection report

4.1 The Care Quality Commission (CQC) recently carried out an inspection in response to concerns raised, specifically regarding the safe, effective and well-led domains. The visit was carried out on 18 March 2021, with the final inspection report published 27 April 2021. The report outlined the CQC's findings during the inspection but as the inspection was focused rather than scheduled the service was not rated. The service was previously inspected in March 2020 and was rated as "good" overall.

4.2 The areas of concerns raised to the CQC included medicines management and the storage of controlled drugs, home visits undertaken by doctors and processes for "failed encounters", effective staffing, availability of managers during operational hours of the out of hours service and inconsistency in following procedures.

4.3 The CQC looked at all the areas of concerns raised, a number of which had already been addressed by the provider. The CQC found no breaches of legislation and no enforcement was instigated and overall the CQC were assured with the actions already taken or recommended as a result of the inspection. The report was discussed at the West Yorkshire Urgent Care/Local Care Direct meeting on the 19 May 2021, where an update

and responses to the recommendations were discussed. It was agreed no formal action plan is necessary as all actions were already complete and embedded. Ongoing monitoring against these will be included in routine assurance processes.

4.4 A link to the full inspection report can be found at the following link: https://www.cqc.org.uk/location/1-346295324

5. National Quality Board Position Statement – Managing Risks and Improving Quality through Integrated Care Systems

5.1 The National Quality Board (NQB) published its updated Shared Commitment to Quality and Position Statement (see Appendix 2) to support Integrated Care Systems (ICS) in embedding quality in their design, planning and decision-making. This information is equally applicable to Integrated Care Partnerships and is being used to inform our thinking about quality governance in Calderdale.

5.2 The Position Statement sets out some key requirements that ICS's are expected to put in place during 2021-22. This includes a designated executive clinical lead for quality (including safety) in the ICS; a System Quality Group (refreshed Quality Surveillance Group) to engage and share intelligence on quality in the ICS; and an agreed way to measure quality, using key quality indicators triangulated with intelligence and professional insight.

5.3 The publications, plus case studies, are available via the following link: https://www.england.nhs.uk/ourwork/part-rel/nqb/.

6. Implications

6.1 Quality and Safety Implications

6.1.1 The Governing Body should note that this report contains information relating to vulnerable patient groups and also contains information in relation to the quality of health services commissioned by the CCG.

6.2 Resources / Finance Implications

6.2.1 The Governing Body 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.

7. Recommendations

7.1 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 updates:

- Learning Disabilities Mortality Review (LeDeR) programme Annual Report
- West Yorkshire Urgent Care/Local Care Direct Care Quality Commission (CQC) inspection report
- National Quality Board Position Statement – Managing Risks and Improving Quality through Integrated Care Systems

8. Appendices

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.

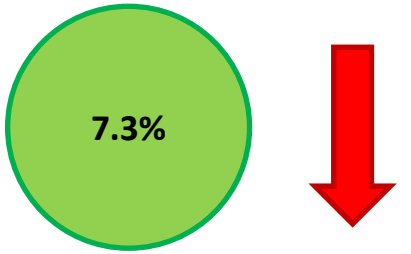
Appendix 2 - National Quality Board Position Statement

Item 13 Appendix 1

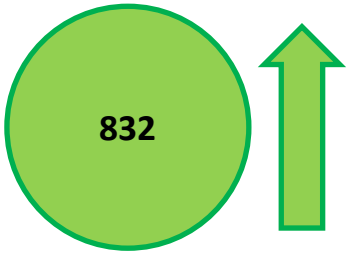
Calderdale CCG Quality Dashboard
May 2021

CCCG Exception Report

Indicator	Target	Month/ Quarter	Month data from	YTD 2020-21
C-Diff	tbc	3	May 2021	4
MRSA	0	0	May 2021	0
MSSA	No target	3	May 2021	5
E-Coli	tbc	8	May 2021	15
Pseudomonas	No target	0	May 2021	1
Klebsiella	No target	2	May 2021	3



Broad spectrum antibiotics as % total antibiotics prescribed March 2021 (updated June 2021)



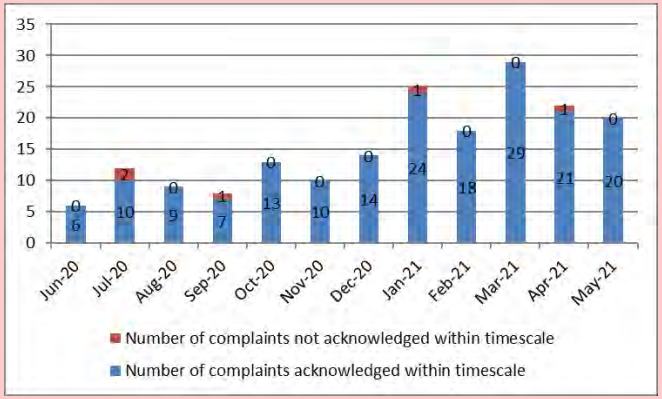
Total antibiotic prescribing items per 1000 STAR PUs March 2021 (updated June 2021)

Healthcare Acquired Infections (HCAI)
Public Health England (PHE) has yet to release the national objectives where applicable.

Broad Spectrum antibiotics
The prescribing of broad spectrum antibiotics as a % of all antibiotics prescribed over a 12 month period up to March 2021 has slightly increased again to a value of 7.3% which is within the NHS England (NHSE) target of 'at or below 10%' this small increase is likely due to the reduction in overall antibiotic prescribing.

Total antibiotic prescribing per 1000 STAR Pus
This is currently within the NHSE target of 965 or below. However there is still concern around remote prescribing of empirical antibiotics.

Complaints – acknowledged within 3 working days



The figures show that just one complaint was not acknowledged on time. This was due to staff absence.
During the quarter the complaints team have noted a rise in complaints regarding access to GP appointments and are working closely with primary care colleagues to monitor the developing trend.

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.	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. Meetings are now established with the Assistant Director for Patient Safety which will facilitate timely updates on expected improvements.	A significant improvement has been seen in the position of alerts with a marked reduction in alerts that are beyond deadline for response. 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

This page provides a summary in relation to the Quality and Safety of services provided at Calderdale and Huddersfield NHS Foundation Trust for the period up to May 2021.

Delay of Surgical Repair of #NOF Within 36 Hours of Admission

Concerns were raised by commissioners (CCG) regarding the reducing performance of this indicator. The pandemic has been a large contributory factor to the reduction in performance. This is due to availability of theatre and consultant capacity. The Trust have recognised the impact and risk of delays in relation to poor patient experience, safety and overall quality of care. This features on the Trusts risk register and improvements are expected as two of the dedicated trauma lists have now been reinstated. The Trust are trialling a 'golden patient' initiative to further drive efficiency. This work is currently ongoing and feedback will be provided to commissioners following the completion of improvement audits and analysis. This item is discussed at the established CCG Quality and Trust Assistant Director for Patient Safety meetings. Updates will also be provided through established quality surveillance mechanisms.

Central Alert Systems (CAS) Indicators

Although not demonstrated in the current data set assurances have been received from the Trust regarding the improving picture of compliance regarding CAS alert indicators. Papers have been and 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.

Oncology

The Trust are currently providing significant support to Mid Yorkshire Hospital Trust (MYHT) to provide non-surgical oncology services. This is noted as a system risk and the situation remains challenging. Work and conversations are ongoing across West Yorkshire and Harrogate to address and seek future mitigations/solutions.

Complaints

Although under performing and data is in arrears the Trust continue to prioritise how they respond and manage complaints. The divisions have made substantial progress regarding the complaints backlog and a step change in the data is expected to be seen in upcoming performance reports.

A Making Complaints Count Improvement Collaborative has been established to compliment the Trusts vision to develop a 'learning from' approach and culture. A refreshed process is in testing stages. This will be integrated and fed back to Boards through established governance routes. The Trust are also developing impact assessments to develop a broader understanding of need from patients with protected characteristics and health inclusion community groups.

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – May 2021

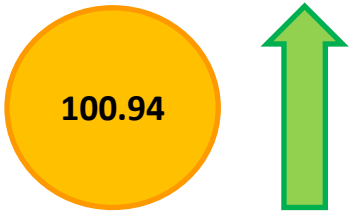
			CHFT			Trend information															
						Direction of Travel			2020-21												2021-22	
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	YTD 2021-22	Month / Period / Year data from	Previous Month / Period	Corresponding month 2020-21	A	M	J	J	A	S	O	N	D	J	F	M	A	M
Safe	C Diff	Monthly	tbc	1	2	May-21	↔	↑	1	2	4	7	2	2	4	2	6	4	1	3	1	1
	E Coli	Monthly	n/a	0	0	May-21	↔	↑	2	5	4	1	0	0	0	0	0	0	0	0	0	0
	MRSA	Monthly	0	0	0	May-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	Monthly	n/a	0	0	May-21	↔	↑	0	2	3	0	0	0	0	0	0	0	0	0	0	0
	Never Events	Monthly	0	0	0	May-21	↔	↑	0	1	1	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	2	6	May-21	↓	↓	1	1	8	2	2	4	2	1	3	5	2	2	4	2
	Overall essential safety compliance	Monthly	>=90% Green >=90%<85% Amber <85% Red	94.85%	-	Apr-21	↓	↑	93.10%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	-
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	27.3%	-	rolling 6 months - Nov 20 - Apr 21	↑	↓	33.3%	36.1%	36.8%	37.1%	34.5%	37.5%	36.4%	30.0%	27.0%	15.0%	31.0%	16.7%	27.3%	-
	VTE Risk Assessment	Monthly	>=95%	95.55%	95.55%	Apr-21	↓	↔	95.56%	96.05%	95.89%	96.26%	96.14%	95.46%	95.37%	96.13%	95.74%	95.67%	95.97%	96.03%	95.55%	-
Caring	EMSA	Monthly	0	0	0	Apr-21	↑	↔	0	0	0	0	0	0	2	3	0	0	0	1	0	-
Responsive	% Complaints closed within target timeframe	Monthly	100%	60.0%	in arrears	Mar-21	↑	-	94.0%	82.0%	80.0%	70.0%	71.0%	62.0%	44.00%	50.00%	41.70%	63.00%	52.90%	60.00%	in arrears	-
	No of complaints re-opened	Monthly	n/a	3	19	Mar-21	↓	-	1	2	4	1	4	3	1	0	0	0	0	3	in arrears	-
	% Last minute cancellations to elective surgery	Monthly	< 0.65%	0.41%	0.41%	Apr-21	↓	↓	0.32%	0.30%	0.00%	0.13%	0.36%	0.38%	0.30%	0.23%	0.00%	0.16%	0.07%	0.32%	0.41%	-
	Percentage Non-elective #NoF Patients with admission to Procedure of < 36 hours	Monthly	>=85%	62.50%	62.50%	Apr-21	↑	↓	56.10%	58.62%	66.67%	42.86%	51.06%	74.36%	75.68%	67.39%	61.70%	45.83%	64.29%	65.85%	62.50%	-
	12 hour breaches in A&E (A&E trolley waits)	Monthly	0	0	0	Apr-21	↔	↔	0	0	0	0	0	0	15	21	0	0	0	0	0	-

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 – May 2021

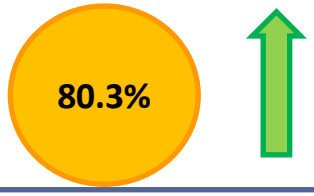
CQC Inspection rating June 2018



SHMI - One year rolling data Jan 20 – Dec 20
Updated April 2021

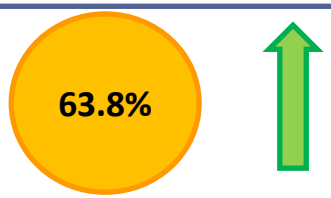
HSMR - One year rolling data Feb 20 – Jan 21
Updated April 2021

Staff Survey – satisfied with the quality of care to patients/SUs



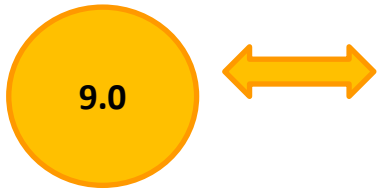
Improvement from previous year (78.4%). Below national average (82%)
Annual – updated April 21

Staff Survey – recommend as a place to work



Improvement from previous year (57.4%). Below national average (66.9%)
Annual – updated April 21

CQC Inpatient Survey – respect & dignity



about the same as other trusts
Annually – updated July 20

CQC Inpatient Survey – involved in care decisions

about the same as other trusts
Annually – updated July 20

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – May 2021

Routine Monitoring

Proposed indicators to return to Routine Monitoring:

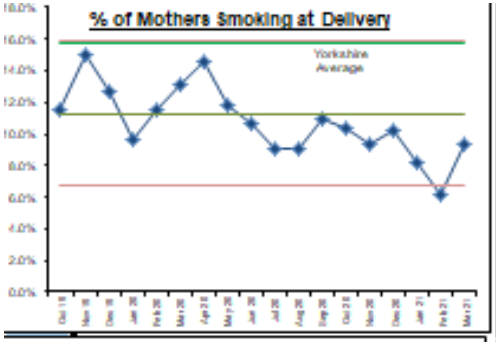
Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard – May 2021

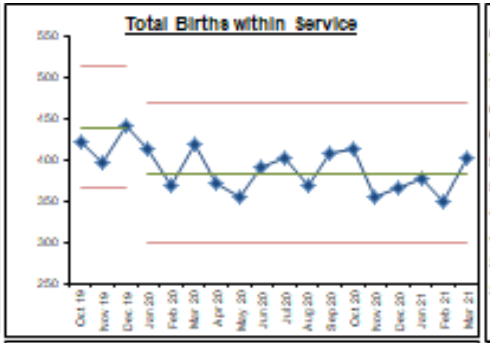
Key Indicators

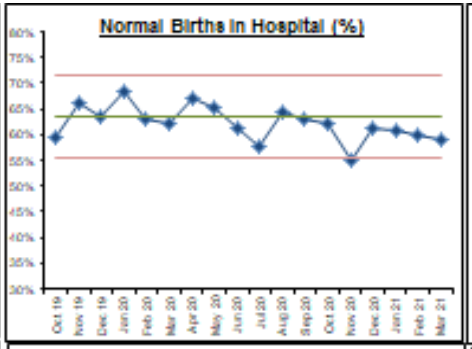
Key Indicators	Thresholds			Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	YTD		
	Green	Amber	Red																	
Total Bookings	>90%	-	<90%	91.8%	92.5%	92.9%	93.0%	92.6%	94.0%	94.7%	90.6%	92.7%	93.2%	90.6%	90.0%	90.5%	94.6%	92.5%		
Total Births within Service	Monitoring Only			368	419	371	356	391	402	368	407	412	354	365	376	349	403	4554		
Normal births	>64.7%	>60.9%	<60.9%	62.8%	62.1%	67.12%	65.45%	61.38%	57.71%	64.40%	63.1%	61.7%	55.4%	61.1%	60.6%	60.2%	58.8%	61.4%		
Assisted vaginal births	<11.0%	<12.9%	>12.9%	8.70%	10.50%	7.55%	10.11%	9.72%	9.70%	10.05%	10.57%	10.92%	11.86%	9.04%	9.57%	11.46%	9.68%	10.0%		
Elective C/S deliveries	<10.4%	<11%	>=11%	11.85%	11.89%	9.86%	9.30%	11.78%	13.03%	10.14%	10.42%	9.61%	11.65%	11.81%	9.43%	12.14%	13.53%	11.07%		
Emergency C/S deliveries	<15.2%	<15.6%	>15.6%	14.88%	14.08%	14.25%	14.93%	15.18%	18.30%	14.52%	15.14%	16.50%	21.02%	17.86%	19.41%	15.61%	17.04%	16.64%		
3rd/4th degree tear - normal birth	<2.6%	<3%	>3%	1.3%	1.5%	1.6%	2.6%	0.4%	2.2%	1.7%	3.1%	2.0%	1.5%	1.8%	0.4%	1.4%	2.1%	1.8%		
3rd/4th degree tear - assisted birth	<5.6%	<9.7%	>9.7%	3.1%	2.3%	10.7%	2.8%	2.6%	7.7%	5.4%	4.7%	4.4%	4.8%	0.0%	0.0%	0.0%	2.6%	3.7%		
PPH ≥ 1500ml	<3%	<3.4%	>=3.5%	2.75%	3.16%	3.01%	2.54%	4.19%	3.26%	4.11%	2.98%	3.69%	3.41%	2.20%	2.43%	1.73%	3.26%	3.08%		
Total stillbirths	0	<3	>=3	0	1	1	0	1	2	1	1	2	3	0	3	1	2	17	5	12
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	1	1	1	0	1	3	1	1	2	3	0	3	2	3	20	8	12
Low birth weight at term - live births - % of live babies at term < 2200g	0%	<1%	>=1%	0.59%	0.26%	0.58%	0.59%	0.28%	0.54%	0.00%	0.79%	0.00%	0.90%	0.59%	0.00%	1.55%	0.53%	0.52%		
Incidence of shoulder dystocia (With Harm)	0	-	>=1	0	0	0	1	0	2	0	1	0	0	0	0	0	0	4		
1:1 Care in Labour	>=98%	>=97%	<97%	99.4%	99.5%	99.4%	99.4%	99.2%	99.5%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	99.7%	99.7%	99.7%		
Induction Rate	Monitoring Only			40.6%	42.7%	36.2%	45.3%	38.9%	42.7%	42.7%	41.6%	39.2%	46.9%	48.6%	46.1%	44.1%	45.5%	43.1%		
Delay in delivery of Category 1 C. Section (>30 minutes from decision to delivery)	Monitoring Only			2	3	2	6	10	8	6	10	5	9	6	6	5	11	84		
Delay in delivery of Category 2 C. Section (>75 minutes from decision to delivery)	Monitoring Only			4	5	1	7	2	9	5	3	4	2	2	4	2	4	45		
Delay in 3rd/4th Degree tear repair (>1hrs post-birth from decision to transfer)	Monitoring Only			0	0	1	3	0	3	1	2	0	2	2	1	3	6	24		
Planned Home Birth	Monitoring Only			0.55%	1.21%	4.11%	1.13%	2.62%	1.00%	1.37%	3.23%	2.71%	3.69%	2.47%	2.96%	2.02%	2.51%	2.49%		
Smoking at Delivery	< 11%	-	> 11%	11.57%	13.11%	14.52%	11.83%	10.73%	9.02%	9.04%	10.92%	10.34%	11.36%	12.09%	9.97%	8.09%	11.03%	10.74%		
Smoking at Delivery (Not recorded)	3%		>3%	0.8%	1.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	1.2%	0.6%	0.3%	3.2%	3.2%	3.0%	1.0%		
Breastfeeding at Initiation	≥	-	< 74.4%	78.0%	76.4%	78.6%	77.7%	81.1%	76.1%	75.3%	72.89%	76.5%	77.7%	75.3%	75.3%	75.7%	75.8%	76.5%		

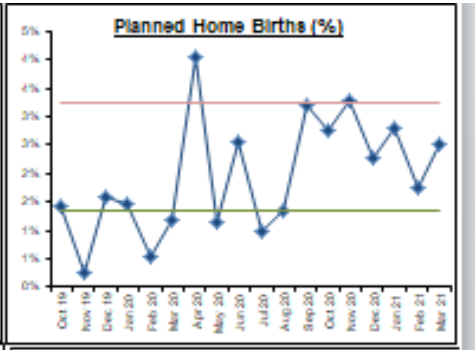
Variance to Same Period in 2019/20
0.7%
Variance to Same Period in 2019/20

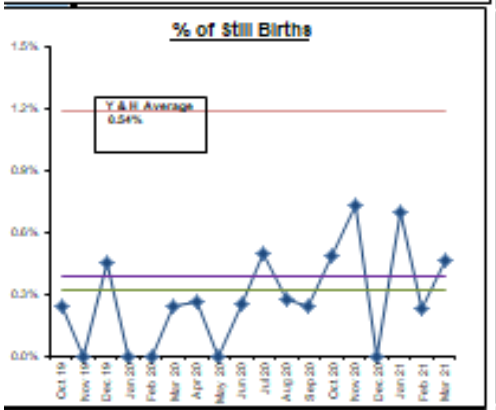
Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard – May 2021

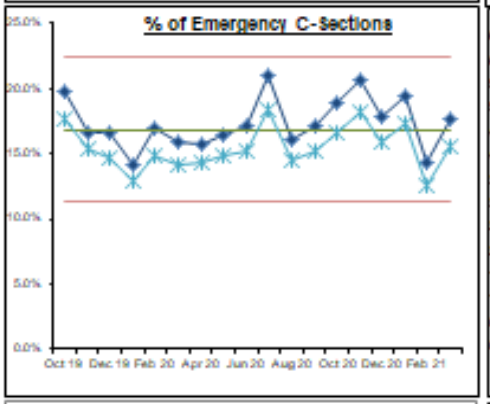


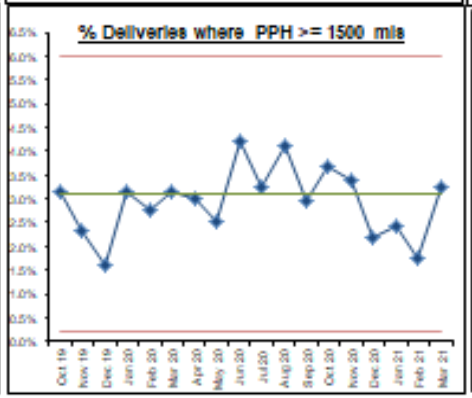


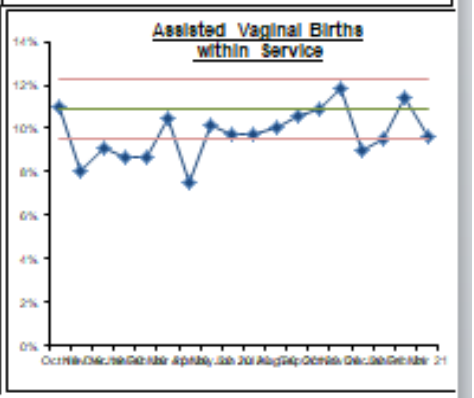


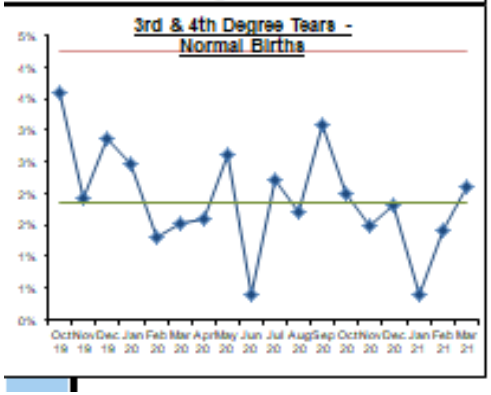


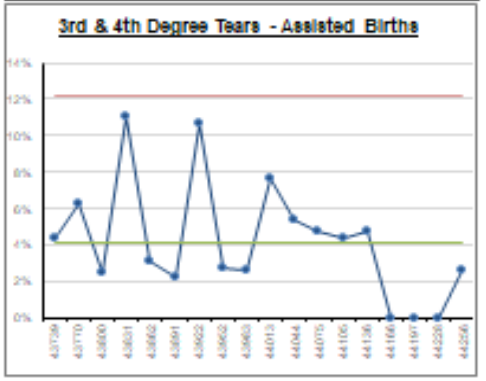


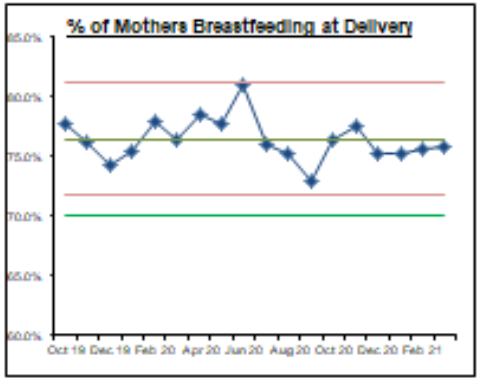












Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard Overview

This page provides a summary in relation to the information presented on the Calderdale and Huddersfield NHS Foundation Trust Maternity dashboard up to March 2021 and an update on maternity compliance with the recommendations of the Ockenden report and Better Births Maternity Transformation for the period up to May 2021.

Dashboard: CHFT are reviewing the maternity dashboard to make it more timely and to ensure that what is included works at Place. An LMS dashboard is being developed with the CCG involved in agreement of what metrics require inclusion.

Stillbirths: All stillbirths are reviewed using the Perinatal mortality review tool which is a national recommendation to ensure systematic, multidisciplinary, high quality reviews of all aspects of care leading up to and surrounding each stillbirth and neonatal death. All stillbirth cases at CHFT are discussed at the maternity services MDT weekly governance meeting as well as the corporate incident review panel.

Third and Fourth degree tears: CHFT rates and improvements mean they are being seen as an exemplar site and are sharing their success via the WY&H Safety Group

Ockenden report update: A Quality Surveillance meeting has taken place with the CCG, LMS and CHFT HOM in attendance. A detailed update was provided via the new CHFT Perinatal Quality Oversight Highlight Report. based on a template devised by the LMS for their region wide submission. All aspects of the requirements of the Ockenden report were included and discussed. CHFT have rated themselves as compliant but have to imminently submit evidence through a national portal and once confirmed will change the rating to embedded. Additional national funding is available which maternity services could bid for, CHFT have applied for funding for additional staffing to meet the Ockenden requirements with decisions expected at the end of May. An update on all HSIB and maternity SI's was given, as well as top themes from incidents and complaints. CHFT have identified Maternity Safety Champions, including a Non Executive. All Maternity SIs are presented to the Board and processes for LMS oversight of SIs including HSIB investigations is progressing. National guidance is awaited on the role of an Independent Advocate. At the next meeting an update from the MVP will be received and a progress report on the Safety Improvement Plan. It was agreed there was nothing requiring escalation to the regional maternity group or QSG.

Continuity of Carer (CoC): Whilst CHFT have made significant progress with BAME women being on a CoC pathway in line with other units they are struggling to achieve the required target which is set that 35% of women will be booked onto a continuity of carer pathway by March 2020-CHFT achieved 19% in March. This is on the CCG risk register. The maternity team have met with the national lead who shared a tool to calculate the workforce required to roll out further teams which is currently considered too high a risk for CHFT without investment. The national lead is due to return to discuss further.

Smoking at time of delivery (SATOD): CO monitoring has recommenced. An increase in SATOD has been noted and data is being pulled now from a variety of sources and interventions are in place with improvements anticipated.

CQC: Maternity services have had their normal Trust engagement meeting with CQC and shared the presentation with the CCG. CHFT reported that CQC were pleased.

HSIB: Have published a report reviewing all maternal deaths nationally during the pandemic. CHFT have confirmed that none of the findings were factors in the cases they have had.

Access to maternity services: CHFT have launched a digital platform allowing women to refer themselves to services and contains all Patient Information. Traditional referral routes will continue.

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – May 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
Information governance breaches	Since the introduction of the improvement action plan in September 2020 the Trust has seen sustained improvement in this area. There has been 78 IG breaches reported from 1st October 2020 to 30th April 2021. This is a reduction of 44 incidents compared to April – October 2020 when 110 breaches were reported.	In September 2020 the Trust introduced a refreshed awareness and communication plan. All teams have engaged with the IG Manager and completed the additional information requested in Datix on time. The communications plan is being assessed to ensure it remains meaningful and has an impact. The IG Breaches have clinical oversight and are discussed in clinical safety and clinical governance meetings with Directors and senior staff	Trust wide IG staff training remained above the 95% target at 97.9% in March 2021. The most reported category of breach is information being disclosed in error, the quality manager has asked the Trust for an update on their improvement plan for this area and will continue to monitor their performance and actions. The Quality Manager has seen the Trusts IG action plan and is confident improvements are being made and recommends this item is removed from enhanced surveillance
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 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 – May 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 2021 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.	It is expected that there will be improvement seen in the next six months as staff become more familiar with the risk assessment tool and it is embedded in practice.

South West Yorkshire Partnership NHS Foundation Trust
Overview/triangulation

The following two pages provide a summary in relation to the Quality and Safety of services provided at South West Yorkshire Partnership NHS Foundation Trust for the period up to May 2021, dashboard data to March 2021.

Covid-19

- The Trust Opel level remains at 2
- The Covid-19 Vaccination programme phase 2 is active with many staff members noted as now having their second vaccination
- A total of 4,483 staff have received their first vaccination (87.2%) and 3,254 staff have received their second vaccination (63.3%)
- In addition to providing vaccinations for SWYPFT staff, they have provided 968 first vaccinations and 864 second vaccinations for partner organisations
- The patient vaccination programme continues to be delivered within the wards
- Mapping of governance structures and ways of working as Business as Usual becomes the norm being discussed.

Quality

- The majority of quality reporting metrics continue to be maintained during the pandemic
- Serious Incident Review Accreditation Network (SIRAN) - the Patient safety support team has achieved accreditation of their serious incident investigation process by the Royal College of Psychiatrists.
- Certification has been achieved from BILD in meeting the Restraint Reduction Training Standards
- The number of restraint incidents during March decreased from 185 to 179
- The number of admissions under 18's to adult wards has remained at 3 in April, for a total of 25 days.
- High acuity on inpatient areas continues, placing additional pressure on staffing
- Clinical supervision target has been achieved
- Duty of Candour – There were no breaches in February

Serious Incidents

- Incident reporting levels have been checked and remain within the expected range.
- Quarterly meetings have continued between CCG Quality Manager, SI team and SWYPFT patient safety support team to review the position statement of incidents, share findings, discuss themes and lessons learnt.
- Serious Incident reports from SWYPFT are very thorough and high quality. There are often delays in receiving the final report due to complexity of incidents and allocation of lead investigator. SWYPFT are open and transparent with reasons for extension requests and can demonstrate that services users/families/NOK are updated and supported throughout the process.
- SWYPFT expect the delays to improve areas return to business as usual with the easing of the pandemic.
- In addition to quarterly meeting from July 2021 SWYPFT will attend an evidence review meeting with CCG Quality manager and SI team to demonstrate lessons learned and how improved processes are embedded in practice.

South West Yorkshire Partnership NHS Foundation Trust
Overview/triangulation

Safer Staffing Inpatients

High levels of acuity continue to be reported by the inpatient areas across the BDUs. There is a higher requirement for increased observation levels which in turn increases the demands on the regular workforce as well as the need for additional flexible staff. Staff absences caused by COVID related issues has decreased in this time however they still face challenging staffing issues.

The number of wards that have failed to achieve 80% registered nurses decreased again by one to nine (28.8%). Four wards were within the Forensic BDU, two in Barnsley and three in Calderdale and Kirklees. Although the overall fill rates remain high, all inpatient areas remain under pressure from a registered staffing perspective. This continues to be compensated by increasing the number of HCAs per shift. Contributory factors included high levels of acuity, high sickness/absence and existing vacancies

Safeguarding

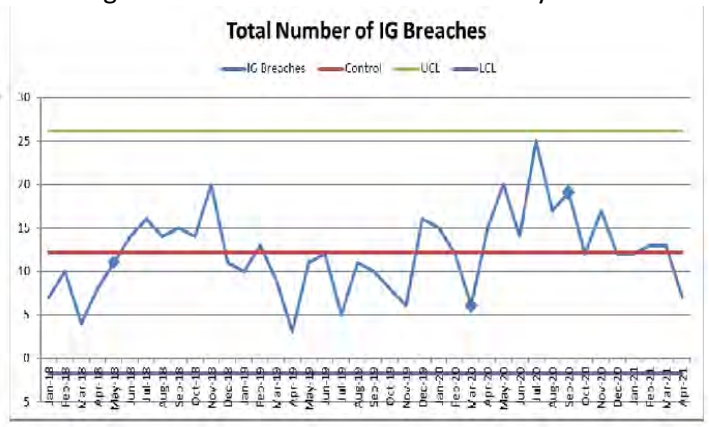
Safeguarding remains a critical service, all statutory duties have been maintained, data flow (internally and externally) has continued in a timely manner and the team have continued to provide supervision. Level 3 Safeguarding adults and children training continues to be delivered virtually via MS Teams. This has been positively received although further work to support interaction is being undertaken. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target. The team are delivering the parental mental health and the impact on children package and this has been well received. The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. External information gathering requests have been responded to and the team have continued to attend Child Safeguarding Practice Review panels, Safeguarding Adult Review panels and a Domestic Abuse panel. The safeguarding team provided a bespoke training session for the Forensic Community team on the Learning from Mental Health Homicide

Information Governance

7 data breaches were reported during April, which is lower than any month during the previous financial year. 5 of the incidents reported involved information being disclosed in error which is the most reported category throughout 2020/21.

The Trust did not report any incidents to the Information Commissioner's Office (ICO) during April and no complaints about the Trust were made by the public.

The graph to the right indicates that data breaches are returning to the expected range. The data point May 2018 highlights introduction of GDPR. Data Point March 2020 highlights start of Covid-19 pandemic and some changes to working practices. Data point September 2020 highlights the start of the Trusts awareness and communication campaign regarding Information Governance. The communication plan is currently being assessed to ensure it remains meaningful and has an impact.



Complaints

The quality manager met with Associate Director of Nursing to discuss under performance of complaints being closed within 40 days. The Trust explained the current position, contributory factors attributing to delays in closing complaints and have introduced a pilot of a new set of performance measures and timeframes for handling complaints. The pilot will categorise complaints as low, moderate or complex and assign a set amount of working days to resolve. The quality manager was assured that measures are in place for all complaints to be risk assessed when they are received, ensuring there is no risk to patient safety and not detrimental to health and well being. The Trust are also extending compliant handling training to more staff to be lead investigators. The quality manager will be meeting with the team in August for an update and to discuss findings of the pilot.

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – May 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	A	M	J	J	A	S	O	N	D	J	F	M	A	M
Safe	Never Events	Monthly	0	0	0	May-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	0	0	May-21	↑	↔	0	3	3	2	6	1	0	3	2	1	0	2	4	0
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	91.0%	-	rolling 6 months - Nov 20 - Apr 21	↓	↓	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	92.0%	92.0%	91.7%	91.0%	-
Effective	% Admissions Gate kept by SRS Teams	Monthly	95%	100.0%	-	Apr-21	↑	↑	99.0%	99.2%	100.0%	96.8%	96.4%	95.2%	100.0%	100.0%	98.0%	100%	99.1%	99.1%	100.0%	-
	No. of records with up to **date risk assessment –** Inpatient	Monthly	95%	61.6%	-	Apr-21	↑	↓	90.4%	91.5%	89.4%	84.3%	93.4%	81.0%	20.9%	46.6%	54.0%	55.5%	53.0%	53.2%	61.6%	-
	No. of records with up to **date risk assessment –** Community	Monthly	95%	46.9%	-	Apr-21	↓	↓	71.2%	83.3%	79.1%	70.0%	74.6%	77.4%	37.3%	47.7%	51.9%	56.0%	63.2%	56.8%	46.9%	-
Caring	EMSA	Monthly	n/a	0	0	Apr-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Responsive	Complaints closed within 40 days	Monthly	80%	39%	-	Apr-21	↓	↓	56%	90%	90%	100%	-	30%	60%	73%	11%	50%	0%	58%	39%	-
	No of complaints re-opened	Monthly	n/a	2	2	Apr-21	↓	-		0	2	0	-	0	0	2	2	0	1	0	2	-
	CAMHS - under 18's admitted to adult wards	Monthly	tbc	3	3	Apr-21	↔	↓	1	2	1	0	3	3	2	4	2	2	1	3	3	-
	Delayed Transfers of Care	Monthly	3.5%	1.2%	-	Apr-21	↑	↑	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1.8%	1.6%	1.8%	1.2%	-
	% Service users on CPA followed up within 7 days of dishcarge	Monthly	95%	96.8%	-	Apr-21	↓	↓	97.8%	100.0%	100.0%	100.0%	98.8%	99.1%	98.9%	100.0%	100.0%	98.90%	100.0%	97.0%	96.8%	-
	Out of Area Beds Days	Monthly	20/21 - Q1 247, Q2 165, Q3 82, Q4, 0	84	-	Apr-21	↓	↑	167	108	140	336	224	177	106	88	122	91	78	82	84	-
Well-led	Information Governance Confidentiality Breaches	Monthly	<=9	7	7	Apr-21	↑	↑	15	20	14	25	17	19	12	17	12	12	13	13	7	-

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 – May 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

National Quality Board

Position Statement: Managing Risks and Improving Quality through Integrated Care Systems

The landscape of health and care is changing. The recently published White Paper - Integration and Innovation: working together to improve health and social care for all[1] – sets out the government's proposals for legislation, including the establishment of statutory Integrated Care Systems (ICSs). As ICSs develop and we recover from the pandemic, it is crucial that ICSs recognise their Triple Aim[2] duty to deliver high-quality care and put quality, including safety, at the forefront of planning and decision-making.

A shared commitment to delivering quality in ICSs

The strengthening of collaboration and partnership working across health and care provides significant opportunity to improve quality. However, we also know from past experience that structural change can put quality, including safety, at risk. Much of the National Quality Board (NQB)'s work since 2009 has focused on providing leadership for quality and supporting quality oversight during periods of transition[3]. For this reason, we understand the importance of "getting quality right" at this crucial time.

The NQB has refreshed its **Shared Commitment to Quality** to provide a common definition and vision of quality for those working in health and care systems. The refreshed version has been co-produced with systems and people with lived experience. It uses the existing Darzi-based definition of high-quality care as being safe, effective and providing a positive experience[4], with a greater emphasis on population health and health inequalities. The document and example system case studies can be accessed here: www.england.nhs.uk/ourwork/part-rel/nqb/

Key requirements for quality oversight in ICSs

Systems and their constituent partnerships and organisations will have two overarching quality responsibilities:

1. **To ensure the fundamental standards of quality are delivered** – including managing quality risks, including safety risks, and addressing inequalities and variation;
2. **To continually improve the quality of services**, in a way that makes a real difference to the people using them.

[1] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

[2] The Triple aim: better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed

[3] Previous NQB work and publications are available on the NQB website: https://www.england.nhs.uk/ourwork/part-rel/nqb/

[4] Department of Health (DH). High quality care for all: NHS Next Stage Review final report. London: Department of Health; 2008

Achievement of these responsibilities in the new operational landscape will require an important culture shift – from instructive to permissive and developmental ways of working, and from individual to collective ownership and management of quality concerns. As the development of ICSs progresses, clear accountabilities for the delivery of quality, including safety, will be needed for all parts of the system. In the interim, system partners must understand that they are all accountable for quality and that they therefore all have a responsibility to escalate concerns.

Quality oversight and improvement will largely be delivered locally through place-based partnerships, but ICSs will have an important role to play – ensuring that inequalities and variation in the quality of care and outcomes are addressed, that serious quality concerns are managed effectively, and that learning, intelligence and improvement are shared across the system and beyond to inform ongoing improvement.

The refreshed Shared Commitment sets out some **key principles** for systems to adopt in delivering their overarching quality, including safety responsibilities, which have been informed by previous NQB work and recent learning from systems. Alongside these, systems are expected to adopt some **consistent operational requirements** for quality oversight during the transition period and beyond.

	Principles	Consistent operational requirements
	**1. Quality is a shared commitment**	**1.** A designated executive clinical lead for quality, including safety, in the ICS, and clinical and care professional leadership embedded at all levels of the system.
	**2. Population focused vision**	**2.** A clear vision and credible strategy to deliver quality improvement across the ICS, which draws together quality planning, quality control, quality improvement and assurance functions to deliver care that is high-quality, personalised and equitable.
	**3. Coproduction with people using services, the public and staff**	**3.** A defined governance and escalation process in place for quality oversight – covering all NHS commissioned services and those commissioned jointly by the NHS and local authorities (included devolved direct commissioning functions) and formally linked to regional quality oversight arrangements (Quality Committees / Joint Strategic Oversight Groups).
	**4. Clear and transparent decision-making**	**4.** A defined way to engage and share intelligence on quality, including safety – at least quarterly and delivered through a System Quality Group (refreshed Quality Surveillance Group), at least initially. This will not replace existing statutory responsibilities.
	**5. Timely and transparent information-sharing**	**5.** An agreed way to measure quality, including safety, using key quality indicators triangulated with intelligence and professional insight, which is reported publicly and transparently at Board-level to inform decision-making and effective management of quality risks. Evidence must show that this is also mirrored by tracking of local metrics within services to inform progress and improvement.
	**6. Subsidiarity**	**6.** A defined approach for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles.

[5] This includes: public, private, not for profit and third sector providers; primary care including general practice, dental, optometry and pharmacy; community services; secondary and tertiary services; mental health; military health and veterans services; directly commissioned services, including specialised commissioning and health and justice; services impacting on locally commissioned services.

System Quality Groups (formally Quality Surveillance Groups)

During 2021-22, systems are expected to set up a System Quality Group[6], a refreshed version of a Quality Surveillance Group (QSG)[7]. The NQB will work with systems and regions in 2021-22 to update the National Guidance on Quality Surveillance Groups and Risk Summits (held in response to serious quality failures). The effectiveness of these arrangements will signal system readiness and maturity. Key updates to the Terms of Reference of System Quality Groups are summarised below:

Terms of Reference of System Quality Groups	
Purpose	A proactive and collaborative forum, providing systems with: • A mechanism to identify system risks to quality and opportunities for improvement, including variation • A mechanism to escalate quality risks from place to system, and system to region (in collaboration with regulators and wider stakeholders) • Opportunities to coordinate actions to drive improvement, respecting statutory responsibilities • Opportunities to identify, share and celebrate learning and best practice across the system.
Scope	A focus on population health and system quality priorities, e.g. across pathways/settings with particular emphasis on reducing inequities of in access, experience and outcomes..
Membership	System-led. Membership expanded, with at a minimum Regional NHSEI teams, local authorities, CQC, HEE, public health, primary care, maternity, patient safety collaboratives, patient safety specialists, provider collaboratives and at least two lay members (inc Healthwatch).
Assurance	Accountable to the ICS Board (subject to legislation) and to Regional NHSEI teams for the quality of care of services. Responsible for ensuring good quality oversight, management of risks, sharing intelligence and working with regulators.

Systems will be expected to work closely with regional NHSEI teams and wider partners to effectively put in place these requirements during the transition period. Practical changes to deliver quality functions sensibly through ICSs, including patient safety functions and devolved functions (e.g. directly commissioned services), will be worked through in 2021/22 and managed appropriately. Regional NHSEI teams are working to update regional quality oversight meetings and support ICS quality leads over 2021-22, in collaboration with national NHSEI teams and wider partners. Engagement will be tailored to ICS needs and may include reviewing wider quality risks, sharing learning and benchmarking data, and supporting effective leadership for quality. In the event of serious or persistent quality failures, NHSEI and regulators will work collaboratively with systems to address issues, in alignment with the System Oversight Framework.

NQB work to support quality oversight in ICSs

The NQB will support the following work in 2021-22:

- **A quality toolkit**, drawing together a library of consistent indicators to help provide a single view of quality. Launched and further developed by NHSEI and available through NHS Viewpoint in Q1 2021/22
- Policy work to clarify **quality oversight arrangements at place and system level**, including risk management approaches. To inform updated guidance on QSGs and Risk Summits – Q 2-3 2021/22
- Policy work to further define **roles and responsibilities for quality** at place, system and regional level – Q2-3 2021/22
- Ongoing work to gather, share and celebrate **learning, improvement and best practice** from systems on quality, including focus on how these are done as well as what is done. Shared through networks, events and case studies.

[6] ICSs may choose to tailor this name. e.g. "Quality Board" and "Joint Intelligence Group" are examples of groups already established.

[7] https://www.england.nhs.uk/publication/quality-surveillance-groups-national-guidance/

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Risk Register Position Statement Risk Cycle 2 2021-22 (17 May – 2 June 2021)**	**Agenda Item No.**	14
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby, Clinical Chair	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary

This paper presents the high-level risk report at the end of the second risk review cycle of 2021-22

The Calderdale Clinical Commissioning Group (CCG) Risk Register currently contains a total of 37 risks with 4 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**	24 June 2021
Name of meeting	Senior Management Team	**Meeting Date**	8 June 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 2 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee on 24 June 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 2

2.1 Risk Cycle 2 commenced on 17 May 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 8 June 2021.

2.2 All risks were submitted to the Quality, Finance and Performance Committee for review at their meeting on 24 June 2021.

2.3 There were three critical risks rated 20 at the end of Risk Cycle 2 (see 2.7). This is the same number that was on the risk register during the last risk cycle.

2.4 The CCG Risk Register for Risk Cycle 2 has now been archived.

Risk Register Summary: Risk Cycle 2

2.5 At the end of Risk Cycle 2 the CCG had 37 risks on the Corporate Risk Register. There are 4 marked for closure this risk cycle meaning there are 33 open risks.

2.6 33 of total CCG risks (89%) are categorised as quality, finance and performance risks and 4 (11%) 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 and the end of Risk Cycle 2. 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 post-C19 bed plans which require minimum delayed patients.	20	Static for 5 risk cycles.
187	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.	20	Static for 2 risk cycles.
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. There is also a risk of significant harm associated with patients spending extended time on a trolley in A&E awaiting a bed within the context of COVID-19-related bed pressures.	20	Static for 6 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 are:

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	Static for 1 risk cycle
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 5 risk cycles
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	Static for 8 risk cycles

	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.		
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 4 risk cycles

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 experienced by the CCG at the end of risk cycle 2 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee on 24 June 2021.

4 Appendices

Appendix 1: High level risk log for risk cycle 2 at 25 June 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.

Appendix 2: Critical risk reports for 187, 1493 and 62.

Risk cycle 2 2021-22 - high level risks

Risk ID	Date Created	Risk Type	Risk Category	Risk Rating	Risk Score	Target Risk Rating	Target Score	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1493	28/02/2020	Quality	Q - Quality of Care	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	No gaps in controls	(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 starts in July 21. (e) Process now in place for reviewing patients on the Reason to Reside list (f) CCG has funded GP input into CHFT virtual ward rounds to optimise discharge	(a) Improvement in commissioning approaches has resulted in sufficient Discharge to Assess capacity being available, including covid beds and home care packages (c) Mutual aid across Calderdale and Kirklees to mitigate risks around any D2A bed capacity (covid beds and EMI covid beds) (d) Postive comparative performance in realtion 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 small number of individual patients, for example bariatric patients. (c) TOC list remains higher than the agree level, and there is a lack of clarity around the long-term sustainability of a lower number - impacting on recovery plans (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.	Static - 5 Archive(s)
187	19/03/2012	Finance	Q - Quality of Care	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.	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 groups 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) Four new workstreams in place to develop new out of hospital pathways for high volume specialties e) Submission made to support access to Elective Recovery Fund - focused on 4 principles	a) Sufficient capacity available to deliver on planning expectations b) Ability to effectively communicate and support all patients on waiting list c) Resolution on issues relating to IS practising privileges and its negative impact on the clinical workforce and its ability to see patients in the IS.	Static - 2 Archive(s)
62	13/06/2013	Finance	F&P - Performance	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 agreed, with focus on reducing A&E attendances, including comms work	(a) CHFT had strong performance nationally and remain in the upper quartile. (b) Extended access in general practice now in place (d) GPs and A&E clinicians meet formally on acute issues to strengthen working relationships. (e) A&E now included in the TOR for the Acute Clinical Interface Group (CHFT & 2 CCGs) (f) 111 First in place in both A&Es (g) Proactive system communications on use of A&E taking place throughout winter period. (h) UEC Board overseeing development of interim urgent care offer	(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 - 6 Archive(s)
1734	03/03/2021	Commissioning Primary Medical Services Committee	CPMS - Q	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.	Static - 1 Archive(s)

1729	19/02/2021	Quality	Q - Quality of Care	16	(I4xL4)	4	(I2xL2)	Penny Woodhead	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.	Initial contract performance meeting held 12/2/21 and the provider given clear actions that must be delivered The situation is being monitored closely at regular contract performance meetings by CKB senior commissioners and contracts management. Each responsible commissioner must review all transition details and sign off an agreed checklist for their clients Monitoring and oversight of implementation plans through weekly quality assurance meetings with all commissioners and the provider Now being monitored under NHSE Quality Surveillance process due to ongoing and increased concerns 1 person in situ and under close review , no further admissions to be agreed Nobody will move in until required assurance is in place and can be evidenced Admission of the Calderdale resident has been delayed until the required assurance is in place and can be evidenced	Individual transitional planning arrangements must be closely monitored and evidence provided that all aspects of the plan are in place period to any move Sign off to move forward with any moves must be made by the senior responsible commissioner from the relevant CCG/LA as applicable. Some plans not signed off due to lack of evidence from the provider Delays to admissions due to concerns about the service and lack of appropriate assurance from the provider	Monthly updates are provided to TCP partnership Board with regards to this new service Any concerns are reported through this board or if required are escalated to Kirklees CCG as the lead commissioner on this project. Escalation of concerns to Director level within each organisation and on corporate risk registers Service now under NHSE Quality Surveillance process and multi agency meetings led by Chief Nurse, awaiting detailed action plan from the provider in response to detailed concerns 26/5/21 Quality surveillance review meeting 28/5/21 Collaboration and sharing of all relevant information between commissioners on an ongoing basis Minimum of weekly meetings between the provider and commissioners to ensure close monitoring	Concerns were raised by commissioners as part of the transition planning process and a performance meeting put in place with immediate effect Concerns and expectations shared with provider and action plan received Progress will be monitored initially weekly The safety and well being of 2 current residents is under close observation by commissioning organisations as well as the clinical support and input of the Intensive Support Team Unannounced visit/review carried out by Kirklees and Barnsley commissioners 24/4/21 and 26/4/21 Detailed report of findings shared with provider and expectations re action plan and timescales 1 person has been moved out on a temporary basis whilst required assurances are put in place Remaining person from Barnsley is settled , no concerns re their safety and close oversight is being maintained by responsible commissioners	This service has been commissioned to provide bespoke care for 6 individuals all of whom have complex and challenging needs and are currently in long term hospital placements This is due to a lack of assurance with regards to the staffing structure, training and skills of staff . This could result in a delay to clients moving in as assurances about the quality and safety of the service must be in place before people are admitted. This will also impact upon the planned CKWB trajectory for hospital discharges under transforming care as reported to NHSE - NHSE involved in Quality Surveillance process. If the provider is unable to make the improvements required it may be necessary to seek an alternative provider. Provider unable to demonstrate satisfactory levels of improvement or governance arrangements in place Further concerns highlighted following unannounced visits to the service by commissioners awaiting detailed action plan and evidence of improvements	Increasing
1501	12/03/2020	Finance	F&P - Performance	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 - 5 Archive(s)
1366	25/06/2019	Finance	F&P - Performance	16	(I4xL4)	4	(I4xL1)	Debbie Graham	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 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.	(a) West Yorkshire Commissioners have established a sub group under WYUECN arrangements to look into commissioning of the services and likely changes for 2020/21. This commissioning group will also look into the long term service developments for GPOOH on a West Yorkshire footprint and will continue to pick up operational risk (C19 and non-C19)	There are no gaps in controls, commissioners and provider continue to work to provide assurance on service delivery and risk during the C19 period, with risks escalated regionally and nationally as needed	(b) Monthly contract report to CMB (c) Risk discussed in various forums and relevant additional assurance requested/received; West Yorkshire Sub-Regional 111 clinical quality meeting, 111/999 Joint Quality Board and 111/WYUC Contract and Performance Meeting. (c) Quality Surveillance groups. (f) The winter funding and investment through WY&H provides opportunity to develop and adjust existing service delivery model to the key future challenges. A highlight report is provided through WY&H urgent care network demonstrating progress on the initiative along with their impact on the service (g) Quality risk articulated on the risk register.	(a) As a mitigating factor for continuous service provision and access along with patient safety, LCD have made communications on a collective as well as individual level with clinicians explaining the application of national guidance on PPE for non- hospital, non-ICU use. (b) As a mitigating action LCD reported to work up a clinical protocol of double triaging of the patients required home visits (where the impact of this risk is higher). (c) Positive assurance was provided that the service will provide home visits to the patients as per clinical needs. (d) Clinical audit of both levels of triages will also be conducted and shared with Commissioners.	The service is facing situation where due to local guidance on PPE (which are higher specs than national PPE guidance) clinicians are refusing to see patients in F2F setting like home visits etc. Therefore three main interconnected issues reported are: (a) Clarity on Guidance- Issue of local guidance from LMC (currently from Bradford CCG) on PPE in spite of National guidance (c) Lack of PPE (d) Clinician's refusal to Face to Face patients LCD has assured that the PPE they are offering matches with national standards of non-hospital, non- ICU.	Static - 8 Archive(s)
240	10/06/2013	Finance	F&P - Contracting	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 2020 - 18%. Feb - 25%. Mar - 20%. Jan 2021 - 56%. Feb - 73%. Mar - 79%. * 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. 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. 2. Two week wait referrals via NHS e-Referral Service from October 2017 has increased ASI's as certain services do not have specific 2WW clinics or appointments so referrals must be deferred to provider. These convert to an ASI list showing huge increases. All 2WW ASI's are dealt with within 24 hours.	Static - 4 Archive(s)

Risks Report Summary

CCG: NHS Calderdale CCG

Archive Deadline: 24/06/2021

New Risks: 4

Total Risks: 37

Old Risks: 33

Marked for Closure: 4

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: 8.07.21

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. However, it has been recognised at an exec level that there is a need to accelerate the pace and scale of the work because: • CHFT's position in relation to its backlog and ASIs is deteriorating, resulting in a risk of harm and poor patient experience • Although CHFT is making positive progress in relation to recovering its activity back to 19/20 levels, it would have to exceed 100% of its pre-covid delivery to start to make an impact on its backlogs

		• 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	• New planning guidance indicates that CHFT should increase elective capacity to levels undertaken in 2019/20. • The restart of our elective services is seen as a critical element of our system recovery work, and work is taking place at pace to mitigate risk and reduce patient harm. • Our local Independent Sector (IS) capacity, provided by Spire and BMI Hospital capacity is vital, as is other IS capacity. • This is supported through a new contracting regime which starts on 1 April 2021 and plans for an optimum amount of capacity to be used to support CHFT's recovery.
6	Actions	At an executive escalation meeting on 18 June 2021, there was agreement on four key principles; • The need for the system to supplement CHFT's divisional management by providing additional capacity to support recovery activities (working as an autonomous In and Outsourcing team) • To quickly identify a range of new and existing providers who could 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. • Clinical staff are fatigued and not able to response to the need to maximise the use of all available estate and theatre capacity, and this provides us with opportunities. • To recognise that, from a finance perspective, this is seen as a

		system call against non-recurrent funding, recognising that this work should support the drawing down of Elective Referral Fund resources in our system. • That we make sure that we consider collaborative opportunities in this work, and build our thinking about what we would be doing if we were in March 22. We have created a short-term In and Outsourcing team, made up of CCG and CHFT staff. ENT will be the first specialty, focusing on increasing capacity for those patients awaiting a first appointment, follow ups and procedures, whilst at the same time planning for the next set of specialties. An Advice and Guidance task and finish group has been established to work 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: 08.07.21

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 48 people on the TOC list in late March 2021. Throughout Q1 2021, to date, this number has reduced and been maintained around 30 patients per day. There were 6.4 referrals onto the TOC list per day in Quarter 1, compared to 6.2 referrals per day in Quarter 4, an increase of 0.2 referrals per day on average. With this increased demand the joint

		discharge teams have been working harder to maintain the position and flex their capacity. Despite this increased demand, the average referral to discharge (length of time a patient is on the TOC list) has been reducing month on month through Quarter 1, and is currently at 5.6 days. This figure was at 14.5 days back in March 2020, and this shows the progress being made. Referrals (or additions onto TOC list) vary massively throughout the week. It is common for there to be no referrals during the weekend and upwards of 40+ on a Monday and Tuesday across both Calderdale and Greater Huddersfield. This surge creates problems operationally. Since the start of the pandemic NHS England suspended reporting of formal Delayed Transfer of Care reporting, and therefore no benchmarking data is available to understand the relative position of Calderdale nationally. However, our system has a live data flow of patients on a discharge journey out of hospital and this is monitored daily to identify mitigating actions. In addition, new datasets are being developed for the A&E Delivery 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.
5	Assessment of the issues	Whilst there is no comparative data, the performance data provided above shows that there has been positive improvement in the rate of discharge in Calderdale. However, as a system we are committed to continuing to safely reduce delays, based on the principles of home first, and reducing the number

		of people in hospital beds to support the safe recovery of services at CHFT. At the current time, although there has been positive progress, there are still avoidable delays in transfer of care out of hospital, and this is causing undue pressure on CHFT, particularly given the increased post-pandemic demand and acuity related to non-elective admission.
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. • Recruited a new System Co-ordinator role for Calderdale which has system oversight of discharge across a range of settings rather than just hospital, ensuring the flow of patients through our pathways. • 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
7	Identified gaps	• Benchmarking information to show the relative position of Calderdale (due to a national pause in data submission) • 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. • Our ability to sustainably deliver discharges at the levels included in CHFT bed modelling assumptions. • Development of new data which builds on the national data set – and demonstrates discharges over the full 24 hour period (current national data only provides data from midnight to 17.00 hours).

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: 08.07.21

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: 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 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 (01.07.2021) – the average 7-day A&E performance was 85.57% • Attendances at A&E significantly increased from March 2021, May has seen 58% increase in attendances compared to previous year – it is the highest month since records began with 14,943 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. 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 – focus is on localities where there is high utilisation of A&E, to identify alternative offers. Generic communications across all other localities (Calderdale and Greater Huddersfield. Also a new system website to support messaging through winter • Implementation of a new 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.
7	Identified gaps	• Clarity of status of current demand wave, and its duration.

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: 08.07.21

Name of Meeting	**Governing Body**	**Meeting Date**	29/07/2021
Title of Report	**Audit Committee Annual Report 2020-21**	**Agenda Item No.**	15a
Report Author	Zoe Akesson, Corporate Governance Officer on behalf of the Chair	**Public / Private Item**	Public
Clinical Lead	Prof Peter Roberts, Audit Committee Chair	**Responsible Officer**	Lesley Stokey, Director of Finance

Executive Summary
This report provides a brief overview of the workings of the Audit Committee in order to evidence the effectiveness and impact of the Committee by demonstrating compliance with the Committee's Terms of Reference and delivery of its work plan.

Previous Considerations

Name of meeting	Audit Committee	**Meeting Date**	20/05/2021
Name of meeting		**Meeting Date**	

Recommendations
It is recommended that the Governing Body **RECEIVES** the Audit Committee's Annual Report.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Not Applicable
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Not Applicable
Resources / Financial Implications (including Staffing/Workforce considerations)	Not Applicable

Sustainability Implications	Not Applicable

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)**	Not Applicable
Legal / CCG Constitutional Implications	This report forms part of the required reporting for the CCG.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Not Applicable

NHS
Calderdale
Clinical Commissioning Group

Audit Committee

Annual Report 2020/21

1. Purpose of the Report

1.1 The purpose of this annual report is to provide a summary of the Audit Committee's activities, demonstrating compliance with the Committee's Terms of Reference, delivery of the work plan, effectiveness, and impact.

2. Background

2.1 The Audit Committee is established as a sub-committee of the Governing Body and in accordance with the Clinical Commissioning Group's (CCG) Constitution and Scheme of Reservation and Delegation.

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

2.3 The Committee has responsibility for maintaining an overview of the adequacy and effectiveness of the systems of internal control and risk management system across the whole of the CCG's activities.

2.4 The Governing Body has delegated scrutiny of the following functions to the Audit Committee:

- Audit
- Governance, Risk Management and Internal Control
- Emergency Preparedness and Business Continuity

2.5 The Committee also has delegated authority to approve the CCG's Annual Report and Accounts and policies, guidelines and procedures in respect of all areas of the Committee's responsibilities.

2.6 The details of the roles and responsibilities are set out in the terms of reference **https://www.calderdaleccg.nhs.uk/download/audit-committee-terms-of-reference**

3. Membership

3.1 The membership of the Committee as set out in the Terms of Reference is as follows:

Members:

- Lay Member with expertise/experience in financial management/audit matters (who will act as Chair)
- Lay Member (Finance and Performance)
- Lay Member (Lay Member - Public and Patient Involvement)
- Lay Advisor
- Registered Nurse or Secondary Care Specialist
- One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.

Required Attendees:

- Chief Operating Officer/Chief Finance Officer and/or the Director of Finance
- External and internal audit representatives shall normally attend meetings.

3.2 The Committee met three times in 2020-21 and has been quorate on all occasions (see **Appendix 1**).

3.3 In February 2021, the Terms of reference were reviewed and there was an amendment to the membership / attendee arrangements recognising the Chief Operating Officer/Chief Finance Officer and/or the Director of Finance along with external and internal audit representatives would be required to attend each meeting. To reflect the organisational changes, the Accountable Officer or Chief Operating Officer/Chief Finance Officer would be invited to attend and would discuss, at least annually, with the Audit Committee the process for assurance that supports the Annual Governance Statement. They would also be invited to attend when the Committee discusses the draft internal audit plan and internal accounts.

3.4 The Terms of Reference were reviewed by the Committee at their meeting on the 25 February 2021 and were approved by the Governing Body at its meeting on 29 April 2021. Several minor proposed amendments were agreed (see **Appendix 2**).

4. Review of the Committees Activities

4.1 The Audit Committee work plan is developed in line with the responsibilities of the committee as set out in the Terms of Reference. It also takes a risk-based approach, reflecting the changing context in which the CCG has operated over the past year. The work plan is reviewed at each meeting. All items listed in the work plan have been considered in a timely manner (see **Appendix 3**)

4.2 Key Activities During 2020-21

The Audit Committee has had a full and productive year, working to provide the Governing Body with the necessary assurances that there are effective systems and processes in place to keep the organisation safe, to comply with statutory and constitutional requirements and to be able to deliver the CCG's objectives.

4.2.1 The Annual Report (2020-21)

Approval of the final Annual Report, Annual Governance Statement and Accounts forms one of the key activities of the Audit Committee at the end of the financial year.
All members of the Governing Body and the Senior Management Team had the opportunity to comment on the draft annual report prior to approval by the Audit Committee on the 10 June 2021 under delegated authority from the Governing Body.
I would like to take this opportunity to express my thanks to all involved in producing the Annual Report and Accounts to a high standard.

4.3 Other Key Areas of Focus

4.3.1 Approval of Policies

Throughout the year the Committee approved and received updates on amendments made to CCG policies. These have been revised as part of the routine review cycle or in response to changes in legislation or regulatory requirements. The policies approved (or non-material amendments noted) were:

- Standing Financial Instructions on 25/02/21
- Management of Conflicts of Interest Policy on 24/09/20
- Information Governance Policies Book on 24/09/20 and update on 25/02/21
- Local Security Management Policy on 25/02/21

4.3.2 Governance Assurance

The governance dashboard, which is received at every meeting, provides the Committee with an overview of compliance with statutory, regulatory, and organisational duties and requirements in areas under the CCG's Governance Framework. Through the dashboard the Committee maintained oversight of and received assurance concerning:

- The submission of the Data Security Protection Toolkit (DSPT) for 2019-20, which the CCG had met all required standards.
- Progression with the DSPT submission for 2020-21, which was deferred to June 2021 and the completion of the IG action plan to ensure compliance with the DSPT.
- Compliance with Data Access Legislation (Freedom of Information and Subject Access Requests) with reports provided on a "by exception" basis in accordance with agreed reporting triggers.
- The occasional reporting of any Information Commissioner's Office (ICO) reportable IG incidents. There was one ICO reportable incident this year, which was recorded as human error and no further action was required. A process has been put in place to remind staff be more vigilant and the breach was also disclosed in the CCG's Annual Report.
- The process for managing conflicts of interest, including any policy breaches, and receiving updates through the year on the review and amendments to the CCG's registers of interest and offers of Gifts, Hospitality and Commercial Sponsorship.
- Any instances when the Standing Orders had been suspended, authority delegated by the Governing Body or its Committees or the Corporate Seal applied.
- The occasion and reporting of any Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents originating at the CCG.
- The effectiveness of the CGG's emergency planning and business continuity arrangements including any incidents and the delivery of planned exercises as a requirement of Emergency Planning Resilience and Response (EPRR) core standards (complemented by an Annual Reports concerning the CCG EPRR activities and compliance against the NHS England emergency planning core standards).
- The effectiveness of the CCG's Risk Management Process (complemented by an annual report on activities within the CCG).
- The completion of the CCG's Governing Body Assurance Framework bi-annual review process.
- Compliance with mandatory training requirements for CCG staff and Governing Body members.

4.3.3 Contracting

At each meeting the Committee received for assurance an update on the contracts register together with the status of contracts held by the CCG; details of contract waivers approved and completed, a forward view of intended or potential waivers and a summary of current, completed and proposed tenders.

4.4 Working with the Auditors

In 2020-21, the Audit Committee was supported in its work by Audit Yorkshire (Internal Auditors, Local Counter Fraud Specialist, and the Local Security Management Specialist) and Grant Thornton UK LLP (External Auditors).

4.4.1 Internal Audit

The Audit Committee approves the internal audit, counter-fraud and local security management annual plans each year and receives updates on progress against these plans at each of its meetings, as well as an annual report at the end of the financial year. The internal auditors provide the Committee with independent and objective opinions on the degree to which risk management, systems of internal control and governance support the achievement of the CCG's objectives. They are also able to provide independent advice and support the improvement of our systems and processes.

The 2020-21 Internal Audit Plan was approved by the Audit Committee on 20 May 2021. Areas reviewed during the year were:

- Core Financial Systems
- Data Security and Protection Toolkit
- Primary Care Co-Commissioning
- Collaboration
- Continuing Healthcare (Controls Improvement Audit)
- Safeguarding
- Conflicts of Interest
- Governance and Risk Management

The Quality, Innovation, Productivity and Prevention (QIPP) audit was cancelled, and the care homes audit was deferred.

Following completion of the planned audit work for 2020-21, I am pleased to be able to report that the Head of Internal Audit Opinion was **SIGNIFICANT ASSURANCE**. The opinion indicated a good system of internal control and risk management was in place. Further detail can be found in the CCG's Annual Report and Accounts 2020-21.

The Committee would like to thank all the CCG's staff for their hard work which has resulted in this Head of Internal Audit Opinion.

4.4.2 Local Counter Fraud (LCF)

An annual assessment (self-review tool) is undertaken of the CCG's compliance with the NHS Counter Fraud Authority's Standards for Commissioners: Fraud, Bribery and Corruption. This was completed and submitted in April 2021 by the LCF Specialist. The assessment was quality assured by NHS Counter Fraud Authority and the outcome of the 2019/20 self-review tool was positive.

The positive work and communications by the fraud team in raising awareness and prevention has helped to embed counter fraud with staff as part of everyday business.

4.4.3 External Audit

The role of the external auditors primarily is to review and report on the CCG's financial statements and to assess whether the CCG has proper arrangements in place for securing economy, efficiency and effectiveness in respect of its use of resources. Grant Thornton UK LLP was appointed as the new external auditor for the CCG in May 2020. They have attended 2 out of the 3 Audit Committee meetings this year and their contribution continues to provide external scrutiny and challenge as well as keeping the Audit Committee members up to date through the provision of technical updates.

4.5 **Private Discussions between Audit Committee Members and Auditors**

Private discussions between Audit Committee members and the external and internal auditors, without management present, ensure that there is a good relationship of trust between the auditors, and allows those present to raise any issues or questions. The meetings allow committee members and the auditors the opportunity to discuss a range of matters without any actual or perceived management influence. Audit Committee members have met with the internal and external auditors on three occasions, including prior to the approval of the Annual Report and Accounts at the end of the financial year.

5.0 Response to Covid 19

5.1 All committees of the Governing Body have been impacted by the demands of responding to Covid 19 in terms of their governance and the business they have been required to discharge within their remits. The Committee adhered to the National Audit Guidance for Committees on finance reporting and management during COVID-19.

5.2 The Committee was made aware of:

- some procurement activity had been paused due to changes in priorities and COVID 19 and information concerning effected procurements was provided at future meetings.
- NHS Digital had delayed the DPST annual submission to the end of September 2021 due to COVID 19.
- Changes to the submission deadlines for the Annual Report and Accounts for both 2019-20 and 2020-21.
- The Register of Interest review of CCG members had been postponed to quarter 2.

5.3 The pandemic impacted on the internal review process relating to SARs and response times for FOI requests due to the practical limitations arising from the need for social distancing as well as the ability for teams to respond due to redeployment of their staff in response to the pandemic however by quarter 2 of this year all out-standing FOI requests had been responded to.

6.0 Reviewing the Effectiveness of the Committee

6.1 The Audit Committee has the role of undertaking an annual review of the effectiveness of the Governing Body's committees. One of the ways in which it does this is by receiving an annual report from each of the committees. The annual reports were presented to the Audit Committee by a representative of each of the committees on the 20 May 2021.

6.2 The Committee is pleased to be able to report that there has been excellent attendance at each of the meetings and would like to acknowledge the commitment of the members and staff in delivering the committee work plans and in discharging their responsibilities as set out in the Terms of Reference. The Annual Governance Statement, which forms part of the CCG's Annual Report 2020-21, provides a useful summary of the work of our committees

during the year and the areas that have been identified in terms of development following their self-assessment.

6.3 The Audit Committee is always looking to improve the way in which it carries out its business as well as setting a good example to the other committees. The findings from the Committee's self-assessment were discussed at its meeting in February and additional training, with both external and internal audit, in areas around value for money was identified as an area for development in 2021-22.

7.0 Recommendations

7.1 It is recommended that the Governing Body **RECEIVES** the Audit Committee's Annual Report.

8.0 Appendices

Appendix 1 Audit Committee Attendance Register 2020-21
Appendix 2 Audit Committee Terms of Reference v10.0 29.04.21
Appendix 3 Audit Committee Work Plan 2020-21

Item 15a Appendix 1

AUDIT COMMITTEE ATTENDANCE 2020-21

NAME	18/06/20	24/09/20	25/02/21
Peter Roberts (Chair)	1	1	1
John Mallalieu	1	1	1
Farrukh Javid	1	1	1
Rob McSherry	1	1	-
Alison MacDonald	1	1	1
Rob Atkinson (sub for RMc)	-	-	1
Denise Cheng Carter	1	1	1
Neil Smurthwaite (interim AO)	1	APOLS	1
Andrew O'Connor	1	1	1
Martin Pursey	1	APOLS	1
Tim Cutler	APOLS	-	-
James Boyle	1	-	-
Gareth Mills	-	1	1
Perminder Sethi	-	1	1
Jonathan Hodgson	1	1	1
Helen Kemp-Taylor	1	-	-
Danielle Hodson	APOLS	1	
Lesley Stokey (Interim CFO)	1	1	1
Olivia Townsend	1	-	-
Rosie Dickinson	-	1	1

Item 15a Appendix 2

NHS
Calderdale
Clinical Commissioning Group

Audit Committee

Terms of Reference

Version:	**10.0 FINAL**
Approved by:	Governing Body
Date Approved:	**29 April 2021**
Responsible Senior Manager:	Director of Finance
Review date:	April 2023 or earlier if required by organisational, statutory or regulatory change.

Contents

1.0 Constitution and Purpose

1.1 The Audit Committee is established in accordance with NHS Calderdale Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2 The Audit Committee is a Committee of the Governing Body of NHS Calderdale CCG.

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

1.4 In addition, the Governing Body has delegated scrutiny of the following functions to the Audit Committee:

- Audit
- Governance, risk management and internal control
- Emergency Preparedness and Business Continuity

2. Authority

2.1 The Audit Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of Calderdale CCG or member of the Governing Body and they are directed to co-operate with any reasonable request made by the Committee.

2.2 The Committee will request and review reports, evidence and assurances from managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the CCG.

2.3 The Committee is authorised by the Governing Body to commission reports or surveys it deems necessary to help fulfil its obligations.

2.4 In exceptional cases, the Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so the Committee must follow any procedures put in place by the Governing Body for obtaining legal or professional advice. The Governing Body is to be informed of any issues relating to such action.

2.5 The Committee is authorised to approve and keep under review policies and procedures of the CCG relevant to the role of the Audit Committee.

3.0 Membership

3.1 The Committee shall be appointed by the Governing Body and consist of:

Members:

- Lay Member with expertise/experience in financial management/audit matters (who will act as Chair)
- Lay Member (Finance and Performance)
- Lay Member (Lay Member – Public and Patient Involvement (PPI)
- Lay Advisor
- Registered Nurse or Secondary Care Specialist
- One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.

Attendees:

The following will be required to attend each meeting:

- Chief Operating Officer/Chief Finance Officer and/or the Director of Finance
- External and internal audit representatives shall normally attend meetings.

3.2 The Chair of the Governing Body shall not be a member of the Committee.

3.3 Other Officers of NHS Calderdale CCG may be required to attend.

3.4 At least once a year, the Committee shall meet privately with the external and internal auditors.

3.5 The Accountable Officer or Chief Operating Officer/Chief Finance Officer shall be invited to attend and will discuss, at least annually, with the Audit Committee the process for assurance that supports the Annual Governance Statement. They will also be invited to attend when the Committee discusses the draft internal audit plan and internal accounts.

3.6 Any full member of the Governing Body is entitled and encouraged to attend this Committee with observer status.

4 Arrangements for the Conduct of Business

4.1 Chairing the Committee

The Lay Member with expertise/experience in financial management/audit matters will Chair the Committee. In the event of the chair of the Committee being unable to attend for all or part of the meeting, the remaining members present will elect one of their number to chair the meeting/that part of the meeting.

4.2 **Quoracy**

Meetings shall be considered quorate when two non-GP members and one GP member of the Governing Body is present.

4.3 **Voting**

Should a vote need to be taken, only the core members of the Committee shall be allowed to vote**.** In the event of a tied vote, the Chair shall have a second and casting vote.

4.4 **Frequency of Meetings**

There will be a minimum of three meetings per year. The External Auditors or Head of Internal Audit may request a meeting if they consider one is necessary.

4.5 **Declaration of Interests**

Any conflicts of interest (real or potential) shall be managed in line with the CCG's Policy and guidance on the management of conflicts of interest**.**

All declarations of interest shall be minuted.

4.6 **Administrative Support**

Administrative support for the Audit Committee will be provided by a member of the Corporate Governance Team.

- Agreement of the agenda with the Chair.
- Circulation of agendas and supporting papers to Committee members at least five working days prior to the meeting.
- Drafting of minutes for approval by the Chair within ten working days of the meeting and then distributed to Committee members within 25 working days.
- Submission of the approved minutes to the Governing Body for information. Keeping an accurate record of attendance
- Keeping an accurate record of the management of conflicts of interest
- Matters arising and issues to be carried forward
- Maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- Arranging meetings between the Audit Committee members, external and internal audit.

5.0 Duties/Responsibility of the Committee

The Duties and Responsibilities of the Committee are as follows:

5.1 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards [1] and provides appropriate independent assurance to the Audit Committee, Chief Officer and the Governing Body. This shall be achieved by:

- Considering the major findings of internal audit work (and managers' responses) and ensuring co-ordination between internal and external auditors to optimise the use of audit resources.
- Agreeing any local Internal Audit Strategy and monitoring its implementation.
- Reviewing, approving and monitoring the implementation of the local internal Audit Plan, ensuring that this is consistent with the audit needs of the CCG as identified in the GBAF.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Undertaking an annual review of the effectiveness of internal audit.

5.2 External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and the organisation's responses to their work. This shall be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.

- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.

- Discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee.

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Governing Body and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is a clear policy in place for the engagement of external auditors to supply non-audit services.

5.3 Counter Fraud and Local Security Management

The Committee shall satisfy itself that the CCG has adequate arrangements, policies and procedures in place for countering fraud and security that meet NHS

[1] Public Sector Internal Audit Standards 2017

Counter Fraud Authority standards and shall review the outcomes of work in these areas.

5.4 **System of internal control and financial reporting**

5.4.1 The Committee shall approve the comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the CCG.

5.4.2 The Committee shall approve the arrangements for the CCG's statutory financial reporting duties.

5.4.3 The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.

5.4.4 The Committee shall ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

5.4.5 The Committee shall approve the Annual Report and Financial Statements on behalf of the Governing Body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Explanations for significant variances.

5.5 **Integrated governance, risk management and internal control**

5.5.1 The Committee shall maintain an overview of the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the CCG's activities that supports the CCG's objectives. In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular, the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances prior to approving the Annual Report and Financial Statement.

- The underlying assurance processes that indicate the degree of achievement of CCG's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements, including the process for reviewing and approving the Governing Body Assurance Framework.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

- The CCG's Integrated Risk Management Framework, highlighting issues to the Governing Body as appropriate.

- The Information Governance system across the whole of the CCG's activities. The Committee shall achieve this by reviewing the annual Senior Information Risk Owner (SIRO) Report, Information Governance (IG) toolkit and any other information governance reports as appropriate.

5.5.2 The Committee will have effective relationships with other Governing Body Committees in order to understand the processes and linkages.

5.6 **Emergency Preparedness and Business Continuity**

The Committee shall maintain an overview of the adequacy and effectiveness of emergency preparedness and business continuity arrangements in place across the organisation.

5.7 **Whistle Blowing**

To review the effectiveness of the arrangements in place for allowing staff/Governing Body to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

5.8 **Other assurance duties**

5.8.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the CCG if and when appropriate.

5.8.2 The Committee will undertake an annual review of the effectiveness of the other Governing Body Committees.

6.0 Reporting Arrangements

6.1 The Audit Committee shall submit the minutes of its meetings to the Governing Body. The Chair of the Committee shall draw the attention of the Governing Body to any issues that require disclosure to the full Governing Body or require executive action.

6.2 The Committee shall submit an annual report to the Governing Body. The annual report will also describe how the Committee has fulfilled its Terms of Reference and provide details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

6.3 Reports on specific issues, together with any recommendations shall be prepared for consideration by the Governing Body as appropriate.

6.4 The Auditor Panel has been established as a sub-group of the Audit Committee. The Audit Committee will maintain close relationships with the Panel as set out in the Auditor Panel Terms of Reference.

7.0 Conduct of the Committee

7.1 All members shall have due regard to and operate within the Constitution of the CCG, Standing Orders, Standing Financial Instructions and other financial procedures.

7.2 Members of the Committee shall abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.3 The Committee shall produce an annual work plan in line with the Governing Body's Assurance Framework.

7.4 The Committee shall undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. Any resulting changes to the terms of reference shall be submitted for approval by the Governing Body.

ENDS 25/02/2021

History

Version No.	Changes Applied	By	Date
Final	**Approved by the Governing Body**	**JS**	**11.04.13**
1.1	Submitted for review to the Audit and Governance Committee	JS	12.11.13
1.2	Amended following Audit and Governance Committee review	JS	21.11.13
2.0 Final	**Approved by the Governing Body**	**JS**	**16.1.14**
2.1	Proposed amendments submitted to Audit Committee for consideration	JS	22.1.15
2.2	Proposed amendments following Audit Committee	JS	23.1.15
3.0 FINAL	**Approved by the Governing Body**	**JS**	**09.4.15**
3.1	Proposed amendments following the Audit Committee Development Session Feb 2016	JS	20.09.16
3.2	Recommended to the Governing Body following the Audit Committee on the 30.09.2016	JS	04.10.16
4.0 FINAL	**Approved by the Governing Body**	**JS**	**13.10.16**
4.1	Amendments to CFO title and para.4.5 to ensure consistency across Committee ToR	**JS**	**25.05.17**
5.0 FINAL	**Approved by the Governing Body**	**JS**	**08.06.17**
5.1	Submitted for review to the Audit Committee	JS	18.01.18
5.2	Incorporated clarification wording to better align with the SoRD following recommendation from Audit Yorkshire	JS/ David Longstaff	29.03.18
6.0 FINAL	**Approved by the Governing Body**	**JS**	**12.04.18**
6.1	Submitted to the Audit Committee for review	JS	17.01.19
6.1	Submitted to the Governing Body for approval	JS	11.04.19
7.0 FINAL	**Approved by the Governing Body**	**AOC**	**11.04.18**
8.0 FINAL	**Change to membership agreed by Chair and CFO/DCO under urgent powers (Lay Advisor joining and Lay Member PPI attendance required).** **(Ratified by Governing Body on 23 April 2020)**	**AOC**	**18.02.20**
8.1	**Proposed amendment submitted to Audit Committee**	**AOC**	**27.02.20**
9.0 FINAL	**Approved by Governing Body**	**AOC**	**22.10.20**
9.1 Draft	**Minor amendments submitted to Audit Committee**	**AOC**	**25.02.21**
10. FINAL	**Approved by Governing Body**	**ZA**	**29.04.21**

Item 15a Appendix 3

NHS
Calderdale
Clinical Commissioning Group

Audit Committee Work Plan for 2020/21

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
	Annual Report						
1.	Receive Draft Head of Internal Audit Opinion			X	X		
2.	Receive final Head of Internal Audit Opinion	X				X	
3.	Review and approval of ARA prior to Chief Officer/CFO sign off	X				X	
4.	Receive ISA 260 (external audit)	X				X	
5.	CCG Management Representation Letter (ARA)	X				X	
	Internal Audit						
6.	Receive Internal Audit Operating Charter			X			
7.	Receive the Internal Audit Annual Report	X (Draft)	X (Final) *Final Received at **June's** meeting in 2020*		X (Draft)	X (Final)	

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
8.	Agree Internal Audit Work Plan			X	X		
9.	Receive/review Internal Audit Reports , in-year progress against work plan and progress on outstanding recommendations	X	X	X	X		
	Counter Fraud						
10.	Receive Approve Counter Fraud Work Plan	X			X		
11.	Receive Progress Report	X	X	X	X		
12.	Receive Counter Fraud Self-Assessment	X			X		
13.	Receive the Counter Fraud Annual Report	X					
14.	Receive and consider any external reports on Counter Fraud						X
	Local Security Management						
15.	Receive and agree Local Security Management work plan	X			-		
16.	Receive Progress Report	X	X	X	-		
17.	Receive risk assessment against standards for commissioners – security management				-		
18.	Receive the Local Security Management Annual Report	X			-		
	External Audit						
19.	Annual Audit letter following approval of the Annual Report and Accounts		X				

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
20.	Review of External Audit Work Plan for 2019/20.			X	X		
21.	Private meetings between Committee Members and Internal and External Audit	X[1]	X		X[2]		
	Risk Management						
22.	Receive assurance report on CCG Risk Management Process	X Annual Report	X (within the Governance Assurance Dashboard)		X Annual report		
23.	Receive assurance on the process for reviewing and approving the Governing Body Assurance Report *(via the Governance Assurance Dashboard)*		X	X			X
	Contracting Assurance						
24.	Receive contracting report including: – waivers – contract register by exception	X	X	X	X		
	Governance Assurance						
25.	Governance Assurance Dashboard	X	X	X	X		
	Information Governance – review the Annual Senior Information Risk Owner report	X			X		

[1] Meeting to take place prior to review of annual report and accounts so that any concerns can be raised

[2] Meeting to take place prior to review of annual report and accounts so that any concerns can be raised

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
	Information Governance – receive toolkit updates	X	X	X	X		
	Receive the Freedom of Information Request Annual Report	X			X		
	Receive exception reports on Freedom of Information Requests, Subject Access Requests, Conflicts of Interest Policy Breaches, Suspension of Standing Orders, Delegation of Authority, Standards of Business Conduct and Receipt of Gifts, Hospitality, Sponsorship						X
	Review exception reports on Application of the Seal						X
	Receive exception reports concerning RIDDOR reportable Health and Safety incidents						X
	Receive Assurance – approval of Updated Registers of Interest by Audit Committee Chair in their role as Conflict of Interest Guardian: 6 monthly - Governing Body and Cttes (GB1); SMT(1); Associates (A1) Annual – CCG members (CCG2), CCG staff (S1)	GB1 SMT1 A1	S1 CCG2	GB1 SMT1 A1	GB1 SMT1 A1		
26.	Review of Audit Committee Work Plan/progress in implementation of Work Plan	X	X	X	X		
27.	Review of draft work plan for 2020/21			X			

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
28.	Undertake self- assessment of effectiveness of Audit Committee, inc review of Audit Committee's attendance, terms of reference and work plan).			X			
29.	Review progress against actions/commitments arising from committee Self-Assessment		X				
30.	Receive annual reports from the other sub-committees including the auditor panel.	X			X		
31.	Produce Audit Committee Annual Report for Governing Body.	X			X		
32.	Annual Audit Committee development session.			X			
	Policies and procedures						
33.	EPRR Compliance and Action Plan Update		X Annual Report	X (within the Governance Assurance Report)			
34.	Bi-Annual Review of Standing Financial Instructions (Next Due September 2020)		X *Deferred to February 2021 in order to align with structural changes*				

No.	Item	18.06.20	24.09.20	25.02.21	20.05.21	10.06.21	As approp.
35.	Receive reports on any issues occurring regarding compliance with Standing Orders or Standing Financial Instructions						X
36.	Losses and Compensations						X
37.	Review of the CCG's Constitution						X
38.	Confidentiality & Data Protection Policy	X					
39.	Management of Conflicts of Interest Policy			X			
40.	Information Security Policy (Network Security)	X					
41.	Standing Financial Instructions *(And Prime Financial Polices)*		X				
42.	Local Security Management Policy and Procedures			X			
	Additional items in year relating to areas of potential high risk or priority						
43.	Receive assurance report on agreements for shared posts or services						X
44.	Update on collaborative commissioning arrangements (to include BCF, STP, MOUs)						X
45.	Mid-year review of internal audit performance		X				

NHS
Calderdale
Clinical Commissioning Group

MINUTES OF THE AUDIT COMMITTEE MEETING
HELD ON 20 MAY 2021, 2PM
VIDEO CONFERENCE

FINAL MINUTES

PRESENT:

Prof Peter Roberts (PR)	Lay Member (Audit) (Chair)
John Mallalieu (JM)	Lay Member (Finance and Performance)
Alison MacDonald (AM)	Lay Member (Patient and Public Involvement)
Denise Cheng-Carter (DCC)	Lay Advisor
Dr Farrukh Javid (FJ)	GP Member
Rob McSherry (RS)	Specialist Nurse
Dr Rob Atkinson (RA)	Secondary Care Specialist

IN ATTENDANCE:

Neil Smurthwaite (NS)	Chief Operating Officer
Lesley Stokey (LS)	Director of Finance
Jonathan Hodgson (JH)	Audit Manager, Audit Yorkshire
Gareth Mills (GM)	Director, Public Sector Audit, Grant Thornton UK LLP
Perminder Sethi (PS)	Director, Public Sector Audit, Grant Thornton UK LLP
Martin Pursey (MP)	Head of Contracting and Procurement
Rob Gibson (RG)	Corporate Systems Manager
Sam Byrnes (SB)	Senior IG Officer
Rosie Dickinson (RD)	Local Counter Fraud Specialist, Audit Yorkshire
Shaun Fleming (SP)	Local Security Management Specialist, Audit Yorkshire
Zoe Akesson (ZA)	Corporate Governance Officer (minutes)

CONTENTS

016/21 APOLOGIES FOR ABSENCE

There were no apologies received for the meeting.

017/21 DECLARATIONS OF INTEREST

In relation to the contacting report, JM made the Committee aware of the waivers within the report that he had signed-off, in case there was any challenge.

FJ made the Committee aware that his practice was mentioned in the report however the report was received for assurance and there were no decisions to be made.

In relation to the receipt of the annual reports for the sub-committees, if any decisions were required around this item the individual Chairs would not participate in the conversation.

The CCG's Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters by appointment.

018/21 MATTERS ARISING FROM THE MEETING HELD ON 25 FEBRUARY 2021

The minutes of the committee meeting on 25 February 2021 had been agreed by the Committee between meetings and submitted to the Governing Body for its assurance.

All actions were recorded as closed apart from **012/21** regarding additional training with internal /external audit, which derived from the committee's self-assessment discussion. The Chair asked that those who expressed a desire for specific training to notify ZA, the action was then closed.

019/21 AMENDMENTS TO THE MANAGEMENT OF CONFLICTS OF INTEREST POLICY

A summary of the amendments was detailed in the report.

An observation was made that it reflected previous conversations, the policy was now up-to-date and adjusted accordingly demonstrating the organisation learns from events and adapts its learning through making the appropriate policy changes.

The revised paragraph 5.2 'When To Make a Declaration' and the new limit on gifts would be communicated to GB members and staff accordingly.

DECISION: The Audit Committee APPROVED the revised Management of Conflicts of Interest Policy.

JH joined the meeting

020/21 CONTRACTING REPORT

The Contracting report, received by the Committee, provided information on waivers and a procurement activity update. The position of outstanding contracts was positive with only one waiver outstanding, which related to the extension of the Covid clinical assessment centre.

The consequence of only having one bidder for the Maternal Mental Health Service Pilot Scheme was raised. MP explained that an assessment would be carried out to check if it would be beneficial to go out again and expand the list of providers.

Recognition was given to the contracting team for the significant amount of work that had taken place to achieve the approval and sign-off of the large number of contracts.

The Audit Committee **RECEIVED** and **NOTED** for assurance the content of the report, appendices, and progress to date.

021/21 RISK MANAGEMENT ANNUAL REPORT 2020-21

The report provided a summary of key activities and development relating to risk management for the period 1 April 2020 to 31 March 2021. RG highlighted that although a review of risks took place during risk cycle 1 the register was not presented at committees due to the pandemic and the focus for committees at that

time was primarily decision making. RG highlighted that risks would continue to be managed appropriately up to transition to the ICS on 1 April 2022.

The Committee felt the report reflected the previous year and the challenge going forwards around the risk of transition to a new footprint. The Chair also asked that the accommodation move, which is also happening at the same time of transition, to be noted within the report.

The Committee **NOTED** the CCG Annual Risk Management Report as a supplement to the ongoing assurances on risk management received during the year and as evidence that the CCG is committed to continually reviewing and developing its risk management processes

022/21 GOVERNANCE ASSURANCE DASHBOARD

The dashboard was received by the Committee.

RA joined the meeting

RG brought the Committee's attention to point 1.3, relating to an Information Governance incident that was notifiable to the Information Commissioner's Office. It was recorded as human error and no further action was required on this occasion however RG explained there was a process in place to remind people to pay extra attention. The breach would also be disclosed in the CCG's Annual Report.

The Chair raised communication issues experienced with the IG trainers providing training materials.

ACTION: SB to feedback to the team.

The Audit Committee **NOTED** the content of the Governance Assurance Dashboard.

023/21 FREEDOM OF INFORMATION (FOI) ANNUAL REPORT 2020-21

The report provided the Committee with an overview of CCG activity and performance in relation to FOI requests received in 2020-21.

The Chair commented on the FOI request breaches. RG explained these were due to capacity in the Continuing Health Care (CHC) team however confirmed no complaints had arisen from these. The rationale for the breaches was questioned and the Committee asked for a formal management response on how the issue would be resolved.

ACTION: MP to raise FOI breaches with CHC colleagues and report back to Committee on how this will be resolved.

ACTION: JH to provide additional assurance through oversight of the review plan by Internal Audit at the next meeting.

An observation was made on how the data is presented and it was asked that this is displayed in a consistent format going forwards.

The Committee **RECEIVED** the report for assurance.

024/21 ANNUAL SENIOR INFORMATION RISK OWNER REPORT

The Audit Committee received for assurance the annual report which summarised the activities relating to information governance and information security risk management for the CCG for the period 1st April 2020 to 31st March 2021.

A point was made that the report didn't bring out enough of the challenges presented with home working during the pandemic. Reminding the Committee that this is a high-level report, SB described how these have been addressed through the IG staff survey, awareness work, incident monitoring and that this information has generated lessons learnt. SB would feedback comments to the team

The Audit Committee **RECEIVED** and were **ASSURED** with the content of the report.

025/21 ANNUAL REPORTS FROM SUB COMMITTEES

025/21 - a **Quality Finance and Performance Committee**

The report was received by the Committee and there were no further comments.

025/21 - b **Commissioning Primary Medical Services Committee**

The report reflected the Committee had made a strong contribution throughout the year. It had shown flexibility by instigating its urgent decision-making process to respond to funding requirements and service changes due to Covid. It was highlighted that managing the variety of conflicts of interest is always a continuous challenge for CPMSC and although sometimes complicated it was acknowledged the Committee always manages these smoothly and safely. There were no further comments.

025/21 - c **Remuneration and Nomination Committee**

The significant increase in volume and complexity in workload for this year was recognised. The report highlighted the Committee members contribution to dealing with these issues correctly and appropriately. There were no further comments.

The Audit Committee **RECEIVED** and were **ASSURED** with the sub-committees' annual reports.

026/21 AUDIT COMMITTEE DRAFT ANNUAL REPORT 2020-21

The draft Audit Committee Annual Report 2020-21 was received by the Committee for comment and approval before being received by the CCG's Governing Body in July. Comments and questions were invited. It was noted that the report should include the FOI breach that was reported to the ICO and the footnote on P248 to be amended to 2017.

DECISION: The Committee APPROVED the draft annual report subject to the above amendments.

027/21 AUDIT YORKSHIRE INTERNAL AUDIT REPORTS

027/21 - a **Draft Internal Audit Annual Report, featuring the Draft Head of Internal Audit Opinion**

The report provided assurance on the delivery of the audit programme, which was on track. With regards to the Accountable Officer review, JH was in the process of drafting and sharing a report with the relevant officers. A final position on the internal audit opinion would be provided at June's meeting however it was reported that the outcome of the audits, recommendations, response to Covid and the fundamental

core governance within the CCG have all been positive resulting in a draft Significant Overall Opinion.

The Committee **NOTED** the contents of the Draft Internal Audit Annual Report and Draft Head of Internal Audit Opinion and took assurance from compliance with the Public Sector Internal Audit Standards.

027/21 - b **Summary of Audits Since Last Audit Committee**

The report was received and noted. There were no further comments.

The Committee were **SATISFIED** with the summary of audits completed since the last Audit Committee.

027/21 - c **Draft Internal Audit Operational Plan 2021-22**

JH highlighted the key audit areas for the coming year, which were featured in the report. The document provided context for the reason for undertaking the proposed audits, including a robust analysis process to achieve the desired outcome of the programme, which had been discussed with the senior management team.

In relation to Governance, the Chair asked about postcode regrouping and impact on the wider system. JH agreed this would affect activity levels for delivery and would therefore include some narrative on this in the plan. A suggestion was made to include benchmarking data and consider comparable regions in relation to the ICS work. There were no further comments.

DECISION: The Committee AGREED the Internal Audit Operational Plan for 2021-22.

028/21 COUNTER FRAUD

028/21 - a **Progress Report**

In presenting the report, RD highlighted that the primary care counter fraud guidance had been revised providing clarity for GP practices if a person wants to register but has no proof of identification. **The Committee was satisfied with the content and would recommend to Governing Body that the guidance is circulated.**

The Committee **NOTED** the content of the report.

028/21 - b **Counter Fraud Self-Assessment**

A draft version of the proposed Counter Fraud Functional Standard Return to be submitted to the NHS Counter Fraud Authority (NHSCFA) by 31/05/21 was shared with the Committee for assurance. RD explained the key responses of the assessment verified the CCG's compliance with the new NHS requirements.

The Committee **NOTED** the content of the report.

028/21 - c **Counter Fraud Work Plan 2021-22**

The Committee received the draft Counter Fraud Work Plan 2021-22. Attention was drawn to the expectation to retain a resource allocation of 18 days and the new activities to achieve compliance against the new requirements.

DECISION: The Committee APPROVED the Counter Fraud work plan for 2021-22 subject to change if required.

028/21 - d **Violence Prevention and Reduction Proposal**

A proposal paper was presented to the Committee for assisting the CCG to achieve compliance with the NHS Violence Prevention and Reduction Standard. Audit Yorkshire's Local Security Management Specialist (LSMS) proposed 4 days of resourcing be allocated for the work to be carried out.

A short discussion followed around contractual requirements and cost. The Committee agreed to defer the item, as more clarity was required around the resourcing implications.

DECISION: The Committee DEFERRED the proposal for resourcing a Local Security Management Specialist.

029/21 EXTERNAL AUDIT

029/21 - a **Work Plan 2021-22**

The Committee received the work plan for 2021-22. In presenting the plan, GM highlighted the significant risk of management overriding control, giving potential to manipulate figures using judgment and estimates. Considering this, the finance team

has carried out a piece of work on accounting estimates, which will be shared with the Committee at June's meeting.

It was noted the National Audit Office has decoupled the Vale For Money (VFM) work from the accounts this year due to it being a new assessment and also due to a significant backlog of Local Authority audits that have been carried over to 2021. GM would share the details with LS in July and then circulate to members of the Committee before presenting formally at October's Committee.
With the transition to ICS and emphasis being on place, the Chair asked about opportunities to internalise and promote multiplier effects in relation to VFM. GM offered to pick up conversations with teams on specific areas/organisations they are engaged with and link into the VFM work on how this has enhanced the arrangements the CCG already has in place.

The Committee **NOTED** the content of the report.

029/21 - b **2019/20 Mental Health Investment Standard Compliance**

The report was received for information. It was noted that NHSE had revised the CCG's baseline number and the CCG achieved the Mental Health Investments Standard (MHIS) compliance target by £1m.
LS emphasised the CCG has committed to meet the MHIS and actively planned every year to deliver significant investments into mental health.

The Committee was **ASSURED** with the compliance.

030/21 AUDIT COMMITTEE WORK PLAN 2021-22

The Committee received the work plan. A request was made to include an update on the ICS transition, which would include any risks around the CCG's formal governance and committees in place post March 2022.
ACTION: ZA to add ICS transition to the workplan.

The Committee **RECEIVED** the Audit Committee work plan for 2021-22.

031/21 ITEMS FOR GOVERNING BODY AND/OR OTHER SUB-COMMITTEES

The Committee agreed the following items for Governing Body:

- To receive the updated Conflict of Interest policy
- To receive the annual reports from the Audit Committee and sub-committees.
- To inform about the internal / external audit work, including the circulation of the counter fraud guidance to member practices and the update to the agreed committee workplan on white paper implications.

032/21 ANNUAL ACCOUNTS AND ANNUAL REPORT 2020-21

The draft accounts and annual report were circulated to the Senior Management Team and Governing Body for comment by 26 May 2021.

033/21 REFLECTIONS ON THE MEETING

The Committee was satisfied with how the meeting's business had been transacted.

034/21 DATE AND TIME OF NEXT MEETINGS

- **10 June 2021 (1pm)**

- Pre-meeting of the Committee Members and CCG Managers (12.00pm)
- Private Meeting of Committee Members and Auditors (12.15pm)
- Audit Committee Sign-off of Annual Report and Accounts Meeting (1.00pm)

- **14 October 2021 (2pm)**

- Pre-meeting of Committee Members and CCG Managers (1.45pm)
- Committee Meeting (2.00pm)

NHS
Calderdale
Clinical Commissioning Group

MINUTES OF THE AUDIT COMMITTEE MEETING
HELD ON 10 JUNE 2021, 2PM
VIDEO CONFERENCE

FINAL MINUTES

PRESENT:

Prof Peter Roberts (PR)	Lay Member (Audit) (Chair)
John Mallalieu (JM)	Lay Member (Finance and Performance)
Denise Cheng-Carter (DCC)	Lay Advisor
Dr Farrukh Javid (FJ)	GP Member
Rob McSherry (RS)	Specialist Nurse
Dr Rob Atkinson (RA)	Secondary Care Specialist

IN ATTENDANCE:

Neil Smurthwaite (NS)	Chief Operating Officer / Chief Finance Officer
Lesley Stokey (LS)	Director of Finance
Martin Pursey (MP)	Head of Contracting and Procurement
Jonathan Hodgson (JH)	Audit Manager, Audit Yorkshire
Helen Kemp Taylor (HT)	Head of Internal Audit, Audit Yorkshire
Rosie Dickinson (RD)	Local Counter Fraud Specialist, Audit Yorkshire
Perminder Sethi (PS)	Director, Public Sector Audit, Grant Thornton UK LLP
Zoe Akesson (ZA)	Corporate Governance Officer (minutes)

035/21 APOLOGIES FOR ABSENCE

Alison MacDonald and Gareth Mills

036/21 DECLARATIONS OF INTEREST

There were no interests declared.

The CCG's Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters by appointment.

037/21 MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 20 MAY 2021

DECISION: The minutes of the committee meeting held on 20 May 2021 were **AGREED** as an accurate record of the meeting.

038/21 MATTERS ARISING FROM THE MEETING HELD ON 20 MAY 2021

There was nothing further to raise.

039/21 INTERNAL AUDIT

039/21-a CCG's Internal Audit Annual Report 2020-21

The final internal audit annual report was received by the Committee and it was advised the team had completed their revised programme of work. It was highlighted that the CCG met 3 out of 4 KPIs and only missed 1 target by 15 days for a draft report, which was extremely pleasing considering the challenges of working remotely.

039/21-b Final Head of Internal Audit Opinion

The overall opinion issued was **SIGNIFICANT ASSURANCE**, which indicated a good system of internal control and risk management in place.

The assurance and risk management frameworks were fit for purpose and provided regular Covid updates to the CCG, evidencing the CCG had maintained and monitored flexibility and there were no significant control weaknesses reported.
It was acknowledged the report reflected a good working relationship with internal audit and the Chair thanked Audit Yorkshire for their exemplary and comprehensive work under the current operating conditions. The Chair thanked HK for her objectivity and support, wished her well in retirement.

The Audit Committee **NOTED** the contents of the Internal Audit Annual Report and Head of Internal Audit Opinion and took assurance from compliance with the Public Sector Internal Audit Standards.

039/21-c Counter Fraud Annual Report 2020/21 (including Self Review Tool)

The report provided an overview of the counter fraud work completed 2020-21, attention was drawn to the following points:

- the report provided a summary of the responses given to the counter fraud functional standard return, which were reviewed at the previous meeting.
- the 'inform and involve' work went electronic enabling the team to send newsletters electronically.
- the majority of fraud alerts were cyber related. Refresher training took place last year and there was coverage in the newsletters.
- there was only 1 referral received but rates are now starting to return to normal. The referral related to personal health budgets, although there was no sufficient evidence to progress as a criminal case, steps have been taken to prevent any recurrence.

The Audit Committee accepted the Counter Fraud Annual Report 2020/21 for assurance purposes and **NOTED** its contents.

040/21 2020-21 AUDIT FINDINGS (ISA260) REPORT

The Committee received the report that set out the findings from external auditors Grant Thornton. PS talked the Committee through the report in order to compensate for the very late circulation of the paper, which prevented detailed scrutiny of all elements by some members of the committee. The auditors' work was largely complete, however there were some final sampling queries still outstanding and final checks to ensure all changes agreed have been processed.

- There was an issue relating to a reverse accrual (unadjusted misstatement). This had been investigated and it appeared to be an error. If adjusted, it would result in the CCG's surplus of £47k moving to a deficit of £550k. The issue was raised with management, however management felt the item was immaterial and proposing not to adjust the accounts.

- The deadline for submission of the Auditor's Annual Report is 20 September 2021, although Grant Thornton is planning on reporting back to the CCG by the end of August.
- There was no change to the planning material identified in the audit on receipt of the draft accounts.
- There were no irregularity issues with regards to the annual and governance reports.
- There was no significant weakness identified in relation to Value for Money
- 2 recommendations were made to management by Grant Thornton - to declutter the accounts, which had been actioned, and the suggestion that the draft annual governance statement, annual report and accounts were formally presented to the Audit Committee as working drafts.

With regards to the unadjusted misstatement, LS reiterated this was not a material value and recommended to the Committee not adjusting the year end accounts, as there would be no benefit in putting the CCG into deficit and for it to be corrected in this year's balance sheet. LS had discussed the unadjusted misstatement with the Chief Finance Officer who agreed with her recommendation. The Committee was assured with this explanation and recommendation.

The Audit Committee **RECEIVED** and **NOTED** the contents of the report for assurance.

041/21 LETTER OF REPRESENTATION ON THE ACCOUNTS

The draft letter was received by the Committee. LS informed that an amendment would be made to paragraph 12 based on the agreement reached on the unadjusted misstatement. The paragraph would be amended to read:
"*We have considered the misclassification and disclosure changes schedules included in your audit findings report. The CCG financial statements have been amended for these misclassifications and disclosure changes and are free of material misstatements including omissions".*

DECISION: The Audit Committee **AGREED** with the management's amendment to the letter.

042/21 CCG'S ANNUAL REPORT AND ACCOUNTS 2020/21

The final annual report and accounts were received by the Committee for approval and submission to NHS England by the 15 June 2021.

Thanks were given to Corinne McDonald who compiled this year's report. The Committee was impressed by the way the report had been put together and the process around providing a good opportunity to engage and respond to its content.

PR asked for an amendment to be made to the Annual Report on page 111 under 'Working Sustainably' and suggested it be reworded to reflect how the CCG is working collaboratively with CMBC and ICS through their climate committees. LS confirmed the report would be updated before submission.

The Annual Accounts were discussed. There were 2 changes from the draft set:

1) Page 17 note 5, there was a minor change to the external audit fee, which was split into 2 parts but no issues to the bottom line.
2) Page 21 note 10, there was a negative balance in relation to the cash book which showed as a negative in current assets. This was an uncleared BACS run and has since been correctly labelled as a bank o/draft. A reference was made to this in note12.

The Committee confirmed that it had:

1) reviewed the Annual Report and the self-certification statements contained within it: page 75 - Modern Slavery Act; pages 76-77 - the statement made by Robin Tuddenham as Accountable Officer,
2) reviewed the Governance Statement,
3) reviewed the Head of Internal Audit Opinion,
4) reviewed the accounts in detail,
5) reviewed the External Audit consideration of the accounts including their opinion and letter of representation,
6) and considered any non-adjusted misstatements, what they were and the Committee's view on these.

In reviewing the above, the Committee felt there was nothing further to escalate to Governing Body.

The Committee concluded that it was happy, in principle, to accept the annual report and accounts and approve them subject to the caveat that members may need to reconvene as a committee should something materialise in the final stages of Grant Thornton's work. PS reaffirmed to the Committee that, at this stage, based on the

work undertaken so far, there were no material items to bring to the Committee's attention. The Committee identified a potential time for the meeting if required.

DECISION: The Audit Committee **APPROVED,** with the above caveat, the Annual Report and Accounts for signature by the Accountable Officer and prior to the submission of the full audited and signed Annual Report and Accounts and full copy of the Head of Internal Audit Opinion to NHS England by the 15 June 2021.

044/21 DATE AND TIME OF NEXT MEETING

14 October 2021

- Pre-meeting of Committee Members and CCG Managers **(1.45pm)**
- Committee Meeting **(2.00pm)**

FINAL MINUTES OF THE
QUALITY, FINANCE AND PERFORMANCE COMMITTEE
24 JUNE 2021
VIA MS TEAMS

PRESENT:

Dr Farrukh Javid (FJ)	Chair, GP Governing Body Member, Calderdale CCG
Lesley Stokey (LS)	Director of Finance
Penny Woodhead (PW)	Chief Quality and Nursing Officer
John Mallalieu (JM)	Lay Member (Finance)
Alison MacDonald (AM)	Lay Member (Patient & Public Involvement)
Rob McSherry (RMcS)	Registered Nurse

IN ATTENDANCE:

Martin Pursey (MP)	Head of Contracting and Procurement
Debbie Winder (DW)	Head of Quality
Tim Shields (TS)	Performance Manager
Emma Bownas (EB)	Senior Primary Care Quality and Improvement Manager (Representing Debbie Robinson)
Zoe Akesson (ZA)	Corporate Governance Officer (minute taker)

PRESENTERS:

Luke Turnbull (LT)	Designated Nurse Safeguarding Adults (item 5)
Louise Fletcher (LF)	Designated Nurse for Safeguarding Children, Children Looked After & Care Leavers (item 5)
Rhona Radley (RR)	Deputy Head of Service Improvement (item 6)
Stella Johnson (SJ)	Research Manager, Bradford CCG (item 7)
Clare Robinson (CR)	Head of Nursing and Safeguarding (item 8)
Lucy Walker (LW)	Quality Manager (item 9)
Andrew Bottomley (AB)	Programme Manager, Service Improvement (item 11)
Rob Gibson (RG)	Corporate Systems Manager (item 13)

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021/21 APOLOGIES FOR ABSENCE

Apologies were received from Neil Smurthwaite and Dr Caroline Taylor.

022/21 DECLARATIONS OF INTEREST

There were no declarations of interest relevant to items on the agenda. **The Register of Interests can be obtained from the CCG's website** or from the CCG's headquarters.

023/21 MINUTES OF THE LAST MEETING

The minutes of the last meeting held **on 25 March 2021** were approved electronically and received by the Governing Body at their April meeting.

The minutes of the meeting were **RECEIVED** and **ACCEPTED** as an accurate record.

024/21 MATTERS ARISING / ACTION LOG

The action log was reviewed. All actions were recorded as complete. .

At this point, the order of the agenda was changed slightly, and the procurement policy and finance report were swapped due to MP's late arrival.

025/21 FINANCE REPORT

The key messages from the report included the sign-off and submission of the accounts for 2020-21, resulting in a positive result of an **unqualified audit opinion**. The report reconfirmed the H1 plan and allocation growth, which had several commitments against it. The CCG submitted a balanced plan although there would be challenges to deliver. It was noted there was a new commitment for this year of a 0.5% contingency and the CCG was planning to deliver the Mental Health Investment Standard 2021-22. The CCG's QIPP target for H1 is £2m. Well-developed plans in CHC and Prescribing would help deliver £0.5m of this and the remaining £1.5m would be met through the 0.5% contingency and other methods such as non-recurrent slippage and underspends carried forward from last year.

In relation to forecasting, there hadn't been much activity information received to date. Acute contracts continue to be on a block contract and there would be some additional

allocation for the independent sector contracts. The CCG's biggest overspend related to costs incurred outside of the baseline that must be claimed back, mainly in relation to the Hospital Discharge Programme, but this would show a balanced position once costs are claimed back from NHSE. Contingency may be required to cover any additional costs such as last year's significant overspend on specific drugs, but it was hoped this will be contained within the 2% uplift given in budget setting. The CCG was still awaiting information on H2.

A concern was raised from the Committee around meeting the remaining QIPP target of £1.5m for H1 in such a short timescale. LS assured the Committee that the CCG would be able to manage non-recurrently and would be mindful when committing to recurrent investment decisions going forwards.

In relation to a question on running costs and the impact of using vacancies to offset costs, LS explained this would not entail a vacancy freeze but would be through natural recruitment savings.

The Committee **NOTED** the forecast and the expected mitigating allocations, the financial plan for H1, QIPP requirement, risks, and mitigations.

026/21 JOINT SAFEGUARDING CHILDREN AND ADULTS QUARTERLY REPORT: Q3 & 4 2020-21

The report was taken as read. It was highlighted there had been a marked improvement in safeguarding training compliance across the organisation. The team was working on putting the safeguarding policies into accessible format whilst revising where appropriate at the same time. The refreshed Domestic Abuse and Prevent Policy would be presented at September's Committee meeting. The team continued to work collaboratively on an Integrated Care System (ICS) footprint and have developed a set of safeguarding standards that will be used across the ICS with commissioned providers. The report also contained a summary of the new Domestic Abuse Act 2021. Funding has been received by the Local Authority and Calderdale's Domestic Abuse Strategic Board is commissioning a needs assessment to ensure the money is spent effectively and to fulfil its obligations under the new act.

LF informed the Committee that due to an outstanding piece of work, the child death review service specification had been deferred to September's meeting. ICON phase 2 was launched in February 2021 with the wider partnership, which is proving successful. It was brought to the Committee's attention that there were currently vacancies in the Children Looked After Team including a named nurse however the Committee was assured that there was appropriate line management in place in the interim and through a member of the team increasing their hours the urgent work would be covered.

PW expressed thanks to the Safeguarding Team for their continued work to support the arrangements for the ICS

JM asked for 2 pieces of information for the next report: an update on the impact of the ICON work and an understanding of the learning from the new Domestic Abuse policy and act in terms of commissioning intentions and future funding.

The Committee **RECEIVED** and **NOTED** the report and was **ASSURED** the CCG is fully engaged in safeguarding arrangements.

027/21 BURNT BRIDGES REPORT: LEARNING AND ACTION

The Committee received a paper on the key learning from a safeguarding adult review into the deaths of 5 men in winter 2018-19, who lived street-based lives in Calderdale. The report, which was also discussed at the CCG's Governing Body development session on 10/06/21, had recommendations and actions for all agencies. Although there would be a systematic action plan, the CCG has specific actions as healthcare commissioners, which were outlined in the draft action plan within the paper.

The challenge around the action on **dual diagnosis** was raised. PW questioned the approach to this action and to consider partners.

Concern was expressed around the **timeframe** set by the Safeguarding Board for the **trauma induced training**. LT confirmed the team recognised the need to do this sooner

and was currently looking at designing different levels of training for primacy care before the end of March 2022.

There was a recognition that Primary Care needs to work differently to reach people with street-based lives and to gain a better understanding of how **access** works for these people. JM offered his expertise in this area.

The Committee approved the draft action plan recognising this was a live document. Offers of support from committee members were received and it was proposed that the Quality Finance and Performance Committee would monitor and govern the action plan on a quarterly basis. A discussion would be required around the structure of the Governing Body conversation for July's public meeting.

DECISION: The Committee **NOTED** the actions required by Calderdale Clinical Commissioning Group in response to the recommendations made in the Burnt Bridges Safeguarding Adult Review.
The Committee **APPROVED** the draft Action Plan and **AGREED** the proposed process to monitor delivery against the Action Plan will be through Quality, Finance and Performance Committee.

028/21 RESEARCH ANNUAL REPORT 2020-21

The report provided a description of the work West Yorkshire Research and Development team had undertaken in delivering a research service on behalf of and in collaboration with the CCG, ensuring it had met its statutory obligations with regards to research.

Learning from research over the last 12 months was raised. It was evident there was a willingness amongst Calderdale Primary Care colleagues to take part in research. With the opportunity to work differently as an Integrated Care Partnership (ICP), PW agreed to take a conversation into the local design group around delivery of the research function in the CIP / ICS. **ACTION: PW to take a conversation into the local ICP design group.**

The Committee **ACCEPTED** the report as a summary of research activities for 2020-21 and was **ASSURED** that their statutory obligations in terms of research have been met.

029/21 LeDeR PROGRAMME ANNUAL REPORT: APRIL 2020 - MARCH 2021

This year's report provided an overview of the programme, assurance around governance and 4 patient stories. There was more detailed analysis on local findings but there was further work to do to gain a better understanding on how the CCG compares nationally. Clearing the backlog of LeDeR reviews was a challenge due to no dedicated resource however with help from providers the CCG was now on target. There is a new NHSE policy to be implemented by April 2022 however the team has already started work on the future programme, working on quality improvement and embedding in local practice. It was also noted that the new national LeDeR policy is recommending an ICS approach moving forward and dedicated resource.

A suggestion was made to strengthen the executive summary by mentioning the learning from local cases and the strategic actions consequently taken.

An observation was made around the balance of the report and how it was strengthened by the improvement activity that had taken place, and the positive stories in relation to the actions and assurance on process. For example, the national mandate around CCG Chief Nurses to ensure all staff in care homes were trained in IPC had equipped care staff with basic skills, empowering them to better look after the people they care for. The approach of the quality team now is to progress this in an integrated way to support care homes and develop a quality charter as part of the Integrated Quality Care Strategy.

DECISION: The Committee **RECEIVED** the report and **CONFIRMED** it was assured the CCG was engaged with the LEDER programme. Subject to the suggestion discussed, the Committee **APPROVED** the annual report for publication on the CCG website.

030/21 QUALITY AND SAFETY REPORT & DASHBOARD

The Committee received the Quality and Safety update, which provided assurance on the CCG's main providers, highlighting the following key points:

- Changes to Parliamentary Health Service Ombudsman (PHSO) processes
- West Yorkshire Urgent Care/Local Care Direct Care Quality Commission (CQC) inspection report
- National Quality Board Position Statement - managing risks and improving quality through integrated care systems
- Serious Incidents Quarters 3 and 4 2020-21
- National Staff Survey - provider results and response

PW commented on the national quality board publication, describing how the quality team is working through the implications for our ICP development and how most of the commitments will be delivered at place. Future ideas will be shared at a Governing Body development session, but the team will maintain strong quality surveillance and improvement mechanisms at place to support the ICS oversight.
A national quality dashboard will be published in the next few months along with revised guidance on how to conduct risk summits and quality review conversations with providers as part of the ICS.

An observation was made around CHFT's maternity dashboard and the rise in the number of still births. Head of Quality was satisfied there were no concerns around the care. The Head of Midwifery provided a very prompt update and the processes used to review them. The Chair asked for more detail in the next paper to Committee.

The Committee **RECEIVED** and **NOTED** the update.

031/21 PROCUREMENT POLICY

Following review, the policy was updated to reflect the UK exit from the European Union and the changes to the public contract regulations. Also, the recommendation from internal audit to make more direct reference in relation to primary medical services and the processes set out in the guidance manual by NHSE. Although there were no material changes at this point, it was recognised a further revision may be required later this year following the consultation and the possibility of a provider selector regime.

DECISION: The Committee **APPROVED** the revised Procurement Policy.

032/21 CONTRACTING REPORT FOR MONTH 12 2020/21 AND MONTH 1 2021/22

In presenting the report, the following key issues were highlighted:

- Development of the elective recovery and arrangements with the independent sector - the contracting team is working with CHFT looking at the requirements of elective services and where capacity could be sourced.
- Calderdale holds the lead contract for the WY Patient Transport Service. A request for the extension of the contract has been done through a VEET notice.
- Designated Covid beds contract was a collaborative piece of work across Calderdale, Kirklees and Wakefield CCGS and 3 local authorities.

PW asked for assurance on the plans to reduce the current waiting lists for ADHD/ASD and other neuro-development pathways.

ACTION: MP to provide the Committee with an update on trajectories/plans to reduce the waiting lists at the next meeting

The Committee **NOTED** the content of the report.

033/22 PERFORMANCE REPORT

In presenting the report, the Committee's attention was drawn to the following points:

- Work continues to restore access levels. People are now returning to all routine services, which is putting pressure on the whole system. It is a major area of focus at the Urgent and Emergency Care Board where regular discussions take place with system colleagues.
- A significant increase is being reported in A&E attendances. Although CHFT's performance is below the national standard, national benchmarking shows performance remains strong.
- Elective Care is a challenge for Calderdale and all efforts are being made to increase capacity. Long waits continue to increase, and the elective care improvement group is focusing their work on the specialities with the largest backlog.
- Cancer waiting times performance remains strong
- Work remains focussed on increasing access to mental health services.

In relation to the waiting times for eating disorders, PW commented as we become part of an ICS system, although numbers are small, the organisation will be more involved in decision making on placement and bed availability. A regional task and finish group is to be set up and PW is currently establishing who will be representing West Yorkshire and reporting back into place.

The performance on SMI physical health checks was raised. PW recommended for this to be a priority indicator on the new local CPMS dashboard. JM concurred.
ACTION: ZA to add SMI health checks to the next CPMSC agenda

In relation to elective recovery and the position with activity, AB assured the Committee that Service Improvement are supporting CHFT identifying AQPs to bring in additional capacity and move patients using the increasing capacity framework. This was also discussed in detail at SMT 29/06/21.

The Committee was **NOTED** 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.

034/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 2 2021 - 2022 (17 MAY - 2 JUNE 2021)

There were 33 risks for consideration, 3 of which were critical. There were 4 new risks, R1865 and R1866 were closed and reopened again for this financial year. R1864 is around ensuring people with current mental health needs are receiving the correct level of support and capacity within the community team.
Not included in the paper were 2 new risks around transition to the ICS. The Committee recommended these be picked up by SMT in the next risk cycle

DECISION: The Committee **REVIEWED** and **APPROVED** the Risk Register for reporting to Governing Body.

035/21 WORK PLAN

The workplan for 2021-22 was received and noted.

036/21 MINUTES AND HIGHLIGHT REPORTS FOR ASSURANCE:

There were no comments on the following minutes received for information:

a) Urgent and Emergency Care Board Highlight Report 08/06/21
b) Integrated Commissioning Executive Highlight Report 12/02/21, 23/04/21
c) Partnership Transformation Board 28/04/21
d) Medicines Advisory Group 27/05/21

037/21 MATTERS FOR THE:

a) Governing Body - routine assurance papers, burnt bridges
b) Senior Management Team - 2 new risks around transition
c) Partnership Transformation Board - NA
d) Local Medical Committee - NA
e) Commissioning Primary Medical Services Committee - SMI physical health checks – focus for local dashboard

038/21 PATIENT EXPERIENCE ANNUAL REPORT 2020 - 2021

The report was received for information.

039/21 COMPLAINTS ANNUAL REPORT 2020 - 2021

The report was received for information on this occasion due to time constraint on the agenda. There is a requirement the report is received by Governing Body; PW explained a decision was taken at agenda setting to receive the report for information and for any comments to be directed to the report author. The Committee agreed this was a sensible decision.

040/21 DATE AND TIME OF NEXT MEETING

The next meeting will be held on **Thursday 23 September 2021, 2.00pm**

Quality Finance and Performance Committee Action Log 2020-21 (wef 24/06/21)

Report Title	Minute No	Action Required	Lead	Comments	Status
Contracting Report	012/21	To circulate feedback to the committee on the telehealth market test.	MP	Referenced in the procurement report. Received a healthy response, when reviewed wouldn't recommission the service, which then expired as intended.	**CLOSED**
Committee Annual Report 2020-21	015/21	To amend to draft Annual Report to reflect the comments made, grammatical tidying and include the committee self-assessment discussion.	ZA	Submitted to Audit Committee 20/05/21	**CLOSED**
Research Annual Report 2020-21	028/21	To take a conversation into the local ICP design group around delivery of the research function in the ICP/ICS.	PW		**OPEN**
Contracting Report	032/21	To provide the Committee with an update on trajectories/plans to reduce the ADHD/ASD waiting lists at the next meeting.	MP		**OPEN**
Performance Report	033/21	To add SMI health checks to the next CPMSC agenda	ZA		**OPEN**

FINAL MINUTES OF CALDERDALE
COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE
27TH MAY 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)
Neil Smurthwaite (NS)	Chief Operating Officer
Lesley Stokey (LS)	Director of Finance
Dr James Gray (JG)	GP Governing Body Member
Dr Steven Cleasby (SC)	GP Governing Body Member, Calderdale CCG Chair
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Penny Woodhead (PW)	Chief Quality and Nursing Officer
Debbie Robinson (DR)	Head of Primary Care, Quality and Improvement
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
Cllr Tim Swift (TS)	Representative of Calderdale Health & Wellbeing Board
Suzanne Howarth (SH)	Contracts Officer (Item 7)
Rob Gibson (RG)	Corporate Systems Manager (Item 8&9)
Zoe Akesson (ZA)	Governance Support Officer (minute taker)

Members of the public were not in attendance

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30/21 APOLOGIES FOR ABSENCE

Alison Macdonald

31/21 DECLARATIONS OF INTEREST

SC and JG declared a **direct financial and professional interest** in item 5, Head of Primary Care (HOPC) report. The Chair proposed, as no decisions were to be made, the GPs were involved in the whole item but for the conversation to remain generic at a commissioner level rather than from an individual provider perspective.

SC and JG declared an **indirect financial and professional interest** in item 6, Quality Assurance and Monitoring Process for General Practice. It was agreed the GPs input into the first part of the paper around formalising the process would be helpful and the Chair welcomed them to take part in the discussion. The second part involved a decision on creating a work group to monitor the process in the practices. The Chair welcomed the GPs to be involved in the discussion but would not be asked for an opinion and would be asked to leave before the decision.

SC and JG declared a **direct financial interest** in item 11, the Finance report. It was proposed the GPs would not partake in this item and would be asked to leave, as it involved the approval of a plan from which their practices are being paid.

SC and JG declared a **direct professional interest** in the private item 15, Potential Surgery Branch Closure. Cllr Swift also declared a **professional interest** in this item, as the practice sits within Cllr Swift's ward. The conflicted members did not receive the paper nor attend the private meeting.

The Committee members agreed to the conflicts being managed in this way.

32/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

33/21 MINUTES OF THE LAST MEETING

The Committee received the minutes of the last meeting on 4th March 2021, which had been agreed by the Committee between meetings and submitted to the

Governing Body for its assurance. A small amendment was made to item 22/21 (page 4), the sentence should read *'taking a broader view around health **and** care services.*

34/21 MATTERS ARISING

The action log was reviewed. The 2 outstanding actions were covered in this month's HOPC report. All actions were recorded as complete.

35/21 HEAD OF PRIMARY CARE REPORT

In presenting the report, DR highlighted the following key pieces of work:

The Standard Operating Procedure (SOP) to support the restoration of General Practice was updated by NHS England on the 17th May 2021 and shared with all practices. The CCG would work with the Clinical Lead for Primary Care and the Local Medical Committee to agree a reasonable process for gaining assurance from all providers of primary medical services in Calderdale that they are meeting the requirements of the SOP. It was highlighted that although Primary Care is extremely busy and all areas of urgent care is under extreme pressure, the level of people receiving access is higher than before. The Committee recognised the vital role of communication in explaining the current demands on the system whilst developing a service that best meets the needs of patient safety.

The report provided an update on the **learning disability health checks** and information about the organisations intentions for matching its outcome from last year of 81% of people with a learning disability having had a health check and completed their health action plan. The Committee was reminded that last year when achievement was high, they challenged the Primary Care team with addressing the quality of health checks. This year patient determined outcome is a key priority and the team is looking at people with lived experience who can tell their story of the impact of their health plans.

The Committee was asked to note the **Digitisation of Lloyd George Records programme**, which is currently paused nationally. There is a key piece of data

mapping work underway to understand the picture of Calderdale's general practice appointments compared to the national picture.

Within the report, there was an ask to **delegate the approval of the detail of the PCN development plan and its associated investment to the CCG's Senior Management Team (SMT).** The Committee was reminded that it had previously approved investment for PCN development support and a discussion had taken place on the type of activities within the plan. The Committee felt that it would only delay the process if it insisted on convening to approve when senior managers could do this within their delegated authority.

DECISION: The Committee **AGREED** to delegate the approval of the PCN development plan to the CCGs Senior Management Team within the agreed financial mandate.

Penny Woodhead arrived

The report focused on some key pieces of work relating to the development of Primary Care estates. The Committee was asked to consider receiving the **draft Estates Strategy document**, as part of a committee development session. The Committee agreed with this approach.

ACTION: DR to share the draft Estates Strategy document at the next CPMSC development session

The Committee was also reminded that shelters and outside space is a key matter for all practices and services going forwards and that it needs to be brought into consideration as soon as possible for patients waiting outside for their appointments.

The Committee **AGREED** with the approach of receiving the Draft Estates Strategy at a future Committee development session.

The final section of the report focussed on the need to procure some **interim phlebotomy capacity.** The Committee was asked to note that any decision to award a contract would be presented to the Committee for approval but due to the timing of the meetings it may be necessary to ask the Chair to convene an additional

meeting. The Committee agreed with the arrangement, the Chair also reminded the Committee of the rapid decision-making process in place.

The Committee **NOTED** the contents of the report.

36/21 QUALITY ASSURANCE AND MONITORING PROCESS FOR GENERAL PRACTICE

A report proposing a quality assurance process for General Practice in Calderdale was presented to the Committee for approval. It described the delegated duties of commissioners, a formal process for discharging these along with the request to develop a local dashboard.

The Chair reminded the Committee that the GP participation in the discussion would be helpful, but they would not be required to vote.

Comments and questions were invited, and the following points were noted:

- The Committee was assured this was a supportive approach, reinforced by the support of the Local Medical Committee (LMC).
- Practice engagement and communications were key factors and would happen through the LMC and Calderdale Practice Managers Group.
- Practices to consider additional PCN support around parts of the process.
- DR clarified this approach was in line with other CCGs across West Yorkshire and had been used for other formal decisions that have been made in this committee in relation to practices. There will be an effective national dashboard at some point, but clinical involvement will be required for designing the key clinical indicators.

  ACTION: DR to present a first draft of the local dashboard at the next Committee.

The Committee **NOTED** the content of the paper.

DECISIONS: The Committee **APPROVED** the quality assurance and monitoring process. The Committee **WELCOMED** and **AGREED** to the development of a local dashboard which will be presented to the August meeting of the Committee for approval.

37/21 CONTRACTING UPDATE

Attention was drawn to the following key points of the report:

- an option is now available for PCNs to follow an incorporation process, there is a toolkit available to guide CCGs and PCNs through the required process.
- the CCG has made a direct award contract to Engage Consult, who provide the GP online consultation software for 9 months, reflecting those practices that are now using this solution.
- national contract variations have been issued to practices.
- the CCG has made direct awards for the continuation of GP community services contracts, which have been distributed to practices for signature.
- A further direct award for the Pennine GP Alliance extended access contract to take it to March 2022, final stages of contract.
- Station Road Rd and Caritas practices have asked for an application for PCN incorporation. The contracting team is currently working through the applications, which will be brought to committee for decision.

A question was raised around the purpose of PCN incorporation and accountability. NS explained that no organisation has overall accountability. The incorporation is an opportunity for practices to partner up, encouraging more joined up working to deliver the enhanced services, which then enables them to hold NHS contracts and become more accountable.

The Committee **NOTED** and was **ASSURED** with the contents of the report

38/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 1 2021-22 (15 FEBRUARY - 3 MARCH 2021)

RG presented the risk register position statement summary for cycle 1 2021-22 of which there were 6 risks for consideration. RG highlighted R1628 around losing the funding for the additional role reimbursement scheme score had increased from 8 to 12. A new risk R1734 had been added to the register, which was scored at 16 around the risk of harm to patients relating to the backlog of work post Covid. There was a challenge from the Committee around the score of R1734 and the consistency of risk reporting in relation to the different care pathway pressures.

ACTION: EB to redefine R1734 and to re-look at the score. EB to complete critical risk template and re-share definition and score with committee before next meeting in August.

Going forwards, RG agreed to inform the Committee in between meetings of any new risks that score 15+.

The Committee was **ASSURED** with 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 2, subject to the revision of R1734.

39/21 RISK REGISTER SUMMARY ANNUAL REPORT 2020-21

The report was received by the Committee, who felt it reflected the risk activity for the last year. There were no further comments.

The Committee was **ASSURED** that the Risk Register represented a fair reflection of the risk activity relating to the commissioning of primary medical services being experienced by the CCG during 2020-21.

40/21 REVIEW OF WORK PLAN

The Committee members received the workplan and were satisfied with the content.

JG and SC left the meeting

41/21 FINANCE REPORT

In presenting the report, LS drew the Committee's attention to the following:

- In 2020-21 the delegated CPSMC budget delivered a balanced plan.
- The accounts were currently being audited for final submission on 15/06/21.
- This year's additional roles allocation is £2.8m, which is a significant increase on last year's budget. Due to not spending all last year's allocation it will leave £1.6m more to spend this year. Taking this into consideration, finance and

primary care teams are working with PCNs, providing them with better forecasting and planning to gain a better position on spend on additional roles and trying to maximise this budget. A short discussion followed on the difficulty finding workforce to fill the additional roles, working in partnership, value for money and the risk around maximising the funding. The Chair asked that a brief overview is provided at the next committee on utilisation and role occupancy which would help the Committee understand the time it took to previously fill the roles and the challenges going forwards with the enhanced scale of the funding year on year.

ACTION: LS and DR to provide a brief overview of previous year's utilisation and role occupancy at the next meeting.

The CCG draft financial plan for the period **April to September 2021** in line with NHS England guidance was presented to the Committee for approval. The allocation given was a half-year budget of £16.8m, which excludes the additional roles budget that can be claimed back. LS advised this was the allocation expected. The financial plan was signed off by Governing Body on 29 April 2021. The challenge this year will be around reserves, which has reduced significantly in comparison to previous years due to the changes to the national contract. LS reassured the Committee that we have created the 0.5% contingency asked for by NHSE and have reserves around £700k for which plans will be developed to commit to this in year.

The Committee **NOTED** the 2020/21 financial position on Primary Medical Services delegated budgets.

DECISION: The Committee **APPROVED** the draft financial plan for April - September 2021.

42/21 DATE AND TIME OF NEXT MEETING IN PUBLIC:

Thursday 26th August 2021, 3.00 – 5.00pm, via MS Teams

Calderdale Commissioning Primary Medical Services Committee Meeting 27th May 2021 Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
HOPC Report	21/21	To discuss LD health checks being business as usual with primary care colleagues and re-establish the target for completion for 2021-22.	DR	Closed	See report 27/05/21
HOPC Report	21/21	To send a reminder to primary care colleagues about Patient Reference Groups restarting from July 2020.	MP	Closed	Actioned
HOPC Report	21/21	To provide assurance around extra activity for people with learning disabilities at next Committee.	DR	Closed	See report 27/05/21
HOPC Report	21/21	To share the Insight report on people accessing vaccines.	PW	Closed	Emailed 17/03/21
Internal Audit Report	22/21	To reword the finding around the procurement policy. To update the annual report and submit to Audit Committee.	DH/MP DH	Closed Closed	Reworded 16/04/21 Submitted 13/05/21
CPMSC Annual Report	27/21	To update and submit to Audit Committee.	ZA	Closed	Submitted 13/05/21
HOPC Report	35/21	To share the draft Estates Strategy document at the next CPMSC development session	DR	Open	
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	Open	
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	Open	

Finance Report	41/21	To provide a brief overview of previous year's utilisation and role occupancy at the next meeting.	LS/DR	Open	

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Minutes of the meeting held in public on Tuesday 6th April 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
Robin Tuddenham	**RT**	Chief Officer, NHS Calderdale CCG
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
Jonathan Webb	**JWb**	Chief Finance Officer, NHS Wakefield CCG (deputy for Jo Webster)
Associate members		
Dr Charles Parker	**CP**	Chair, NHS North Yorkshire CCG
Apologies		
Jo Webster	**JW**	Chief Officer, NHS Wakefield CCG
Amanda Bloor	**AB**	Chief Executive, NHS North Yorkshire CCG
Matthew Groom	**MG**	Assistant Director, Specialised Commissioning, NHS England
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)
Ian Holmes	**IH**	Director, WY&H HCP
Anthony Kealy	**AKe**	Locality Director WY&H, NHS England & NHS Improvement
Item 17/21		
Andy Weir	**AW**	Senior Responsible Officer, Assessment and Treatment Units (ATU)
Tom Jackson	**TJ**	ATU Clinical Lead, SWYFT
Patrick Scott	**PS**	Chief Operating Officer, Bradford District Care Trust, Provider ATU Lead
Jo Butterfield	**JB**	WY&H Programme Manager, Mental Health & Learning Disabilities
Jamie Wike	**JWi**	Chief Operating Officer, NHS Barnsley CCG

Items 18 and 18a/21		
Dr Steve Ollerton	**SO**	Healthy Hearts Project Sponsor, NHS Kirklees CCG
Pete Waddingham	**PW**	Yorkshire and the Humber Academic Health Science Network

Item No.		Action
11/21	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting, including Dr Khalid Naeem and Carol McKenna to their first meeting as representatives of the newly-merged Kirklees CCG. The Chair proposed a formal vote of thanks to Dr Steve Ollerton for his contribution to the Committee as Chair of Greater Huddersfield CCG. The Chair noted that levels of COVID-19 had reduced significantly since the last meeting and that lockdown restrictions were starting to be lifted. On behalf of the Committee, she thanked colleagues who had been working on the COVID response, including those involved in the West Yorkshire Vaccination Programme.	
12/21	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. None were declared.	
13/21	**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:	
14/21	**Minutes of the meeting in public – 12th January 2021**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 12 January 2021.	
15/21	**Actions and matters arising – 12th January 2021**	
	SG presented an updated the action log.	
	The Joint Committee: Noted the action log.	
16/21	**Joint Committee membership and voting**	
	Stephen Gregg advised that on 1st April 2021, NHS Greater Huddersfield CCG and North Kirklees CCGs had merged to form NHS Kirklees CCG. Kirklees CCG was now a party to the MoU and a member of the Joint Committee.	
	The Joint Committee: a) **Noted** that Kirklees CCG was now a party to the MoU and a member of the Joint Committee	
17/21	**Assessment and Treatment Units (ATUs) for people with a learning disability**	
	Helen Hirst introduced the report, highlighting the benefits of developing a single approach across West Yorkshire. The report focussed on the commissioning arrangements.	

Item No.		Action
	Andy Weir outlined the detailed work that had been undertaken, including extensive engagement with service users, carers and staff and work in Leeds to ensure connectivity into the single system and centre of excellence. Commissioners and providers had worked together collaboratively to develop the proposed approach and Bradford Care Trust had been identified as the lead provider for the new care model. The model also included ATU provision commissioned by Barnsley CCG. The collaborative commissioning model, governance arrangements and financial model had been developed by representatives of all the affected CCGs and were now presented to the Joint Committee for formal approval. Jamie Wike, Chief Operating Officer for Barnsley CCG, confirmed that Barnsley fully supported the proposals.	
	The Joint Committee: a) **Approved** the oversight framework, collaborative commissioning and risk / benefits approach detailed in this report for Year 1. b) **Requested** the CCG Accountable Officers to nominate a lead CCG/ commissioner to hold the contract on behalf of the CCGs. c) **Endorsed** the approach to further develop the collaborative commissioning model and agree a financial investment mechanism for year 2 onwards. d) **Supported** the staged implementation of the new model with effect from Quarter 2 onward.	
18/21	**West Yorkshire and Harrogate Healthy Hearts - Project delivery timescales**	
	Steve Ollerton presented the report. Delivery of the Healthy Hearts had been due to end on 31 March 2021. As a result of the impact of COVID-19, phase three of the project had experienced significant delays. It was therefore proposed that the delivery timeframe be extended by a further 12 months.	
	The Joint Committee: a) **Agreed** the extension of the WYH Healthy Hearts project by a further 12 months until 31 March 2022 to support the implementation of phases two and three of the Healthy Hearts project. b) **Approved** the use of £80,000 of membership fees to enable full delivery.	
18a/21	**West Yorkshire and Harrogate Healthy Hearts - Diabetes Treatment Guidance**	
	Steve Ollerton presented the report, which highlighted that Cardiovascular disease (CVD) was a major complication and the most common cause of death in adults with type 2 diabetes The paper presented standardised and simplified treatment guidance for Type 2 Diabetes patients with CVD or at high risk of CVD. The guidance supported phase three of West Yorkshire and Harrogate (WY&H) Healthy Hearts and had been developed for use in primary care, following extensive stakeholder engagement. It had been approved by the WY&H Area Prescribing Committee and Improving Planned Care Board. SC welcomed the guidance, noting that some primary care clinicians might need support in implementing it. SO confirmed that support would be available.	
	The Joint Committee: Agreed the Diabetes Treatment Guidance to enable adoption across West Yorkshire and Harrogate.	

Item No.		Action
19/21	**White Paper: Integration and Innovation**	
	Carol McKenna presented a report on the White Paper "Integration and Innovation: Working together to improve integration and innovation for all", which set out proposals for health legislation, including how Integrated Care Systems (ICSs) would be established in statute. The presentation focused on how the proposals would affect CCGs. It outlined the proposed future arrangements, including the employment of staff working in CCGs, how the change would be managed and the expected timescales. CMc outlined the work that was underway in West Yorkshire and Harrogate including the ICS operating model, Integrated Care Partnerships (ICP) in place, workforce, financial arrangements, clinical and professional leadership and citizen involvement. SH highlighted the importance of strong clinical leadership and citizen voice in the new arrangements. JT outlined the work underway to support clinical and professional leadership and HH noted that the ICP development framework recognised the critical role of citizen voice. The Chair highlighted the extent of collaborative working across West Yorkshire and Harrogate and that the partnership was well placed to transition to the new arrangements. AS endorsed this and said that the system was making good progress. A further update would be brought to a future meeting,	**SG**
	The Joint Committee: Noted the update on the White Paper and the associated implications for CCGs alongside the planned future employment arrangements	
20/21	**Risk management**	
	Stephen Gregg 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 9 risks scored at 12 or above after mitigation, including two new risks.	
	The Joint Committee **Reviewed** the risks to delivery of the Joint Committee workplan and **noted** the actions being taken to mitigate the risks.	
	Any other business	
	There was none.	

Next Joint Committee in public – Tuesday 6 July 2021, 11am – 1pm.

West Yorkshire & Harrogate Joint Committee of CCGs

Annual report 2020/2021 – Summary version for CCGs

The role of the Joint Committee

The Committee has delegated authority from the WY CCGs to take joint decisions on agreed priorities. The Committee also makes recommendations when a collaborative approach across WY&H will help to achieve better outcomes. The Committee has an independent lay chair, three CCG lay members and two representatives from each WY CCG. North Yorkshire CCG is an associate member. As a result of COVID-19, all meetings were held virtually in 2020/21 and were live streamed. The attendance record is at Appendix 1.

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

1. Improving outcomes

Responding to COVID-19

The Committee considered how WY&H health and care programmes had refocused to support the response to COVID-19. The Committee agreed that its work during the year would need to evolve to reflect the new priorities arising from COVID-19.

West Yorkshire and Harrogate Healthy Hearts

In 2018, the Joint Committee recommended the CCGs to adopt the Healthy Hearts improvement project, building on successful work in Bradford. The project aims to identify more people with high blood pressure, help them to control it better and reduce the risk of heart attacks and strokes. As a result, 22,000 more people have had their blood pressure controlled to target numbers. WY&H Healthy Hearts won the Health Service Journal Cardiovascular Initiative of the Year award in 2020.

Assessment and Treatment Units (ATUs) for people with complex learning disabilities

The Committee supported a proposal to commission a new care model for people with a learning disability. This involved collaborative commissioning between commissioners and providers across the whole pathway for people with learning disabilities. The aim is to develop a single system and centre of excellence. The Committee noted plans for engaging with people who had accessed care in ATUs, their carers and staff. Formal approval for the proposals was sought at a meeting in 2021/22, following further engagement.

Urgent and emergency care

The Committee supported a national programme which built on learning from COVID-19. It encouraged people to phone 111 as an alternative to 'walking' unheralded into Emergency Departments (EDs). The integrated offer included alternative pathways, for example GPs, pharmacists and mental health advice. Patients are remotely triaged to determine if there is a clinical need to be seen face to face.

The Committee considered a report on primary medical care services in West Yorkshire, which were provided by Local Care Direct (LCD). The response to COVID-19, changes in national policy and potential changes to the commissioner landscape meant that there was uncertainty about what should be commissioned for the future. The Committee felt that in the current circumstances a pragmatic approach should be taken and agreed to extend the service from LCD for three years.

Improving planned care

The Committee supported changes to the Improving Planned Care programme, which focused on restarting planned care following the first wave of COVID-19. This included improving access to diagnostic testing services and more shared decision making between primary and secondary care.

The Committee approved an amendment to a WY&H policy for flash glucose monitors - small sensors worn on the skin for monitoring the glucose levels of people with diabetes. The amendment covered type 2 diabetes patients with learning disabilities who need to use insulin. Self-management of diabetes by patients with learning disabilities would promote independence and reduce health inequalities.

The Joint Committee had previously agreed a number of clinical threshold policies, which had improved equality of access across WY&H and reduced levels of surgery where non-surgical interventions could be more effective.

Stroke

In 2018, the Joint Committee agreed a common approach for commissioning hyper acute stroke services and all stages from prevention to recovery. The specialist hyper-acute stroke pathways are now well established, with 4 units providing hyper-acute care during the first 72 hours following stroke across WY&H. A sustainable stroke clinical network has been established, working to provide the best stroke services possible and further improve quality and stroke outcomes in each of our six places. Priorities include preventing strokes, delivering effective care when people have a stroke and ensuring that there is good support and rehabilitation for people after a stroke.

2. Working better together

The Committee led new approaches to collaborative working between commissioners and providers. The Commissioning Futures programme was developed in collaboration with partners across the health and care system, based on our successful model of place-based working. Work is only carried out at WY&H level if it adds value to our places

The Committee supported collaboration between commissioners and providers through the Cancer Alliance, Improving Planned Care programme, Local Maternity System and Mental Health, Learning Disability and Autism Alliance. The Committee also supported the Yorkshire and Humber framework for integrated commissioning of Integrated Urgent and Emergency Care Services provided by Yorkshire Ambulance Service.

3. Governance

In 2020, the WY CCGs agreed a revised Memorandum of Understanding for Collaborative Commissioning, which included a new work plan and the delegation of new commissioning decisions to the Joint Committee.

The Committee maintains a register of members' interests and declarations of interest are a standing item on all agendas. At each meeting, the Committee reviews the significant risks to the delivery of its work programme and assesses how these risks are being mitigated.

West Yorkshire & Harrogate Joint Committee of CCGs

Annual report 2020/2021 – Summary version for CCGs

Attendance record **Appendix 1**

Organisation and role	**Member**	**Attendance** (eligible)
Independent Lay Chair	Marie Burnham	**3** (3)
CCG Lay members		
	Stephen Hardy	**3** (3)
(to 7th July 2020 meeting)	Richard Wilkinson	**1** (1)
(from 6th October 2020 meeting)	Ruby Bhatti	**2** (2)
(from 6th October 2020 meeting)	John Mallalieu	**2** (2)
NHS Bradford, District and Craven CCG		
Clinical Chair	Dr James Thomas	**3** (3)
Chief Officer	Helen Hirst	**2** (3)
Strategic Director of Quality and Nursing	Michelle Thomas *(Deputy for Helen Hirst)*	**1** (1)
NHS Calderdale CCG		
Clinical Chair	Dr Steven Cleasby	**2** (3)
Deputy Chief Officer (to 6th October 2020 meeting)	Neil Smurthwaite	**2** (2)
Chief Officer (from 21st January 2021 meeting)	Robin Tuddenham	**1** (1)
NHS Greater Huddersfield CCG		
Clinical Chair	Dr Steve Ollerton	**3** (3)
NHS North Kirklees CCG		
Clinical Chair	Dr Khalid Naeem	**2** (3)
NHS Greater Huddersfield and North Kirklees CCGs		
Chief Officer	Carol McKenna	**3** (3)
NHS Leeds CCG		
Clinical Chair	Dr Jason Broch	**3** (3)
Chief Executive	Tim Ryley	**3** (3)
NHS Wakefield CCG		
Clinical Chair	Dr Adam Sheppard	**3** (3)
Chief Officer	Jo Webster	**3** (3)
	Associate member	
NHS North Yorkshire CCG		
Clinical Chair	Dr Charles Parker	**2** (3)
Chief Officer	Amanda Bloor	**1** (3)