Item 3

NHS Calderdale Clinical Commissioning Group

Public Section of the Governing Body Meeting held on Thursday 22nd October at 2pm via Video Conference

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

Draft MINUTES

Present	Dr Steven Cleasby	SC	Chair, GP Member
	Robin Tuddenham	RT	Accountable Officer
	Neil Smurthwaite	NS	Interim Accountable Officer
	Dr Caroline Taylor	CT	Clinical Vice Chair, GP Member
	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 Engagement)
	Dr Rob Atkinson	RA	Secondary Care Specialist
	Prof Rob McSherry	RM	Registered Nurse
	Prof P Roberts	PR	Lay Member (Audit)
In attendance	Denise Cheng-Carter	DCC	Lay Advisor
	Deborah Harkins	DH	Director of Public Health, Calderdale Metropolitan Borough Council
	Iain Baines	IB	Director of Adult Services, Calderdale Metropolitan Borough Council
	Lesley Stokey	LS	Director of Finance
	Andrew O'Connor	AOC	Senior Corporate Governance Officer (Minutes)
	Jill Dufton	(JD)	Engagement Manager (for item 6, minute 66/20 and item 8, minute 68/20)
	Rob Gibson	(RG)	Corporate Systems Manager (for item 9, minute 69/20 and item 12, minute 72/20)
	Rhona Radley	(RR)	Deputy Head of Service Improvement (for item 16, minute 76/20)
	Kym Brearley	(KB)	Project Co-ordinator (for item 16, minute 76/20)
			(Accompanied by three young people, Beth, Josh and Anya, and representatives from providers (North Point and the South West Yorkshire Partnership NHS Foundation Trust) and

			commissioners (Calderdale CCG and Calderdale Council)
Observing	Steven Reed	SR	Communications Officer

60/20 Minutes Silence **Action**

The Governing Body observed a minutes silence for Dr Krishna Kumar, former Governing Body member, and his family following the death of their youngest daughter.

61/20 Accountable Officer Appointment

SC welcomed Robin Tuddenham (RT) as the newly appointed joint Accountable Officer for NHS Calderdale CCG, as part of a shared role with Calderdale Metropolitan Borough Council.

John Mallalieu (JM) presented the report which set out for the appointment process, including a summary of Governing Body decisions, for members' assurance. The process undertaken was summarised. The paper also recommended that the Governing Body recognise the leadership provided by the Interim Accountable Officer, Interim Chief Finance Officer, the CCG's Senior Management Team and all CCG staff during the intervening period.

RT thanked everyone for their warm welcome to the CCG and those who had been involved in the appointment process. He also thanked the CCG's Senior Management Team, including the Interim Chief Accountable Officer, for their work in the months preceding their appointment.

Decision:

The Governing Body:

1. **Received** the report and **noted** that, following NHS England approval, the current Calderdale Metropolitan Borough Council (CMBC) Chief Executive had been appointed as the Accountable Officer for Calderdale CCG as part of a shared role with CMBC with effect from 16th October 2020.

2. **Recognised** the leadership provided by the current Interim Accountable Officer, Interim Chief Financial Officer, and the CCG's Senior Management Team during the intervening period.

62/20 Apologies for absence

There were no apologies.

63/20 Declaration of interest

Alison MacDonald (AM) declared a direct professional interest in item 16

(Patient Story). She had been involved in supporting the Autism Spectrum Disorder summit around the time she joined the CCG as a Governing Body Member.

AM also declared an indirect personal interest in item 16 as her daughter had been and continued to be involved in the CCG's work on services for young people with Autism Spectrum Disorder on a voluntary basis and would be in attendance during the item.

Decision:

The Governing Body **agreed** that AM could take part in the item without restriction.

There were no further conflicts of interest declared.

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

64/20 MINUTES

Decision:

The minutes of the public section of the Governing Body meeting and the CCG's Annual General Meeting held on 23 July 2020 were **received** and **adopted** as a correct record.

Matters Arising

It was agreed that the outstanding action at 77/19 would be handed over to Penny Woodhead (PW) as a potential future Patient Story and removed the log.

65/20 INTERIM ACCOUNTABLE OFFICER'S REPORT

Neil Smurthwaite (NS) presented the report for the Governing Body's assurance drawing attention the follow key matters:

- **Covid-19** – The work being undertaken by the CCG and partners across the system to tackle to pandemic was recognised. Specific reference was made to the work on testing being carried out Deborah Harkins (DH) in cooperation with CCG.
- **Primary Care** – The work being undertaken across general practice and within the CCG to maintain consistent services for the public was recognised. Public concerns regarding access to General Practice were being addressed through resource allocation and work to ensure clear lines of communication. Clinical Directors' were committed to tackling the difficult issues. The potential for significant benefits to be realised through the consistent application of innovation and technology across member practices in the coming months were recognised.
- **Flu** – The Flu Group, Chaired by Karen Walker, Public Health, and

supported by all partners, was developing a sophisticated understanding of the current position on vaccinations. The work undertaken by General Practice early in the flu season had put the area in a strong position. Concerns regarding vaccine supply and levels of demand were not unique to the current year and assurances had been received from NHS England.

- **Reverse Advent Calendar** – CCG Teams were being asked to create food/gift parcels over the period of a month for donation to the Gathering Place. Governing Body members were invited to take part.

Comments and questions were invited:

- In response to a question, Robin Tuddenham (RT) confirmed that there were ongoing and regular communications taking place between the CCG and the Local Authority concerning Covid-19 and the possibility of moving to Tier 3. There had been no formal meeting with ministers but there were concerns about the local infection and positivity rate and the level of pressure on acute and social care systems. The perspective of Directors of Public Health across West Yorkshire regarding moving to Tier 3 restrictions had been clearly communicated at as recent national gold meeting.
- NS reported that an escalation gold meeting had been established within the local system to support the local hospitals. Colleagues from across the system were involved.
- In response to a question, NS confirmed that the release of vaccines on a phased programme meant that there was potential for demand to outstrip supply on occasion. The promised supply of porcine free vaccines had not materialised which had implications for BAME communities. Additional work was taking place to encourage individuals to take up the vaccination offer. Dr Farrukh Javid (FJ) advised that practices would shortly begin to focus on people in the 50-64 cohort which was the only planned work taking place in addition to the annual over 66s vaccination programme.
- In response to a question concerning Covid Testing Centres, NS confirmed a degree of confusion among the public had been recognised a few weeks earlier and that communications introduced by Public Health with the CCG had started to have an impact.
- Deborah Harkins (DH) confirmed that, following demand for Covid 19 testing outstripping supply in September, Rhona Radley (Deputy Head of Service Improvement, Calderdale CCG) had reviewed the Testing Strategy so that it could respond to such changes should they arise again.

Decision:

The Governing Body **received** and **noted** the content of the report.

66/20 Healthwatch Calderdale Covid-19 Engagement

Penny Woodhead (PW) presented the item seeking Governing Body's views on the CCG's draft response to Healthwatch Calderdale's report "Health and Care Experiences of People living in Calderdale during the Covid-19 outbreak. The report was provided in full at Appendix 1. Healthwatch had chosen to exercise its ability to require a response within 20 days for the first time, with the response being due on the day of the Governing Body's meeting. The CCG had advised Healthwatch Calderdale that it would look at its provider responses to identify any further actions the CCG would want to undertake when they became available.

Comments and questions were invited:

- The CCG's commitment to acting on the findings of the report was welcomed.
- The West Yorkshire and Harrogate Health and Care Partnership had published its *Tackling Health In*equalities for BAME Communities and Colleagues on the day of the meeting. It was suggested that there were some recommendations therein which could be usefully referred to.
- There was a suggestion that the CCG's summary might be amended to include a commitment to keeping patients updated alongside its commitment to continuing to work with them, partners and providers. It was also suggested that Healthwatch might be asked how it could help the CCG to do this to best effect. PW responded saying this the changes could be made; adding that Healthwatch would be central to the place based communications and engagement network that would established through the Involving People Strategy and that this would enable them to contribute to CCG's work as well as that of its partners and providers. Jill Dufton (JD) added that the intention was for the place based group to provide a collective system response to the content of the report in the future.
- In response to a question, PW confirmed that Healthwatch would seek assurance on the CCG's delivery of it commitments in the future and explained the verisght and assurance arrangements in place concerning this.
- In response to a comment concerning making additional use of community assets to reach different groups and individuals, JD explained that an Involving People network was being development which would help to deliver what was being described.
- There was a suggestion that Healthwatch be invited to help the CCG in its understanding of contributory factors to it findgins. Moreover, and that an understanding of the implications of spatial variation, for example, access to open spaces, would be useful.

In conclusion, PW surmised that the draft letter as presented would be submitted along with a covering message setting out the Governing Body's comments. Thereafter the comments, along with any issues emerging from the response of providers, would be added as an addendum to the CCG response.

Decision:

The Governing Body**:**

1. **Noted** and considered the Healthwatch engagement reports.

2. **Noted** the CCG response letter.

3. **Noted** that the response letter would be published on the CCG website once Healthwatch have received the formal response.

67/20 CCG Stabilisation, Reset and Planning

Debbie Graham (DG) presented the report which provided assurance to the Governing Body concerning CCG activities undertaken as part of the NHS Stabilisation and Reset process. Attention was drawn to the following key matters:

- The overview of the three main reset stages and expectations at 2.1.
- The work taking place concerning the winter reset at 3.0 and four key issues identified at 3.4 in bold concerning which rapid appraisals had been carried out and recommendations submitted to the Integrated Commissioning Executive.
- The CCG's Stabilisation and Reset plan explained at 4.0, provided in full at Appendix A, and reporting arrangements at 4.3. A paper would be submitted to the Integrated Commissioning Executive concerning those elements where greater dialogue and integrated working would be of benefit.
- The Planning Requirements concerning the submission of planning and financial assumptions at 5.0, particularly in relation to Continuing Health Care, Cancer, Mental Health, the Mental Health Investment Standard, Workforce and Finance. The performance update to Governing Body would provide information concerning the progress made.

Comments and questions were invited:

- In response to a question concerning communications with the public, it was reported that the Calderdale system had been sending out a considerable amount of communications concerning urgent care and these were reducing attendances for minor ailments. In terms of planned care, it was a communications plan was reported having being submitted to the Outpatient Transformation Board and that Patient and Local Medical Committee representatives were involved in developing patient communications. Calderdale and Huddersfield NHS Trust had allocated priority scores to patients requiring follow-ups and were recruiting buddies to make the required regular contacts.
- There was recognition the Governing Body would need to be kept informed between meetings of changes in priorities and plans in order to support communications outside the organisation.
- There was recognition of importance of connectivity, locally, regionally and

between programmes. The planned conversation at the Integrated Commissioning was welcomed.

- In response to a question, Ian Baines (IB) reported there had been a policy change in the last seven days meaning that no one with a positive test result would be discharged back to a care home directly. Each area was required to designate a site or sites where care home residents with a positive result would be transferred. The need to ensure that the availability of beds at designated sites did not slow down hospital discharge was noted. Protocols established locally during the first wave were said to have been a major factor in keeping infection rates and deaths in care homes relatively low compared to other areas. Moreover, that a recent spate of outbreaks had been predominantly among staff meant the protocols had been having a positive impact on reducing the risk to residents.
- Looking to the next iteration of the plan, Robin Tuddenham (RT) suggested that there should be consideration given to the risks that might have an impact so as to strengthen the CCG's position when entering into discussions with NHS England.
- Neil Smurthwaite provided assurance with regard involving in the Governing Body in decisions making, particularly around elective care. Workforce resilience was noted as one of the key factors in decisions concerning care homes and hospitals. A letter had been received from Richard Barker (North East and Yorkshire Regional Director) advising CCG's to ensure it had undertaken the appropriate conversations as part of its decision making processes.

Decision:

The Governing Body:

1. **Received** and **noted** the contents of report;
2. **Identified** any areas for further assurance;
3. **Requested** regular updates on reset and planning.

68/20 Involving People strategy

Penny Woodhead (PW) presented the CCG's Involving People Strategy for Governing Body approval. The strategy was a high level joint strategy, developed with partners setting out shared set of principles for involving people across Calderdale – supporting the delivery of Calderdale Cares, Well-being strategy and Vision 2024. The CCG was rated as "good" by NHS England in terms of involving people with internal audit outcomes confirming the position. The strategy had been signed off by the Calderdale Wellbeing Board during the week preceding the meeting and replaced the CCG's previous Patient and Public Engagement and Experience Strategy.

Comments and questions were invited:

- There was support for the adoption of the strategy.
- There was recognition that a single shared strategy could enable the feedback to be heard across the partnership.
- There was a suggestion that some of the management language be

replaced along with an amendment to one of the maps.

- There was a suggestion that some information on how to get involved be inserted.
- The need to publicise the strategy widely and inclusively was noted. Jill Dufton commented that the system response to the Healthwatch Report may provide an opportunity to talk about the Involving People Strategy.

Decision:

The Governing Body:

1. **Approved** the Involving People Strategy.
2. **Approved** governance structure for system wide engagement and communication across Calderdale.
3. **Adopted** and **agreed** to publish the joint strategy and governance structure as a vision and shared set of principles and approach for involving people across Calderdale.

69/20 Emergency Preparedness, Resilience and Response (EPRR) Annual Update

Rob Gibson (RG) presented the report providing which provided a summary of the CCG's activities in relation to emergency preparedness and business continuity in 2019/20. It also included activities that had taken place during 2020/21 to date. The paper also sought Governing Body approval of the CCGs Emergency Planning Framework (2020). The report and framework were noted to have been received and discussed at the CCG's Audit Committee meeting in September. Attention was drawn to the following:

- The CCG's response to Covid 19 at Section 3.
- The desk top exercise concerning the sharing of potentially commercially sensitive data that had taken place in February 2020 as described at 3.5. In addition to the report, RG advised that three risk assessments had been produced and actions identified.
- The completion of the annual EPRR assurance process as described at 4.0.

Comments and questions were invited.

- John Mallalieu (JM) recognised that Audit Committee feedback had been incorporated into the report.

Decision:

The Governing Body:

1. **Received** and **noted** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year.
2. **Approved** the CCG's Emergency Planning Framework (2020).

70/20 Performance Reports

a. Interim Chief Finance Officer's Report (Including Performance Report)

Lesley Stokey (LS) presented the report. The CCG was forecasting an overspend against initial allocations due to Covid-19 and other pressures. The CCG had received an additional £3.3m for April-August against the reported cost pressures. However, a forecast overspend of £0.2m remained. A table at 1.4 provided an overview of Covid related costs up to month 6. The largest area of expenditure (£2.6m) was in relation to the CCG's contribution to the new Section 75 pooled budget for the Hospital Discharge Programme.

A new financial regime would commence from October 2020. The regime would remain consistent in many ways with that which had been in place for the preceding six months. CCG's had received allocations for the rest of the financial year (as shown at 1.5.4) and there would be funds for additional costs, top-ups and growth managed at an Integrated Care System (ICS) level. It was noted that the CCG would continue to claim for the costs associated with the hospital discharge programme separately to this. The table provided at 1.5.4 showed the variation between the CCG's original allocation and that being provided using the new model. This resulted in £6.9m reduction against the originally allocated sum. LS provided assurance that, with the arrival of further additional allocation, the CCG was projected to deliver a break even position for 2020/21. This was noted to place the CCG in a strong position relative to its ICS partners. The plan submitted by the ICS also forecast a break even position; however, a degree of significant challenge in delivering the position was noted.

A&E activity continued to increase month-on-month. Targeted communications work had been taking place to reduce unnecessary attendances. Cancer waiting times had suffered due to Covid-19. There was a significant degree of focus in the reset plans on recovering the CCG' position in relation cancer waiting times, 18 week referral to treatment and planned care.

Metrics relating to mental health service were provided at 3.6.2. The CCG was committed to monitoring these on a more regular basis. They were being received at the Quality, Finance and Performance committee as well as being reported on to the Governing Body.

A System Oversight Dashboard had been provided at Appendix E setting out the ICS performance metrics.

Comments and questions were invited:

- In response to a question asking whether the performance data was still representative of the system position, LS confirmed that the information presented was the data available at the time of publication but that a number of pressure related issues addressed by the A&E Delivery Board. Neil Smurthwaite (NE) added that information recently received indicated that referrals for two week waits for certain specialities had started to exceed pre-Covid 19 activity levels. He explained that this had been

expected and that Calderdale was managing to meet the demand through its planned use of the independent sector; although, the CCG would not know the precise position for few more weeks. The West Yorkshire Cancer Alliance was looking at new tests that would speed up the process.

- In response to a request, LS confirmed that the technical deficit submitted was £2.2 - £2.3m, but, as referenced earlier, additional income streams were anticipated in relation to the expansion of roles in primary care and independent sector activity increases. She provided assurance concerning the assumptions that had been made in arriving at the planned break even position. The CCG main variable costs were reported to be in prescribing and Continuing Health Care (CHC). In relation to CHC, much of this was tied down in block contracts while the CCG would be able to claim for costs relating to the hospital discharge programme outside of its revised allocation. Current prescribing data showed an overspend and this has been built into the CGG's forecasting. The chief risk would be if the additional revenue streams did not materialise; however, the strength of the CCG's position was reconfirmed.
- In relation to the increase in referrals, Dr Farrukh Javid (FJ) suggested that the CCG monitor outcomes for a period to ensure the two weeks referrals were appropriate. NS agreed to take this suggestion away but confirmed his understanding that there was an increase in diagnosis, but that this was in speciality areas where the screening process had re-established itself over the preceding months, (e.g.) breast cancer, cervical lower gastro intestinal. Dr Rob Atkinson (RA) added that during the process of dealing with backlog secondary had developed more robust ways of challenging the referrals which may ultimately lead to a change in the risk stratification process involved.

Decision:

The Governing Body **noted:**

1. the new temporary financial regime for the period April - September 2020.
2. the forecast overspend for the period April – September 2020.
3. new planning guidance due for the period October 2020– March 2021.
4. the contacting update.
5. the impact of COVID-19 on the progress being made towards achieving the standards set out in the NHS Constitution.
6. the indicators available and reporting arrangements to support the mental health programme for Calderdale. The latest developments to support system oversight and assurance across the West Yorkshire and Harrogate Partnership.

b. Quality and Safety Report and Dashboard

Penny Woodhead (PW) presented the report including dashboard which had been reviewed at Quality, Finance and Performance Committee in September.

The committee had received the Children Looked After Annual Report for

2019/20. Summary slides concerning the report had been provided at Appendix 2 and reflected the CCG's strong position in terms compliance with the relevant statutory responsibilities and performance against key performance indicators. Further more detailed information could be made available at request.

The Governing Body also received information concerning the Learning Disability Mortality Review (LeDeR) Annual report (2019-20) process. The programme was run collaboratively across Calderdale, Greater Huddersfield, North Kirklees and Wakefield with learning applied at a place and system level as appropriate. In accordance with the NHS England requirement the report had been published at the send of September on the CCG's website.

Comments and questions were invited:

- The publication by the Quality Care Commissions of its independent report concerning care for individuals with Learning Disabilities was noted along with the possibility of drawing on its findings and recommendations.
- PW noted that there was very little additional resource provided to support the LeDeR review process and this created an ongoing challenge. Cloverleaf had been commissioned to undertake some of the less complex reviews.
- In response to a question, PW confirmed she would look to see if there was any more up-to-date data available concerning the impact on deaths during the Covid 19 period.
- In response to a questioning concerning the impact of Covid 19 on expected deaths, PW responded that both the Summary Hospital Health Mortality and Hospital Standardised Mortality Ratio indicators were in range, but the latter had a slightly deteriorating position at the end of March 2020. PW confirmed she would refer to colleagues concerning the availability for data for the Covid 19 period.
- Dr Caroline Taylor (CT) provided an overview of an ongoing programme aimed at better supporting the health needs of people with a learning disability. This included work aimed at achieving the target of 75% of patients with a learning disability receiving a health check annually and the better use of health action plans.

Decision:

The Governing Body:

- **Received** the update on Quality and Safety information to provide assurance regarding its main providers, plus the following information:
    - Friends and Family Test guidance
    - Children Looked After – Annual report 2019 -20
    - Learning Disability Mortality Review Annual report 2019-20

71/20 Committee Terms of Reference

AOC presented a number of minor changes to committee terms of reference which had been agreed by committees earlier in the year. It was explained that NHS England had agreed to consider the amendments as part of the ongoing application to vary the CCG constitution.

Comments and questions were invited.

- The Governing Body recognised that further changes would need to be made to the Terms of Reference during the next cycle of meetings so as to reflect changes in the CCG's organisational structure.

Decision:

The Governing Body:

- **Approved** the proposed amendments to the following committee Terms of Reference:
    a. Commissioning Primary Medical Services Committee
    b. Quality, Finance and Performance Committee
    c. Audit Committee
    d. Remuneration and Nomination Committee

72/20 High Level Risk Log and Report - Risk Cycle 3 2020/21

RG represented the report for the Governing Body's assurance. There were two ongoing critical risks scoring 20 detailed at 2.7. There five ongoing serious risks detailed at 2.8. During risk cycle 3, three serious risks were down rated as detailed at 2.9.

Comments and questions were invited.

- Concerning the seven risks on the risk register that fell within the remit of the Commissioning Primary Medical Services Committee, JM confirmed that the risks had been reviewed by the committee at its last meeting

Decision:

The Governing Body:

- **Confirmed** that it was **assured** that the High Level Risk Register represents a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 3 of 2020-21. This is following a review of the risks at the combined Quality, Finance and Performance Committee meeting on 24 September 2020.

73/20 Committee Minutes

Prof P. Roberts (PR) drew Governing Body's attention the approval of CCG's Annual Report and Accounts and the findings of Internal and External Audit as detailed in the Audit Committee minutes of the 18 June 2020.

Dr Farrukh Javid (FJ) noted that during the meeting the Governing Body had received updated information concerning a number of matters detailed in the minutes of the meeting of the Quality, Finance and Performance Committee held on 25 June 2020.

John Mallalieu (JM) noted that the Commissioning Primary Medical Services Committee Decision Notice dated 3 September 2020 concerned the formation of a Rapid Decision Making group.

Decision:

The Governing Body **received** the following:

i. The minutes of the Audit Committee meeting held on 18 June 2020
ii. The minutes of the Quality, Finance and Performance Committee meeting held on 25 June 2020
iii. The minutes of the Commissioning Primary Medical Services Committee meeting held on 23 July 2020.
iv. A Commissioning Primary Medical Services Committee Decision Notice dated 3 September 2020.

74/20 External Meetings

Decision:

The Governing Body **received** the minutes of the meeting of the West Yorkshire and Harrogate Joint Committee of CCGs held on 7 July 2020

75/20 Key Messages for Practices

Decision:

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

- Healthwatch report and response — Coms
- Involving People Strategy

76/20 Patient Story - THRIVE and Autism Spectrum Disorder Update

Rhona Radley (RR) introduced the Patient Story and report explaining that it provided an overview of the work that had taken place with children and young people in Calderdale in the delivery of THRIVE and work within the system to better meets the needs of Children and Young People, including those with

Autism Spectrum Disorder. Three young people were in attendance to share their experiences along with representatives from the South West Yorkshire Partnership NHS Trust, North Point, Calderdale Council and the CCG.

A short film sharing the story of a young person from Calderdale was played. The film related to THRIVE, a person-centred, whole system approach for meeting the emotional wellbeing and mental health needs of children and young people.

PW thanked those involved for sharing their story and invited the three young people in attendance to share the main issues that had come out of the "Find Your Brave" summit held in February 2020.

Beth, Josh and Anya shared the following key issues and ambitions:

1. **Education**

- Improved mental health and SEND support for individuals around exams providing more options for individuals in terms of the support they need
- Improved levels of knowledge and awareness among staff regarding autism and how it effects individuals
- Improved access to support including via Educational Health Care Plans
- Improved support arrangements at points of transition
- Improved inclusion with all children and young people with special needs and autism attending main stream classes with the required support in place

2. Mental Health

- Diagnosis to be made available as soon as possible
- Improved access to therapies for children, young people and adults with autism with a wider variety of option for support with mental health difficulties

3. General Support

- Improved post diagnoses support including support for sustaining, developing and understanding relationships.
- Wider availability and advertisement of quiet rooms and areas in public spaces
- Training for other services including companies, the fire service, paramedics and transport workers.

4. Post 18

- Better longer term support options.
- As an ambition, there would be support for mental health, social understanding and employment, in addition to others.
- For present, existing support options should be made more accessible.

SC thanked Beth, Josh and Anya for their feedback and views.

Comments and questions were invited from the Governing Body. The following key points arose from the resulting discussions:

- The Governing Body was keen to understand how it could demonstrate it had heard what was being asked for in its response. In response, it was suggested that the CCG use the young persons' reference group which was being established to act as an interface between the autistic community and services to gauge the community's response. PW agreed this would be possible.
- The Governing Body recognised that this was a real example of the co-production of services and the need to invite them back again at a later point to receive a further update.
- In response to a question asking what the CCG could do to support the reference group, it was suggested that the creation of an autistic specific group, distinct from mental health, would be beneficial.
- Alison MacDonald (AM) reflected there had been a great number of changes and improvements since the first summit but that there was still a long way to go in terms of educating people about autistic spectrum disorder.
- In response to a question asking the young people if, as was intended, they felt they were part of the Open Mind Partnership and whether there was more than could be done, there was a positive response in terms of their level of involvement and an invitation concerning a more regular stream of information in to the young persons' reference group. It was also suggested that the SEND reference group could also be involved.
- There was recognition of the importance of making sure there was enough post diagnosis support in place and that the services were responding to the needs of individuals.
- There was recognition that the summits provided a new dynamic in terms provider and commissioner accountabilities to service users.
- There was recognition that the work that had been undertaken locally was attracting interest from other regions.
- There was recognition that the investment of time and energy in the delivery of better quality engagement activities had delivered a great deal of improvements and change.
- There was a suggestion concerning having a young person appointed to a position on the Governing Body in the future.

Beth, Josh, Anya and representatives from providers and commissioners were thanked for taking part in the meeting.

Decision:

The Governing Body:

1. **Received** the patient story and report.
2. **Noted** the significant contribution made by all the children and young people involved in shaping how mental health and emotional wellbeing services are designed and delivered for them. This included those who designed and led the '*Find Your Brave*' Summit in February 2020 and who helped create the video shown at the meeting.
3. **Noted** the key issues arising from the impact of COVID-19 and **received assurance** of how these were being managed as a system by the Open

Minds Partnership.

77/20 DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

Decision:
The Governing Body **noted** that the next meeting would take place as follows:
Governing Body Meeting
Thursday 28 January 2021
2.00pm
Via Video Conference

Governing Body Meeting – 22 October 2020 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
KEY MESSAGES FOR MEMBER PRACTICES	**75/20**	▪ Healthwatch report and response ▪ Involving People Strategy	Comms	COMPLETE	Published on member Connect the week following the meeting.

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**Accountable Officer's Report**	**Agenda Item No.**	6
Report Author	Robin Tuddenham, Accountable Officer	**Public / Private Item**	Public
GB / Clinical Lead	-	**Responsible Officer**	Robin Tuddenham, Accountable Officer

Executive Summary							
Please include a brief summary of the purpose of the report	This report updates the Governing Body on current issues.						
Previous consideration	**Name of meeting**	N/A		**Meeting Date**			
	Name of meeting	N/A		**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: 1. **NOTES** the content of the report. 2. **NOTES** the approval and adoption of the policy for Primary Care Network (PCN) Governance for the Safe and Secure Handling of the COVID-19 Vaccines in Calderdale using urgent decision making powers. 3. **DELEGATE** approval of the annual Equalities Report to the Quality, Finance and Performance Committee.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications	None identified.		
Public / Patient / Other Engagement	The CCG is committed to working with public, staff, patients, partners and other stakeholders to improve health care services.		
Resources / Finance implications	None identified.		
Strategic Objectives (which of the CCG objectives does this relate to – delete as applicable)	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality	**Risks**	None identified.

	▪ Improving value ▪ Improving governance		
Legal / Constitutional Implications	None identified.	**Conflicts of Interest**	Any conflicts of interest will be managed in line with the CCG's Conflict of Interest Policy

1.0 Introduction

1.1 This is my first report to Governing Body as Accountable Officer, since I formally took up the post on 16 October 2020. I would like to thank the Governing Body and colleagues for their support to date. This report indicates the breadth and scale of the work the CCG is undertaking as we respond to, and seek to mitigate, the impact of the pandemic, as well as perform a leading part in the implementation of the biggest vaccination programme ever undertaken in this country. Our overarching focus has been on supporting our health and care system through the second wave of the pandemic and the vaccine roll out. I would like to thank Neil Smurthwaite, Chief Operating Officer/Place Senior Responsible Officer and Kate Horne, Programme Manager, for the Vaccine Programme for their excellent work to date, and the Primary Care Networks, Calderdale and Huddersfield NHS Foundation Trust and Boots for their role as one of the first community pharmacies in the country to go live on 14 January 2021.

1.2 We are developing our model of integrated place-based care with our partners within the NHS, local authority and voluntary and community sector. This is in the context of the Integrated Care System consultation. A full paper will come to the next Governing Body meeting.

2.0 COVID-19

2.1 COVID-19 Update

2.1.1 As the Governing Body will be aware, we are currently subject to the third national lockdown to reduce infection rates and the considerable pressure on the health and care system. We are focusing on the wellbeing of our staff, who predominantly work at home, and collaborating with our partners through resilience and partnership structures to protect our communities and our staff.

2.1.2 At the time of writing our infection rates have continued to modestly decline and our relative position to our other local authority areas has improved, as has our positivity rate. After a period of reducing demand on our acute system, the level of occupancy within our hospital has escalated fast over recent days reaching its current position which is the highest level it has been at any stage in the pandemic. Our social care sector has seen a slight increase in outbreaks and positive cases within the workforce, but is stable at present. I will provide a verbal update on the Calderdale SITREP at the meeting as the information on COVID is changing daily.

2.2 COVID-19 Vaccination Programme

2.2.1 We have been sharing regular briefings to the Governing Body. We have mobilised 3 delivery models within Calderdale,

- General Practice through our five Primary Care Networks (PCN)
- Calderdale Royal Hospital Hub
- Community Pharmacy – Boots, Halifax

2.2.2 Vaccinations started in December and we have had a phased roll out across our 5 PCN. There have been issues surround the supply of vaccine and delivery of supporting set up equipment however all of our delivery models, including the PCNs have been fantastic in their response, ensuring minimal wastage and maximum coverage of our over 80s, care home residents and staff and health and social care workers.

2.2.3 The Government has an aspiration for the top 4 cohorts from the Joint Committee of Vaccination and Immunisation (JCVI) by the middle of February and within Calderdale we are expected to meet this. Prior to this a new target was set for all care home (elderly) residents and staff to be vaccinated by the 24 January. At the time of writing we are expecting to achieve this target.

2.2.4 In Calderdale we were one of the first to have our community pharmacy centre open, at Boots Market Street, which opened with five others in the country on 14 January. This centre complements the access at our PCNs and Acute trust. Nationally letters are being sent to residents within 45 minutes travel of the mass vaccination centres, this covers part of Calderdale and has initially covered the over 80 and 75-79 cohorts. Those invited are given the option to book locally or wait for contact by their GP. We will also see our PCNs mobilise their roving teams to manage those housebound and unable to reach centres. I will provide updated data on our performance at the Governing Body meeting, and also the work undertaken to address better real time data reporting and tackle health inequalities within the programme.

2.3 Long Covid

2.3.1 The National Institute for Heath and Care Excellence (NICE) published NG188, COVID-19 rapid guideline: managing the long-term effects of COVID-19 https://www.nice.org.uk/guidance/ng188 in December 2020.

2.3.2 The NICE guideline covers identifying, assessing and managing the long-term effects of COVID-19, often described as 'long COVID'. It makes recommendations about care in all healthcare settings for adults, children and young people who have new or ongoing symptoms 4 weeks or more after the start of acute COVID-19. It also includes advice on organising services for long COVID.

2.3.3 The guideline has been developed jointly by NICE, the Scottish Intercollegiate Guidelines Network (SIGN) and the Royal College of General Practitioners (RCGP).

There are 3 Referral Routes for Clinics;

1) People never admitted to hospital with their acute illness but managed independently or in the community.
2) People hospitalised with COVID-19.
3) People cared for in an Intensive Care Unit (ICU) or High Dependency Unit (HDU) with COVID-19.

2.3.4 The West Yorkshire and Harrogate approach for CCGs is for clinics to be delivered at place (building on secondary care post-acute pathways already in place). This work is currently in development across the Calderdale and Kirklees footprint.

2.4 Primary Care Network (PCN) Governance for the Safe and Secure Handling of the COVID-19 Vaccines

2.4.1 The Chief Pharmaceutical Officer for England wrote to CCGs on 8 December 2020 to set out principles and expectations for safe handling of Covid vaccines in Primary Care Network (PCN) sites. One of the NHSE expectations was that each CCG should have a COVID-19 Vaccine handling and management policy authorised and adopted by a suitable prescribing committee and shared with the clinical leads for the PCN sites prior to delivery of vaccinations. A model policy was shared by NHSE for this purpose and formatted as a Calderdale CCG policy. This required urgent ratification as the first PCN site required CCG designation to receive vaccinations and go live week beginning 14 December 2020.

2.4.2 Calderdale CCG does not have a prescribing committee, but is a member of the South West Yorkshire Area Prescribing Committee. This has no delegated responsibility from member CCGs to ratify policies. Therefore the Governing Body of the CCG was considered the most appropriate place to authorise this policy.

2.4.3 The policy needed approval for use in Calderdale by 14 December 2020. There was no scheduled meeting of the Governing Body preceding this that would allow the deadline to be met; so the policy was approved under urgent decision making powers as set out in the CCG's Constitution. The Constitution specifies that the powers which the Governing Body has reserved to itself may, in an emergency or for an urgent decision, be exercised by the Accountable Officer (or in his absence by the Chief Operating Officer) and the Chair (or in his absence by the Deputy Chair), after having consulted at least two other Governing Body members. On 11 December 2020 the Policy was approved by CCG Chair, Accountable Officer and Chief Operating Officer having consulted with the following Governing Body Members: Penny Woodhead (Chief Quality and Nursing Officer); Dr James Gray (GP Governing Member) and Dr Rob Atkinson (Secondary Care Specialist). In accordance with the requirements of the Constitution where these powers have been exercised, the decision is being reported to the Governing Body. The policy is provided at **Appendix 1** to this paper.

2.4.4 **Recommendation**

It is recommended that the Governing Body **NOTES** the policy's approval and adoption in Calderdale using urgent decision making powers.

3.0 All Age Mental Health

3.1 Transformation and Crisis Alternatives bids for funding

3.1.1 We know that mental health impacts on the pandemic will be a considerable challenge for our health and care system for many years to come. This builds an additional challenge alongside the ability to meet the mental health needs of our population. Community Mental Health Transformation is an exciting opportunity which aligns with the work of the Calderdale Collaborative Communities Partnership Board, the

Calderdale Wellbeing Strategy and Calderdale Cares to strengthen our neighbourhood locality based approach, harnessing the power of our communities with an ethos of user involvement and place consistent with our values and objectives.

3.1.2 Calderdale is submitting a bid to the West Yorkshire & Harrogate (WY&H) Integrated Care System (ICS) for NHS England & Improvement funding in January 2021. Over a three-year period, Calderdale will implement a holistic, neighbourhood approach to mental health and wellbeing for adults and older adults with Severe Mental Illness, built around Primary Care Networks (PCN). The aim is to dissolve barriers between primary and secondary care and connect people to the services and support they need in all aspects of their lives. The programme will be designed and implemented via partnership working with people with lived experience and system partners including the Voluntary and Community Sector, NHS and local authority. We have excellent support from our partners and are drawing from specialist public health resources to learn from best practice nationally.

3.1.3 In addition, Calderdale has submitted a separate bid for funding re Crisis Alternatives: piloting two link workers, one in A&E to work with individuals who attend frequently, in order to develop an alternative support network. The other will work in a pilot Primary Care Network area (to be confirmed) to work with people presenting in distress generated by social determinants. The bid will also help sustain the 24/7 Mental Health crisis line currently in place.

3.2 Mental Health Winter Pressures Funding

3.2.1 We have been successful in securing winter pressures moneys to:

- Enhance Mental Health support to Emergency Department and Acute floors to track and support service users presenting with physical issues, but have mental health needs in Calderdale and Huddersfield NHS Foundation Trust (CHFT).
- Enhance the Health psychology offer, focused on reducing frequent attendance at CHFT.
- Sustain Healthy Minds support in the Upper Valley, providing an alternative support offer in the community to reduce crisis presentations across the wider system.

4.0 Open Minds Partnership

4.1 The COVID pandemic has had a significant impact on the wellbeing, mental health and life chances of our young people. Evidence nationally from Young Minds suggests that 80% of children and young people feel that their mental health has deteriorated as a result of the pandemic. Children have found it challenging and isolating to be away from school, but also to return to school. Of teachers surveyed 92% believe children's vocabulary has declined as a result of not being at school. In Calderdale, the economic impacts of the pandemic have led to 596 more children receiving free school meals, food bank use accelerate and local authority children's social care demand increase.

4.2 We are supporting the emotional health and wellbeing of our children and young people through our work with the Wider Open Minds Partnership. Their second focused meeting took place on 20 October 2020 to focus on the impact of COVID on

children and young people returning fully to education, the delivery of the NHS Long Term Plan Children and Young People mental health commitments and the remaining areas for improvement from the Calderdale Local Transformation Plan. Meeting quarterly, this wider cooperative of local authority, NHS, education, voluntary and third sector organisations brings together the Local Authority's Emotional Health and Wellbeing Taskforce, Open Minds core mental health partners (Commissioners and Providers) and other key partners. This Partnership aims to foster a stronger partnership approach to delivering improvements in emotional health and wellbeing services for children and young people.

4.3 The Neurodevelopment (formerly Autism Spectrum Disorder (ASD)) Steering Group continued to meet despite the COVID-19 pandemic. The Group carried out an in-depth review of progress to date, the recommendations from the independent review in 2018, and feedback from young people at the 'Finding Your Brave' Summit in February 2020. The focus is to continue to take a whole system approach to meeting the needs of children and young people with ASD and Attention Deficiency Hyper Activity Disorder (ADHD). This builds on ways of working established through the Open Minds Partnership. The steering group remains committed to taking a system approach to providing support at the earliest opportunity regardless of whether a diagnosis has been made, and involving children, young people and their families in shaping the group's actions.

5.0 Elective Care

5.1 Calderdale and Huddersfield NHS Foundation Trust (CHFT) continue to cautiously increase theatre capacity where it is safe, although the infection rates and level of Covid positive patients within the acute system heighten the risk that some of this capacity could be lost. We have ongoing partnership discussions on this balance, seeking to restore services and support CHFT address the backlog in elective care.

5.2 The Independent Sector has a valuable role to play to enhance capacity and in order to support the system to see as many urgent patients as possible, using the Guidance provided by The Royal College of Surgeons to categorise patients, Andrew Bottomley is focusing on maximising activity in the available capacity across our 3 main providers. This involves moving priority and urgent patients into the Independent Sector Hospitals where appropriate, trying to minimise any risk of harm that may occur to long waits. This works is informed by the regional and national agreements in place and we work closely with colleagues in the Integrated Care System to maximise the benefits of this approach.

6.0 Integrating Care – CCG Response and West Yorkshire & Harrogate (WY&H) Next Steps

6.1 Attached is the response the CCG submitted to the national engagement exercise on Integrating Care (**Appendix 4**). In addition, there is a Calderdale place submission (**Appendix 5**) which was agreed with all local partners. Calderdale CCG have held a number of discussions with staff and partners on the proposals, and invited the ICS lead to a consultation event to outline the potential implications for Calderdale.

6.2 All CCGs shared responses, and Accountable Officers held a number of discussions collectively and with the ICS. The Integrated Care System (ICS) submitted an article to Local Government Association First which reached a large audience within local government written by myself, Councillor Swift, and Rob Webster, ICS lead Chief Executive. This builds upon our core principles in place and as a system. I have also participated in workshop discussions with the Kings Fund, Local Government Association and Institute for Public Policy Reseach to inform the development of policy positions on the proposals. On 13 January, I attended a reference group discussion with the Department of Health and Social Care Legislation Team who will be drafting the legislation to enact these proposals.

6.3 There were a number of common themes from responses within West Yorkshire;

- The importance of place as the primary unit of planning and collaboration. Future arrangements need to support this place focus, irrespective of organisational structure. Place based partnership is the default, needs to come first and is where most health and care is delivered.
- That ICSs are much broader than the NHS, and to realise their potential there needs to be effective partnership with local government, the voluntary and community sector and communities. This is potentially more problematic if the ICS becomes a statutory body in law, as by definition this will not include other partners, though it is hoped that the legislation is sufficiently permissive to enable more mature systems to not be inhibited by this.
- ICSs are uniquely placed to focus collective effort on health inequalities, through a population health focus and integrated working at neighbourhood level. The COVID-19 pandemic has brought these inequalities into sharp focus. Making health inequalities a priority is in the spirit of the Phase 3 letter in response to the pandemic sent by Sir Simon Stevens to all NHS Accountable Officers (AO) and Chief Executives on 31 July 2020.
- Throughout the document there is a welcome emphasis on creating flexibility and permissiveness within the arrangements to allow systems to develop arrangements that make sense locally.

6.4 There are a number of further developments across WY&H including;

- Reviewing the ICS operating model, looking at structure and operation of the ICS and the interaction between sectors, programmes and places.
- Part of the foundation of the ICS operating model is the Integrated Care Partnership (ICP) development framework. This will describe the essential features and working arrangements of place level ICPs, building on best practice across WY&H. This work will also broaden to describe in detail the potential governance and operating models for ICPs. I am involved in a small working group led by my colleague, Helen Hirst, AO for Bradford CCG, which is further developing this model.
- A new financial framework. This will be subject to further consultation with all CCGS.
- System clinical leadership, building on the WY&H Clinical forum. Dr James Thomas is leading this work on behalf of the ICS, and the effective integration of

clinical leadership at place and system level is recognised as something which needs strengthening from the current ICS Consultation Paper.

- Developing a common HR framework to support organisational change process. We recognise the changes proposed are unsettling for many staff, and we are working through check ins and staff workshops to ensure staff are updated and involved in the design of what happens next. We are committed to involving and supporting our workforce as we move forward on this.

7.0 EU Exit/Transition

7.1 In November 2020, the CCG responded to a series of questions asked by NHS England (NHSE) identifying any risks to the organisation in relation to EU-Exit. Areas that were included were: supplies of medicines and pharmacy, supply of non-clinical consumables, goods and services, workforce and data flow. Information was collated on these areas which established that the CCG had no EU Exit related issues expected to impact business critical areas.

7.2 Since 23 December 2020, all NHS organisations have been required to submit a daily situation report in which each organisation is expected to identify if they had similar issues. At the time of writing no issues have been identified. This requirement to submit daily situation reports continues until further notice.

7.3 The UK government has reached an agreement with the EU as to the relationship beyond the end of the transition period. The risk of disruption at the border remains when the UK leaves the Single Market and Customs Union at the end of the year, and so, organisations are asked to keep in place any plans and mitigations stood up for the end of the transition period until further notice. However, in terms of medicines there are still adequate national stockpiles and with this agreement in place it is less likely that there will be a need to draw down on them. The CCG is part of the district resilience arrangements through Gold and any risks are and will be evaluated in relation to the transition.

7.4 In relation to data transfer with data flows from the EU, there is now a bilateral agreement in place whereby the UK is regarded as ‘data adequate’ with no immediate impact on data transfers. Effectively the EU won’t treat as third country.

7.5 It is important to note that Covid vaccines are not affected by the UK leaving the Single Market and Customs Union.

8.0 Equality Information

8.1 On an annual basis the CCG publishes equality information, including setting and monitoring progress against equality objectives, to demonstrate CCG compliance with the Equality Act (2010) and how we are meeting the Public Sector Equality Duty. The CCG does this through the publication of an annual Equalities report; the timescale for publication is March 2021. To ensure the report fully reflects the activity and progress made during 2020/21 the Governing Body is asked to delegate approval, for

publication, to the Quality, Finance and Performance Committee and receive the full Equalities annual report for consideration at its April meeting.

8.2 We recognise as a CCG the disproportionate negative impacts of the pandemic for many of our most structurally disadvantaged communities, and have worked with other partner health and care leaders in place to support delivery of an action plan for our Black, Asian and Minority Ethnic (BAME) communities. We were also involved in the Integrated Care System (ICS) BAME Review, chaired by Dame Donna Kinnair, and are working to support implementation of the recommendations. We have also been involved in work at ICS level of health inequalities relating to learning disability, and mental health. We have led on an Equality Impact Assessment of the rollout of the vaccine in Calderdale as a system, and we are working to support improvement in data and delivery of our health and care services in this context.

8.3 These issues will be incorporated into the Equality Report that is being written.

8.4 **Recommendation**

It is recommended that the Governing Body **DELEGATES** approval of the annual Equalities Report to the Quality, Finance and Performance Committee.

9.0 Portable Appliance Testing

9.1 The CCG has a fire safety policy in place for the organisation. The policy includes details of the CCG's approach to minimising the incidences of fires within its premise and the impact of fire on safety. Although not a legal requirement, included in the policy is the requirement for annual PAT (portable appliance testing) testing for portable electrical equipment and this normally takes place in January. Staff are all currently working from home due to the COVID19 pandemic and therefore the CCG has decided that it is neither practical nor safe for staff to be invited into the office with their laptop, screen cables etc to have them PAT at this point.

9.2 Instead the following safety measures have been introduced;

- Regular updates to staff on electrical safety in the home including advice on undertaking simple visual inspections of cables and equipment (this is supported by advice given on the Health & Safety Executive's website). Technical knowledge of electrical items is not required to undertake these visual inspections.

- Annual fire training via Teams is starting on 5 January 2020 and will incorporate information on electrical/fire safety

10.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

10.1 I have appended a summary of the discussions and decisions reached at the Joint Committee of CCGs, which took place on 6 October 2020 and 12 January 2021.

11.0 Recommendations

11.1 It is recommended that the Governing Body

1. **NOTES** the content of the report.

2. **NOTES** the approval and adoption of the policy for Primary Care Network (PCN) Governance for the Safe and Secure Handling of the COVID-19 Vaccines in Calderdale using urgent decision making powers.

3. **DELEGATES** approval of the annual Equalities Report to the Quality, Finance and Performance Committee.

12.0 Appendices

- Appendix 1 Primary Care Network (PCN) Governance for the Safe and Secure Handling of the COVID-19 Vaccines
- Appendix 2 WY&H Joint Committee Key Decisions 6 October 2020
- Appendix 3 WY&H Joint Committee Key Decisions 12 January 2021
- Appendix 4 Integrating Care Partnership - CCG response to engagement
- Appendix 5 Integrating Care Partnership - Calderdale Place Submission

Primary Care Network (PCN) Governance for the Safe and Secure Handling of the COVID-19 Vaccines

Policy Ref No: 002

Version/Status:	1.0 / FINAL
Responsible Committee:	Governing Body
Date Approved:	11 December 2020
Author:	Helen Foster / Medicines Optimisation Lead
Responsible Lead:	Neil Smurthwaite, Chief Operating Officer
Review Date:	December 2021

Version History

Version No.	Date	Author	Document Status	Commentary:	Circulation
0.1	11/12/20	Helen Foster / Medicines Optimisation Lead	Draft	To be approved under Governing Body Urgent Decision Making arrangements as set out in the CCG Constitution (9.13.3)	- Dr Steven Cleasby, CCG Chair; - Robin Tuddenham, Accountable Officer; - Neil Smurthwaite, Chief Operating Officer; - Penny Woodhead, Chief Quality and Nursing Officer; - Dr James Gray, GP Member; - Dr Rob Atkinson; Secondary Care Specialist
1.0	11/12/20	Andrew O'Connor Senior Corporate Governance Officer	FINAL	**APPROVED** under Governing Body Urgent Decision Making arrangements as set out in the CCG Constitution (9.13.3)	- Governing Body - Helen Foster (Medicines Optimisation Lead) - CCG Website

Contents

Appendices

1 Introduction and Purpose

The COVID-19 vaccination programme is of the highest priority for the NHS. In order to deliver this programme both safely and effectively, good practice in the handling and management of vaccine is paramount. It is anticipated that a number of COVID-19 vaccines will be introduced during 2020 and 2021, so good governance is essential. Clarity of both the overarching principles and the detailed 'standard operating procedures' are required to enable safe, effective implementation and delivery of the vaccination programme. This document is to be read alongside the Standard Operating Procedure documentation developed for all COVID-19 vaccines and all environments in which they are handled.

This policy document enables corporate and professional governance for use of the COVID-19 vaccines, with the expectation that all areas detailed are addressed locally and that standard NHS medicines governance arrangements are in place.

The document is intended to provide the overarching principles for robust governance of the safe and secure handling and management of COVID-19 vaccines in the end-to-end supply chain for the vaccination programme.

2 Aims and Objectives

- To ensure that all staff involved in delivery of the vaccination programme are aware of, and adhere to, the correct procedures for the ordering, receipt, storage, supply and administration of the product.
- To ensure that the physical and biochemical integrity and sterility of all vaccines and related medicines is maintained.
- To ensure that all staff involved in delivery of the vaccination programme are aware of the relevant characteristics of COVID-19 vaccines and the implications this has for vaccine efficacy and patient safety.
- To provide assurance that vaccine safety, sterility, quality and efficacy is protected.
- To define key roles and responsibilities needed to deliver this assurance.
- To ensure that all staff understand their critical roles and responsibilities in delivering these objectives.

3 Scope of the Policy

All staff responsible for planning and managing the primary care COVID-19 vaccination programme in 2020/21and Pharmacy staff engaged in supporting and delivering the COVID-19 vaccination programme in 2020/21.

4 Roles and Responsibilities

The legal entity responsible for operating the vaccination site is to assign responsibility for clinical and operational oversight.

The PCN Clinical Director is responsible for service provision, aided by the relevant Primary Care Lead Pharmacist to ensure safe and secure handling and management of the COVID-19 vaccine and related medicines.

The CCG Governing Body is responsible for the approval and review of this policy.

5. Policy Details

COVID-19 Vaccines

There are a number of COVID-19 vaccines under development and it is anticipated that a range will be utilised in the vaccination programme. None will be authorised at the start of the programme so initially they will be unlicensed products temporarily authorised for supply under Regulation 174 of the Human Regulations 2012. This regulation enables the Medicines and Healthcare products Regulatory Agency (MHRA) to authorise use of a product on a temporary basis in response to the spread of pathogenic agents.

The characteristics of the different vaccines may vary considerably and will increase in clarity over time. Prior to licensing the product characteristics are available in the relevant 'Healthcare Professional Factsheet' and patient information in the 'Consumer Factsheet'. Following award of the Marketing Authorisation this information is available in the Summary of Product Characteristics and Patient Information leaflet respectively. The first requires transport and storage under ULT conditions (-70 +/- 10 C). This may not be the case for those that follow, but cold chain will be critical for all. Use of vaccines that have deviated from recommended storage or transportation conditions risks compromising vaccine efficacy and patient safety. Vaccines that have not been transported or stored correctly may be ineffective or harmful; they would therefore no longer be within the terms of their product authorisation or temporary regulation 174 authorisation and must not be used. Means of detecting when a temperature excursion has occurred are required. The focus on avoidance of waste should also be of high priority.

Further information concerning COVID-19 vaccines is available in the Public Health England publication 'COVID-19 vaccination programme Information for healthcare practitioners', available on:

https://www.gov.uk/government/publications/covid-19-vaccination-programme-guidance-for-healthcare-practitioners

Legal framework and practice standards.

All activity is to be undertaken in accordance with the Human Medicines Regulations 2012, as amended by the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020.

Adherence to national standards of good practice is required including those set by the Care Quality Commission, the National Institute for Health and Care Excellence, Public Health England and the Royal Pharmaceutical Society of Great Britain, as detailed in the Appendix 1 below.

Accountability and responsibility for vaccines, associated medicines and their supply chain

- The PCN Clinical Director is accountable for the safe and secure handling and management of medicines on all vaccination sites operating within or under the jurisdiction of their employing legal entity. This includes oversight of those elements of practice within designated vaccination sites that may impact upon product integrity, from receipt of product to vaccine administration. The PCN Clinical Director will be aided by the relevant Primary Care Lead Pharmacist.

- Calderdale CCG Governing Body will ensure that the above named individuals are documented.

- The PCN Clinical Director may delegate operational responsibility for oversight of ordering, receipt, storage and safe handling of vaccines and medicines, to a named and suitably trained member of staff on each vaccination site, aided by the relevant Primary Care Lead Pharmacist.

- This responsibility extends to oversight of issue of vaccines and medicines to roving vaccinators and for administration of vaccines by PCN staff within care homes.

- The Specialist Pharmacy Services Regional Quality Assurance Specialists will work with the Primary Care Lead Pharmacist to provide specialist pharmaceutical expertise in the development of systems and processes of work to ensure the safe and secure handling of the vaccine.

Handling and management of vaccine and medicines in vaccination sites

The PCN Clinical Director must ensure that all activities are carried out in accordance with:

- This policy document
- The relevant nationally authored documents and Standard Operating Procedures (SOPs)
- Relevant local organisational medicines policies
- Standard good practice guidance including aseptic technique
- Relevant Health and Safety guidance
- National Standards including those detailed in Appendix 1

Local amendments to this policy

Any amendments to this policy or relevant SOPs must be ratified by the CCG's Governing Body.

Staff authorisation to be supplied with and administer COVID-19 Vaccines

The Primary Care Lead Pharmacist must ensure that appropriate and formal authorisation for vaccine administration is in place such as a Patient Group Direction, protocol or written instruction, and that the staff groups who are supplied with, prepare, and administer the COVID-19 vaccine are those defined as eligible to do so.

Safety and security of vaccines and related medicines

The Primary Care Lead Pharmacist must ensure that that safe and secure handling and storage of vaccine and medicines are in place in accordance with principles and guidance encompassed in 'Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society of Great Britain)', available on https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines.

Storage and transportation of vaccines

The 'cold chain' is a term used to describe the cold temperature conditions in which certain products need to be kept during storage and distribution. Maintaining the cold chain ensures that vaccines are transported and stored according to the manufacturer's recommended temperature range until the point of administration.

Vaccines must be stored at the correct temperature and transported only in approved and validated packaging, and the temperature of the vaccine carrier and contents monitored and reviewed before use.

The Primary Care Lead Pharmacist must ensure that storage and transportation are undertaken in accordance with the relevant SOPs, that cold chain temperatures are monitored correctly and that any 'out of specification' recordings are addressed promptly and appropriately, and that a full audit trail is maintained. Further details are included in the relevant SOPs and in manufacturers' information.

Workforce and training

All staff undertaking duties at the vaccination site must meet the necessary training standards and competencies in line with the SOPs and standard organisational processes. A training needs assessment is required for the roles within the vaccination services, with corresponding training materials and assessment process, to enable timely and focussed workforce development.

As detailed in 'Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society of Great Britain)' (see Appendix 1) 'the named individual ensures that accountable individuals are competent and supported in their role as it relates to the safe and secure handling of medicines'.

The roles assigned to support the rollout of COVID-19 vaccination need to be in accordance with legislation including that detailed in the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020.

Precautions

Anaphylaxis kits including injections of intramuscular adrenaline 1:1,000 must be in date and readily available at all locations undertaking vaccination.

Any needlestick or other injuries must be addressed in accordance with the policies of the relevant employing legal entity.

Maintenance of records

All records must be maintained in accordance with relevant SOPs. These include the ordering, receipt and issue of vaccines, tracking of product, plus patient focused records including consent and administration.

Any serious adverse reactions are to be escalated for immediate senior clinical input; such situations are to be fully documented following the event and a record kept of relevant product batch numbers. A record of all serious adverse events is to be provided to the Primary Care Lead Pharmacist.

Data Protection

All staff have a responsibility to ensure that they do not disclose information about the service, service users, staff members and corporate documentation to unauthorised individuals.

Disposal of vaccines and other waste

Disposal of waste vaccines and any sharps must be undertaken in a safe and secure manner in accordance with relevant SOPs.

If any packaging includes dry ice this must also be disposed of in a safe and secure manner using appropriate personal protective equipment.

Business Continuity Planning

The Primary Care Lead Pharmacist will be responsible for establishing an agreed business continuity plan in relation to safe and secure handling of vaccines, and for testing this plan in line with the organisational emergency preparedness processes and NHS Core Standards for Emergency Preparedness, Resilience and Response (https://www.england.nhs.uk/ourwork/eprr/gf/). The business continuity plan should detail how the relevant aspects of the service will respond, recover and manage during disruption relating to people, information, security, premises including utilities, facilities particularly refrigerator (and if relevant ULT) failure, supplier, IT and data.

6. Appendices

Appendix 1 Links to relevant National Standards

Appendix 1: Links to relevant National Standards

CQC Regulation 12: Safe Care and Treatment
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment
'The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staffs have the qualifications, competence, skills and experience to keep people safe.
• Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.
• Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare.
The CQC understands that there may be inherent risks in carrying out care and treatment, and we will not consider it to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services and to manage risks that may arise during care and treatment'

NICE Clinical Guideline QS61: Infection Prevention and Control
https://www.nice.org.uk/guidance/qs61
This quality standard covers preventing and controlling infection in adults, young people and children receiving healthcare in primary, community and secondary care settings.

The Green Book - Immunisation against infectious disease (Public Health England)
https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book
The latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK. The COVID-19 vaccine chapter is available on:
https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a

Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society of Great Britain)
Adhere to the documented governance principles and relevant guidance.
Available on https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines

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

Summary of key decisions - Meeting in public, Tuesday 6th October 2020

Joint Committee governance
The Committee welcomed 2 new CCG Lay Members to their first meeting – Ruby Bhatti from Bradford District and Craven CCG and John Mallalieu from Calderdale CCG. The delegation of new commissioning decisions to the Joint Committee was noted.
The Committee: Noted that the new Joint Committee work plan had been agreed by all the West Yorkshire CCGs and **reviewed** the risks to the delivery of the work plan.
Commissioning Futures
The Commissioning Futures programme is being developed in collaboration with partners across the health and care system, including providers and local authorities and is based on our successful model of place-based working. There are three levels of commissioning, each tailored to local need and focused on improving population health. With an emphasis on place, work will only be carried out at WY&H level if it adds value to our places. A proposed operating model would come to a future meeting for approval.
The Committee: Agreed the next steps in developing the Commissioning Futures operating model.
Mental health learning disabilities & autism - Assessment and Treatment Units (ATUs)
The Committee considered proposals for ATUs, which involved collaborative commissioning between commissioners and providers. The proposal considered the whole pathway for people with learning disabilities. The Committee noted plans for engaging with people who had accessed care in ATUs, their carers and staff. Formal approval for commissioning ATUs would be sought at a future meeting of the Joint Committee, once the engagement had been completed.
The Committee: a) **Endorsed** the proposal to commission a new care model for people with a learning disability. b) **Supported** the proposed approach of provider-managed risk, subject to the further work of provider Directors of Finance and CCG Chief Finance Officers.
Urgent and emergency care – NHS 111 First
The NHS 111 First national programme builds on learning from COVID-19 about the high use of 111 by the public for advice and signposting. It encourages people to phone 111 as an alternative to 'walking' unheralded into Emergency Departments (EDs). The integrated offer includes alternative pathways, for example GPs, pharmacists and mental health advice. The aim was not to stop people attending ED, but to make it easier for them to access quickly the right support.
The Committee: Noted the national specification for NHS 111 First and the process for local implementation through a Yorkshire and Humber Programme Oversight Group.
Yorkshire and Humber commissioning framework for Yorkshire Ambulance Service (YAS)
YAS provides integrated urgent and emergency services across Yorkshire and the Humber (Y&H), which covers 3 Integrated Care Systems. A framework has been developed to strengthen the coordination of the commissioning of YAS services. It aims to balance the advantages of operating at scale with the need to be responsive to the needs of local places.
The Committee: **Noted** the development of the Yorkshire and Humber framework for integrated commissioning of Integrated Urgent and Emergency Care Services provided by Yorkshire Ambulance Service and **supported** the proposed next steps.

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

Summary of key decisions - Meeting in public, Tuesday 12th January 2021

Urgent and emergency care (UEC) - provider collaboration review
The Committee received a presentation on the Care Quality Commission (CQC) provider collaboration review (PCR) which had reviewed how health and social care providers were working together in response to Covid. Deep dive reviews were conducted in Kirklees and Harrogate, but the pathway had been reviewed across all places in WY&H. CQC had concluded that the system had worked well together, well established partnerships had allowed effective collaboration and that the response to Covid broke down barriers to achieving shared objectives.
The Committee: Welcomed the report and the best practice identified. It **noted** that the UEC Programme Board would be co-ordinating work across place, providers and ICS programmes to embed any findings that required substantial change.
Commissioning out of hours primary medical care services across West Yorkshire 2021 to 2024
The Committee considered a report on primary medical care services in West Yorkshire, which were provided by Local Care Direct (LCD). The current contract expired at the end of March 2021 and work to understand what would be required from April 2021 had been put on hold by the pandemic. LCD was a key partner in the system's integrated urgent and emergency care approach. The response to the pandemic, changes driven by national policy and potential changes to the commissioner landscape meant that there was uncertainty about what should be commissioned. To ensure continuity of service, prevent uncertainty and support system planning it was proposed that the service be extended for a further 3 year period. The Committee noted the long lead times for complex procurements and that in the current circumstances a pragmatic approach should be taken, This would give commissioners time to develop their requirements and inform a further decision about procurement during 2022.
The Committee: The Committee **agreed** to extend the current service from LCD for three years from 1st April 2021.
Amendment to Flash Glucose Monitoring Commissioning Policy
The Committee had previously approved a policy for commissioning flash glucose monitors - small sensors worn on the skin for monitoring the glucose levels of people with diabetes. The policy applied to patients with Type 1 Diabetes and the report proposed to amend the policy to include 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 proposed amendment was in line with advice from NHS England.
The Committee: The Committee **agreed** the amendments to the WY&H Flash Glucose Monitoring policy with immediate effect.
Joint Committee work plan – implementation update and risks to delivery
The Committee considered a high level summary of progress in implementing its work plan. This included improvements in urgent and emergency care and acute stroke services and the detection and treatment of atrial fibrillation. West Yorkshire Healthy Hearts had improved the treatment of people with high blood pressure and policies on evidence based interventions had reduced unnecessary procedures. A more detailed summary would feed into the Joint Committee's annual report
The Committee: Noted the report, alongside an update on the risks to delivery of its workplan.

Appendix 4

Integrating care Next steps to building strong and effective integrated care systems across England – Calderdale Place Feedback

Organisation	Calderdale Clinical Commissioning Group

Legislative Proposals: Please provide your comments on the 4 specific questions asked in the NHSE/I document.

Q1. *Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?*

We support the legislative proposals to place ICSs on a statutory footing. We would see this as based upon the core principles of place, provider collaboratives and system in that order of priority for health and care into the future. We see this paper as an opportunity to build upon strong existing relationships between our West Yorkshire ICS and Calderdale CCG. This relationship is founded upon the principle of subsidiarity, delivering at a local level by default, harnessing the potential of our partners and communities, based upon the lived experience of those who use our services, within the context of democratic accountability in our place. These are the founding principles of Calderdale Cares.

We believe our existing ICS exemplifies how a large health and care system can operate and this has been achieved without statutory impetus, but through partnership and collaboration. We believe you cannot mandate genuine collaboration, and would seek an authorising environment based upon minimum levels of intervention to shift how we operate now focused upon maximum impact.

CCGs play a pivotal role in our place-based arrangements and our partnership/collaborative working that then feeds into our ICS structure. The way that CCGs operate today is far removed from how they were configured by the 2012 Health and Social Care Act. Completely removing the local structure of our CCG into a wider system role without clarity and understanding of accountability risks losing the strong relationships built in Calderdale.

We see positive potential in the proposals to focus our place-based partnerships on the determinants of health and population health, but hope to see the final legislation have a greater focus on population health and reducing health inequalities throughout all elements of the legislation and future system model. This could be informed by the work done by our system at all levels, through PCNs, through our commissioned services and through our ICS Improving Population Health programme. We also think that the renewed aim of NHSE to address health inequalities can only be realised through sustained commitment to place based partnerships with local government with relentless focus on social care and public health, prevention and wellbeing as well as delivery of health services.

There needs to be a clear understanding of the financial framework and local accountability, as without knowing what locally you are accountable for will cause difficulty on relationships and delivery. This is undeveloped in the paper and will

contribute significantly to how the system operates.

Learning from the close down of Primary Care Trusts, the process needs to recognise that changing organisational structures can have major impacts on resource, relationships, partnerships, delivery, and will be a huge distraction working through governance and contractual responsibilities necessary for the change. We shouldn't underestimate the impact these changes will have on staff and lack of clarity that just increases uncertainty.

We are sceptical that these changes can be achieved by the stated dates in the consultation, though believe there is greater support for the shift than during the changes brought about by the 2012 Act.

Q2. *Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?*

Comments:

Both options provide clear accountability and simplify the number of organisations with statutory accountability, but we are not sure either provides greater incentive for collaboration. Within the West Yorkshire ICS and Calderdale, the local place based accountability and arrangements recognise place is where the greatest impact is for patients and recognises the benefits for working at scale across West Yorkshire where needed. This needs to be further thought about in proposals to recognise and not disrupt what is working across out local and larger footprints.

Relationships are key to collaboration and the models need to work through how accountability allows greater collaboration, there are clear issues with how foundation trusts and primary care (general practice) are contracted and represented that don't always assist with collaboration and ownership of priorities, which isn't solved by simpler accountability to parliament and can lessen the patient voice.

The lack of reference to user voice and key bodies such as Healthwatch in the proposals is very disappointing. We hope that the next iteration of the proposals aligns how place, provider collaboratives and system supports our communities, our families, our residents meaningfully shape the health and care services they receive throughout their lives.

Q3. *Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?*

Comments:

Yes, this very much supports the model adopted in Calderdale and West Yorkshire where we pride ourselves on ensuring participation from a wide range of groups, such as Health watch, third sector organisations and hospices. This model of participation has been developed in our local arrangements and ensure voices from all key partners are heard and can influence services for patients.

Clarity will be need to ensure the models proposed on how CCGs functions move to an ICS and into local arrangements so they can continue to flourish. The link between the ICS and place is critical and the ability to shape governance would be key as it would risk undermining everything we currently have in place.

PCNs clearly have a role but we need to recognise their development is still at a relatively early stage, though we have very recently seen PCNs respond brilliantly to the deployment of the vaccine. Significant progress had been made in their development, but contractual methods doesn't enable them to realise the potential of their strategic role within the place and ICS.

Clinical leadership is pivotal through all our work in place, provider collaboratives and within the ICS. Clinical leadership brings expertise, grip on practice and authority to inform the best outcomes for our health and care systems at all levels. The ability to shape our own governance informed by clinical leadership is key. We need to ensure collective voice for our clinicians, minimising the bureaucratic burden, ensuring patient and user voice is heard and acted upon.

Q4. *Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?*

Comments:

Yes, there needs to be significant work on those safeguards and to learn from the delegation of primary care. The services need to be transferred and not delegated as delegation just creates additional layers of bureaucracy and can slow down decision making.

This process needs to be combined with effective system leadership, focus on outcomes, clinical and patient voice and a shift in organisational cultures which incentivise the right interventions, and align budgets with effective long term planning.

In summary, we support these proposed changes with maximum flexibility and a core emphasis on the primacy of place as where all of us live our lives and where those that access our services receive them.

Integrating care Next steps to building strong and effective integrated care systems across England – Calderdale Place Feedback

Other Comments: *Please provide any other comments you have on the NHSE/I proposals.*
Comments: There needs to be more recognition of the impact this will have on CCG staff and the risk of them seeking new roles elsewhere. Clarity about future employer needs to be achieved as soon as possible. The impact of numerous changes over the years with CSUs shouldn't be underestimated in West Yorkshrie. Staff need to be looked after, valued and recognised which wasn't fully reflected in the employment guarantee. The process of transition between now and 2022 will be more complex than suggested in the NHSE/I paper. The timescales are extremely ambitious given the extent of work required to close down existing CCGs, manage TUPE transfers, novate contracts, establish new governance arrangements etc.

Calderdale Health & Care Leaders response to NHS England and NHS Improvement's publication on 26 November 2020 - ***Integrating Care: Next steps to building strong and effective integrated care systems across England***.

Our 'Calderdale Cares' has been our adopted programme in for integration and was adopted by all partners in 2018 through our Health & Wellbeing Board. Partners include Calderdale CCG, Calderdale Council, Calderdale & Huddersfield NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Locala, Calderdale Healthwatch and Calderdale Voluntary Sector Alliance to deliver an integrated system of health and social care across Calderdale.

Its aim is to develop a system model for integrated services that joins up care around the mental, physical and social needs for the people of Calderdale. Our strategic thinking has developed over time and we now have a mature partnership ready to move to the next phase of integrated partnership working.

This programme has made better use of scarce resources, and has built resilience across Calderdale's communities, recognising the strengths individuals have. Our five localities have been a vital part of our new architecture, enabling us to work with our communities, and build new offers with our partners.

The fundamental aim of the Calderdale Cares Programme is to improve the health and wellbeing of the people we serve, enabling them to live fulfilled lives. At its heart are principles around voice and influence, and the wider factors that influence wellbeing; particularly addressing economic factors and inequalities.

The programme is important in delivering our ambition to the to be the best borough in the North; working with our distinctive communities, designing for kindness and parity of esteem for emotional health, valuing our enterprising and talented staff, and creating a resilient health and care system (as set out in Vision 2024).

We therefore welcomes the publication of Integrating Care: Next steps to building strong and effective integrated care systems across England which builds on the NHS Long Term Plan ambitions and the lessons learned from successful collaborations during the Covid-19 response as this represents a step change in the evolution of system working underpinned by detailed policy and proposed legislation.

We have strived to move away from traditional ways of thinking about health and care services, recognising the benefits of community resilience in supporting people, and that connectivity is needed between health and care and a person's wider needs such as housing, education, employment and family. Our approach is tailored to the local population, and features multi-disciplinary teams in local care networks built around primary care, using community assets to wrap around citizens. The emphasis of our model is on supporting people to be healthy and well and this will continue to be our focus moving forward.

In Calderdale we developed the Voluntary Sector Alliance, a co commissioned structure, which represents a number of charitable and community organisations and enables a single voice to heard and represented at our Health & Wellbeing board. The importance of this sector is recognised in the Council Inclusion Strategy and was shown by the number of volunteers that have helped during the recent floods and with shielded patients during this pandemic. Having an Alliance has enabled quicker decision making to fund projects such as the Gathering Place which provides our winter homeless shelter to extend this offering to the vulnerable group during the pandemic.

As a place and partnership we have developed an asset based approach that ensures people live a larger life through accessing creative cultural and physical activities and spaces that enables them to live well and improve their mental and physical health.

Health & Social care leadership has continued to grow will multi discipline working enabling reductions in our delayed discharge over the last 18 months. And we have seen significant strides in our young peoples mental health with the development of our Thrive Model and the Open Minds partnership which is led by patients.

Calderdale recognises the benefits of the place and system, having coterminous local authority and health commissioning at place sitting withing the system level of West Yorkshire, we hope that this relationship and the work undertaken in place and system with Combined Authorities and the Health Care partnership are not lost in developing the models and builds on the strong relationships already developed.

In addition, we have worked very closely at Place with our all partners in our response to Covid-19 in the face of some of the highest Covid activity in the country. We believe that this and the previous work that we have done to date puts us in an extremely strong position to move forward with the ambitions, proposals and structural changes outlined in the NHSE/I Integrating Care Document. We welcome a clear transition plan for staff colleagues affected by the changes which will be critical in minimising any disruptions and supporting our people during what is already an unprecedented and challenging time.

Any proposed changes will need to build on the progress that places and systems are making and not be received as a top down major restructure that distracts from the significant collective effort that will be required in 2021 to deliver our commitments to the public and fully restore services inclusively.

We remain fully committed to improving the health of our population, addressing health inequalities and providing better quality and value of care for the people of Calderdale.

In response to the specific questions asked:

1. **Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?**

   AGREE

   We agree with this approach and believe it is a positive step change in evolving system working and emphasising population health, clinical engagement and leadership in decision making. However, we do add the caveat that the new statutory bodies should focus on collaboration with partners across all areas including local authorities, social care, voluntary sector, education and other public services and seek to embed partnership working. Our Local Authority would welcome more clarity around inclusion and funding models etc and there appears to be a lack of funding around social care which is not addressed in the document.

   We would also like to see greater clarity about the statutory accountability of organisations in relation to place, provider collaboratives across ICS and the system.

   There needs to be a clear commitment and some assurances that all ICSs give equal voice to all partners including MH, LD&A, public health, community and primary care including where organisations span more than one ICS in the delivery of care in decision making and representation at ICS level.

2. **Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?**

AGREE

We agree that Option 2 offers a better model to support collaboration and eliminate competition amongst organisations than the current legislative framework. We have worked very hard in Calderdale to work collaboratively in spite of the constraints of current legislation and welcome the opportunity to build on this through the new model.

We welcome the recognition of the role of local government and the need to work at place. However, there is no specific commitment to build on what exists – for example, existing integrated care partnerships and health and wellbeing boards.

We would like to see more clarity around the structure of Place and delegation of budgets as mentioned in Section 2.43 of the document and the accountability around this process. We welcome the opportunity to work with the ICS to ensure that significant budgets are devolved to Place level and look forward to the new powers that will make it easier to form joint budgets with the local authority, including for public health functions.

The principle of subsidiarity should be strengthened and consistently applied across ICSs to ensure that primacy of place is paramount in decision making and collaboration with communities and the public to tackle inequalities, address the wider determinants and improve health and care outcomes with the public accountability measures outlined in the proposals adopted across all ICSs. Place needs to be the starting point and should only push up to ICS that which Place collectively agree needs to happen at a system level asking the question “what can the ICS do for Place to add value”.

3. **Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to be suit their population needs?**

AGREE

We agree with this statement and to support us in continuing and building on our success to date we would encourage optimum devolvement, on the basis of subsidiarity, of the ICS to Place level as much as possible.
We are in total agreement and aligned with the direction of travel of the West Yorkshire & Harrogate Health Care Partnership (ICS) that decisions should be taken as close to patients and communities as possible.

We would like to see a stronger emphasis on ensuring the system governance arrangements build on and enhance existing place and neighbourhood governance arrangements.

We consider it extremely important to have strong place-based partners on an equal footing in terms of joint decision making and senior leader investment into the process. Primary Care at scale (GP Federation / PCNs), Community Care, Mental Health, Public Health and Prevention, Voluntary sector partners and other key stakeholders as well as the larger providers need to be included as equal and valued partners in our future place-based governance. There needs to be whole place discussions around the table and transparency of Place and ICS governance, including public accountability and assuredness.

We welcome local flexibility and we would endorse a stronger commitment to ensure that the voice of the public and communities is strengthened or maintained in Place partnership arrangements through Healthwatch and the voluntary and community sector.

4. **Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?**

   AGREE

   We would support this approach in principle as there are clear advantages of commissioning strategically at system level and aligning resources and funding to population need. However, we would ask for more clarity on the commissioning proposals and ownership as this transition, and the others above, will require clear, effective and robust planning of governance, accountability, financial flows and statutory responsibilities to ensure avoidance of duplication across levels. Greater clarity on how funding will be allocated and prioritised will be important at both place level and ICS level simultaneously and how pooled budgets with LA partners will work in practice.

   In respect of the Public Contracts Regulations 2015 and the proposal to remove the NHS from the scope of the 2015 regulation we would recommend that local government and the NHS to operate within the same legal framework wherever possible. The proposed changes would lead to a lack of alignment between NHS and councils which might be a challenge for joint commissioning.

   We support commissioning to continue to have a strong place-based focus, with a strong and proactive role in HWBs involvement in commissioning plans, with greater clarity on the potential role of the ICS in specialised commissioning and its impact on providers and collaboratives.

   As Place will play a critical role, leading on system integration, public involvement, driving our population health-based approach, supporting the development of clinical leadership and ensuring clear and strong local accountability we need to ensure that we retain accountability, leadership capacity and skills at Place level and that these are not weakened by the proposed changes in transferring or delegating services.

Name of Meeting	**Governing Body**	**Meeting Date**	28/01/2021
Title of Report	**Seamless Home from Hospital Service**	**Agenda Item No.**	7
Report Author	Brenda Powell, Procurement Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby	**Responsible Officer**	Martin Pursey, Head of Contracting & Procurement

Executive Summary							
Please include a brief summary of the purpose of the report	The purpose of this report is to: ▪ Provide assurance for the Governing Body as lead commissioner in respect of the robust tender process, evaluation and recommendation for the appointment of a provider of the Seamless Home from Hospital Service ▪ To enable the Governing Body to consider the recommendations and approve the contract award to the identified bidder for the service ▪ To provide details of the next steps in terms of contract award and mobilisation of the service						
Previous consideration	**Name of meeting**	Quality Committee		**Meeting Date**	21.05.2018		
	Name of meeting			**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: 1. **APPROVE** the contract award to the recommended provider. 2. **NOTE** the process for selecting the provider for the Seamless Home from Hospital Service.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications	Not applicable		
Public / Patient / Other Engagement	Not applicable		
Resources / Finance implications	The CCG will commission and ensure the provision of sustainable services within the resources it has available		
Strategic Objectives	• Achieving the agreed strategic direction for Calderdale • Improving quality • Improving value	**Risk**	Not applicable

Legal / CCG Constitutional Implications	The CCG will apply appropriate governance, follow procurement policy and ensure sound financial management in doing so.	**Conflicts of Interest**	Any interests will be managed in line with the CCG's policy for managing Conflicts of Interest

1. Introduction

1.1 NHS Calderdale and Greater Huddersfield CCGs are seeking to commission a Seamless Home from Hospital Service (SHFH). The service will contribute to the delivery of Calderdale and Greater Huddersfield CCGs objectives of promoting health and wellbeing, commissioning and providing the best possible care for patients. The aims of the service are to contribute to a reduction in avoidable hospital admissions and delayed transfers of care. Avoidable admissions include admissions from A&E for non-clinical reasons and readmissions after discharge.

1.2 Patients referred to SHFH will be resident in Calderdale or Greater Huddersfield CCG areas. They will have presented at or been admitted to Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH). In some cases the patient may have subsequently been transferred to Intermediate Care.

1.3 SHFH provides a service to patients to avoid admission and those being discharged:

- The service to patients avoiding admission is offered as part of the Integrated Admission Avoidance service, in conjunction with the Hospital Avoidance Teams (HAT). These patients will have presented at A&E at HRI or CRH. Clinical staff will have determined no clinical reason to admit to an inpatient ward but the patient is frail or vulnerable and needs additional support to ensure their safety and wellbeing to return home.

- Patients being discharged will have been inpatients at HRI, CRH or an associated Intermediate Care facility. Patients will be medically fit for discharge however may be frail or vulnerable and need additional support to ensure their safety and wellbeing going home.

2. Detail

Process

2.1 A Market Test was undertaken in November 2019 to gauge interest with providers. At the deadline four responses were received. The response demonstrated provider's ability to offer the service requirements.

2.2 Following approval to proceed to procurement, a competitive tender process was undertaken using the CCG's normal procurement resource and procedures i.e. NHSSourcing (Bravo) e-tendering system and AWARD e-evaluation system

2.3 The service is to be delivered under a NHS Standard Contract which will have a term of 3 years from 1 April 2021, with an option to extend for 2 years, the financial envelope for the whole term, including the extension period of the contract is anticipated to be £1,580,480 (Calderdale: £790,240)

2.4 The procurement timetable as agreed is provided below (this was subject to change):

Stage	Key dates
ITT submission dates	*1 September – 6 October 2020*
ITT Evaluation	*8 October – 17 November 2020*
Consensus meeting	*18 November 2020*
CCG Approval route (if applicable)	*Governing Body 28 January 2021*
Notification of Outcomes	*29 January 2021*

End of 10 day stand still (Alcatel)	*9 February 2021*
Contract Award & Mobilisation period	*10 February – 31 March 2021*
Service Start Date	*1 April 2021*

2.5 In accordance with a competitive procedure the criteria for contract award was agreed and the Invitation to Tender (ITT) documents published for all providers to access. The ITT was issued in accordance with the timetable and the project plan.

2.6 Twenty-five suppliers registered an interest for this service with four suppliers submitting the completed ITT documentation by the deadline date. These responses were then subject to evaluation. Details of the service specific questions are attached as Appendix 1.

Evaluation

2.7 In accordance with the CCG's procedures, the evaluations were undertaken by a suitably qualified and experienced panel comprising of a CCG Service Leads, Quality Officer, Contract Officer, and Finance Lead. The responses were evaluated in accordance with the pre-determined percentage weighted criteria.

2.8 Scoring rationale used for this procurement was:

Score	Definition	Score
Excellent Response	Bidder demonstrates a clear approach and addresses ALL of the required aspects of the question and provides practical examples	100
Very Good Response	Bidder demonstrates understanding and a clear approach and the answer addresses ALL the required aspects of the question	90
Good Response	Bidder demonstrates understanding and a clear approach and the answer addresses the majority of the required aspects of the question	70
Minor Concerns	Incomplete answer; fails to address some of the required aspects of the question	30
Moderate Concerns	Incomplete answer; fails to address all the required aspects of the question. Demonstrates a lack of understanding	10
Major Concerns	Inadequate answer	0

2.9 Scores were combined and the top scoring provider will be identified as the preferred bidder. This will then form the basis of the recommendation to award a contract.

2.10 The AWARD e-evaluation system was used by evaluators to input their score and rationale/comments on the bids received to ensure a full audit trail and to aid feedback following the award of the contract.

2.11 The summary of the aggregate scores are detailed below. An example of a consensus extract from the AWARD e-evaluation system is attached as Appendix 2. The AWARD system provides a full audit trail to demonstrate the robustness of the process.

Provider	Evaluated Score (%)	Moderated Score (%)
Bidder 1	2.4	0
Bidder 2	88.8	87.5
Bidder 3	45.3	34
Bidder 4	73.8	70.5

2.12 On the basis of this evaluation and moderation, **Bidder 2** scored the highest overall score, and is the preferred bidder for recommendation for approval to award.

3. Next Steps

3.1 To consider the process undertaken to procure the services for the Seamless Home from Hospitals Service and confirm both the robustness and compliance of the process and their confidence in the outcome of the evaluation.

3.2 Following approval to award the contract to the identified bidder, the Procurement Team will proceed to award the contract and provide debriefing reports to the unsuccessful bidders with further feedback provided if requested.

3.3 Service commencement 1 April 2021.

4. Recommendations

5.1 It is recommended that the Governing Body:

1. **APPROVE** the contract award to the recommended provider
2. **NOTE** the process for selecting the provider for the Seamless Home from Hospital Service

5. Appendices

Appendix 1 – Service specific questions
Appendix 2 – Submission scores

Appendix 1 – Service specific questions

Service Delivery (Weighting 25%)
2.1.1 Please provide details of your proposed service delivery model and how you fulfil the requirements of the specification. **Maximum word count:** 1500 words

Your response must include the following:
 	
A description of the model of delivery and service pathway, identifying the key aspects of the model:
 	
• Please provide details of your approach to providing services:
  o For a demographically diverse population of service users in Calderdale.
  o That meets people's physical and psychological needs.
  o Delivered by a multi-disciplinary team.
  o As part of an integrated system based on effective processes, communication, collaboration and partnership working.
  o Engagement with other relevant health and social care stakeholders and partners.
• How the service will support the personalised care agenda/needs.
• How the service will be sustainable.
• Examples of how the multi-disciplinary team would operate.
• How you will ensure that your service has the required capacity to ensure timely service provision, including your method of managing demand and activity.
• How you would build and maintain effective working relationships with other stakeholders such as primary care, acute trust, Calderdale and Kirklees Councils and other providers.
• Any sub-contract arrangements and how these will be managed to ensure they comply with the specification and NHS quality and Information Governance requirements. If you do not have any sub-contract arrangements please provide confirmation of this in your answer.
• Please illustrate your answers with any relevant previous experiences where appropriate.
 	
An illustration of the service delivery model on one side of A4 can be provided. This will not be included in the word count.

Service Quality (Weighting 20%)
2.2.1 Please describe your approach to adherence of the national/local targets and standards set out in the specification in delivery of this service, including, but not limited to: • CQC Essential Standards of Quality and Safety • Health and Social Care Act (2008) • NHS High Quality Care for All (2008) • National Service Frameworks • National Institute for Health and Clinical Excellence (NICE) guidance and guidelines including Safe Staffing Guidelines 1 • Mental Capacity Act 2005 • Deprivation Of Liberties Safeguards • Local Transport Act 2008 • Quality for Health **Maximum word count:** 500 words

Your response must include the following:

- Management of quality assurance, patient safety and staff safety, safeguarding, infection prevention and control, complaints handling and incident reporting and management (including serious incidents).
- How the service facilitates learning from, for example, quality audits, service user and stakeholder experience and action planning, including improvement of quality of care to service users.

2.2.2 Please describe how you will engage and involve service users in the mobilisation, development and delivery of the service.

Maximum word count: 750 words

Responses should include, but not be limited to:

- Identifying key service users/groups from the diverse communities of Calderdale.
- How service users will be engaged and involved in service development, particularly in relation to accessibility, information and communication and information sharing.
- How you will gather and act upon service user feedback to improve the service.
- How this will be shared with the Commissioner.

Workforce (Weighting 15%)

2.3.1 Please describe the proposed structure of the multidisciplinary workforce who will deliver this service.

Maximum word count: 1000 words

Your response must also include the following:

- A description of how the workforce will be configured to maximise innovation, cost effectiveness, and flexibility.
- A description or illustration of how this workforce fits into your organisation structure.
- The professional, technical and quality skills, knowledge and experience of these staff
- Supervision arrangements.
- How you will ensure staff are trained and supported to maintain appropriate levels of continuous development, reduce turnover and support retention.

Mobilisation (Weighting 15%)

2.4.1 Please provide a detailed plan of how you will mobilise and implement the service.

Maximum word count: 500 words

Your plan must include the following:

- Details of the mobilisation and implementation team
- Key contacts and details of accountability
- Governance arrangements
- Key tasks and milestones, including completion dates
- Risks and mitigation
- Where key tasks are critical and dependent on others and how these will be mitigated
- Service user and other stakeholder communication, engagement and involvement
- How you will interface with other relevant providers
- Prospective locations for service delivery
- IT and information systems and set up
- Demand, activity and outputs/outcomes monitoring
- Details regarding TUPE of staff

Please illustrate your answers with relevant previous experiences where appropriate.
Please provide a Gantt Chart or plan. This will not be included in the word count.

Performance (Weighting 10%)

2.5.1 Please describe your approach to monitoring performance and outline how you will meet the monitoring and reporting requirements, as detailed in the service specification.

Maximum word count: 500 words

Response should include, but not be limited to:

- Key performance indicators
- National standards and guidelines
- The mechanisms by which you will internally analyse performance to outline areas for improvement
- How you will monitor and report quality information i.e. incidents, complaints and concerns for discussion at contract meetings
- How you will feed back and escalate issues and risks to Commissioners

Please provide an example of a performance report. This will not be included in the word count.

Finance (Weighting 15%)

2.6.1 Please complete and upload the costing matrix, this can be found under the supplier attachment area.

Appendix 2 – Submission scores

Report Type: Results Worksheet
Project: Calderdale & Greater Huddersfield CCGs: Seamless Home from Hospital Service
Exercise: Consensus Revision: Base Version Lot: All
Submission: All Anonymous Submissions: No
Answer Measures: Score

Report Date: 24/Nov/2020 15:30:07 Report Timezone: (GMT) Western Europe Time, London, Lisbon

Section	Question	Submission	Measure: Score - Answer	Weighting (%)	Score (%)
Overall		Bidder 1		100	0
Overall		Bidder 2		100	87.5
Overall		Bidder 3		100	34
Overall		Bidder 4		100	70.5
Technical	2.1.1	Bidder 1	Major Concerns	25.0	0.0
Technical	2.2.1	Bidder 1	Major Concerns	10.0	0.0
Technical	2.2.2	Bidder 1	Major Concerns	10.0	0.0
Technical	2.3.1	Bidder 1	Major Concerns	15.0	0.0
Technical	2.4.1	Bidder 1	Major Concerns	15.0	0.0
Technical	2.5.1	Bidder 1	Major Concerns	10.0	0.0
Technical	2.6.1	Bidder 1	Major Concerns	15.0	0.0
Technical	2.1.1	Bidder 2	Very Good Response	25.0	22.5
Technical	2.2.1	Bidder 2	Minor Concerns	10.0	3.0
Technical	2.2.2	Bidder 2	Excellent Response	10.0	10.0
Technical	2.3.1	Bidder 2	Very Good Response	15.0	13.5
Technical	2.4.1	Bidder 2	Very Good Response	15.0	13.5
Technical	2.5.1	Bidder 2	Excellent Response	10.0	10.0
Technical	2.6.1	Bidder 2	Excellent Response	15.0	15.0
Technical	2.1.1	Bidder 3	Minor Concerns	25.0	7.5
Technical	2.2.1	Bidder 3	Minor Concerns	10.0	3.0
Technical	2.2.2	Bidder 3	Good Response	10.0	7.0
Technical	2.3.1	Bidder 3	Minor Concerns	15.0	4.5
Technical	2.4.1	Bidder 3	Minor Concerns	15.0	4.5
Technical	2.5.1	Bidder 3	Minor Concerns	10.0	3.0
Technical	2.6.1	Bidder 3	Minor Concerns	15.0	4.5
Technical	2.1.1	Bidder 4	Good Response	25.0	17.5
Technical	2.2.1	Bidder 4	Good Response	10.0	7.0
Technical	2.2.2	Bidder 4	Good Response	10.0	7.0
Technical	2.3.1	Bidder 4	Good Response	15.0	10.5
Technical	2.4.1	Bidder 4	Good Response	15.0	10.5
Technical	2.5.1	Bidder 4	Minor Concerns	10.0	3.0
Technical	2.6.1	Bidder 4	Excellent Response	15.0	15.0

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**Equality and Inclusion Strategy 2020-22**	**Agenda Item No.**	8
Report Author	Kate Bell, Equality Lead	**Public / Private Item**	Public
GB / Clinical Lead	Alison MacDonald, Lay Member, Patient and Public Involvement	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary							
Please include a brief summary of the purpose of the report	The Equality and Inclusion Strategy 2020-22 delivers a public statement of commitment to equality, diversity and inclusion. It also provides a framework to help us deliver our ambition to move beyond compliance to real inclusion, where the voices of our communities and staff are actively listened to and prioritised in decision-making.						
Previous consideration	**Name of meeting**	Senior Operational Group	**Meeting Date**	30/11/2020			
	Name of meeting	Senior Management Team	**Meeting Date**	05/01/2021			
Recommendation (s)	It is recommended that the Governing Body **APPROVE** the strategy for publication.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications							
Quality & Safety implications	None						
Engagement & Equality implications	The report outlines the CCGs commitment to equality and describes what we will do to meet our equality obligations. It also describes the interdependencies between engagement and equality.						
Resources / Finance implications	None						
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	x	
Strategic Objectives	Improving quality Improving governance	**Risk**	n/a				
Legal / CCG Constitutional Implications	No legal or constitutional implications	**Conflicts of Interest**	No conflicts of interest have been identified.				

1.0 Introduction

1.1 The Equality and Inclusion Strategy 2020-22 delivers a public statement of our commitment to equality, diversity and inclusion. It also provides a framework that helps us deliver our ambition to move beyond compliance to real inclusion, where the voices of our communities and staff are actively listened to and prioritised in decision-making.

2.0 Detail

2.1 The updated strategy reflects our evolving priorities due to the onset of COVID-19 and the differential impact it has had on some communities.

2.2 The pandemic has amplified the health and wider inequalities that already exist in our society. The virus has been particularly damaging to people living in areas of high deprivation, people from Black, Asian and Minority Ethnic (BAME) communities, older people, men, those who are obese, those with long-term health conditions, including severe mental illness, people with a learning disability and other inclusion health groups, and those in certain occupations.

2.3 The CCG's response to the inequalities highlighted by COVID-19 is crucial. The strategy ensures that addressing health inequalities is at the centre of our commissioning decisions and that services are restored and redesigned in a way that challenges entrenched inequalities and improves inclusion.

2.4 The third phase of the NHS response to COVID-19 urges NHS organisations, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities. The strategy highlights our commitment to working with partners across the system to share insights and resources and develop innovative ways to advance equality and reduce health inequalities.

2.5 The strategy identifies the following key measures to track progress:

- Progress against Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and workforce equality action plans
- Progress against equality objectives and action plans
- Progress against the COVID-19 reset action plan
- Improved engagement with local communities and inclusion health groups, e.g. homeless people, refugees and asylum seekers etc.
- Increased representation of BAME voice in decision making
- Reduction in the % of BAME and disabled colleagues who experience bullying and harassment
- Increase in the % of BAME colleagues in senior and leadership roles

3 Next Steps

3.1 To publish the strategy on our website and share with partners. An accessible version of the document will be developed and published alongside the strategy.

4 Recommendations

4.1 It is recommended the Governing Body **APPROVE** the strategy for publication.

5.0 Appendices

5.1 Appendix 1 – Equality and Inclusion Strategy 2020-22

NHS
Calderdale
Clinical Commissioning Group

Equality & Inclusion Strategy 2020-2022

IMPROVING HEALTH, IMPROVING LIVES

Introduction

NHS Calderdale Clinical Commissioning Group

NHS Calderdale CCG aims to improve the lives of local people by reducing unfair and avoidable differences in health (health inequalities) and making sure we commission and plan good quality services that meet the needs of our diverse communities.

We will work with patients, staff and our health and social care partners, such as the West Yorkshire and Harrogate Health and Care Partnership, local hospitals, local authorities and local community groups, to make sure services meet local needs.

Our Equality and Inclusion Strategy outlines how equality is central to the way we do business. It provides a flexible framework to help us deliver our ambition to move beyond compliance to real inclusion, where the voices of our communities and staff are actively listened to and prioritised in decision-making.

Our aims

NHS Calderdale Clinical Commissioning Group

The CCG aims to:

- Ensure that we make decisions and commission services in a fair and transparent way that meets the healthcare needs of all our communities and reduces health inequalities.
- Involve our patients, carers, staff and the wider public in shaping and improving our services by proactively seeking their views and making sure we reach those who are not always heard.
- Be a strong leader working with our partners to champion and drive equality and inclusion.
- Employ a diverse and representative workforce where all staff are treated fairly and supported to reach their full potential.
- Employ a diverse leadership that reflects our communities.

Context

NHS Calderdale Clinical Commissioning Group

This updated strategy reflects our evolving priorities due to the onset of COVID-19 and the differential impact it has had on some communities. The pandemic has amplified the health and wider inequalities that already exist in our society.

The virus has been particularly damaging to people living in areas of high deprivation, people from Black, Asian and Minority Ethnic (BAME) communities, older people, men, those who are obese, those with long-term health conditions, including severe mental illness, people with a learning disability and other inclusion health groups, and those in certain occupations.

The CCG's response to the inequalities highlighted by COVID-19 is crucial. We will ensure that addressing health inequalities is at the centre of our commissioning decisions and that services are restored and redesigned in a way that challenges entrenched inequalities and improves inclusion.

Our local population

NHS Calderdale Clinical Commissioning Group

To make sure we know enough about our communities to address their needs we use this data to help us commission fair and equitable services. This is supplemented by conversations and engagement with local people.

Calderdale Overview

Calderdale Demographics

Calderdale Health Profile

Joint Strategic Needs Assessment (JSNA)

Health inequalities

NHS Calderdale Clinical Commissioning Group

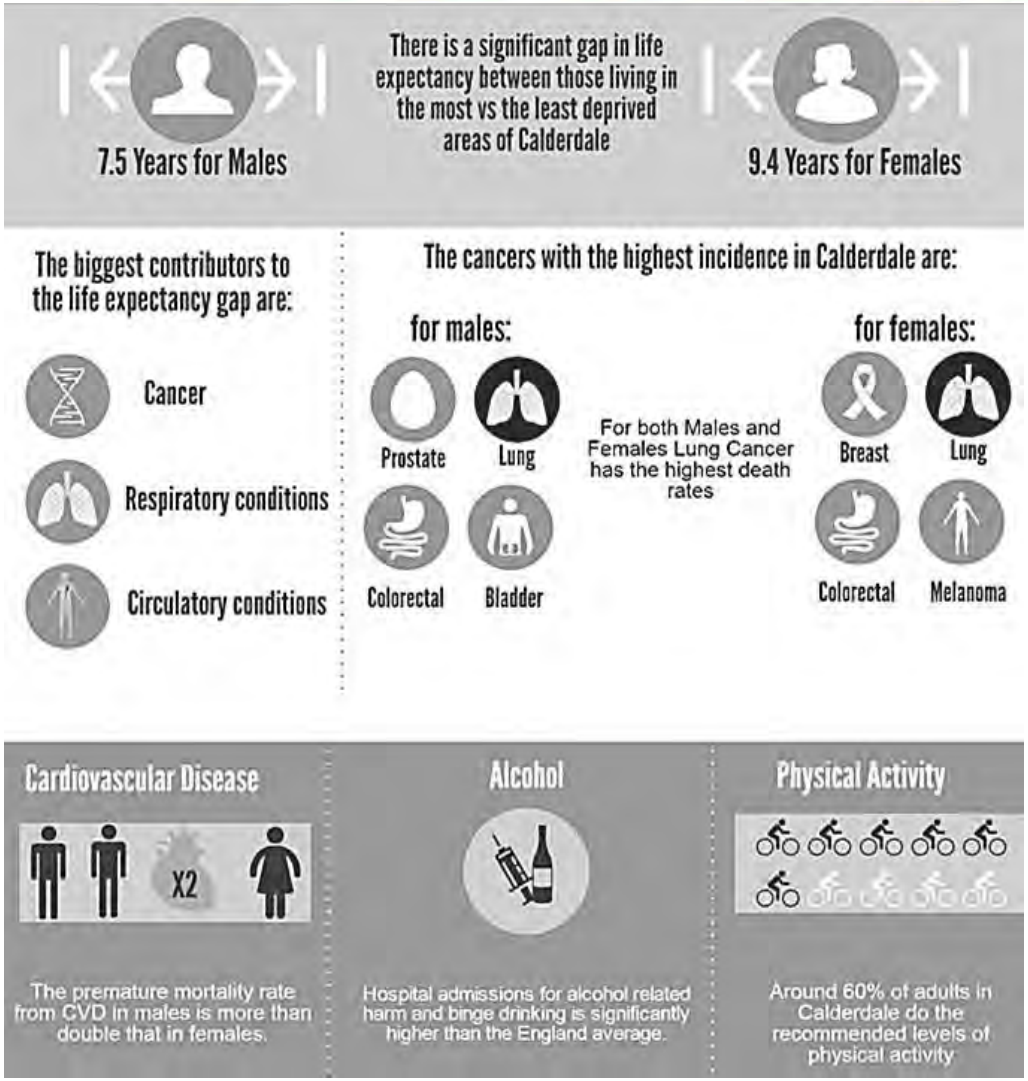
Health inequalities are **unfair and avoidable differences in health** across the population, and between different groups within society.

COVID-19 has exposed deeply entrenched health inequalities. It is clear that those worst affected by the virus are often those who had worse health outcomes before the pandemic, including people from BAME communities, older people, those with a learning disability and those living in poorer areas. There is a renewed focus on tackling health inequalities in the NHS and the CCG is working with local partners to address these and improve people's health.

The third phase of the NHS response to COVID-19 urges NHS organisations, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities. It recognises that addressing health inequalities will be enhanced by ensuring that our leadership reflects the diverse communities we serve. The CCG has developed a reset action plan, which incorporates a range of actions designed to reduce health inequalities and improve leadership diversity.

Health inequalities

NHS Calderdale Clinical Commissioning Group



Source: Calderdale JSNA. www.calderdale.gov.uk/jsna

Black, Asian and Minority Ethnic (BAME)

NHS Calderdale Clinical Commissioning Group

COVID-19 continues to have a disproportionate impact on BAME communities and staff, not only in increased infection and death rates but also wider impacts to employment and income. The work by the Black Lives Matter movement reignited calls for an end to racism and injustice across the world and challenged public institutions to address systemic racism.

Both have brought attention to the layered impacts of years of disadvantage and inequality and have acted as a catalyst for change by strengthening the call to improve outcomes for BAME communities and colleagues.

The CCG reset action plan includes specific actions to tackle health inequalities for the BAME population. We also have an equality objective to improve access to GP Practices for people from BAME backgrounds. This will build on the work already being carried out by the CCG and partners to improve access to services for BAME patients and other disadvantaged groups during the pandemic.

We are also working with staff to tackle workplace inequalities. The CCG undertakes the Workforce Race Equality Standard annually to understand the experience of BAME staff. An action plan has been developed to address areas for improvement and incorporates actions from the NHS People Plan 2020-21 and the WY&H BAME Staff Network.

Delivering our strategy

Legal responsibilities

NHS Calderdale Clinical Commissioning Group

We deliver;

- Public Sector Equality Duty publish an equality information report evidencing our compliance with the duty and equality progress
- Equality Delivery System (EDS2) an NHS equality assurance framework delivered with health partners and communities
- Equality objectives to drive forward equality for particular groups
- WRES publish report and actions to demonstrate progress against nine indicators of workforce equality for BAME staff
- Accessible Information Standard to meet the communication needs of disabled patients and staff
- Equality Impact Assessments to ensure decisions are only taken after a full and robust understanding of the impact on equality and health inequalities on different groups of people

Our equality objectives

NHS Calderdale Clinical Commissioning Group

Our equality objectives are informed by conversations with local communities delivered through the EDS2. In partnership with local stakeholders, the CCG developed the following equality objectives:

1. Improve access to GP Practices for specific equality groups
2. Improve engagement with specific equality groups

For 2020-2022, Objectives 1 and 2 will focus on BAME communities and Carers. A new objective has been developed in response to the wider inequalities highlighted by COVID-19 and will support the CCG to achieve a more diverse leadership.

Detailed implementation plans are developed annually in partnership with a multi-agency steering group. These are monitored by the Quality, Finance and Performance Committee and published online.

Workforce

NHS Calderdale Clinical Commissioning Group

We know that the best way to serve our communities is to have a workforce that reflects the diversity and broad range of talent in Calderdale.

We are implementing a variety of measures to help us achieve our ambition to employ a diverse and representative workforce and leadership. These include;

- Workforce Race and Disability Equality Standards (WRES) - measures progress against national metrics
- NHS Staff Survey - annual survey on staff experience
- Staff Equality Networks
- Unconscious bias training
- Diverse recruitment panels

Involving local people

NHS Calderdale Clinical Commissioning Group

The engagement and involvement of local communities is central to the commissioning of services which meet local health needs. All our engagement activity is underpinned by the Involving People Strategy, which is a shared set of principles for involving people across Calderdale.

We are proactive in seeking the views of our communities and reaching those groups who are not always heard. Engagement activity is equality monitored to assess the representativeness of the views gathered; where there are gaps we target specific communities. The feedback is analysed to understand if there are differences based on protected groups.

We also facilitate a community based Equality Health Panel where voluntary and community sector groups representing diverse communities engage with local NHS organisations to help improve services for protected groups and other disadvantaged groups.

Procurement

NHS Calderdale Clinical Commissioning Group

The CCG commissions health care services on behalf of people in Calderdale. Equality and inclusion is embedded in the processes and governance around the procurement of these services.

Specifically:

- Services are designed, planned and developed with support from the equality team and insight from our local communities. Equality impact assessments are undertaken to understand potential impact on protected groups or on health inequalities.
- Our Invitation to Tenders process (ITTs) includes equality questions for potential providers, which are assessed by the CCG's equality team.
- Providers are monitored and reviewed to ensure that they are meeting their equality duties and standards.

Working with partners

NHS Calderdale Clinical Commissioning Group

The CCG works with local providers to ensure that together we achieve the best health outcomes for local people. Some larger providers are subject to the same legal responsibilities as the CCG, such as Calderdale and Huddersfield NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Locala and Yorkshire Ambulance Service. These providers are supported by the equality team and progress is monitored through quarterly meetings with them. With smaller providers, the team works with contracting colleagues to monitor equality performance.

Working with partners

NHS Calderdale Clinical Commissioning Group

The speed and scale of the response required by COVID-19 has highlighted the benefits of working with partners to develop creative solutions to local issues. Working across the system with the West Yorkshire and Harrogate Partnership and locally with statutory and voluntary sector partners has never been more important and is critical to the success of this strategy and the work we are doing in response to the pandemic. We will continue to work with partners to share insights and resources and develop innovative ways to advance equality and reduce health inequalities. We will do this through our involvement in a range of existing and new networks including the WY&H Health Inequalities Network and the Calderdale Involving People Network.

Equality Impact Assessments

NHS Calderdale Clinical Commissioning Group

Equality Impact Assessments (EIAs) form an integral part of our scrutiny process and ensure that all our key decisions are evaluated for their impact on equality and other groups.

EIAs improve our decision-making by helping us to understand the effect of our activities on different groups of people. They also help us to target our engagement activities and provide protected groups with a voice in shaping our services.

Targeted workshops are delivered by the equality team to support the completion of Equality Impact Assessments (EIAs).

Training

NHS Calderdale Clinical Commissioning Group

All staff complete a mandatory equality and diversity e-learning module once every three years.

In 2020 the CCG adopted the recommendations of the West Yorkshire & Harrogate Partnership BAME Network and is rolling out a programme of Unconscious Bias and face-to-face equality and diversity training to all staff.

In addition, specific equality and diversity training is delivered to Governing Body members, which focuses on equality for decision-makers.

Governance

Governance

NHS Calderdale Clinical Commissioning Group

The CCG demonstrates robust governance for equality and inclusion through the following arrangements:

- **Senior Operational Group** Monitors the COVID-19 reset action plan
- **Governing Body** Provides strategic leadership and ensures the CCG complies with the Public Sector Equality Duty
- **Quality, Finance & Performance Committee** Monitors this Strategy, the Equality Objectives Action Plans and the following annual reports: PSED, EDS2, Workforce Race Equality Standard (WRES)

Measuring progress

NHS Calderdale Clinical Commissioning Group

Successful implementation of this strategy will be measured by:

- Progress against WRES, WDES and workforce equality action plans
- Progress against equality objectives and action plans
- Progress against the COVID-19 reset action plan
- Improved engagement with local communities and inclusion health groups, e.g. homeless people, refugees and asylum seekers etc.
- Increased representation of BAME voice in decision making
- Reduction in the % of BAME and disabled colleagues who experience bullying and harassment
- Increase in the % of BAME colleagues in senior and leadership roles

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**Workforce Report**	**Agenda Item No.**	9
Report Author	Tazeem Hanif (HR Business Partner)	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite – Chief Operating Officer	**Responsible Officer**	Jenna McGuinness – HR Manager, North of England Commissioning Support Unit

Executive Summary							
Please include a brief summary of the purpose of the report	This paper presents an overview of the CCG's workforce data as part of the bi-annual update between the periods of 01 July to 31 December 2020. 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 consideration	**Name of meeting**	Senior Management Meeting		**Meeting Date**	13/01/2021		
Recommendation (s)	It is recommended that the Governing Body: ▪ **RECEIVES** and **NOTES** the content of the CCG workforce report update.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications	
Quality & Safety implications	None identified.
Engagement & Equality implications	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.

<table>
<tr><td colspan="2">Resources / Finance implications</td><td colspan="6">The report provides the Governing Body with an overview of staff resource available to the CCG.</td></tr>
<tr><td colspan="2">Has a Data Protection Impact Assessment (DPIA) been completed?</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>x</td></tr>
<tr><td>Strategic Objectives</td><td>Achieving the agreed strategic direction for Calderdale
Improving quality
Improving value</td><td colspan="3">Risk</td><td colspan="3">None identified.</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>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.</td><td colspan="3">Conflicts of Interest</td><td colspan="3">Any conflicts arising from this report will be managed in line with the CCG’s Management of Conflicts of Interest policy.</td></tr>
</table>

1.0 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 July to 31 December 2020. It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce.

1.2 The 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.

2.0 Workforce Composition

2.1 The workforce composition of CCG employed staff as at 31 December 2020 was 84 equating to 76.96 Full Time Equivalents (FTE). The CCG also has arrangements in place to share staff resource with other local CCGs, particularly, NHS Greater Huddersfield CCG.

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) which are the Chief Operating Officer and Director of Finance.

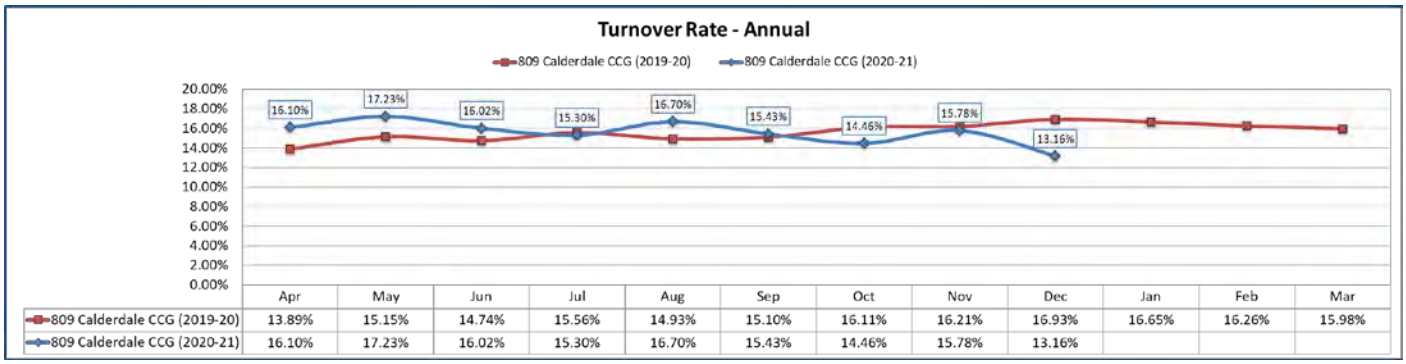
3.0 Staff Turnover

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:

$$\frac{\text{Leavers over a rolling 12 months}}{\text{Average total number employed over a rolling 12 months}} \times 100$$

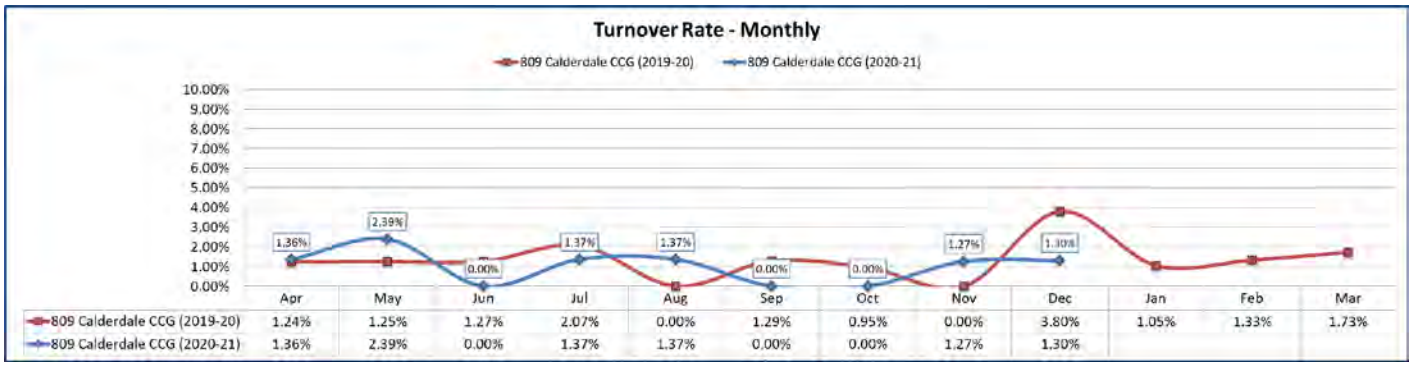
3.2 The data set out in Table 1 and 2 includes the CCG's annual and monthly staff turnover rates until 31 December 2020 and a comparison with turnover for the previous financial year.

Table 1 – CCG Annual Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2019-20)	13.89%	15.15%	14.74%	15.56%	14.93%	15.10%	16.11%	16.21%	16.93%	16.65%	16.26%	15.98%
809 Calderdale CCG (2020-21)	16.10%	17.23%	16.02%	15.30%	16.70%	15.43%	14.46%	15.78%	13.16%			

Table 2 – CCG Monthly Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2019-20)	1.24%	1.25%	1.27%	2.07%	0.00%	1.29%	0.95%	0.00%	3.80%	1.05%	1.33%	1.73%
809 Calderdale CCG (2020-21)	1.36%	2.39%	0.00%	1.37%	1.37%	0.00%	0.00%	1.27%	1.30%			

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. The rolling percentage between July and December 2020 was 4.82% reflecting 4 leavers.

3.4 Where individuals have left the organisation, this has been a combination of retirement and voluntary resignation for reasons of promotion and relocation. 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 there have been no exit questionnaires received; or any unplanned leavers during this period. A level of turnover is to be expected and is appropriate in any organisation.

4.0 Sickness Absence

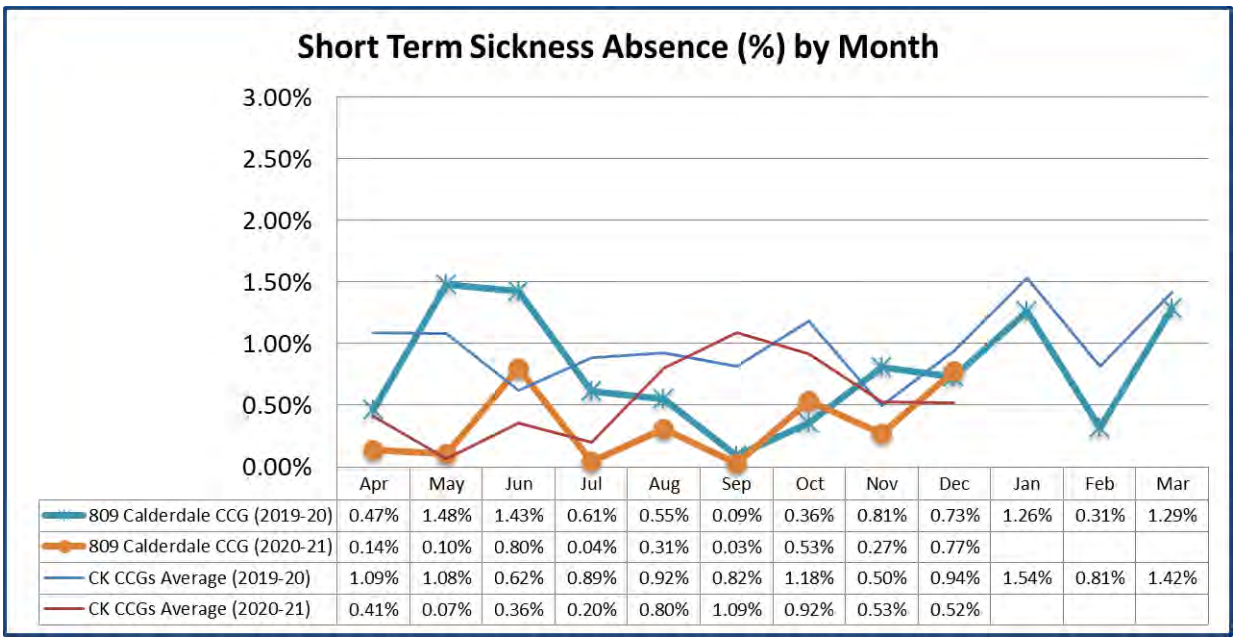
4.1 Sickness absence figures are calculated based on a percentage of total time available, using the following calculation:

$$\frac{\text{Total absence (hours or days) in the period x100}}{\text{Possible total (hours or days) in the period}}$$

4.2 The overall sickness absence percentages can be found in table 3 and 4 which is both the long and short term sickness. Long term sickness is defined as any single instance of sickness absence, which lasts for 28 days or more.

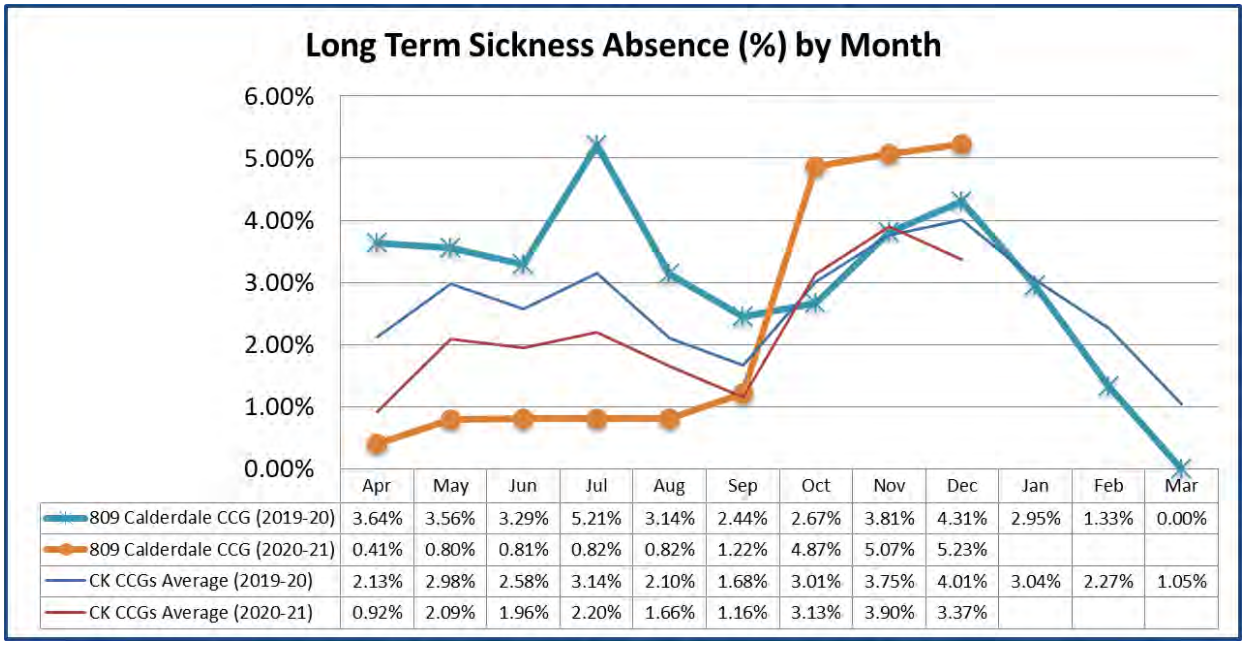
4.3 There is currently no benchmarking information available nationally from NHS Digital as a comparator against CCG sickness data. Sickness absence levels continue to fluctuate, though for the majority of the year has been lower than the previous financial year. The majority of sickness absence continues to be driven by long term sickness which peaked from Oct-Dec 2020 and managed carefully on an individual basis, in line with the CCG's policies. Anxiety and stress is 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 5 highlights the top three sickness reasons.

Table 3 – Short Term Sickness Absence



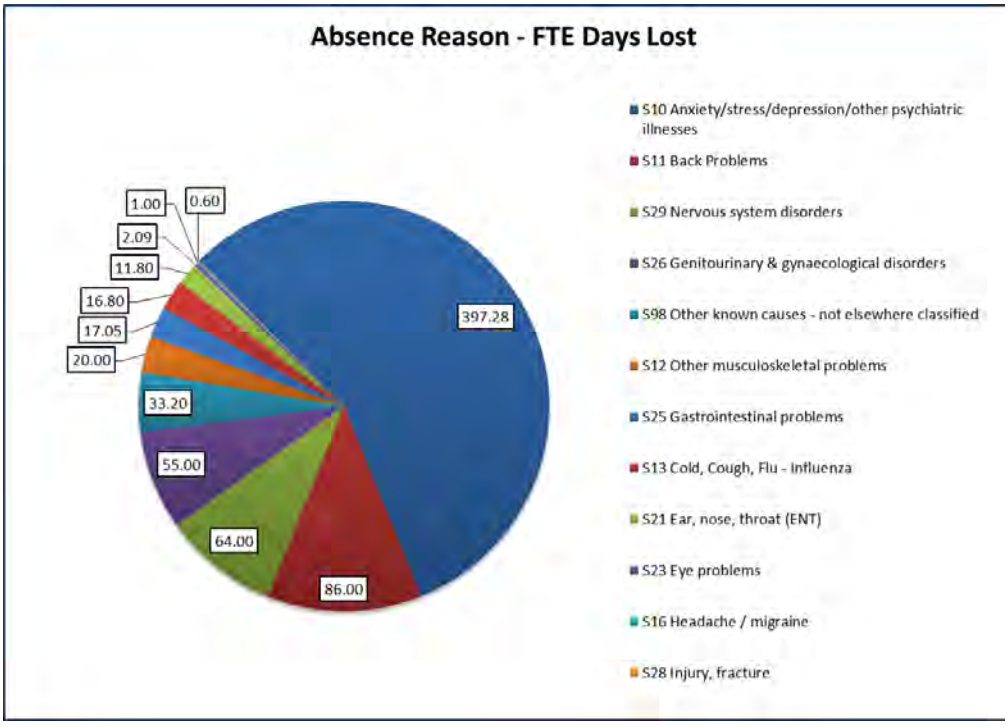
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2019-20)	0.47%	1.48%	1.43%	0.61%	0.55%	0.09%	0.36%	0.81%	0.73%	1.26%	0.31%	1.29%
809 Calderdale CCG (2020-21)	0.14%	0.10%	0.80%	0.04%	0.31%	0.03%	0.53%	0.27%	0.77%			
CK CCGs Average (2019-20)	1.09%	1.08%	0.62%	0.89%	0.92%	0.82%	1.18%	0.50%	0.94%	1.54%	0.81%	1.42%
CK CCGs Average (2020-21)	0.41%	0.07%	0.36%	0.20%	0.80%	1.09%	0.92%	0.53%	0.52%			

Table 4 – Long Term Sickness Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2019-20)	3.64%	3.56%	3.29%	5.21%	3.14%	2.44%	2.67%	3.81%	4.31%	2.95%	1.33%	0.00%
809 Calderdale CCG (2020-21)	0.41%	0.80%	0.81%	0.82%	0.82%	1.22%	4.87%	5.07%	5.23%			
CK CCGs Average (2019-20)	2.13%	2.98%	2.58%	3.14%	2.10%	1.68%	3.01%	3.75%	4.01%	3.04%	2.27%	1.05%
CK CCGs Average (2020-21)	0.92%	2.09%	1.96%	2.20%	1.66%	1.16%	3.13%	3.90%	3.37%			

Table 5 – Sickness Reason - Top 3



4.4 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 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).

4.5 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 31 December 2020 was 100%.

4.6 The CCG has a number of support mechanisms in place such the Employee Assistance Programme, additional Mental Health First Aiders and access to Occupational Health advice. Staff feedback has been positive about the benefits of these services in supporting them to remain at work and to return to work more quickly.

5.0 Equality & Diversity

5.1 The CCG is committed to equality and diversity in all areas of its work. The equality and diversity information is included in table 6, and is reported in a way that ensures that data is not personally identifiable. The data demonstrates that:

- The workforce is predominantly female.
- 8.33% of the workforce declared that they have a disability.
- The majority of the workforce declared their sexual orientation as heterosexual.
- Just over 51% of staff reported that their religion is Christianity and 22.62% of staff not disclosing their religion.
- Over 89% of staff of a white ethnic origin.
- Over 77% of the workforce is aged 41 or over, with very small numbers aged below 31 and over 60.

Table 6 – Ethnicity and Diversity Information

Equality & Diversity			
Disability	**FTE**	**Headcount**	**%**
No	67.57	73	86.90%
Not Declared	≤5	≤5	≤5
Yes	6.09	7	8.33%
Gender	**FTE**	**Headcount**	**%**
Female	60.46	67	79.76%
Male	16.50	17	20.24%
Sexual Orientation	**FTE**	**Headcount**	**%**
Gay or Lesbian	5.49	6	7.14%
Heterosexual	60.87	65	77.38%
Not Disclosed	10.60	13	15.48%
Religious Belief	**FTE**	**Headcount**	**%**
Atheism	15.40	16	19.05%
Buddhism	≤5	≤5	≤5
Christianity	39.77	43	51.19%
Islam	≤5	≤5	≤5
Not Disclosed	16.40	19	22.62%
Other	≤5	≤5	≤5
Sikhism	≤5	≤5	≤5
Ethnic Origin	**FTE**	**Headcount**	**%**
Asian or Asian British	≤5	≤5	≤5
Mixed	≤5	≤5	≤5
Not stated	≤5	≤5	≤5
White	68.66	75	89.29%
Age Profile	**FTE**	**Headcount**	**%**
20-25	≤5	≤5	≤5
26-30	≤5	≤5	≤5
31-35	5.60	6	7.14%
36-40	7.00	8	9.52%
41-45	9.79	11	13.10%
46-50	23.37	24	28.57%
51-55	14.59	16	19.05%
56-60	12.20	14	16.67%
61-65	≤5	≤5	≤5
66-70	0.00	0	0.00%

5.2 The CCG has signed up to the Integrated Care System (ICS) Black Asian and Minority Ethnic (BAME) Network action plan to further promote equality and diversity amongst its workforce. Linked to this is the reporting of the Workplace Race Equality Standards (WRES) and the Equality Delivery System as part of internal facing goals and with the aim of increasing the diversity of the CCG workforce by way of -

- Delivery of virtual Unconscious Bias training for all staff including Governing Body.
- Establishment of a BAME staff equality network.
- Communication of the WRES report and actions to all staff.
- The delivery of 2 recruitment and selection training sessions aimed at existing or new managers will take place from April 2021 and work is underway to refresh the training.

6.0 Workforce Headlines

This section provides a summary of other key activities, which have taken place in relation to the workforce.

6.1 Human Resources Policies

6.1.2 The CCG has a comprehensive suite of 25 HR policies, which are reviewed on a regular basis to ensure they remain fit for purpose and compliant with employment law and best practice. All the HR polices are due for renewal in 2021 and SMT have agreed for the remainder of the HR policies with the exception of a few to extend for a further year in light of wider NHS changes. These will still go through the normal committee approval processes for assurance.

6.2 Employee Relations

6.2.1 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.

6.2.2 To support line management training with a focus on challenging behaviours, SMT agreed an action for Advisory, Conciliation and Arbitration Service (ACAS) to deliver three half day virtual training sessions to take place from December 2020 to January 2021. Uptake has been high and feedback to date has been positive in supporting managers on how to address challenging behaviours.

6.3 Staff Survey

6.3.1 The national staff survey response rate at the end of November 2020 was 82.3% compared to 77.1% in 2019. The contract with Picker included a number of localised questions in addition to core questions. Expected data will be made available by end of January 2021 analysed by a member of the Organisational Development Team (OD) and findings/actions shared with SMT.

6.4 Flu Vaccinations

6.4.1 The CCG offered two drive thru staff flu sessions between the periods of October to November 2020 with Flu Xpress. The use of local pharmacies at the individuals' convenience and the claim back of costs had been encouraged for a high uptake of flu vaccinations in addition to obtaining a vaccination at the local GP. The final flu uptake as at 15 January 2021 was 76% (including 9 GB members) compared to 66% uptake (including 9 GB members) in 2019.

6.5 COVID-19 1-1 risk assessments

6.5.1 Current Government guidance is that if possible everyone should work from home. The CCG expects most staff will continue to work from home until further notice, unless there is a significant risk in them doing so. As part of the CCG COVID-19 recovery strategy with the aim of managing the health and wellbeing of staff – all staff have been requested to undertake a risk assessment with the expectation that this will be reviewed on a regular basis should circumstances change. As such 1-1 risk assessments in line with best practice were developed and completed by all staff across the organisation with a compliance rate of 100%.

6.5.2 There have been no immediate concerns highlighted in the 1-1 conversations and control measures have been put in place such as continuing to work from home and regular conversations with managers/teams as part of one's health and wellbeing. A further reminder to staff has been issued on the importance of this.

6.6 Learning & Development

6.6.1 The monthly statutory mandatory training dashboards provided to SMT show a steady increase of overall staff compliance but there is an expectation that compliance needs to be 100%. Heads of Service are mindful of staff pressures in response to the pandemic are actively encouraging staff to review their compliance through various staff communication methods and team meetings.

6.6.2 The appraisal dashboard report shows the current appraisal compliance has been completed for all GP's and Lay Member roles on the Governing Body. The appraisal compliance for staff is just over 40%. It is possible that a number of conversations have taken place and that the actual appraisal has not been logged in ESR. Staff have been recently reminded of the need to ensure appraisals are taking place and that these are being recorded in ESR.

6.6.3 A training needs analysis (TNA) was undertaken during December 2020 based on 31 completed appraisals across all staff groups. It was identified that individuals preferred 'on the job' training rather than through training courses which need to be booked and funded. It has been recommended that, where individuals have identified that 'on the job' training is possible that this is undertaken if there is the agreement that the subject matter Is dealt with in an appropriate way and a 'best practice' approach is used. In addition to undertaking TNA through the review of individual requests, SMT have been recommended to discuss and identify what they think their services require enabling the effective delivery of their objectives.

7.0 Recommendations

7.1 It is recommended that the Governing Body:

- **RECEIVES** and **NOTES** the content of the CCG workforce report update.

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**Director of Finance Report**	**Agenda Item No.**	10 a
Report Author	Lesley Stokey, Director of Finance	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Chief Operating Officer	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary				
Please include a brief summary of the purpose of the report	**Finance** • The CCG is operating under temporary financial arrangements due to the impact of Covid-19. As a consequence the original plan and allocations for 2020/21 have been superseded. • The CCG submitted a revised financial plan on 22nd October 2020. • The CCG is forecasting to deliver a small surplus of £35k once the outstanding allocations have been received. **Contracting** • The update provides key messages relating to main areas of contracting activity presented to Committee. The Governing Body is asked to note the position regarding the revised and new arrangements for activity commissioned from the independent sector. **Performance** • Phase 3 of the NHS response has seen a greater emphasis on services returning activity levels to near pre-Covid levels. • The impact of Covid can be noted in the performance levels reported in the majority of areas. • Performance against the cancer waiting times have remained strong during the pandemic. • Key challenges remain with the restoration of elective activity, managing waiting times and the scale of the waiting list. • Mental Health is a key feature of the Long Term Plan and core metrics are included in this report for the first time.			
Previous consideration	**Name of meeting**	N/A	**Meeting Date**	
	Name of meeting	N/A	**Meeting Date**	
Recommendation (s)	The Governing Body is asked to: 1. Note the new temporary financial regime for the period April – March 2021. 2. Note the financial forecast for the period April –March 2021. 3. Note the contracting update.			

	4. Note the impact of COVID-19 on the progress being made towards achieving the standards set out in the NHS Constitution.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications	None identified.		
Public / Patient / Other Engagement	None identified.		
Resources / Finance implications	None identified.		
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving value	**Risk**	None identified.
Legal / Constitutional Implications	None identified.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest arising from this paper will be managed in accordance with the CCG Management of Conflicts of Interest Policy.

1.0 INTRODUCTION

This report shows the latest positions and key messages in respect of finance, contracting and performance for Calderdale Clinical Commissioning Group.

2.0 FINANCE

This report updates the financial position as at month 9, key messages are:-

- The CCG is operating under temporary financial arrangements due to the impact of Covid-19. As a consequence the original plan and allocations for 2020/21 have been superseded.
- The CCG submitted a revised financial plan in October for a technical deficit of £0.9m but an expected surplus of £35k once outstanding allocations have been accounted for.
- The CCG is currently forecasting an overspend against the allocations due to Covid costs and other cost pressures but allocations are expected to match against these costs.
- The CCG has a revised QIPP target of £0.5m.
- The CCG is working with the West Yorkshire & Harrogate (WY&H) Integrated Care System (ICS) Finance Forum regarding proposals for financial risk share arrangements.

2.1 2020/21 Temporary Finance Regime – Covid-19

In response to COVID-19, a temporary financial regime has been put in the place by NHS England and Improvement which replaced the CCG expected financial plan for 2020/21. The CCG submitted its revised financial plan for the full year in October 2020.

As part of the ICS Financial plan the CCG was allocated £1.428m of additional allocation to cover COVID-19 costs for the period October 2020 to March 2021.

A summary of the CCG financial plan is shown below:

CCG Plan Submission	Programme	Delegated Primary Medical Services Budgets	Running Cost	Total
	£'000	£'000	£'000	£'000
CCG Confirmed Allocation	-302900	-31816	-4115	-338831
CCG Covid Allocation	-1428			-1428
Total CCG Allocation	**-304328**	**-31816**	**-4115**	**-340259**
CCG Expenditure Plan	**305043**	**32011**	**4115**	**341848**
Variance	**715**	**195**	**0**	**910**
Expected additional allocations:				0
- Primary Care Aditional Roles	- 750			-750
- Primary Care Allocations		-195		-195
Total Additional Allocations expected	**- 750**	**- 195**	**-**	**- 945**
Net expected surplus	**-35**	**0**	**0**	**-35**

The CCG submitted a deficit plan of £910k overspend. However the CCG is expecting to receive additional allocations in relation to Primary Care Additional Roles £750k and also some Primary Care additional allocations of £195k. After these have been accounted for the CCG is expecting to deliver a small surplus of £35k. As there was a level of uncertainty regarding these additional allocations at the time of submission it was felt prudent to include the expenditure in the plan position.

Within the plan submission there is an expectation that the CCG delivers £0.5m of QIPP.

2.2 Financial forecast 2020/21

The CCG submitted its financial position to the end of December which is showing approximately £1.9m of pressures against the confirmed allocation received for the financial year. The CCG is expecting to receive allocations for the £1.2m for hospital discharge costs relating to month 7-9. In addition the CCG is forecasting to spend £0.75m in relation to Primary Care Additional Roles for which the allocation has not yet been received. Once these allocations have been received, the CCG is forecasting to deliver a small surplus of £35k.

A high level summary is shown in the table below:

High Level Forecast position M1-M12	Programme £'000	Delegated Primary Medical Services Budgets £'000	Running Cost £'000	Total £'000
Initial Allocation - Covid Regime	-300,109	-31,526	-3,850	-335,485
Latest Forecast for M12	306,163	33,291	4,115	343,569
Net overspend	6,054	1,765	265	8,084
Covid costs to date M1-M12	5,527	0	0	5,527
Other pressures (forecast M1-M12)	527	1,765	265	2,557
Total variance	6,054	1,765	265	8,084
Allocation adjustment M8	-4,619	-1,258	-265	-6,142
Net position	1,435	507	0	1,942
Expected further allocations:-				
- Retrospective Hosptal Discharge Programme	-1227			-1227
- Primary Care Aditional Roles	-750			-750
Net adjusted forecast	**-542**	**507**	**0**	**-35**

The makeup of these pressures can be seen in Appendices A-C and summarised below, however it is important to note that the CCG is still experiencing some difficulties moving budgets around to match the expenditure profile.

- **Acute:** Showing an underspend in part due to underspends on independent sector activity and also the community elements of the Calderdale and Huddersfield NHS Foundation Trust (CHFT) contract as the budget is included in acute but the expenditure forecast is included in community.
- **Mental Health**: No longer showing an underspend as Non-Contract Activity (NCA) has increased and plans in place to meet the Mental Health Investment Standard (MHIS).
- **Prescribing**: Showing a potential overspend due to the fact that NHSE assumption was 2019/20 plus 1%. The forecast has been based on the latest data for October. Cost pressures are due to continued increases in NSCO, Cat M and general price increases and potential under delivery of QIPP.
- **Primary Care (Not delegated)**: Showing an underspend due to budget alignment issues.
- **Primary Care – Delegated**: Showing an overspend as awaiting allocation for Additional Roles forecast spend over the budget included in the baseline.
- **Community** – showing an overspend until the budget can be realigned between acute and community in relation to the community element of the CHFT contract.

- **Continuing Healthcare:** is showing an underspend. The CCG is currently undertaking work to complete reviews of continuing healthcare packages which were put on hold in the early stages of the COVID-19 pandemic.
- **Other / Reserves**: Showing an overspend due to budget alignment issues in relation to patient transport and NHS111.
- **Better Care Fund** : Showing an overspend due to budget alignment issues as these needs to be realigned to match the planned 20/21 BCF contribution.
- **Running Costs**: The Allocation from NHS England has been calculated by taking 2019/20 expenditure less 11.8%. This percentage reduction is the equivalent to the planned for reductions in allocations between the 2019/20 and 2020/21. The allocation for running costs has now been adjusted to be in line with our original plan.

2.3 Covid-19 Cost Update

Included in our forecast positions are a number of Covid-19 related cost pressures. The summary below shows a high level view of the Covid-19 costs incurred year to. Data has been collected on Covid-19 expenditure and submitted to NHSE for April to December.

Calderdale CCG Covid Expenditure Summary at 31st December 2020

	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9
Covid Expenditure	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)	CCG Costs YTD (£'000)
Hospital Discharge Programme - CMBC S75	1,047	1,450	2,071	2,608	2,955	3,321	3,567	3,728
Hospital Discharge Programme - CCCG Commissioned	106	133	180	232	274	321	314	331
MH Services	10	11	11	23	24	28	28	312
Continuing Care Services	321	221	388	475	558	649	792	1,003
Prescribing	1	1	2	2	2	2	2	2
Community Based Services - Primary Care	400	529	513	569	608	603	603	790
Other Programme	46	45	106	105	157	157	216	163
Running Costs	4	4	4	4	4	5	5	5
Grand Total	**1,935**	**2,394**	**3,275**	**4,018**	**4,582**	**5,086**	**5,527**	**6,334**

The most significant areas of spend are in relation to the CCG contribution to the new Section 75 pooled budget with Calderdale Metropolitan Borough Council (CMBC) in relation to the hospital discharge programme, and also some direct commissioned services to support this programme.

The other notable area of expenditure is in relation to primary care – primarily to support bank holiday working.

2.4 Public Sector Payment Policy

The CCG has a target of 95%, and performance is currently between 93.38% and 99.9% across NHS and Non NHS invoices. Appendix D shows the public sector payment policy in more detail.

2.5 Risks

The CCG has a number of risks to manage in the new financial plan:

- Risk of QIPP delivery against the new £0.5m Quality Innovation Productivity and Prevention (QIPP) target.
- Risk of overspends on prescribing
- Risk of increase on independent sector activity which is not part of the national framework.
- Risk of overspend on continuing healthcare.
- Risk that requirement for expenditure to support COVID-19 programmes exceeds the £1.4m allocation.

The CCG is working with partners to ensure that all available funding sources are fully explored particularly in relation to COVID to help ensure that this does not cause a cost pressure.

Although the CCG has not been able to plan for a contingency, the CCG is undertaking a review of all budgets to ensure that any underspends can be utilised if required to mitigate against risk.

3.0 CONTRACTING

3.1 Acute and Independent Sector Providers

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place. Therefore no 2020/21 contracts are in place and contracted NHS acute providers are paid on a nationally set block amount. The 2020/21 terms and conditions from the NHS Standard Contract do apply. A national agreement continues to be place for the majority of local independent sector providers.

Activity reporting indicates a significant reduction in activity as expected due to the impact of COVID-19 but has seen a steady increase up to the end of September. There has been a continued increase in non-face-to-face activity at all of our providers and there has been an increase in the use of Advice and Guidance.

In September / October COVID-19 demand began to rise again, and by early November the pressure in CHFT exceeded that of wave I. Calderdale and Huddersfield NHS Foundation Trust were reduced to one operating theatre, plus the protected Independent Sector capacity as part of the national contract. As a result of this the surge clause of the national contract was triggered which meant that 100% of IS capacity was available to the NHS.

The national contract was due to expire on 31 December 2020 and NHS England had served notice to terminate the contract on 24 December 2020.

A new national Framework for Increasing Capacity in Independent Sector providers went live in November 2020. All regions escalated risk and concern due to loss of capacity/case mix changes in Quarter 4, this was recognised and a new national contract was negotiated for 1 January 2021 to 31 March 2021.

The 24 December 2020 notice was rescinded and therefore the old contract expired 31 December 2020.

The guaranteed capacity under the new national contract is a minimum of the average volume of activity provided during October and November.

3.2 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

An agreed contract value for 2020/21 was not finalised at the time that the COVID-19 guidance was published. Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place for the SWYPFT contract. System planning for the next phase of the management of the COVID-19 pandemic has commenced. The national target (95%) for follow up on CPA within 7 days of discharge was met in Month 6 (100%). The national target (60%) for Early Intervention in Psychosis-NICE approved care package within 2 weeks was also achieved in Month 6 (100%).

3.3 Yorkshire Ambulance Service (YAS) 999 Ambulance

Initial performance information for Month 6 for Calderdale shows that 63.3% of Category 1 Calls were reached within 7 minutes. YAS overall average performance for Category 1 shows that 67% of all category 1 calls were reached within 7 minutes.

3.4 Integrated Urgent Care (IUC, formerly NHS 111) and West Yorkshire Urgent Care (WYUC)

The Contract reports for IUC activity in Month 6 are not available at the time of writing this report, due to proposed changes in the reporting process. Validated WYUC activity in Calderdale shows 1,802 cases for Month 6, a decrease of 22 cases compared to the total for Month 6 of 2019/20.

3.5 Posture and Mobility (Wheelchairs) Service (Ross Care)

Performance in the service has been good despite the impact of COVID-19. Total new referrals reached 224 in September. For Calderdale there were 53 adult referrals with 26 of these being re-referrals and 18 paediatric referrals with 11 being re-referrals.

3.6 Procurements

Service description	Status	Contract start date	CCG Annual contract value
Covid-19 Positive Enhanced Care Beds	Contract Award	01.10.2020	£51,664 (6 months)
GP Support: Covid-19 Beds (Calderdale Retreat)	Contract Award	01.10.2020	£16,000
GP Support: Covid-19 Beds (Cartron House)	Contract Award	01.10.2020	£9,000
Dermatology Service	Procurement paused for 18 months	01.10.2022	£350,000
Seamless Home from Hospital	Evaluation Underway	01.04.2021	£316,096
West Yorkshire & Harrogate Advance Care Planning	Procurement underway	01.11.2020	£30,000
Community Ophthalmology Service	Review of service and procurement under discussion	01.04.2021	To be confirmed
Continuing Healthcare Domiciliary Care	Re-opening of Procurement (Approved Provider List) in 2021	TBC	Approximately £1m (multiple providers)

4.0 PERFORMANCE

4.1 Urgent and Emergency Care

Ambulance and urgent and emergency care
(Provider Submitted Only KPIs)

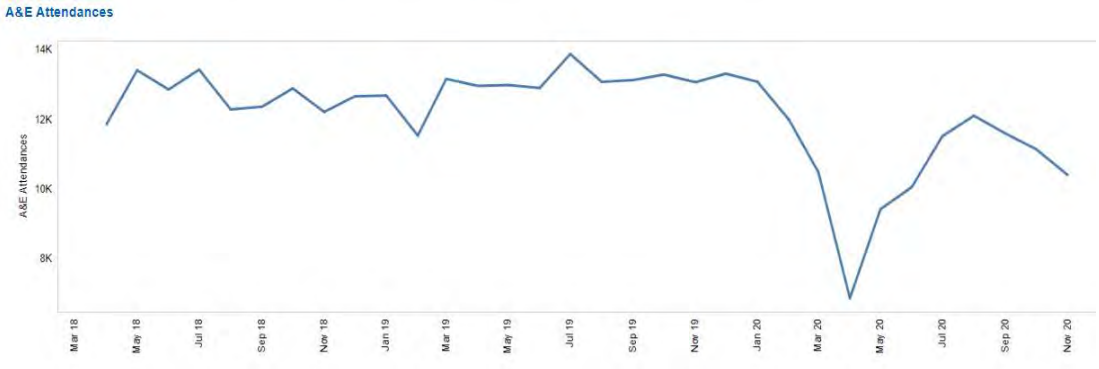
Indicator Details	Latest Period	Target	Value	Change
A&E - % waiting under 4 hours	November 2020	95% and above	81.4%	⇑ 0.2%
A&E - No. waiting 12+ hours from DTA	November 2020	0	21	⇑ 40.0%

4.2 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.

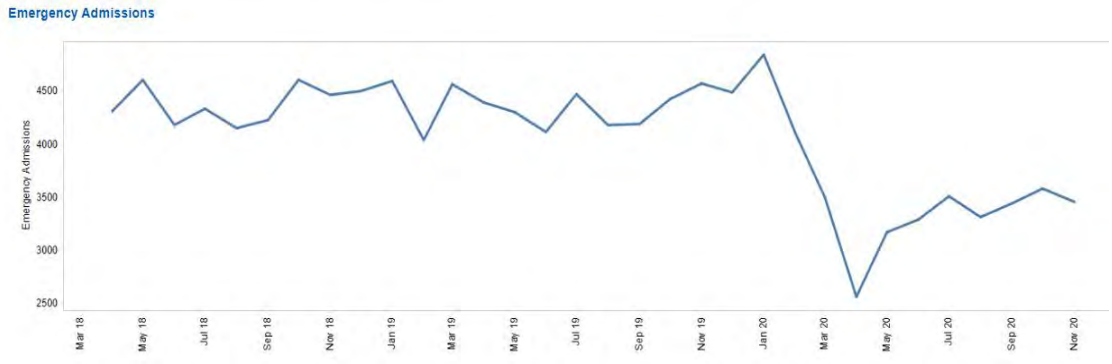
4.3 Attendances

Following national and local communications campaigns to reiterate to the public that the NHS is open for business, we have seen an increase in the number of patients accessing A&E. In November 2020 there were over 10,000 attendances at A&E at CHFT. Although still below pre-covid levels of activity, this is a 33% increase since April 2020.



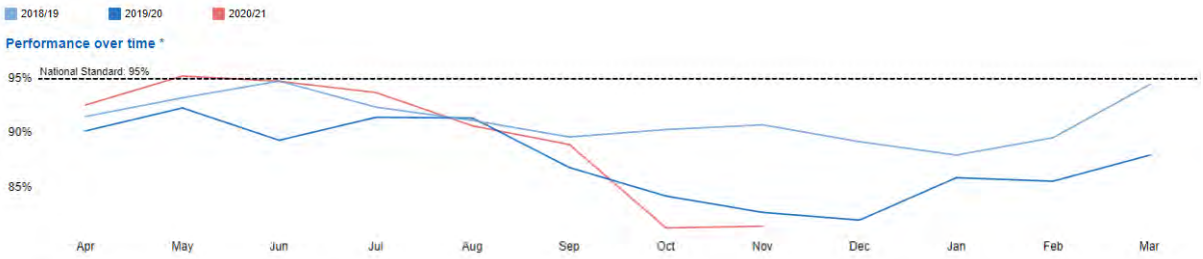
4.4 Emergency Admissions

Similarly with emergency admissions, activity levels remain below pre-covid levels, but there has been a 35% increase in emergency admissions since April this year.



4.5 Performance

A&E performance achieved 81.4% in November. Whilst following seasonal patterns, this is the lowest level of performance reported for November during the last 3 years.



4.6 Impact of Covid 19

Whilst the activity levels for non covid emergency care has been increasing in recent months, the number of admissions linked to the second wave of covid has reached volumes greater than those reported during wave 1. When combined together, the flow of covid and non covid patients into the hospital has placed pressure on the acute bed capacity available. This has contributed to delays in the A&E department and the volume of patient breaches reported including the series of trolley breaches.

4.7 A&E Delivery Board

The A&E Delivery Board continues to have oversight of delivery of the 4 hour target, and the following actions are taking place:

- Breaches - analysis of data to understand themes and learning including trolley breaches within A&E
- Communications - reframing of communications strategy for winter with a focus on localities where there is high utilisation of A&E, to identify alternative offers. Generic communications across all other localities (Calderdale and Greater Huddersfield)
- Winter Plan - A&E Delivery Board agreed a new Winter Plan for the system which aims to reduce demand for A&E and hospital beds and protecting the capacity for those who need it most
- Continuation of the work on development of urgent care hubs
- 111 - implementation of a new 111 First model (December for our system), 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 the emergency department if necessary
- Developing a new face to face GP offer in emergency department commencing in December

4.8 Elective Care

Elective care
(Commissioner)

Indicator Details	Latest Period	Target	Value	Change
Diagnostics - % waiting over 6 weeks	October 2020	1% and below	38.5%	⇩ -9.0%
RTT - % waiting over 18 weeks	October 2020	92% and above	N/A	
RTT - No. waiting over 52 weeks	October 2020	0	539	⇧ 35.8%
RTT - Total Incomplete Waiting List	October 2020	0% growth at March 2019	17355	⇧ 8.9%

4.9 Referral to Treatment (RTT)

In April 2019, Professor Stephen Powis published an Interim Report on the Clinically-led Review of NHS Access Standards. The report set out a series of proposals regarding changes to the national access standards for urgent and emergency care, elective care, cancer diagnosis and treatment and mental health care.

Twelve field sites (including Calderdale and Huddersfield NHS Foundation trust (CHFT) have 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.

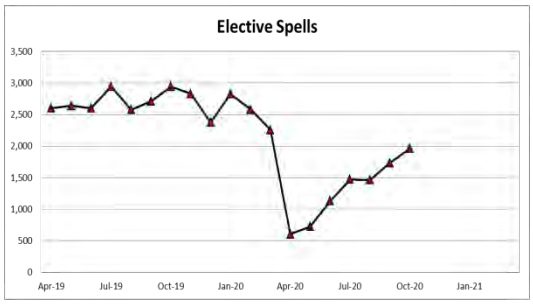
A new reporting and performance management regime commenced on the 1st August 2019 and the pilot was initially expected to last 4 months, but the development of the field test has been suspended during the NHS response to covid. We await further updates from NHS England on the next steps.

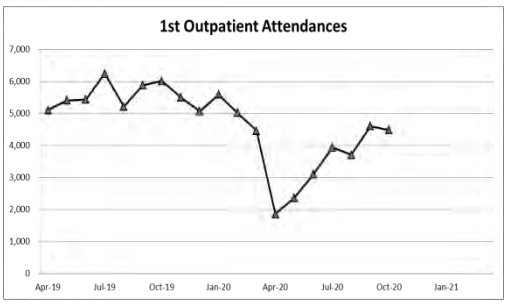
4.10 Impact of Covid

Phase 3 of the NHS response has seen a greater emphasis on services returning activity levels to near pre-covid levels.

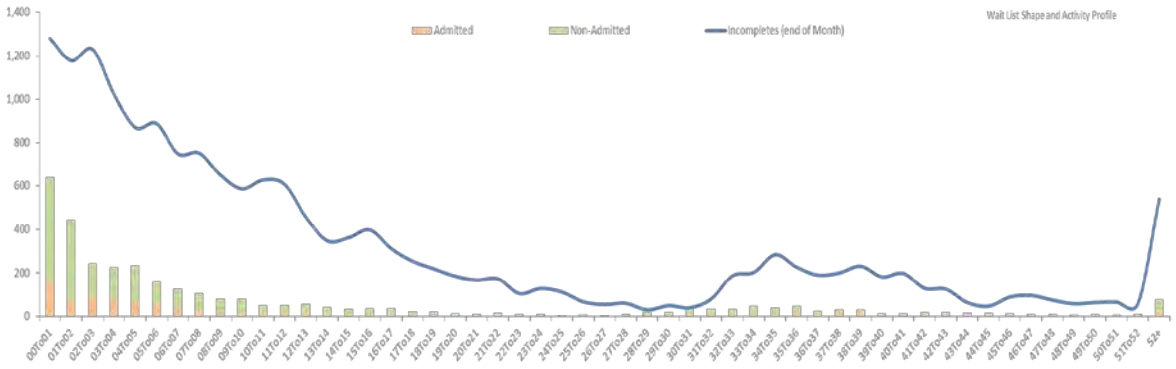
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/20200731-Phase-3-letter-final-1.pdf

Published data illustrates an increasing number of patients being treated - completed elective activity pathways have been increasing month on month since April.





However the hospital pressures associated with wave 2 of the covid pandemic (noted in section 2.5 of this report) are beginning to limit the progress being made as capacity (beds, theatres, ICU and workforce) are redirected to support the emergency response. The scale of pressures can be noted in the length and pattern of the waiting list (incomplete pathways) – see the chart below - which is increasing both in terms of the overall number of patients and the length of the waiting time patients are experiencing.

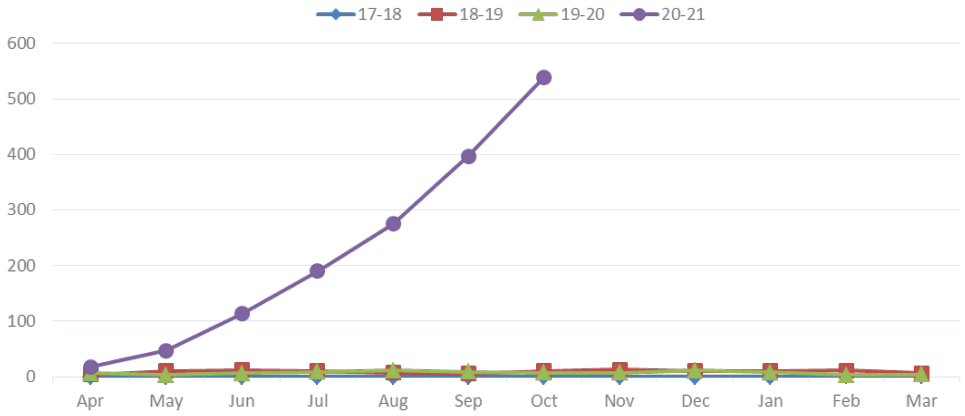


4.11 52 Weeks

During the pilot phase of the field testing, the standards associated with managing long patients waits would continue to be applied.

Under the NHS Constitution, patients should wait no longer than 18 weeks from GP referral to treatment for non-urgent treatment. In some cases there are instances where patients exercise their right and choose to wait longer for a procedure if it is clinically acceptable. However, patients are not expected to wait longer than a period of 52 weeks to be treated.

The chart below summarises the number (539) of Calderdale patients waiting greater than 52 weeks and the high volume specialties involved.



Specialty	52+
Trauma & Orthopaedics	128
General Surgery	84
ENT	42
Urology	35
Ophthalmology	23
Plastic Surgery	20

4.12 Actions

Actions being taken across the system include:

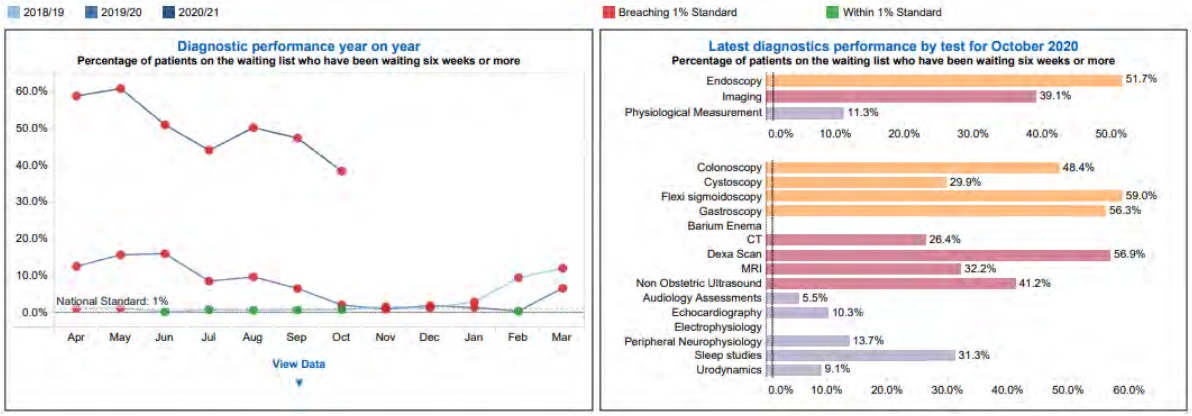
- Referrals remain open
- Clinical Assessment Services set up to support triage and diagnostics prior to booking
- Regular communications with patients on their referral status
- Utilisation of digital capability - conversion of face to face appointments to phone/ video
- Joint clinical interface sessions (GPs and Consultants) to review pathways and quality of referrals
- Increased use of Advice and Guidance as pre-cursor to referral
- Targeted effort to reduce >22 week waiters
- All patients that have exceeded the appointment due date by 6 weeks or more are validated and undergo clinical review to confirm priority status using the categories developed by the Royal College of Surgeons:

- ❑ P1 – patient appointment to be within 2 weeks
- ❑ P2 – patient appointment to be within 6 weeks
- ❑ P3 – patient appointment to be within 12 weeks
- ❑ P4 – patient appointment to be within x months and advice to GP (i.e. 4, 5, 6…12+)
- ❑ P5 – patient to be discharged

4.13 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 overall performance in this area – see chart below. In October 38.5% of patients experienced waits greater than 6 weeks across the spectrum of diagnostic tests.



As with elective care, access to diagnostic testing capacity has been restricted due to the impact of covid. Phase 3 of the reset has focussed on maximising the volume of diagnostic capacity that can be made available safely across the system to treat patients in safe and timely manner. Systems are implementing 'Adopt and Adapt' blueprints for endoscopy and CT/MRI. These initiatives include increasing working hours, procurement of equipment to increase capacity and enabling staff to work across areas more flexibly to provide mutual aid. An increased use of FIT testing and CT colonoscopy and Colon Capsule Endoscopy are also being utilised to reduce the demand for traditional endoscopy.

4.14 Cancer Waiting Times

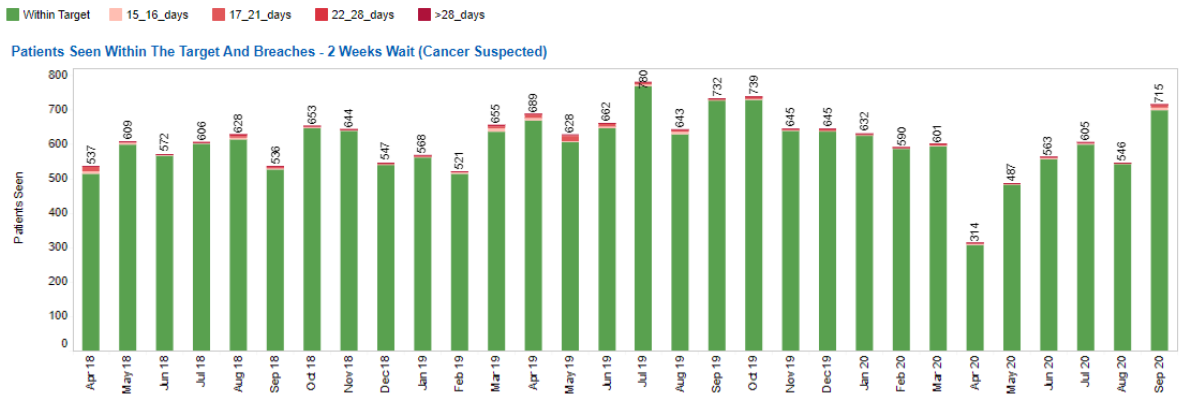
In September Calderdale delivered strong levels of performance across the majority of the cancer waiting times standards – see table below:

Cancer waiting times (monthly)

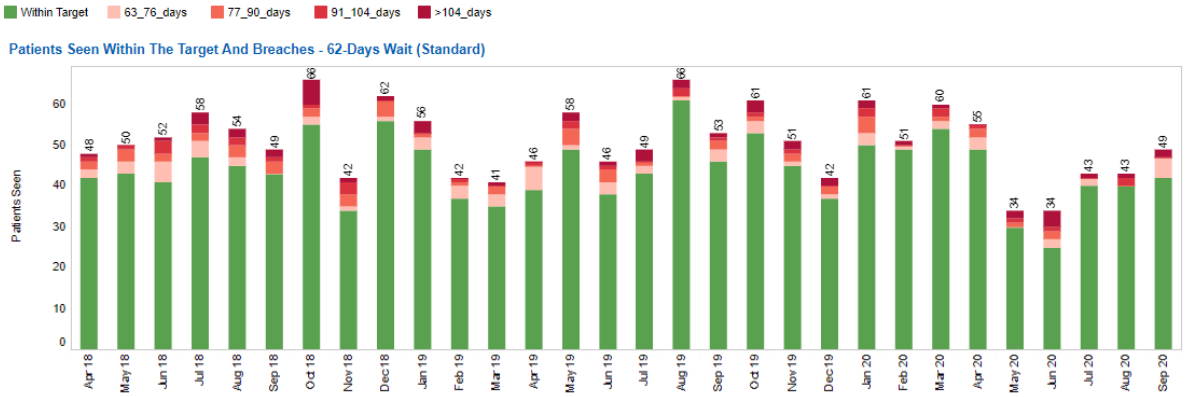
(Commissioner)

Indicator Details	Latest Period	Target	Value	Change
Cancer - % seen within 2 weeks (breast symptoms)	September 2020	93% and above	100.0%	⇔ 0.0%
Cancer - % seen within 2 weeks	September 2020	93% and above	97.6%	⇩ -2.0%
Cancer - % treated within 31 days	September 2020	96% and above	99.8%	⇧ 3.4%
Cancer - % treated within 31 days (Drugs)	September 2020	98% and above	100.0%	⇔ 0.0%
Cancer - % treated within 31 days (Radiotherapy)	September 2020	94% and above	100.0%	⇧ 8.7%
Cancer - % treated within 31 days (Surgery)	September 2020	94% and above	100.0%	⇧ 14.3%
Cancer - % treated within 62 days (Consultant Upgrade)	September 2020	No target	50.0%	⇩ -50.0%
Cancer - % treated within 62 days (Screening)	September 2020	90% and above	0.0%	⇩ -100.0%
Cancer - % treated within 62 days	September 2020	85% and above	85.7%	⇩ -7.3%

This has been underpinned by the increasing level of referrals onto the 2 week wait pathway. Volumes reported in September are similar to pre-covid levels of activity – see table below:



Additional clinic capacity and diagnostics have been put in place and this is supporting the delivery of patient treatment within the required standards – see 62 days access to treatment levels in the chart below:

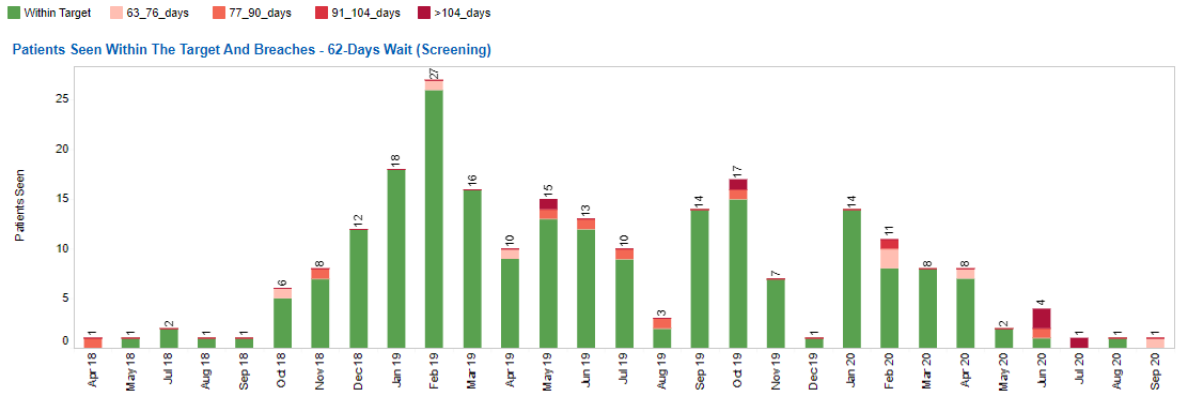


4.15 Cancer Screening

Following referral from a cancer screening service, patients should expect to receive their first definitive treatment with 62 days. The standard to achieve is >90%. Screening services paused during the lockdown, hence the numbers reported are low. Screening services have now reopened and we expect numbers on screening pathways to increase

Performance in September was below the required standard. Only one patient had been referred from a screening service for treatment. The complex nature of this lower GI pathway led to a breach of the waiting time which has now been closed.

All screening services are offering invitations and the challenge remains how to encourage the take up of appointments.



4.16 Mental Health, Learning Disabilities and Autism Programme

A Reset All-Age Mental Health, Learning Disabilities and Autism Programme to take account of national, regional and local mental health requirements, and the evolving picture around the effects of COVID-19 on wellbeing has been established for Calderdale.

The programme involves partners from across Calderdale ‘place’ including representatives from the local authority, providers, Voluntary and Community

Sector, Primary Care Networks and links with the West Yorkshire and Harrogate Healthcare Partnership.

4.17 Performance Summary

The core mental health indicators to assess performance are captured in the table below:

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
CYP Eating Disorder Waiting time - Urgent					0.0%			50.0%			50.0%		
CYP Eating Disorder Waiting time - Routine					95.0%			95.2%			96.0%		
IAPT access rate	5.73%	5.66%	5.00%	4.52%	4.35%	3.19%	3.69%	3.46%	4.56%	4.04%			
IAPT recovery rate	55.9%	53.8%	54.7%	56.1%	55.8%	53.8%	50.7%	48.3%	50.6%	50.5%			
IAPT waiting times 6 weeks	97.8%	95.8%	96.1%	94.7%	93.2%	90.9%	94.1%	94.9%	89.2%	80.6%			
IAPT waiting times 18 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%			
EIP waiting times - MHSDS	72.0%	80.0%	90.0%	95.0%	93.0%	91.0%	71.0%	77.0%	83.0%	70.0%	82.0%		
SMI % achievement		24.9%			23.3%			16.9%			13.7%		
Out of area placement bed days (inappropriate only)	50.0	85.0	170.0	210.0	240.0	215.0	160.0	155.0	245.0	270.0	245.0		
Dementia diagnosis rate	65.9%	66.0%	66.9%	65.6%	65.2%	62.9%	61.2%	61.0%	59.9%	59.5%	58.5%	58.3%	58.1%
Perinatal Access	105.00	105.00	95.00	90.00	100.00	100.00	105.00	105.00	110.00	110.00	115.00		
Perinatal Access Rate	4.3%	4.3%	3.8%	3.6%	4.0%	4.0%	4.3%	4.3%	4.5%	4.5%	4.7%		

Despite COVID-19, the majority of mental health performance indicators continue to be achieved. Two areas to highlight include:

- **Children and Young People (CYP) Access Rates:** Kooth, the online service for children and young people has made a significant contribution to the delivery in this area during the pandemic

- **Individual Placement and Support Service (IPS):** a new service which started in October 2019, providing specialist employment specialists as an integral part of multi-disciplinary core and enhanced mental health community teams. Despite COVID-19 and the extremely challenging employment market (where Calderdale benefit claims have increased by 86%, accompanied by a 55% reduction in vacancies), the team helped secure employment for 19 service users in the service's first year. This provides a great foundation from which to continue taking a system approach to providing employment support, supporting people in Calderdale and meeting our Long Term Plan commitments

Key areas of variance to note and the actions being taken:

- **CYP Eating Disorder Waiting Times – Urgent:** this continues to be a challenge, with increased demand and a lack of Tier 4 beds. This is reflective of the national situation. Calderdale has contributed to a West Yorkshire and Harrogate bid for NHSE funding to support prevention and early intervention

- **Improving Access to Psychology Therapies (IAPT) access**: local performance is the strongest in West Yorkshire and above regional and national levels. However access level remain below target. Both providers continue to be proactive in promoting their services. They have promoted an 'open and here to help message' to GPs, in the local newspaper and via social media campaigns. GPs now have access to assessment slots with Vitaminds, and can book directly into these.

- **Serious Medical Illness (SMI) - physical health checks:** A bid has been submitted by Calderdale for Community Mental Health transformation funding aims to identify and implement the most effective approaches to provide meaningful and effective health checks. This requires a multi-disciplinary approach involving housing, substance misuse, benefits services (for example), and will take account of learning from other Calderdale mental health initiatives.

- **Dementia Diagnosis Rate:** the Dementia referral guidelines are being reviewed by the All-Age Mental Health Team and clinical lead for Dementia, and will be recirculated to primary care at the beginning of 2021.

5.0 RECOMMENDATIONS

It is recommended that the Governing Body **NOTE**:

1. the new temporary financial regime for the period April –March 2021.
2. the financial forecast for the period April –March 2021.
3. the contacting update.
4. the impact of COVID-19 on the progress being made towards achieving the standards set out in the NHS Constitution.

6.0 APPENDICES

Appendix A - shows a summary of the CCG's programme budgets ledger position.
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 at cost centre level.
Appendix D - shows a summary of the CCG public sector payment policy target performance.
Appendix E - shows a summary of the CCG's allocation.

Appendix A

Calderdale CCG Resource Allocation Summary as at 31st December 2020 **Appendix A**

Centre Code / Name	Annual Budget (£)	In Month (£) Budget	In Month (£) Actual	In Month (£) Variance	Year To Date (£) Budget	Year To Date (£) Actual	Year To Date (£) Variance	Forecast (£) Outturn	Forecast (£) Variance	Mth 08 Forecast Outturn	Mth 08 Forecast Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS IN YEAR	(337,512)	(28,147)	(28,147)	0	(253,336)	(253,336)	0	(337,512)	0	(336,482)	(1,030)
ACUTE	171,81	14,979	14,229	(750)	126,881	123,291	(3,591)	164,380	(7,437)	163,571	809
MENTAL HEALTH	37,093	3,234	2,776	(458)	27,390	27,609	220	37,273	180	37,250	23
CONTINUING CARE	22,893	1,816	1,545	(271)	17,443	16,164	(1,279)	22,477	(415)	21,964	513
PRESCRIBING	35,787	3,028	3,067	39	26,705	27,595	890	36,792	1,005	36,792	0
PRIMARY CARE	7,426	750	549	(200)	5,177	5,055	(122)	6,780	(654)	7,253	(473)
DELEGATED CO-COMMISSIONING	32,784	2,867	2,810	(57)	23,828	24,049	221	33,291	507	32,032	1,259
COMMUNITY HEALTH SERVICES	8,934	177	1,323	1,146	8,403	11,779	3,376	15,72	6,787	15,684	37
OTHER	4,004	211	486	275	3,370	3,961	590	5,220	1,215	5,181	39
BCF	12,713	1,047	1,11	70	9,573	10,080	507	13,416	704	13,412	5
COMMISSIONING RESERVE	4,971	118	536	417	4,578	4,488	(90)	4,104	(867)	4,594	(491)
Grand Total	**910**	**79**	**290**	**210**	**12**	**734**	**722**	**1,942**	**1,024**	**1,251**	**691**
Anticipated HDP costs reclaim								(1,227)		(652)	
Anticipated ARRS cost reclaim								(750)		(634)	
Expected year end surplus								**(35)**		**(35)**	

Appendix B

Calderdale CCG Running Cost Allocation Summary at 31st December 2020

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 8 Outturn	Month 8 Movement
ADMINISTRATION & BUSINESS SUPPORT	40	3	2	(1)	30	22	(7)	30	(10)	30	0
CEO/ BOARD OFFICE	541	45	48	3	406	443	37	602	61	602	0
IM&T	74	6	10	4	55	47	(8)	148	74	146	2
CORPORATE COSTS & SERVICES	175	15	15	0	131	125	(6)	161	(13)	165	(3)
EQUALITY AND DIVERSITY	40	3	3	(0)	30	25	(4)	35	(5)	35	0
PATIENT AND PUBLIC INVOLVEMENT	78	7	5	(2)	59	51	(8)	68	(11)	68	0
CONTRACT MANAGEMENT	337	28	29	1	253	267	14	355	18	355	(0)
MEDICAL DIRECTORATE	329	27	26	(2)	247	231	(16)	342	13	314	28
HUMAN RESOURCES	35	3	3	(0)	27	23	(3)	31	(5)	32	(2)
STRATEGY & DEVELOPMENT	617	51	86	35	463	464	1	646	29	573	73
BUSINESS INFORMATICS	347	29	20	(9)	260	181	(79)	242	(105)	251	(9)
QUALITY ASSURANCE	381	32	30	(1)	285	234	(51)	325	(56)	324	1
ESTATES AND FACILITIES	256	21	28	6	192	175	(17)	258	2	224	34
FINANCE	538	45	34	(11)	403	267	(136)	367	(171)	359	8
GENERAL RESERVE - ADMIN	8	10	(50)	(60)	(21)	330	351	284	276	424	(140)
CORPORATE GOVERNANCE	320	27	28	2	240	172	(68)	223	(96)	213	10
Grand Total	**4,115**	**352**	**316**	**(36)**	**3,059**	**3,059**	**0**	**4,115**	**0**	**4,115**	**(0)**

Appendix C

Calderdale CCG Delegated Primary Medical Services Summary at 31st December 2020

PRIMARY CARE SERVICES:	Annual	In month			Year To Date (£)			Forecast M09		Forecast M08	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	18,372	1,531	1,566	35	13,779	13,772	(7)	18,372	0	18,372	0
PMS	1,667	139	137	(2)	1,250	1,268	18	1,678	10	1,678	0
APMS	762	63	63	0	571	571	0	762	0	762	0
QOF	2,714	226	226	(0)	2,036	2,036	(0)	2,714	(0)	2,714	(0)
Enhanced Services	314	26	34	8	235	233	(2)	314	0	295	19
Premises - Reimbursed Costs	3,202	267	272	6	2,402	2,427	25	3,241	39	3,241	(0)
Premises - Other	262	22	20	(1)	196	198	1	264	2	264	(0)
Prof Fees Prescribing & Dispensing	82	7	18	11	62	160	98	187	105	141	46
Collaborative Payments	0	0	0	0	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	163	14	6	(8)	122	282	160	316	153	327	(11)
Other Non GP Services	759	63	63	0	570	570	0	759	0	759	0
Pensions	0	0	0	0	0	0	0	0	0	0	0
PCN	2,093	174	206	31	1,570	1,773	203	2,600	507	2,600	0
Reserves	1,484	259	9	(250)	353	572	219	1,174	(310)	721	453
Reserves - Contingency	159	13	0	(13)	119	0	(119)	159	(0)	159	0
Covid Fair Share	751	63	188	125	563	188	(375)	751	0	0	751
Total Primary Care Medical	**32,784**	**2,867**	**2,810**	**(57)**	**23,828**	**24,049**	**221**	**33,291**	**507**	**32,033**	**1,258**

Appendix D

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 31st December 2020

Supplier	In Month				Year To Date			
	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target
NHS	42	97.67%	£16,996,774.70	99.92%	810	96.43%	£172,476,942.57	99.95%
Non NHS	722	98.10%	£8,456,003.84	97.00%	6,766	97.73%	£69,724,265.09	93.38%
Total	764	98.07%	£25,452,778.54	98.93%	7,576	97.59%	£242,201,207.66	97.97%

Appendix E

Calderdale CCG Resource Allocation Summary at 31st December 2020

Resource Allocation	Programme Costs (£'000)	Co-Commissioning Costs (£'000)	Running costs (£'000)
Confirmed Allocation	(312,497)	0	(4,115)
Co Commissioning	0	(32,454)	0
Reduction for indemnity scheme	0	932	0
IR PEL's Transfer	(99)	0	0
Additional Core Services Funding	(226)	0	0
Mth 1-4 Allocation Transfer to Central	208,548	21,015	2,743
Prospective 4 months Non- Recurrent	3,963	127	177
CCG CFS Mth 3 Retro Top Up	(1,059)	(116)	(88)
CCG CFS Mth 4 Retro Top up	(1,170)	(66)	(48)
Mth 5-6 Allocation Transfer to Central	(50,155)	(5,190)	(597)
CCG CFS Mth 5 Retro Top up	(25)	(50)	(41)
CCG CFS Mth 6 Retro Top up	(537)	(58)	(44)
Mth 7-12 Allocation Transfer from Central	(156,210)	(15,956)	(2,058)
NR Adjustment	6,926	0	0
STP COVID Distribution	(1,428)	0	0
CYPMH Green Paper	(218)	0	0
LD Mortality Review	(4)	0	0
Digital Primary Care	(48)	0	0
Winter Pressure	(78)	0	0
Flash Glucose	(4)	0	0
Children's & Toung People Palliative Care	(7)	0	0
Impact & Investment	0	(91)	0
Care Homes Premium	0	(66)	0
Increase in Practice Funding	0	(38)	0
CCG CFS Mth 7 Retro Top up	(121)	(22)	(44)
WYH - Distribute Primary Care SDF funding 20/21 - GP second wave, practice resilience, reception training, retained doctors schemes	0	(751)	0
WYH - Distribute Adult Crisis SDF funding 20/21 1st installment	(169)	0	0
WYH - Distribute Ageing Well SDF 20/21	(56)	0	0
Long Covid Clinic Allocation 20/21 WY ICS	(36)	0	0
Ageing Well - EHCH training and development funding	(8)	0	0
Clinical Leads Oximetry @Home	(10)	0	0
Grand Total	**(304,728)**	**(32,784)**	**(4,115)**

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	Quality and Safety Report and Quality Dashboard	**Agenda Item No.**	10 b
Report Author	Alison Waters, Project Support Officer Penny Woodhead, Chief Quality and Nursing Officer	**Public / Private Item**	Public
GB / Clinical Lead	Dr Caroline Taylor, GP Member, Vice Clinical Chair	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary							
Please include a brief summary of the purpose of the report	This report provides the Governing Body with an update on progress against recent quality and patient safety activities. The report also includes a copy of the Quality Dashboard for November 2020, providing quality and safety information for our main providers, and the following information: • Infection Prevention and Control • Calderdale and Huddersfield NHS Foundation Trust (CHFT) Maternity Update • Ockenden Review • New Care Quality Commission Process • Serious Incident Reporting Bi-Annual Update • LeDeR Programme • 2019/20 Provider Quality Accounts.						
Previous consideration	**Name of meeting**	N/A	**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended the Governing Body: ▪ **RECEIVES** and **NOTES** this update on Quality and Safety information to provide assurance regarding its main providers, plus the following information: - Infection Prevention and Control - Calderdale and Huddersfield NHS Foundation Trust (CHFT) Maternity Update - Ockenden Review - New Care Quality Commission Process - Serious Incident Reporting Bi-Annual Update - LeDeR Programme - 2019/20 Provider Quality Accounts.						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications						
Quality & Safety implications	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.					
Engagement & Equality implications	Not required					
Resources / Finance implications	Not applicable					
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	X
Strategic Objectives (which of the CCG objectives does this relate to?	▪ Improving quality ▪ Achieving the agreed strategic direction for Calderdale	**Risk** (include risk number and a brief description of the risk)	1635 - IPC capacity 1007 - LeDeR 1565 - Capacity / QA. 1361 - LCD.			
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 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 Care Quality Commission inspections, clinical and patient related outcome measures and patient and staff experience measures.

2.2 The quality dashboard seeks to provide the Quality, Finance and Performance 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, Finance and Performance 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, Finance and Performance 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. Infection Prevention and Control

3.1 Covid-19 outbreaks continue to cause extreme pressures and challenges for providers and for the Local Authority Infection Prevention and Control team (IPC). A robust process of declaring and managing outbreaks in community settings is underway with Local Authority IPC colleagues also attending outbreak management meetings in secondary care. Identified learning is shared and included in communications and training offers.

3.2 Calderdale and Huddersfield NHS Trust (CHFT) had an invited external peer review of IPC practices, standards, processes and leadership. The CCG have contributed to outbreak meetings and the Quality team are supporting the IPC team with reminder IPC and PPE training offers and support to care homes and primary care settings.

3.3 <u>CHFT update</u>

3.3.1 CHFT has also experienced challenges with large numbers of COVID outbreaks and nosocomial transmission. An external peer review by the Head of Health Protection (Kirklees) and NHS England / Improvement IPC Lead has taken place. It was noted that the IPC team is well resourced, with attachment to the clinical divisions and an

effective link nurse system with regular teaching and support. Areas of discussion included: testing regimes, social distancing and bed spacing in some ward areas.

3.3.2 It was noted there was good compliance with mask wearing and hand hygiene and efforts to encourage social distancing were in place in public areas. Environmental cleaning audits were positive with some learning from the region shared.

3.3.3 It was clear on the visit that there is significant executive ownership of the Covid-19 response in the Trust, and of outbreaks. An update on the position against version 2 of the IPC Board Assurance Framework is expected at the next internal Quality Committee. Whilst increasing use of digital media allows virtual leadership, the external visit team recommended the leadership and executive team maintain and enhance daily visibility across all clinical and non-clinical areas.

4. Calderdale and Huddersfield NHS Foundation Trust (CHFT) Maternity Update

4.1 <u>COVID in Maternity Services update</u>

4.1.1 Maternity services have adhered to national guidance provided in response to the pandemic. This has presented some challenges, particularly around visiting.

4.1.2 A recent survey by Healthwatch in Calderdale of people's experiences of accessing services during the pandemic included feedback from women who were dissatisfied with their experience of maternity services. A further survey was undertaken for 6 weeks which closed in early September, with the aim of gathering feedback from women around their experiences of the changes to services due to COVID, to support and assist Maternity Services going forward. It involved all partners in the local system. Colleagues from the University of Huddersfield along with the Calderdale and Huddersfield Maternity Voices Partnership Chair have been undertaking the analysis. Over 600 responses were obtained and early findings have been shared within a working group to allow providers of Maternity Services to take any urgent action, with the final report and action plan around communication being worked on at the moment.

4.1.3 The Maternity Service continues to review updated national guidance with a re set task and finish group for maternity in place. At the latest CCG update meeting with the Head of Midwifery in October, all four choices of place of birth were being offered, but it was acknowledged that this may change. It was noted however that the majority of Consultant antenatal clinic services including the Antenatal Day Unit are being offered in Calderdale due to the environment at Huddersfield Royal Infirmary having been risk assessed as unsuitable. Women are offered the choice of face to face or telephone antenatal booking appointments plus all ante- and postnatal appointments, with a robust risk assessments process in place. Three Consultant Obstetricians continue to review referrals and align antenatal care to NICE guidance.

4.1.4 Antenatal appointments remain 'woman only' to attend however partners are allowed at the 20 week ultrasound scan. A weekly senior meeting is taking place to undertake reviews of women's cases who have extenuating circumstances. National guidance on visiting in maternity services guidance is expected to change again.

4.1.5 Calderdale and Huddersfield NHS Foundation Trust continue to follow the national recommendation not to undertake carbon monoxide monitoring with no date set to restart this. Women are asked about smoking and referred to smoking cessation services as required.

4.1.6 Escalation and diversion plans have not altered as a result of COVID. Staff continue to be moved across the service dependant on acuity with continual prioritisation of essential work within acute and community Maternity Services. In addition a COVID staffing mobilisation plan to support a continuing safe service has been written. The Maternity Services business continuity plan was reviewed in March 2020 and is currently under further review.

4.2 Saving Babies Lives Care Bundle 2 update

4.2.1 This is an NHS England / Improvement care bundle which was produced to help reduce perinatal mortality across England, building on the achievements of version one, including the evaluation. The elements of the care bundle are:

- Reducing smoking in pregnancy
- Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
- Raising awareness of reduced fetal movement (RFM)
- Effective fetal monitoring during labour
- Reducing preterm birth.

4.2.2 The third survey of compliance with the five standards has been completed and sent to NHS England / Improvement. Calderdale and Huddersfield NHS Foundation Trust (CHFT) have identified compliance issues with an updated element to undertake uterine artery doppler measurement in 'high risk of placental dysfunction' pregnancies which requires training of the ultrasonography workforce. CHFT have completed a train the trainer approach with further roll out required. It has also been reported that due to resources CHFT are currently unable to scan all pregnant smokers but are scanning smokers with one or more co-morbidities. A paper is to be written and taken through internal governance process. It should be noted that CHFT have the lowest stillbirth rate recorded on the West Yorkshire and Humber Maternity Dashboard with a rolling annual rate of 1.8% against a threshold of <4.7%.

4.3 Continuity of Carer update

4.3.1 The national trajectory of women who should receive Continuity of Carer changed to 35% by March 2021 with an increased focus on Black, Asian and Minority Ethnic (BAME) and complex need. Meeting this continues to be a challenge for CHFT. Three continuity teams were launched just before the pandemic and have continued. There are currently 25% women booked or placed onto the pathways in September. 35% are from BAME community and the service is making plans to increase this.

5. Ockenden Review

5.1 A national independent maternity review has taken place focusing on all reported cases of maternal and neonatal harm at Shrewsbury and Telford NHS Trust between the years 2000 and 2019. The full report can be accessed here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf

5.2 The Ockenden review included cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (grades 2 and 3) and other severe complications in mothers and newborn babies. Whilst the total number of families to be included in the final report due to be published in 2021 is 1,862, an initial report was published in early December. The panel reviewing the report identified important themes which required sharing across all maternity services as a matter of urgency as the Ockenden investigation found that important recommendations from previous national maternity reviews and local investigations had either not been implemented or not evaluated. This meant that changes implemented had failed to result in the intended outcome of improving safety in maternity care provision. The review of 250 cases confirmed missed opportunities to learn in order to prevent serious harm to mothers and babies.

5.3 The report contains recommendations for the Trust, and in addition all Trusts were asked to assess and confirm their compliance against the 12 urgent clinical priorities listed below by 21st December with full assurance required through an NHSE assurance assessment tool by January 15th 2021:

1. Plans in place to implement the Perinatal Clinical Quality Surveillance Model.
2. All maternity Serious Incidents to be shared with Trust boards at least monthly and the Local Maternity System,(LMS) as well as continuing to report to HSIB
3. Evidence of robust mechanisms for gathering service user feedback and assurance of work with service users through Maternity Voices Partnership (MVP) to coproduce local maternity services
4. Identification of an Executive Director with specific responsibility for maternity services, plus confirmation of a named non-executive director who will support the Board Maternity Safety champion to bring independent challenge to the oversight of maternity and neonatal services and ensure that the voices of service users and staff are heard.
5. Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
6. Assurance that a Multi-Disciplinary Team training schedule is in place
7. Confirmation that funding allocated for maternity staff training is ring fenced and that Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety
8. All women with complex pregnancy must have a named Consultant lead with mechanisms to regularly audit compliance against this
9. Understand what further steps are required by organisations to support the development of maternal medicine specialist centres

10. A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth and include regular audits to assess compliance with personalised care and support plans
11. Identification of a second lead to support regular training sessions, review of cases and ensure compliance with NHSE Saving Babies lives care bundle 2 plus national guidelines.
12. Pathways of care must be clearly described in written information in formats consistent with NHS policy and posted on the Trust website

5.4 The West Yorkshire and Harrogate Local Maternity System co-ordinated responses from all provider maternity services. Calderdale and Huddersfield NHS Foundation Trust confirmed compliance in all aspects and in some instances have already commenced plans to strengthen internal compliance. This will form part of ongoing CCG assurance.

6. New Care Quality Commission Process

6.1 On 16th September 2020 the Care Quality Commission (CQC) published a statement explaining how they will regulate during the next phase of the pandemic. They started a transitional regulatory approach in early October which started with adult social care and dental services. The CQC state an intention to use a flexible approach building on learning from the pandemic.

6.2 The key components are:

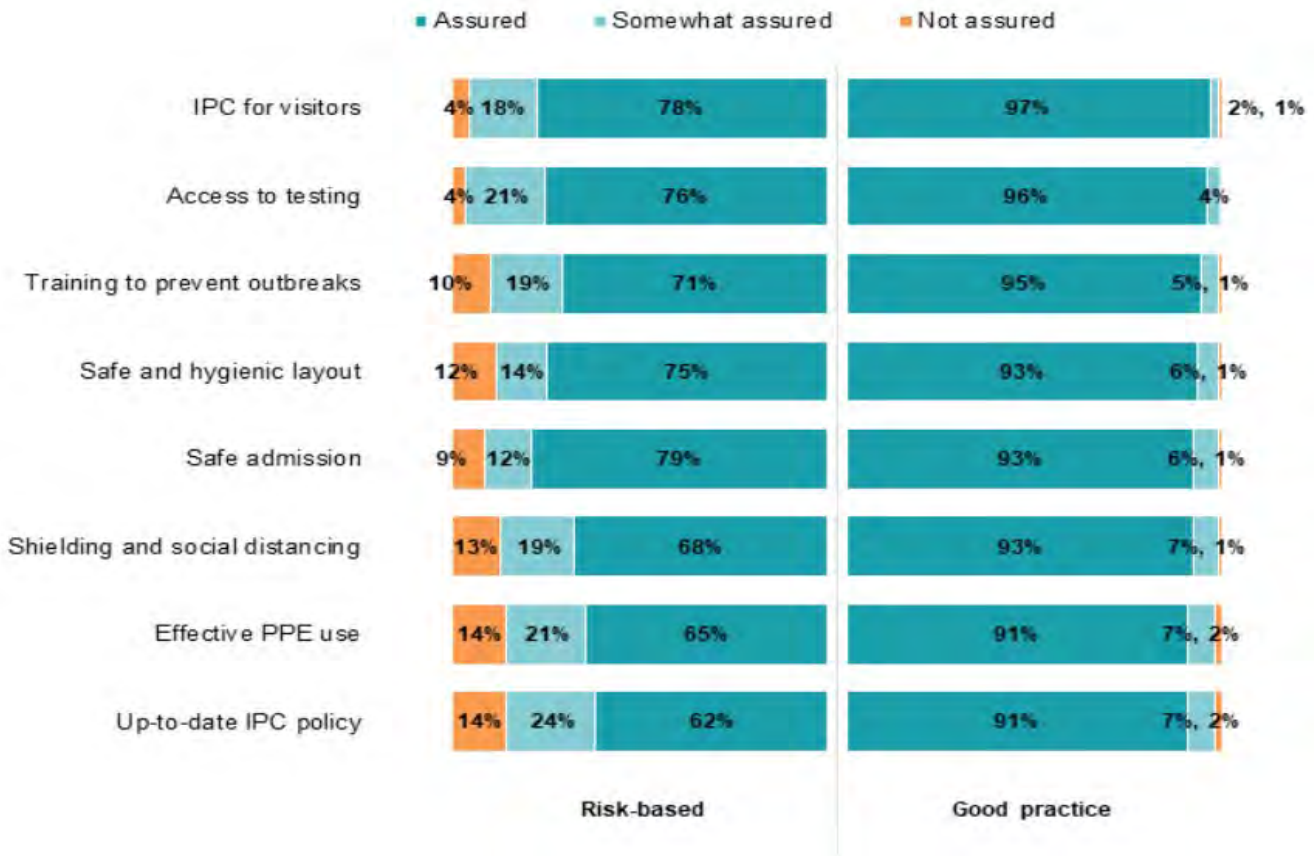
- A strengthened approach to monitoring, with clear areas of focus based on existing Key Lines of Enquiry (KLOEs), to enable us to continually monitor risk in a service
- Use of technology and our local relationships to have better direct contact with people who are using services, their families and staff in services
- Inspection activity that is more targeted and focused on where we have concerns, without returning to a routine programme of planned inspections.

6.3 A commitment has been made to be adaptive and responsive as the situation changes plus consideration of longer-term changes to how they regulate. Plans to re-commence assessing other service types are:

- All trusts from 12 October
- GP, independent doctors, slimming clinics, urgent care and out-of-hours on 19 October
- Further detail on rollout plans for the remaining service types are due to be released in due course.

6.4 In November the Infection Prevention and Control (IPC) CQC published a report of a special programme of Infection Prevention and Control inspections in care homes they had carried out during August 2020. The 301 homes were selected as potential examples of where IPC was being done well plus a review of IPC in 139 ‘risked-based’ inspections between 1 August and 4 September which were carried out in response to concerns about safety and quality. These inspections reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall and across ‘eight ticks’. The findings are presented in the diagram below. The

CQC committed to completing a further 500 stand-alone IPC care home inspections by the end of November including services where they expect to see good IPC practice, so they can continue to learn and share what works well as the situation develops, however the CQC have stated they will also take action in services that are not adapting well to the pandemic. It has been published by the CQC that they have not seen any clear relationship between care home ratings and the number of deaths due to COVID-19.



7. Serious Incident Reporting Bi-Annual Update

7.1 Update from the Serious Incident (SI) Team

7.1.1 As part of developing and preparing for changes, the Serious Incident Team have begun the process of considering what will be the impact of the new Patient Safety Incident Reporting Framework (PSIRF) for our providers when it comes in to place in autumn 2021.

7.2 SI reporting during the pandemic

7.2.1 Quarter 1 this year saw the advent of the Coronavirus Act 2020 and a change in national reporting guidelines. It was acknowledged that staff shortages may make it more difficult for providers to undertake SI investigations.

7.2.2 Organisations were granted leniency on the 60-day timeframe for investigations during this period. The CCG recognised that key senior staff had been redeployed to support frontline care and communication was restricted accordingly. Concerns that there may

be a failure to report SIs were not evident and SI reporting continued. The evidence of this is revealed in the numbers identified in the appendices. Alternative approaches to achieve closure of SIs were encouraged. Quality Leads in the four CCGs stepped in to support SI closures across the area. The SI team strived to utilise this period effectively to provide a supportive role to already challenged providers and triangulation with Quality colleagues via the Quality log.

7.3 Other work of the SI team

7.3.1 The SI team members have continued to meet with provider leads to review SIs along with Quality Managers, taking a transparent open approach to challenging where there are concerns about an organisational response to an SI, seeking to move away from apportioning blame and instead focussing on organisational learning that can be shared, both within a provider and with other health partners.

6.3.2 In November 2020 the SI team hosted the West Yorkshire Learning Forum virtually. The goal of the forum is to provide up-to-date information and a shared network for providers to explore similar concerns. World Patient Safety Day was celebrated with providers by the team with the emphasis being 'safe staff'.

8. Learning Disabilities Mortality Review Programme update

8.1 At the onset of the pandemic it was identified by NHS England (NHSE) that learning Disabilities Mortality Review Programme (LeDeR) reviews being undertaken could be temporarily halted in order to focus all efforts on responding to the pandemic. In June NHSE requested that the reviews recommence with an urgent focus on reviews being completed for people with a Learning Disability (LD) who had died during the Covid-19 Pandemic, so that analysis could be undertaken and any learning identified.

8.2 Subsequently, on 12 November 2020 the University of Bristol published its report analysing the LeDeR Reviews that had been undertaken of the deaths of 206 people with a learning disability (LD) at the start of the pandemic. The report highlighted some good practice in the care of people with a learning disability, but it also highlighted concerns in 4 key areas:

- Issue 1: Identifying deterioration in health.
- Issue 2: Do not attempt cardiopulmonary resuscitation (DNACPR) and Learning Disability as a cause of death
- Issue 3: Diagnostic overshadowing
- Issue 4: Reasonable adjustments

8.3 The NHS England/Improvement (NHSE/I) response to the Bristol University report committed the NHS to working with partners and stakeholders to embed the learning from the report and detailed some specific actions to respond to that learning.

8.4 The NHSE/I response report has been discussed at SMT and a task and finish group set-up led by the commissioning team for transforming care for people with LD to:

- Review the report

- Commence a stocktake of the work that is already underway locally and assessing the CCG against the actions described in NHSE/I response report
- From this identify any gaps and take these forward in to local actions.

8.5 To review the NHSE/I short report detailing the learning and key actions please access the link below: https://www.england.nhs.uk/wp-content/uploads/2020/11/C0843-Covid-LeDeR-report-131120.pdf

9. 2019/20 Provider Quality Accounts

9.1 Regulations making revisions to 2019/20 quality account deadlines were put in force from 1st May 2020. Whilst primary legislation still requires providers of NHS services to prepare a quality account for each financial year, the amended regulations mean that there is no fixed deadline by which providers must publish their 2019/20 quality account. However, NHS England and NHS Improvement recommended a revised deadline of 15 December 2020 in light of the pressures caused by the coronavirus pandemic.

9.2 Providers were still required to share draft quality accounts with stakeholders for 'document assurance' as required by the quality accounts regulations to allow scrutiny and comment; however, there is no requirement this year under the revised legislation to obtain assurance from external auditors.

9.3 Despite the ongoing challenges faced by providers due to the coronavirus pandemic from quarter 4, 19/20, all our providers required to produce quality accounts have shared pre-publication drafts for review and commissioner statements have been returned for inclusion in the published document by the revised deadline of 15th December 2020.

9.4 Draft quality accounts were received from:

- Calderdale and Huddersfield NHS Foundation Trust
- South West Yorkshire Partnerships NHS Foundation Trust.

10. Implications

10.1 Quality and Safety Implications

10.1.1 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.

10.2 Resources / Finance Implications

10.2.1 None identified.

11. Recommendations

11.1 It is recommended that the Governing Body **RECEIVES** and **NOTED** this update on Quality and Safety information to provide assurance regarding its main providers, plus the following updates:

- Infection Prevention and Control
- Calderdale and Huddersfield NHS Foundation Trust (CHFT) Maternity Update
- New Care Quality Commission Process
- Serious incident Reporting Bi-Annual Update
- LeDeR Programme
- 2019/20 Provider Quality Accounts
- Ockenden Review.

12. Appendices

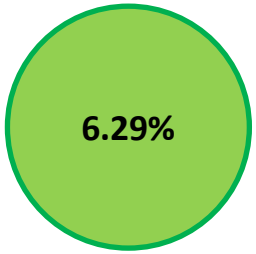
12.1 Appendix 1 – Quality Dashboard.

Item 10 b Appendix 1

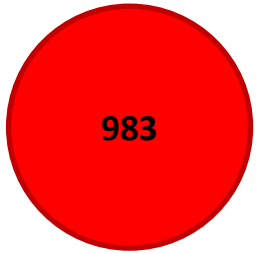
Calderdale CCG Quality Dashboard November 2020

CCCG Exception Report

Indicator	Target	Month/ Quarter	Month data from	YTD 2020-21
C-Diff	tbc	4	Nov 2020	39
MRSA	0	0	Nov 2020	0
MSSA	No target	4	Nov 2020	35
E-Coli	tbc	12	Nov 2020	111
Pseudomonas	No target	1	Nov 2020	4
Klebsiella	No target	1	Nov 2020	21



Broad spectrum antibiotics as % total antibiotics prescribed August 2020 (updated November 2020)



Total antibiotic prescribing items per 1000 STAR PUs August 2020 (updated November 2020)

Healthcare Acquired Infections (HCAI)

Public Health England have yet to release targets for both C-Diff and E-Coli cases for 2020-21. No cases of MRSA have been reported so far for 2020-21.Some figures for previous months have been adjusted, so year to date totals may be a little different than expected.

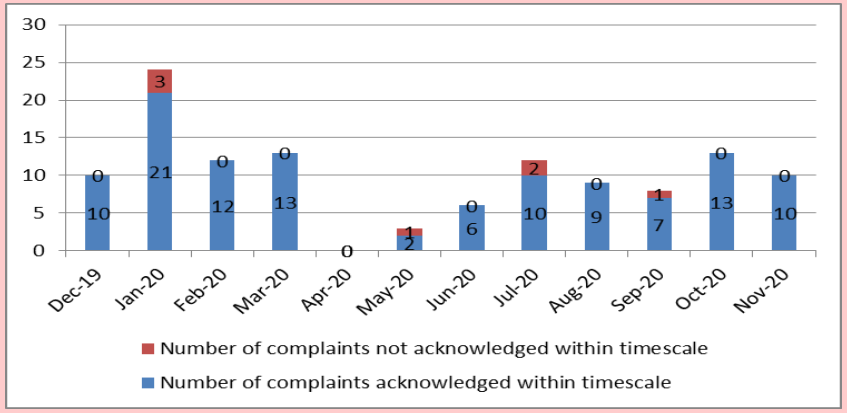
Broad Spectrum antibiotics

The prescribing of broad spectrum antibiotics as a % of all antibiotics prescribed over a 12 month period up to August 2020 has slightly increased to a value of 6.29% (up from 6.2%) which is within the NHSE target of 'at or below 10%'

Total antibiotic prescribing per 1000 STAR Pus

This is currently within the NHSE target of 1161 and continues to work towards the stretch target set of 965 or below.

Complaints – acknowledged within 3 working days



The NHS complaints process was paused for all CCGs and providers during COVID19 . Despite this, 9 complaints/enquiries/concerns were handled by the CCG in Q1. None related to the pause of NHS clinical or administrative processes. The complaints process formally re-started on 01/07/2020 and future reports will highlight themes or specific learning from CCG complaints responded to during the reporting period.

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 Sectary in Q1. 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.	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 in in place and an increase in timely closure of the data is expected in the coming months.

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 December 2020.

Falls Resulting In Harm

As one of the Trusts key priorities a paper to outline the starting point of this quality initiative has been was shared stating the aims of the Trusts falls collaborative. A target of an intention to reduce the inpatient falls rate by 10% over the next 12 months has been set. The Trust aim to sustain this reduction for a further 12 months.

Participation in the National Audit of Inpatient Falls and outcomes suggested that the Trust can do more to reduce the incidences of falls amongst their inpatients. Organisational oversight will continue to support the management of performance against this in order to improve patients safety with updates provided via the Quality Committee.

Never Events

The Trust have reported 2 Never Events this financial year. These relate to a retained swab and a wrong site surgery. These incidents occurred in May and June 2020. The Trust have completed and submitted one of the investigation reports and continue to investigate the second incident. The CCG Quality Manager and Serious Incident Lead continue to develop strong working relationships and mechanisms for investigation updates and assurances have continued virtually throughout the pandemic.

Complaints

Following an extensive review of the Complaints function by CHFT's newly appointed Assistant Director-Patient Experience a 'Making Complaints Count' paper has been shared. The review paper is extensive and includes the reality of the current service challenges and highlights key risks (Business continuity and Covid impact). It contains recommendations and the intentions for service improvement over the next 3 years. Overall the Trust have seen a reduction in complaints but continue to strive for progress in relation to the proportion of complaints closed in time.

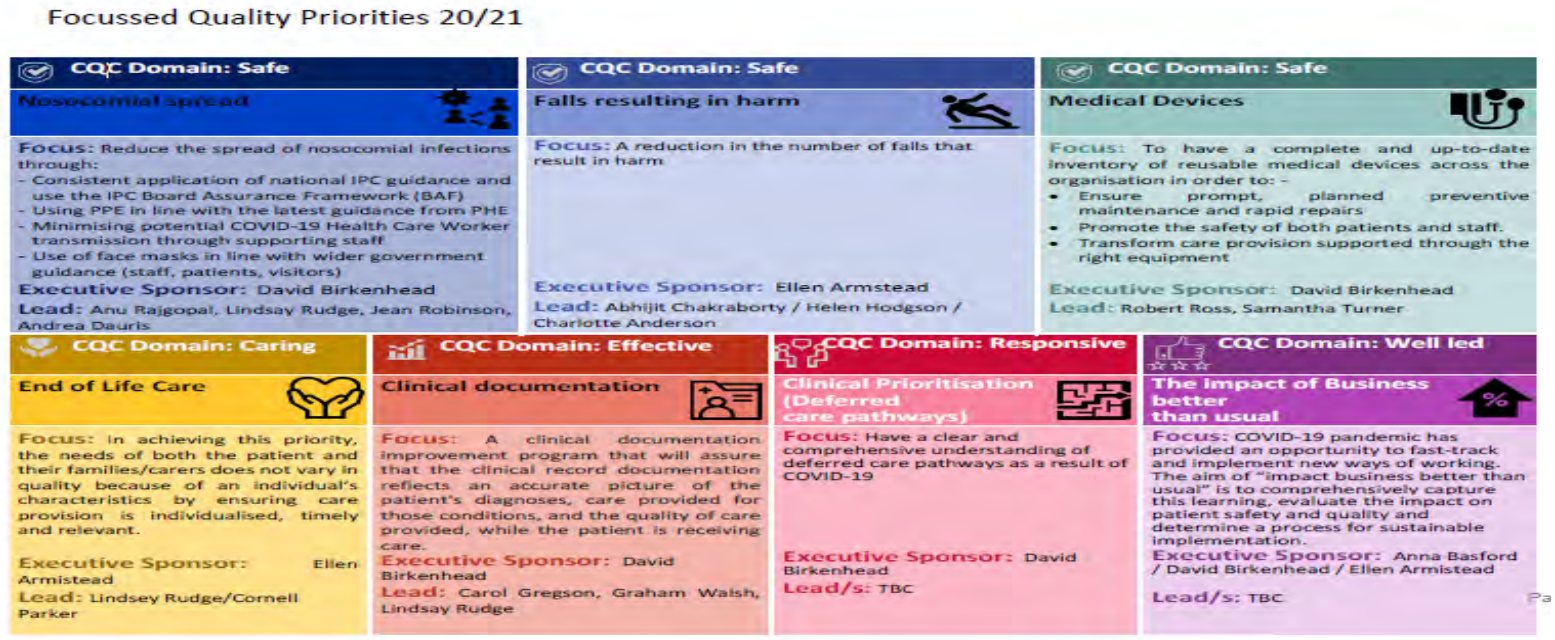
Calderdale and Huddersfield NHS Foundation Trust
Overview

Quality and Safety Strategy

The September Quality Committee saw the Trust launch their Quality and Safety Strategy 2020-2022 - One Culture of Care: Learning and Improving.
The strategy is underpinned by the Trusts 4 pillars

- Put the patient First
- Go see
- Work together to get results
- Doing the must do's

The long-term strategy, behaviours and actions required to meet the 2020/21 goals were outlined.
The Trust is dedicated to the single shared view of quality and state that to provide high-quality care, high-quality providers and commissioners work together in partnership with, and for, the local communities to provide well-led services that are open and collaborative internally and externally who are committed to learning and improving, use recourses sustainably, responsibly and efficiently to provide fair access to all according to need and are equitable for all to ensure that inequalities in healthcare outcomes are a focus for quality improvement.
A number of next steps have been developed to reflect the strategy and prioritise the actions. These continue to be discussed and included in the work plan for the Trusts Quality Committee which is attended regularly by the CCG Quality Manager. The focus priorities are included below.



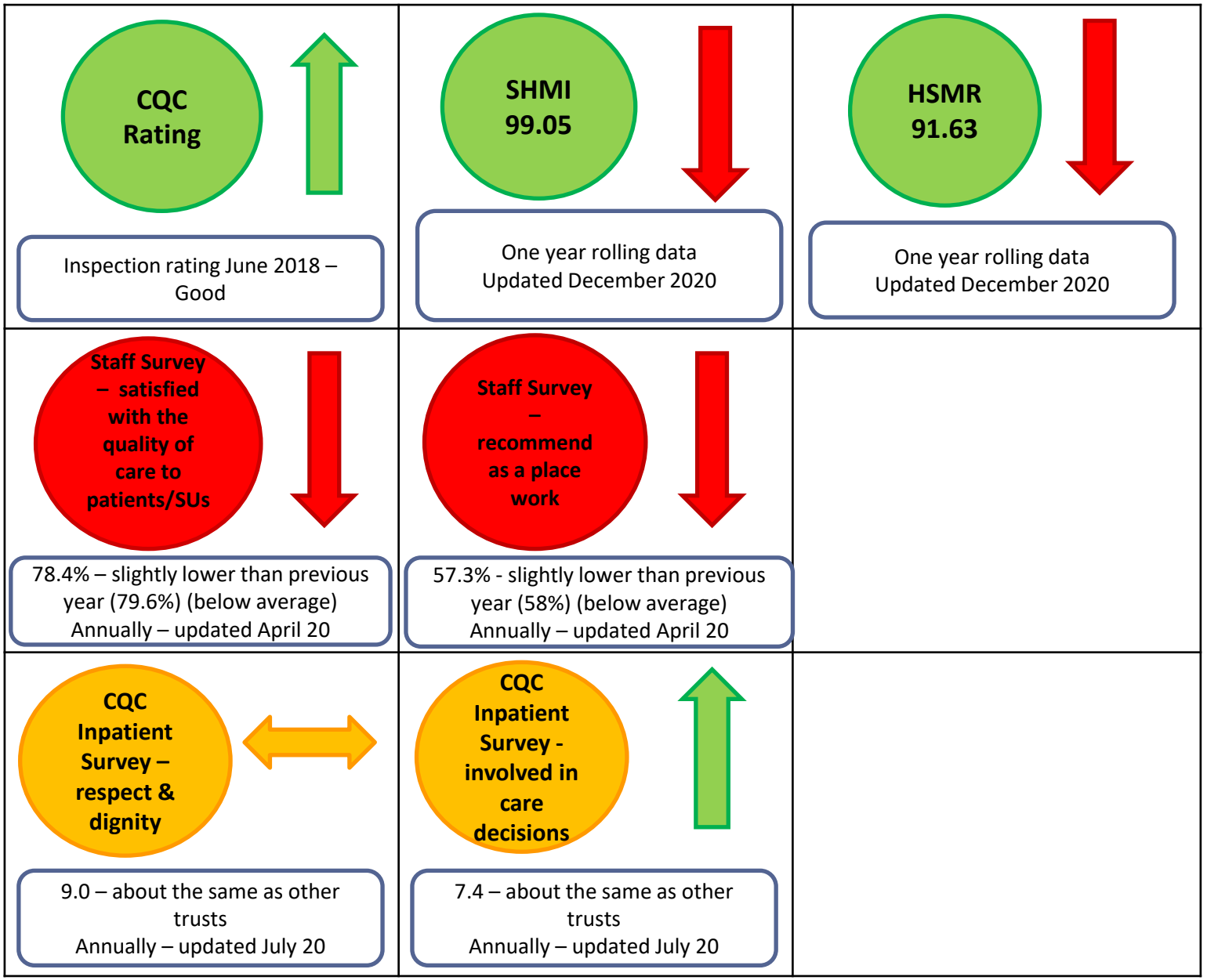
Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – December 2020

Quality Domain	Indicator	Reporting Frequency	CHFT			Trend information														
						Direction of Travel			2019-20						2020-21					
			Period Target	Month/ Period	YTD 2020 - 21	Month / Period / Year data from	Previous Month / Period	Corresponding month 2019-20	O	N	D	J	F	M	A	M	J	J	A	S	O	N
Safe	C Diff	Monthly	tbc	1	24	Nov-20	↑	↔	1	2	0	2	3	5	1	2	4	7	2	2	4	2
	E Coli	Monthly	n/a	0	12	Nov-20	↔	↔	1	0	1	3	1	4	2	5	4	1	0	0	0	0
	MRSA	Monthly	0	0	0	Nov-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	Monthly	n/a	0	5	Nov-20	↔	↑	1	2	2	4	1	0	0	2	3	0	0	0	0	0
	Never Events	Monthly	0	0	2	Nov-20	↔	↔	0	0	1	0	0	0	0	1	1	0	0	0	0	0
	Serious Incidents	Monthly	n/a	1	22	Nov-20	↑	↑	3	6	3	2	2	0	1	1	8	2	2	4	2	1
	Overall essential safety compliance	Monthly	>=95% Green >=90%<95% Amber <90% Red	95.51%	-	Oct-20	↑	↑	95.30%	95.32%	95.13%	94.79%	94.88%	94.81%	93.10%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	_
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	34.5%	-	rolling 6 months - Feb - July 20	↓	↓	59.0%	55.0%	46.4%	42.8%	37.8%	31.6%	33.3%	36.1%	36.8%	37.1%	34.5%	_	_	_
	VTE Risk Assessment	Monthly	95%	95.37%	95.82%	Oct-20	↓	↓	95.98%	96.60%	96.38%	95.97%	96.06%	95.46%	95.56%	96.05%	95.89%	96.26%	96.14%	95.46%	95.37%	_
Caring	EMSA	Monthly	0	0	0	Oct-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	_
Responsive	% Complaints closed within target timeframe	Monthly	100%	44.0%	72%	Oct-20	↓	↑	40%	41%	50%	51%	47%	64%	94.0%	82.0%	80.0%	70.0%	71.0%	62.0%	44.00%	_
	No of complaints re-opened	Monthly	n/a	1	16	Oct-20	↑	-							1	2	4	1	4	3	1	_
	% Last minute cancellations to elective surgery	Monthly	< 0.65%	0.30%	0.26%	Oct-20	↑	↑	1.31%	1.07%	0.92%	1.06%	0.79%	0.81%	0.32%	0.30%	0.00%	0.13%	0.36%	0.38%	0.30%	_
	Percentage Non-elective #NoF Patients with admission to Procedure of < 36 hours	Monthly	85%	75.68%	60.76%	Oct-20	↑	↑	77.55%	91.89%	72.41%	77.36%	67.57%	77.08%	56.10%	58.62%	66.67%	42.86%	51.06%	74.36%	75.68%	_
	12 hour breaches in A&E (A&E trolley waits)	Monthly	0	15	15	Oct-20	↓	↓	0	9	0	0	0	0	0	0	0	0	0	0	15	_

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 – December 2020



Calderdale and Huddersfield NHS Foundation Trust
Exception Report – December 2020

Routine Monitoring

Proposed indicators to return to Routine Monitoring:

Never Events	The Trust have reported 2 Never Events in this financial year. Established assurance processes are in place for the monitoring of the status of the investigations and review of the reports. Incidents and Never Events are monitored frequently and escalation mechanisms are in place.
Complaints	The Trust continue to find responding to complaints challenging but continue to engage and update the Quality Manager regularly. The Trust shared a detailed paper 'Making complaints Count' in September. The recommendations from this will be monitored through the Trusts internal Quality Committee and is regularly attended by the Quality Manager.

Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard

Key Indicators

	Thresholds			Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	YTD
	Green	Amber	Red								
Total Bookings	>90%	-	<90%	92.5%	92.9%	93.0%	92.6%	94.0%	94.7%	90.4%	92.9%
Total Births within Service	Monitoring Only			419	371	356	391	402	368	407	2295
Normal births	>64.7%	>60.9%	<60.9%	62.1%	67.12%	65.45%	61.38%	57.71%	64.40%	63.1%	63.1%
Assisted vaginal births	<11.0%	<12.9%	>12.9%	10.50%	7.55%	10.11%	9.72%	9.70%	10.05%	10.57%	9.6%
Elective C/S deliveries	<10.4%	<11%	>=11%	11.89%	9.86%	9.30%	11.78%	13.03%	10.14%	10.42%	10.80%
Emergency C/S deliveries	<15.2%	<15.6%	>15.6%	14.08%	14.25%	14.93%	15.18%	18.30%	14.52%	15.14%	15.43%
3rd/4th degree tear - normal birth	<2.6%	<3%	>3%	1.5%	1.6%	2.6%	0.4%	2.2%	1.7%	3.1%	1.9%
3rd/4th degree tear - assisted birth	<5.6%	<9.7%	>9.7%	2.3%	10.7%	2.8%	2.6%	7.7%	5.4%	4.7%	5.4%
PPH ≥ 1500ml	<3%	<3.4%	>=3.5%	3.16%	3.01%	2.54%	4.19%	3.26%	4.11%	2.98%	3.35%
Total stillbirths	0	<3	>=3	1	1	0	1	2	1	1	6
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	1	1	0	1	3	1	1	7
Low birth weight at term - live births - % of live babies at term < 2200g	0%	<1%	>=1%	0.26%	0.58%	0.59%	0.28%	0.54%	0.00%	0.79%	0.47%
Incidence of shoulder dystocia (With Harm)	0	-	>=1	0	0	1	0	2	0	1	4
1:1 Care in Labour	>=98%	>=97%	<97%	99.5%	99.4%	99.4%	99.2%	99.5%	100.0%	100.0%	99.6%
Induction Rate	Monitoring Only			42.7%	36.2%	45.3%	38.9%	42.7%	42.7%	41.6%	41.2%
Total number of maternity incidents	Monitoring Only			115	98	113	109	154	142	138	754
Total number of maternity incidents - Harm Caused	Monitoring Only			11	3	2	2	14	4	4	29
Delay in delivery of Category 1 C. Section (>30 minutes from decision to delivery)	Monitoring Only			3	2	6	10	8	6	10	42
Delay in delivery of Category 2 C. Section (>75 minutes from decision to delivery)	Monitoring Only			5	1	7	2	9	5	3	27
Delay in 3rd/4th Degree tear repair (>1hrs post-birth from decision to transfer)	Monitoring Only			0	1	3	0	3	1	2	10
Planned Home Birth	Monitoring Only			1.21%	4.11%	1.13%	2.62%	1.00%	1.37%	3.23%	2.25%
Smoking at Delivery	< 11%	-	> 11%	13.11%	14.52%	11.83%	10.73%	9.02%	9.04%	10.92%	10.97%
Smoking at Delivery (Not recorded)	3%		>3%	1.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
Breastfeeding at Initiation	≥ 74.4%	-	< 74.4%	76.4%	78.6%	77.7%	81.1%	76.1%	75.3%	72.89%	76.9%

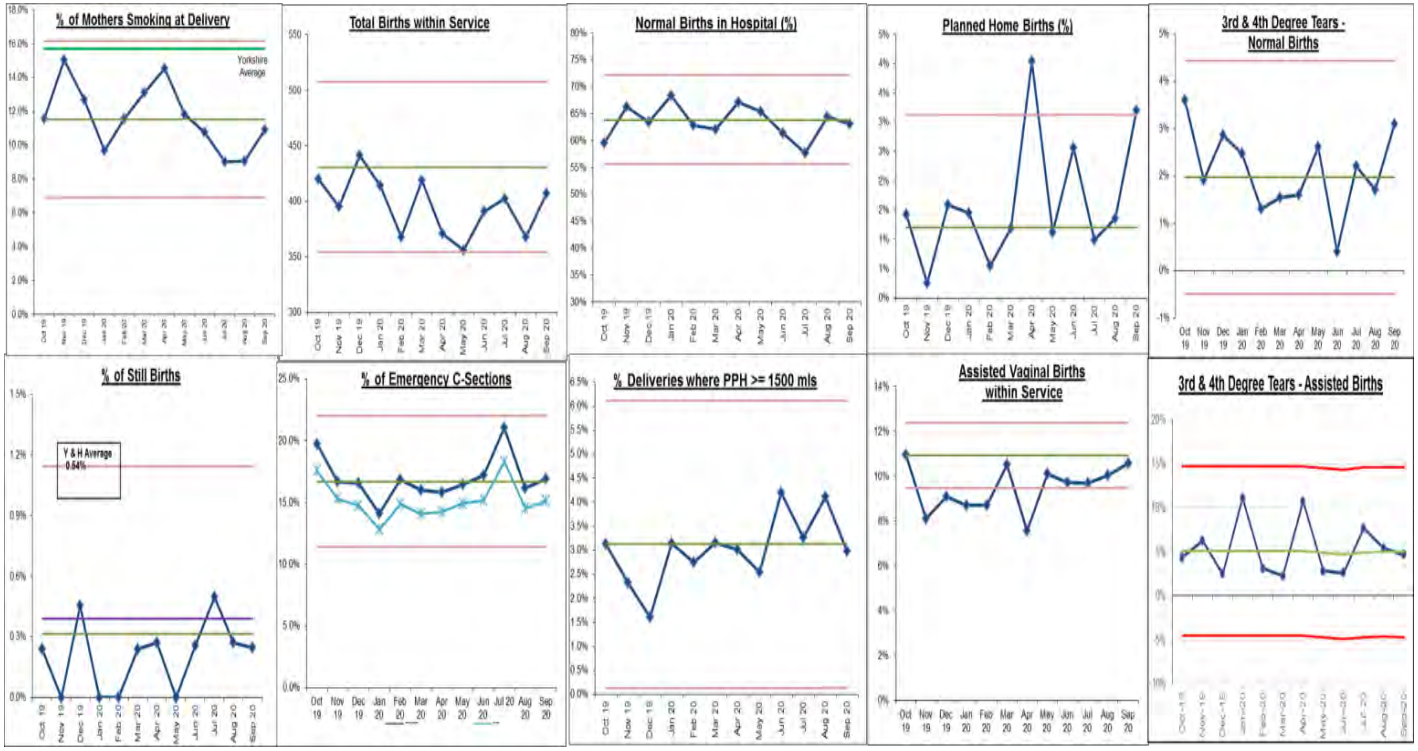
Variance to Same Period in 2019/20
-1.2%

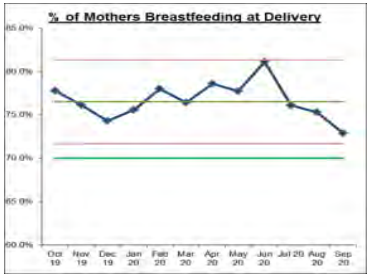
Variance to Same Period in 2019/20
2
1

Calderdale and Huddersfield NHS Foundation Trust
Maternity Dashboard Update

The maternity dashboard data for CHFT Maternity services is in line with normal variation and they compare favourably with other regional providers on the indicators contained in the WY&H Regional Maternity dashboard. The only outlier is breastfeeding initiation which dropped to 72.89% in September (76.8% Huddersfield; 68.7% Calderdale). Potential reasons for this dip are being explored by the CHFT Infant Feeding Co-ordinator, including checking the data and additional telephone support for women where need is identified before discharge. The year to date breastfeeding initiation is reassuring at 76.9% which is above the WY&H target of 74.4%.

A Birthrate Plus review has recently taken place to explore staffing models in more detail. Birthrate Plus is a workforce planning system endorsed by NICE, based on a minimum standard of providing one-to-one care in labour. The report will be considered internally with any recommendations shared with the CCG and will include the requirements of the full Continuity of Carer implementation. A staffing shortfall RAG rating has been undertaken and the workforce is moved dependant on acuity.





South West Yorkshire Partnership NHS Foundation Trust
Exception Report – November 2020

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	The Trust has reported 110 information governance breaches from 1st April to 30th September 2020.	• Trust IG lead requested that managers address the issues with individual staff members. • Creative communications published via The Brief and Twitter focusing on real life examples to raise awareness of the consequences on individuals. • Work has begun on Quality Improvement (QI). • Teams will be invited to the improving clinical information group (ICIG) to discuss improvements made to prevent future occurrences. • Options for running webinars to improve service quality are being explored. • The CCG Head of Quality/Quality Manager have been invited to attend the Trust's Clinical Governance and Safety Committee where further actions will be discussed and monitored.	Trust wide Information Governance staff training remains above the 95% target at 98.8% in September 2020. It is hoped that improvement will be seen and sustained over the next 6 months.
Complaints closed with in 40 days	Work has been ongoing for over 12 months now to understand why the 40 day standard has not been achieved with the following reasons identified: • Increased number of complaints seen • Increase in complexity • Sign off process adding to delays.	• The Trust has reviewed the complaints sign off and reporting process and improved the proactive management when first contact is made with the customer services team. • Timescales are agreed with complainants where complaints are deemed complex and may take longer to resolve which manages expectations and improves experience of the process. • The complaints system has moved onto Datix.	Further improvements to those made leading up to the coronavirus pandemic are expected within the next 6 months depending on the allocation of lead investigators by services which has been problematic due to the demand on clinical time services are experiencing.

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – November 2020

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%)	August data continues to show improvement on the percentage of records with an up to date risk assessment ; 93.4% (inpatient) 74.6% (community) although this remains below target.	• During September and early October most services have moved from the Sainsbury tool on SystmOne to the FIRM (formulation of informed risk assessment) tool which supports the Trust values.	Data is next available in November; although achievement of the 95% target in the community may take well into the new year 2021.

South West Yorkshire Partnership NHS Foundation Trust
Overview/triangulation

The following 2 pages provide a summary in relation to the Quality and Safety of services provided at South West Yorkshire Partnership NHS Foundation Trust for the period up to November 2020, dashboard data to September 2020.

The Trust continue to report via a revised Integrated Performance Report (IPR) in line with interim reporting arrangements agreed by the Trust Board in March 2020 due to the coronavirus pandemic . The interim arrangements commenced in April and the aim is to provide a report that provides information on:

- The Trust's response to Covid-19
- Other areas of performance the Trust needs to keep in focus and under control
- Priority programmes in so far as they contribute to the Trust response to Covid-19
- Locality sections in terms of how business continuity plans are operating

Some changes have been made to the executive dashboard to add in key metrics related to the Covid-19 response and others have been suspended. The quality section of the Trust's IPR remains largely unaltered given the need to ensure the Trust retains focus on the provision of its core services. The most recent IPR is September 2020.

Covid-19

As at 20th October 2020, 108 staff were absent from work due to Covid -19 compared to 19th May 2020 where the figure stood at 204.

- Sufficient PPE remains in place
- The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in
- Symptomatic patient testing is being undertaken
- Hotspot outbreak management testing is being provided internally
- The Trust participated in ICS stress testing workshops in both West Yorkshire and South Yorkshire
- Reporting is developing to help identify areas of focus in response to the eight urgent actions to address inequalities; to support with this a refresh of the Equality, Inclusion and Involvement strategy is underway
- Increased demand modelling taking place
- National guidance continues to be monitored, reviewed and adopted
- The Trust Opel level remains at 2

Quality

- Majority of quality reporting metrics continue to be maintained during the pandemic
- Safer staffing levels on inpatient wards maintained as staff absence increases
- Downward trend in number of moderate-severe incidents reported
- Downward trend in restraint incidents continues
- Number of under 18s admitted to adult wards the same but the number of days stay is increasing and under review
- Complaints response times performance under review
- Non Covid-19 sickness remained at 3.8% in September
- Staff turnover remained steady at 8.9%, which is below the trend of recent years

South West Yorkshire Partnership NHS Foundation Trust
Overview/triangulation

SWYPFT continued…

Risk Assessments

Number of records with up to date risk assessment – Inpatient and Community (Target 95%)

August data continues to show improvement on the percentage of records with an up to date risk assessment ; 93.4% (inpatient) 74.6% (community). Data is next available in November. During September and early October most services have moved from the Sainsbury tool on SystmOne to the FIRM tool (formulation of informed risk assessment) which supports the Trust values. In addition from September, SystmOne tasking is now operational.

Complaints

- There were 32 new formal complaints in September 2020. Of these 3 have had timescales start, 1 has been closed as no consent/contact and 28 are awaiting consent/questions
- 19% of new formal complaints (n=6) had staff attitude as a primary subject
- 10 formal complaints were closed in September 2020. Of the 10, 30% of complaints (n=3) were closed within 40 working days .
- Count of written complaints/count of whole time equivalent. 4.73WTE (Including a band 6 and 7)
- In September 2020 only 30% of complaints achieved the Trust's 40 day target. There were 3 complaints that were within 41-48 days and 2 of these were complex complaints (CS20785 (26 page response) and CS20606 (65 point complaint letter with the other delayed due to obtaining staff witness statements due to annual leave. Allocation of a lead investigator by services as also been problematic due to clinical increases services are experiencing.
- **19 compliments were received**

Information Governance Breaches

- September saw a slight increase in the number of confidentiality breaches from 17 to 19
- The number of breaches due to information being disclosed in error rose from 12 to 16
- During September, breaches of this type were largely related to use of email, such as, omitting to blind copy service users' and volunteers' personal email addresses, sending to addresses that are similar to the intended recipients', possibly due to a reliance on auto-filling commonly and recently used addresses and incorrect attachments being sent.
- Creative communications have been published via The Brief and Twitter that focus on real life examples to raise awareness of the consequences of IG breaches on individuals. Work has begun on Quality Improvement (QI) on this issue across the Trust. Where data demonstrates a theme teams will be invited to the improving clinical information group (ICIG) to discuss what improvements have been made to prevent future occurrences and options for running webinars to improve service quality are being explored.

Out of Area Beds – As at 20th October 2020, there were 177 out of area bed days which is a decrease from 224 in September 2020. The Trust continue to work across the ICS (Integrated Care System) to consider model options to manage any impact of Covid and out of area bed usage; this could be due to the increase in demand for services and/or due to ward outbreaks and needing to manage patients elsewhere. Predominantly within SWYPFT this has been due to requiring additional PICU (psychiatric intensive care unit) capacity due to increasing acuity which continues.

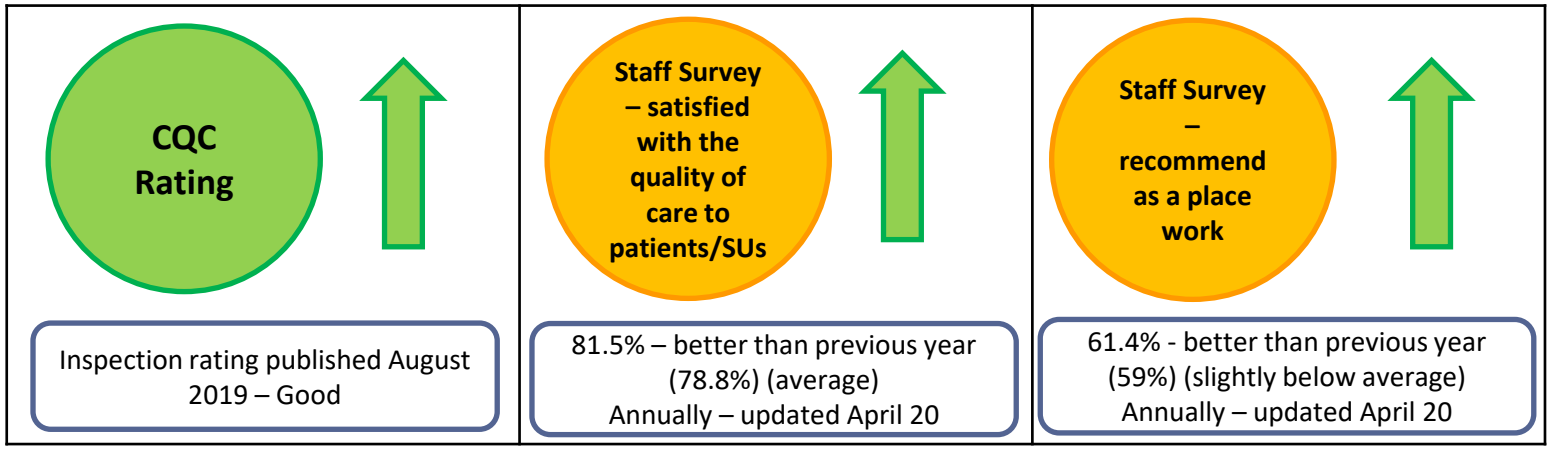
South West Yorkshire Partnership Foundation Trust
Quality Dashboard – November 2020

Quality Domain	Indicator	Reporting Frequency	SWYPFT				Direction of Travel		2019-20								2020-21						
			Period Target	Month/ Period	YTD 2020-21	Month/ Period/Year data from	Previous Month/Period	Corresponding month 2019--20	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
Safe	Never Events	Monthly	0	0	0	Oct-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	0	15	Oct-20	↓	↓	2	5	2	1	3	8	2	2	0	3	3	2	6	1	0
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	100.0%	100.0%	Oct-20	↔	↑	91.7%	97.0%	97.0%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Effective	No of inpatient admissions gate kept by Crisis Resolution Home Treatment (CRHT) teams	Quarterly	95%	95.2%		Sep-20	↓	N/A	98.2%			99.7%		Data collection paused		97.7%	99.0%	99.2%	100.0%	96.8%	96.4%	95.2%	
	No. of records with up to date risk assessment – Inpatient and Community		95%	84.0%		Aug-20	↑	N/A	_	_	_	_	_	_	_	83.3%	80.8%	87.4%	84.3%	77.2%	84.0%		
Caring	EMSA	Monthly	n/a	0	0	Sep-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Responsive	Complaints closed within 40 days	Monthly	80%	30%	-	Sep-20	↓	↓	53%	45%	55%	54%	80%	71%	80%	Paused	56%	90%	90%	100%	-	30%	
	No of complaints re-opened	Monthly	n/a	0	-	Sep-20	↔	N/A										0	2	0	-	0	
	CAMHS - under 18's admitted to adult wards	Monthly	tbc	3	10	Sep-20	↔	↑	1	0	1	1	1	1	0	2	1	2	1	0	3	3	
	Delayed Transfers of Care	Monthly	3.5%	1.0%	-	Sep-20	↑	↑	1.6%	1.4%	1.6%	1.0%	1.6%	0.7%	1.8%	1.9%	2.0%	1.7%	1.4%	1.0%	1.3%	1.1%	1.5%
	% Service users on CPA followed up within 7 days of dishcarge	Monthly	95%	99.1%	-	Sep-20	↑	↑	95.7%	98.0%	99.1%	95.7%	97.9%	95.4%	95.2%	98.1%	97.8%	100.0%	100.0%	100.0%	100.0%	97.2%	99.1%
	Out of Area Beds Days	Monthly	20/21 - Q1 247, Q2 165, Q3 82, Q4, 0	177	-	Sep-20	↓	↑	146	21	4	55	49	139	175	350	167	108	140	336	224	177	
Well-led	Information Governance Confidentiality Breaches	Monthly	82, Q4 0	25	74	Jul-20	↓	↓	11	10	8	6	16	15	12	6	15	20	14	25	17	19	

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 – November 2020



Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**Terms of Reference of the Quality, Finance and Performance Committee**	**Agenda Item No.**	11 a
Report Author	Andrew O'Connor (Senior Governance Officer)	**Public / Private Item**	
GB / Clinical Lead	Dr Farrukh Javid, GP Member, QPFC Chair	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary							
Please include a brief summary of the purpose of the report	As part of committees' annual self-assessment process, the Quality, Finance and Performance Committee reviewed its Terms of Reference. Due to recent changes in the organisations structure following the appointment of of the new Accountable Officer, which is a shared post with Calderdale Metropolitan District Council, changes are proposed by the committee with regard to its membership and quoracy arrangements. These have been considered by the Remuneration and Nomination Committee in accordance with its oversight role for changes to committee membership. The Remuneration and Nomination Committee recommends the changes to the Governing Body. All proposed changes are reflected as tracked changes in the draft Terms of Reference provided at Appendix 1 but also summarised in the body of the paper.						
Previous consideration	**Name of meeting**	Quality Finance and Performance Committee	**Meeting Date**	17/12/2020			
	Name of meeting	Remuneration and Nomination Committee	**Meeting Date**	18/12/2020			
Recommendation (s)	The Governing Body **APPROVE** the amended Terms of Reference of the Quality, Finance and Performance Committee.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	Click here to enter text.

Implications	
Quality & Safety implications	None
Engagement & Equality implications	None

Resources / Finance implications		None					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)		**Yes**		**No**		**N/A**	X
Strategic Objectives	Improving governance	**Risk**			None		
Legal / CCG Constitutional Implications	The Governing Body is responsible for approving changes to Committee Terms of Reference. As an Appendix to the Constitution, the updated Terms of Reference, subject to approval, will be submitted to NHSE as part of an application to update the CCG's Constitution at a later date.	**Conflicts of Interest**			None Any conflicts arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest Policy		

1.1 The Quality, Finance and Performance Committee reviewed and proposed changes to the Committee Terms of Reference at its meeting on 17th December.

1.2 Due to recent changes in the organisational structure following the appointment of the new Accountable Officer, which is a shared post with Calderdale Metropolitan District Council, changes were required to both the membership and quoracy arrangements within the Committee's Terms of Reference.

1.3 The Remuneration and Nomination Committee is responsible for ensuring that the Governing Body and its committees have the appropriate balance of skills, experience, knowledge, perspectives and independence to enable them to discharge their respective duties and responsibilities effectively. As part of this role, the committee oversee changes to the membership of the CCG's committees making recommendations to the Governing Body concerning any changes.

1.4 The Remuneration and Nomination Committee considered the proposed changes at its meeting on the 18 December 2020 and recommends them to the Governing Body.

1.5 The existing and proposed membership and quoracy arrangements are set out below.

2. Current Committee Membership and Quoracy

2.1

<table>
<tr><th>Current Committee Membership</th><th>Current Quoracy</th></tr>
<tr><td><u>Chief Officer</u></td><td rowspan="8">Meetings shall be considered quorate when the following are present:

▪ One GP member of the Governing Body
▪ One Lay Member to the Governing Body
▪ Either the Chief Officer or Chief Finance Officer (CFO)/Deputy Chief Officer
▪ Chief Quality and Nursing Officer (or the Head of Quality as their deputy)

Where one or more members of the Committee are unable to take part in a particular agenda item due to a conflict of interest, the alternative quoracy arrangements will be made up of at least three remaining members of the committee.</td></tr>
<tr><td><u>Chief Finance Officer / Deputy Chief Officer</u></td></tr>
<tr><td>Chief Quality and Nursing Officer</td></tr>
<tr><td>Two GP Members of the Governing Body
(one of whom will act as Chair)</td></tr>
<tr><td>Lay Member (Finance &Performance)</td></tr>
<tr><td>Lay Member (Public Patient Involvement)</td></tr>
<tr><td>Registered Nurse or
the Secondary Care Specialist as nominated deputy</td></tr>
</table>

Required attendees ▪ Head of Quality ▪ Head of Contracting and Procurement ▪ **Head of Finance** ▪ Head of Primary Care Quality and Improvement ▪ Head of Service Improvement ▪ Performance Manager

3. Proposed Committee Membership and Quoracy

3.1 Given that the Accountable Officer is a shared post it is not recommended that the Accountable Officer role is included in the committee's membership.

3.2 There is no requirement for the Accountable Officer to a member of the committee.

3.3 The proposed membership and quoracy arrangements of the Quality, Finance and Performance Committee is as follows:

Proposed Committee Membership	**Proposed Quoracy**
Chief Operating Officer	Meetings shall be considered quorate when the following are present: ▪ One GP member of the Governing Body ▪ One Lay Member to the Governing Body ▪ **Either the Chief Operating Officer or Director of Finance** ▪ Chief Quality and Nursing Officer (or the Head of Quality as their deputy) Where one or more members of the Committee are unable to take part in a particular agenda item due to a conflict of interest, the alternative quoracy arrangements will be made up of at least three remaining members of the committee.
Director of Finance	
Chief Quality and Nursing Officer	
Two GP Members of the Governing Body *(one of whom will act as Chair)*	
Lay Member (Finance &Performance)	
Lay Member (Public Patient Involvement)	
Registered Nurse **or** the Secondary Care Specialist as nominated deputy	
Required attendees ▪ Head of Quality ▪ Head of Contracting and Procurement ▪ ~~**Head of Finance**~~ ▪ Head of Primary Care Quality and Improvement ▪ Head of Service Improvement ▪ Performance Manager	

3.4 Under these changes that the Chief Operating Officer will become one the committee's two Senior Responsible Lead Officers. This is reflected on the front page of the draft Terms of Reference.

3. Next Steps

3.1 Subject to the approval of the Governing Body, the committee will begin meet under its revised membership and quoracy arrangements.

3.2 The updated Terms of Reference will be published on the CCG website,

3.3 As an Appendix to the Constitution, the revised Terms of Reference will be submitted to NHS England as part of an application to agree revisions to the CCG Constitution later in the year.

4. Recommendations

4.1 It is recommended that the Governing Body:

- The Governing Body **APPROVE** the amended Terms of Reference of the Quality, Finance and Performance Committee.

5. Appendix

- **DRAFT** Quality, Finance and Performance Committee Terms of Reference

Quality, Finance & Performance Committee

Terms of Reference

Current Version/Status:	**1.10 ~~FINAL~~ DRAFT**
Approved by:	Governing Body
Date:	~~24 October 2019~~ TBC
Responsible Senior Officer:	Chief Operating Officer / Chief Quality and Nursing Officer.
Review Date:	April 2023~~1~~ or earlier if required by organisational, statutory or regulatory change.

Contents

NHS Calderdale Clinical Commissioning Group

Quality, Finance & Performance Committee

1.0 Constitution and Purpose

1.1 The Committee Terms of Reference is established in accordance with NHS Calderdale Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2 The Committee is a committee of the Governing Body to which it is accountable.

1.3 The role of the Committee is to advise and support the Governing Body:

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

1.4 These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2.0 Authority

2.1 Authority is delegated to the Committee as set out in Schedule of Reservation and delegation (i.e.)

- Approving policies in respect of all areas of the Committee's responsibilities;
- Approving arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes;
- Approval of arrangements for supporting NHS England in discharging its responsibilities in relation to securing continuous improvement in quality of primary medical services;
- Approving the CCG's arrangements for handling complaints.

2.2 The Committee is authorised by the Governing Body to commission any reports or surveys it deems necessary to help it fulfil its obligations. In doing so the Committee

must operate within the requirements of the CCG's Standing Financial Instructions and Standing Orders.

2.3 The Committee is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers delegated within these Terms of Reference (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

3.0 Membership

3.1 The committee shall be appointed by the Governing Body and consist of:

- Chief Operating Officer
- ~~Chief Finance Officer (CFO)/ Deputy Chief Officer (DCO)~~ Director of Finance
- Chief Quality and Nursing Officer
- Two GP Members of the Governing Body (one of whom will act as Chair)
- Lay Member to the Governing Body (Finance and Performance)
- Lay Member to the Governing Body (Patient Public Involvement)
- Registered Nurse (or the Secondary Care Specialist as nominated deputy)

In attendance:

- Head of Quality
- Head of Contracting and Procurement
- ~~Head of Finance~~
- Head of Primary Care Quality and Improvement
- Head of Service Improvement
- Performance Manager

Or nominated Deputy can attend.

3.2 The Committee shall be chaired by one of the GP members of the Governing Body.

3.3 The Deputy Chair shall be one of the Lay Members on the Committee.

3.4 The Public Health Consultant (Calderdale Council) will attend as required.

3.5 Any member of the Governing Body is entitled and encouraged to attend this committee with observer status.

3.6 Officers can also request to attend meeting of the committee as an observer.

4.0 Arrangements for the Conduct of Business

4.1 Chairing the Committee

The meetings shall be run by the Chair. In the event of the Chair's absence the meeting shall be chaired by the Deputy Chair of the Committee.

4.2 Quoracy

4.2.1 Meetings shall be considered quorate when the following are present:

a) One GP member of the Governing Body
b) One Lay Member to the Governing Body
c) Either the Chief Operating Officer or ~~Chief Finance Officer (CFO)/Deputy Chief Officer~~ Director of Finance
d) Chief Quality and Nursing Officer (or the Head of Quality as their deputy)

Where one or more members of the Committee are unable to take part in a particular agenda item due to a conflict of interest, the alternative quoracy arrangements will be made up of at least three remaining members of the committee.

4.2.2 Members of the Committee may participate in meetings by telephone or by the use of video conferencing facilities where they are available and with prior approval by the Chair of the meeting or if the Chair of the meeting is not present, by the Deputy Chair of the meeting. Participation in a meeting by any of these means shall be deemed to constitute presence in person at the meeting and should be captured in the minutes.[1]

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

The Committee shall meet a minimum of 4 times a year.

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

[1] Paragraph 9.10.2, NHS Calderdale CCG, Constitution v.5 (revised August 2018)

4.6.1 NHS Calderdale Clinical Commissioning Group Lead Officers are the Chief Officer and Chief Quality and Nursing Officer.

4.6.2 Administration support to the Committee shall be provided by the CCG's administrative team. The administrative support to the Committee shall:

- agree the agenda with the Chair in consultation with the CCG Lead Officers;
- circulate agendas and supporting papers to Committee members at least five working days prior to the meeting;
- attend to provide appropriate support to the Chair and Committee members and take the meeting minutes;
- Keep an accurate record of: attendance; the management of conflicts of interest; and matters arising to be carried forward;
- maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions;
- draft minutes for approval by the Chair within 10 working days of the meeting and then distributed to the committee members for electronic approval within 15 working days.

4.6.3 The Agenda shall be determined by the Chair and/or the Deputy Chair of the Committee in consultation with the Committee Lead Officers. Other members of the Committee should submit their agenda items to the Chair.

4.6.4 Agendas and supporting papers shall be sent to members five working days prior to the meeting.

4.6.5 An agenda setting meeting will be established to take place the week prior to the distribution of the agenda and papers.

5.0 Duties/ responsibilities of the Committee

The Committee shall:

5.1 Carry out a regular review of the overall performance of NHS Calderdale CCG.

This shall include:

- Performance against the delivery of the Operational Plan, advising the Governing Body on progress against any action plans stemming from performance issues.
- Progress and achievement against regulatory and key national, regional and local targets for service improvement.
- Progress and achievement against outcomes and targets agreed with external partner organisations.
- An assessment of pressures within the whole system and how these affect contracts and performance.
- Opportunities to further improve performance through benchmarking and identification of best practice.
- Providing advice / feedback to management teams on the setting of performance indicators within plans and strategies.

- Seeking assurance from providers, raising formal queries and referring issues to the Governing Body where there are significant concerns, which may compromise performance, quality and patient safety.
- Ensuring that there are clearly defined escalation processes is in place for performance issues and safety and quality measures, taking action as required to ensure that improvements are implemented where necessary.
- Overseeing the continued development of the corporate performance framework and making recommendations concerning the same to the Governing Body.

5.2 Ensure financial and contract management achieves value for money, efficiency and effectiveness in the use of resources with a continuing focus on cost reduction and achievement of efficiency targets.

5.3 Review performance against the CCG's annual budgets and short term financial plans.

5.4 Actively review and oversee operational delivery of the CCG's programme of work to improve and support delivery of Quality, Innovation, Productivity and Prevention (QIPP) ensuring that evidence from quality assurance processes drive the quality improvement agenda.

5.5 Monitor and review the quality, performance and finance agenda as it pertains to the co-commissioning of Primary Medical Services.

5.6 Satisfy itself that children and adult's safeguarding duties are being met and that robust actions are taken to address concerns.

5.7 The Committee has delegated authority from the Governing Body to make decisions in respect of:

a) Reviewing the effectiveness of quality governance arrangements to ensure that the health care commissioned on behalf of NHS Calderdale Clinical Commissioning Group is safe and of high quality.
b) Ensuring that systems to monitor the quality of commissioned services are in place and are functioning appropriately.
c) Reviewing quality information from a range of sources in accordance with the work plan.
d) Ensuring that the Governing Body develops a culture of excellence by involving patients, their carers, staff and key stakeholders and by seeking patient feedback on their experiences of health care.
e) Providing leadership to the quality work of the organisation overseeing the systems and processes that are in place to ensure quality is embedded in the commissioning organisation, including approval of service specifications.
f) Giving direction and overseeing the delivery of the statutory requirements in respect of equality and diversity.
g) Overseeing research governance.
h) Seeking assurance of the clinical quality of the continuing care function of the CCG.
i) Considering best practice in quality and make recommendations to the Governing Body for local application.

j) Scrutinising and monitoring quality work-streams, including the approval of implementation plans such as:

- Patient safety (including Safeguarding adults and children and Infection Prevention and control)
- Clinical Effectiveness
- Patient and Public Engagement and Experience

k) Oversee work on improving clinical effectiveness including sharing lessons learnt and approving the CCG arrangements for the handling of complaints.

5.8 The Committee also has delegated authority from the Governing Body to approve policies, commissioning statements and guidelines of the CCG in respect of all areas of the Committee's responsibilities.

6.0 Risk Management

6.1 The Committee has responsibility for risks relating to its responsibilities and duties as set out in the Corporate Risk Register and Governing Body Assurance Framework (GBAF).

The Committee shall:

- Review the GBAF at a frequency specified by the Governing Body providing assurance that the strategic objectives of the CCG are accurate; the principal risks to the achievement of those objectives are identified; and the controls in place to mitigate or manage those risks are identified.

- Review and monitor the Corporate Risk Register in respect of the risks for which the Committee has responsibility ensuring that variance against target performance levels is reflected on the Risk Register and Governing Body Assurance Framework as appropriate.

- Identify and respond to any corporate risks relating to health and safety, security management and Information Governance.

- Request action by accountable individuals to manage risk and variation in performance, quality and patient safety, ensuring plans are put in place to address the achievement of objectives and targets. This shall include bringing expenditure back in line with allocation and deliver financial balance or planned underspend.

- Review the clinical risks captured on the quarterly Clinical Risk Management report. These reports include incidents, complaints or claims.

- Review information about serious incidents including all Never Events and serious adult / practice reviews to identify themes/areas of risk and to ensure that actions are identified and completed to improve care delivery.

- Review and make recommendations to the Governing Body on all Quality Impact Assessments with a high risk rating.

- Provide the Audit Committee with assurance that risks for which the Committee is responsible are being managed effectively via the CCG's risk management process highlighting any issues it may wish to address via the Committee's annual report.

7.0 Reporting arrangements

7.1 The minutes of the following will be received by the Committee for assurance against key objectives and to allow the identification of any risks or issues requiring action by the CCG:

- A&E Delivery Board
- Calderdale Integrated Commissioning Executive
- Partnership Transformation Board
- Patient and Public Engagement and Experience Steering Group
- Medicines Advisory Group.
- Clinical Quality Board – Calderdale and Huddersfield NHS Foundation Trust
- Clinical Quality Board – South West Yorkshire Partnership NHS Trust
- Calderdale Health Protection Advisory Group

7.2 The minutes of the Committee shall be presented to each formal Governing Body meeting and reports shall be presented as agreed in the annual work plan.

7.4 Other reports on specific issues shall also be prepared for consideration by the Governing Body as required.

7.3 The Committee shall ensure that requests for information, documents, records or other items relating to areas delegated to it by the Governing Body, are submitted to the Secretary of State or the NHS England as necessary.

8.0 Conduct of the Committee

8.1 All members of the Committee shall abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

8.2 All members shall have due regard to and operate within the Standing Orders and Standing Financial Instructions and other financial procedures.

8.3 Apologies for absence from meetings shall be notified, in advance of the relevant meeting wherever possible, to either the Committee's Chair or secretary and shall be recorded in the minutes.

8.4 The Committee shall produce an Annual Work Plan which is in line with the Governing Body's Assurance Framework.

8.5 The Committee shall undertake an annual self-assessment of its performance including a review of annual plan, membership, attendance and terms of reference. This self-assessment shall form the basis of the annual report from the Finance and Performance Committee to the Audit Committee.

8.6 Any resulting changes to the terms of reference shall be submitted for approval by the Governing Body.

Ends: ~~10 Oct 2019~~ December 2020

Change History

Version No.	Changes Applied	By	Date
0.1	First Draft	JS	05/09/2019
0.2	Recommendations from Q,F&P Committee	JS	26/09/2019
0.3	Recommendations from Remuneration and Nomination Committee	JS	10/10/2019
1.0	**Approved by Governing Body**	**AOC**	**24/10/2019**
1.1	**QPFC proposed changes to membership and Quoracy to Rem and Nom Committee**	**AOC**	**17/12/2020**
1.2	**Rem and Nom Committee recommended proposed changes to membership and quoracy to Governing Body**	**AOC**	**18/12/2020**

Item 11 b

To Follow

Name of Meeting	Governing Body	**Meeting Date**	28/01/2021
Title of Report	**High Level Risk Log and Report - Risk Cycle 4 2020-21 (9 – 25 November 2020)**	**Agenda Item No.**	12
Report Author	Robert Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary							
Please include a brief summary of the purpose of the report	▪ This paper presents the high level risk report at the end of the fourth risk review cycle of 2020-21. ▪ The Calderdale Clinical Commissioning Group Risk Register currently contains a total of 37 risks with 2 risks marked for closure. ▪ Of these open risks, there are: - 3 CRITICAL risks (scoring 20) - 5 SERIOUS risks (scoring 15-16).						
Previous consideration	**Name of meeting**	Combined Quality, Finance & Performance Committee	**Meeting Date**	17/12/20			
	Name of meeting	Senior Management Team	**Meeting Date**	02/12/20			
Recommendation (s)	It is recommended that the Governing Body: ▪ **CONFIRMS** that it is **ASSURED** that the High Level Risk Register represents a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 4 of 2020-21. This is following a review of the risks at the combined Quality, Finance and Performance Committee meeting on 17 December 2020.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications						
Quality & Safety implications	No quality & safety implications.					
Engagement & Equality implications	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 / Finance implications	No resource / finance implications.					
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	X

Strategic Objectives	▪ Achieving the strategic direction for Calderdale ▪ Improving Governance ▪ Improving quality ▪ Improving Value	**Risk**	None identified
Legal / CCG Constitutional Implications	Risk is managed in line with the CCG's Integrated Risk Management Framework.	**Conflicts of Interest**	Any interests will be managed in line with the CCG's Management of Conflicts of Interests policy.

1.0 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 & 62 (see Appendix 2).

2.0 Risk Review: Risk Cycle 3

2.1 Risk Cycle 4 commenced on 9 November 2020. 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 2 December 2020.

2.2 All risks were submitted to the combined Quality, Finance & Performance Committee for review at their meeting on 17 December 2020.

2.3 There were three critical risks rated 20 at the end of Risk Cycle 4 (see 2.7). This is one more than in the previous risk cycle.

2.4 The CCG Risk Register for Risk Cycle 4 has now been archived.

Risk Register Summary: Risk Cycle 4

2.5 At the end of Risk Cycle 4, the CCG had 37 risks on the Corporate Risk Register. There are 2 risks marked for closure this risk cycle meaning there are 35 open risks (there were 32 open risks at the last risk cycle).

2.6 31 of total CCG risks (84%) are categorised as quality, finance & performance risks and 6 (16%) are categorised as commissioning of primary medical services (CPMS) risks.

High Level Risks

2.7 There are three Critical risks (scoring 20) on the risk register at the end of Risk Cycle 4. There were two at this position at the end of Risk Cycle 3.

The two open risks rated as Critical this risk cycle is:

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 3 risk cycles

Risk ID	Risk Summary	Risk Score	Risk Movement
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	Increased from 16 due to system pressures have in effect paused the reset and pressures are greater than in the first wave.
62	That the system will return to the pre-C19 levels of demand and will not 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-related bed pressures.	20	Static for 4 risk cycles

Risk 187 became a critical risk outside the current risk cycle. In line with the CCG's Integrated Risk Management Framework when such a circumstance occurs the Governing Body must be directly informed. Governing Body members were notified by e-mail on 7 December 2020.

See appendix 2 for the Critical risk reports

2.8 There are 5 open risks rated as Serious (with a score of 15 or 16) during the current risk cycle (there were also 5 at the end of the last risk cycle) these are detailed below.

The 5 open risks rated as Serious this risk cycle are:

Risk ID	Risk Summary	Risk Score	Risk Movement
1688	There is a risk that Calderdale is unable to deliver on national expectations on uptake of the Covid 19 vaccine due to; the lack of workforce, vaccine supply, vaccine instability, or the appetite of our population, resulting in our population not being protected from the virus, higher morbidity and mortality, continued high demand for health and care services and in inability to restart the local economy.	16	New
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 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 3 risk cycles

Risk ID	Risk Summary	Risk Score	Risk Movement
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 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.	16	Static for 6 risk cycles
202	There is a risk that key performance targets will continue adversely affected due to continued high demand for West Yorkshire Urgent Care and capacity of Local Care Direct to meet the demand in respect of the required response to the COVID-19 pandemic. This could lead to a deterioration of service and patient experience and possible reputational damage to the CCG.	15	Static for 2 risk cycles
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 2 risk cycles

3.0 Recommendations

3.1 It is recommended that the Governing Body:

- **CONFIRMS** that it is **ASSURED** that the High Level risk register represents a fair reflection of the risks being experienced by the CCG at the end of Risk Cycle 4 of 2020-21. This is following a review of the risks at the combined Quality, Finance & Performance Committee meeting on 17 December 2020.

4.0 Appendices

Appendix 1: High level risk log for risk cycle 4 as at 31 December 2020.

Appendix 2: Critical risk reports for risks 187, 1493 and 62

Item 12 Appendix 1

High level risk register for GB - 280121

Risk ID	Date Created	Risk Type	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	20	(I4xL5)	8	(I4xL2)	NS	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. 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) A&EDB 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 A&EDB	(a) Completion of work to predictive modelling tool to enable to optimise the flow rate - matching demand and capacity - to be used as a key operational and assurance tool.	(a) A&EDB highlight report considered by QF&P as a standing item (b) Performance updated to QF&P includes TOC performance (c) TOC list reviewed daily during weekdays (d) Implementation of new guidance is in final stages. (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) Although national DTOC reporting is paused our local data shows positive performance improvement. (b) Improvement in commissioning approaches has resulted in sufficient Discharge to Assess capacity being available, including covid beds (c) Mutual aid across Calderdale and Kirklees to mitigate risks around any D2A bed capacity (covid beds and EMI covid beds)	(a) Recruitment of new System Discharge Post as set out in guidance. CHFT leading, but delayed due to focus on current pressures. (b) Ensuring availability of 7 days services to ensure flow of weekend discharges. (c) Systems' ability to commission for the discharge needs of a small number of individual patients, for example bariatric patients. (d) Comparing daily numbers between 2019 to 2020. The 2019 daily snapshot number was 57 patients awaiting discharge, compared to a daily snapshot number for 2020 of 18 patients waiting.	Static - 3 Archive(s)
187	19/03/2012	Finance	20	(I4xL5)	8	(I4xL2)	PW	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, which reports to Out Patient Transformation Board b) Joint (GP, Consultant) clinical reviews of patients waiting over 16 weeks 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. f) Closer working with the IS to ensure we maximise their available capacity	a) Sufficient capacity available to deliver on Phase 3 activity expectations b) Ability to effectively communicate and support all patients on waiting list in line with Phase 3 expectations c) Knowledge of the impact of the second covid wave on patient care in elective services	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) Notes of Out Patient Transformation Board to be considered at QF&P	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) New series of specialty specific Joint Clinical Interface Sessions launched across the C&GH system	a) CCGs and referrers are not fully sighted on progress and issues and implications for patients b) Current system challenges have put system reset plans at risk - we do not yet understand the full impact - but likelihood of significant patient harm c) Understanding the implications/risks of IS sector contract changes from December and the resulting reduction in surgical lists	Increasing
62	13/06/2013	Finance	20	(I4xL5)	8	(I4xL2)	NS	That the system will return to the pre-C19 levels of demand and will not 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-related bed pressures.	(a) Surge & Escalation processes triggered to mitigate performance risk in line with agreed plan (b) A&E Delivery 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) Assurance to A&EDB about harm associated with patients spending extended periods on trolleys in A&E pre admission. Trolley waits November 19 = 0, Trolley waits November 20 to date = 20	(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 (April/June), deterioration (July/Aug), significant drop (Sept to date) - however they remain 11/44 in the North, and 44/123 nationally. Snapshot performance at Nov 19 was 82%, and at Nov 20 was 79% - which is relatively strong performance given system pressures (b) Extended access in general practice now in place (d) Walk-in centre contract extended until March 2021 (e) GPs and A&E clinicians met to strengthen working relationships. (f) GP winter offer proposal to provide face to face offer (g) 111 first to come onstream in December 20	(a) Understanding of patient harm from the significant number of 12 hour trolley waits in A&E (b) Learning from Urgent Care Hub proof of concept - paused due to covid, but Calderdale GP alternative being consider for winter. (b) Ability of the system to not return to pre-C19 levels of demand (c) Urgent Treatment Centre new build timeline is 2023/24 (d) Impact of 111F	Static - 4 Archive(s)

1688	20/11/2020	Quality	16	(I4xL4)	5	(I5xL1)	NS	There is a risk that Calderdale is unable to deliver on national expectations on uptake of the Covid 19 vaccine due to; the lack of workforce, vaccine supply, vaccine instability, or the appetite of our population, resulting in our population not being protected from the virus, higher morbidity and mortality, continued high demand for health and care services and in inability to restart the local economy.	(a) WY ICS SRO Programme established at WY (meetings twice weekly) (b) Calderdale Programme developed (b) Calderdale Health Protection Advisory Group receiving updates for assurance (c) Links created with the Calderdale flu programme	(a) Agreement on assurance routes for PCN DES delivery and understanding of moving picture of risk - particularly workforce (b) Agreement on assurance routes for mass site development/outsourced contracts (c) No current lead provider to hold workforce, training, clinical governance lead (although dependent on model of delivery) (d) Confirmation of the local approach to call and recall	(a) Calderdale programme established (SRO, PM and work-stream leads) (b) Routine updates being provided into key forums (in line with agreed parameters) (b) CCG proactive involvement in WY SRO activities	(a) Calderdale Programme connected into GH and Wakefield programmes (b) Calderdale Programme connected to local providers - agreement that Calderdale take a lead with CHFT (c) Programme receiving offers of mutual aid from Overgate and private sector	(a) Gaps in knowledge about the safety of the vaccine for particular for those over 80 - will impact on both clinical and patient uptake) (b) Understanding of our ability to outsource elements of the delivery model (c) Need to confirm workforce leadership going forward (c) Clarity on finance regimes (c) Risk register for programme	New - Open
1501	12/03/2020	Finance	16	(I4xL4)	4	(I2xL2)	NS	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 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 national response to the pandemic is changing on a daily basis.	Static - 3 Archive(s)
1366	25/06/2019	Finance	16	(I4xL4)	4	(I4xL1)	DG	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 - 6 Archive(s)

240	10/06/2013	Finance	15	(I3xL5)	2	(I2xL1)	MP	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.	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 2019 - 30%. Feb 2019 - 49%. Mar - 46%. Apr - 35%. May - 29%. June - 36%. July - 35%. Aug 26%. Sept 26%. Oct - 23%. Nov - 31%. Dec - 23%. Jan 2020 - 18%. Feb - 25%. Mar - 20%. Apr - 100%. May - 100%. Jun - 100%. July 86%. Aug 79%. Sourced from NHS Digital on a monthly basis.	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 - 2 Archive(s)
202	26/02/2013	Finance	15	(I3xL5)	3	(I3xL1)	NS	There is a risk that key performance targets will continue adversely affected due to continued high demand for West Yorkshire Urgent Care and capacity of Local Care Direct to meet the demand in respect of the required response to the COVID-19 pandemic. This could lead to a deterioration of service and patient experience and possible reputational damage to the CCG.	a) Robust WYUC Contract and Quality Governance arrangements in place where regular monitoring of the service takes place. b) Daily routine SITREP reports received and where required escalation process in place (and teleconferences, where required) where WYUC performance is reviewed. c) High level of local involvement from GHCCG as Lead Commissioner - d) Greater Huddersfield CCG hosting contract management on behalf of the West Yorkshire CCGs. e) Contract performance reviewed at Finance and Performance Committee; quality reviewed by Quality & Safety and Performance of WYUC/LCD service managed and monitored via a WY Sub Regional Group; mitigating actions taken to support improvement but issues continue. f) WY U&EC Network leading focused piece of work on current issues - mitigations, risks, etc.	a) Ability to manage demand into WYUC, increase in changes in demand acuity combined with the financial cap creates service performance pressure b) Sensitivity to extraordinary increases in core demand coming from NHS111 i.e. escalation pressure sees NHS111 pass calls to Out of Hours providers for certain cohorts of patients	a) Contract Management Board receive regular updates - led by Greater Huddersfield CCG b) Sub-Regional WYUC Contract Management and Clinical Governance arrangements in place. c) Local contingency plan held by the A&E Delivery Board for times of increased pressure e.g. Bank Holidays d) Escalation in relation to service through GH & C CCG On-Call arrangements then to NHS England e) Issues are identified and worked through as they arise.	a) Robust WYUC Contract Governance processes in place (Greater Huddersfield CCG is lead commissioner) b) WYUC West Yorkshire Sub-Regional Commissioning Group supported by GHCCG. Meeting arrangements have been revised to allow for better representation from WY CCGs c) WY Urgent and Emergency Care Network may impact on future commissioned model for WYUC d) Serious Incident (SI) process in place to be used in the event of a material service failure e) LCD risk review identifies an reducing risk trajectory in line with action arising from the independent Service Review f) WYUC workshop held in June with WY commissioners- provided update highlighting positive mitigation of risks in the service, providing some assurance that the risk is being monitored and managed	a) The contract value agreed for 2019/20 represented a gap between Commissioner funding and provider income expectation for 2019/20. Performance in respect of WYUC has remained fairly consistent - however changes in the pathway has increased acuity of dispositions coming from NHS111, this is impacting on staff scheduling and consequently on meeting the targets as set. This and the dependency on what flows from NHS111 means that the risk to performance is there.	Static - 2 Archive(s)

Item 12, Appendix 2

To Follow

Item 13 a

NHS Calderdale Clinical Commissioning Group

Minutes of the Audit Committee Meeting
held on 24 September 2020, 11:00am
Video Conference

FINAL MINUTES

Present	Prof Peter Roberts	(PR)	Lay Member (Audit) (Chair)
	John Mallalieu	(JM)	Lay Member (Finance and Performance)
	Rob McSherry	(RM)	Registered Nurse
	Alison MacDonald	(AM)	Lay Member (Patient and Public Involvement)
	Denise Cheng-Carter	(DCC)	Lay Advisor
	Dr Farrukh Javid	(FJ)	GP Member
In attendance	Lesley Stokey	(LS)	Interim Chief Finance Officer
	Andrew O'Connor	(AOC)	Senior Corporate Governance Officer (Minutes)
	Jonathan Hodgson	(JH)	Audit Manager, Audit Yorkshire
	Danielle Hodson	(DH)	Assistant Audit Manager, Audit Yorkshire
	Rosie Dickinson	(RD)	Local Counter Fraud Specialist, Audit Yorkshire
	Gareth Mills	(GM)	Director, Public Sector Audit, Grant Thornton UK LLP
	Perminder Sethi	(PS)	Director, Public Sector Audit, Grant Thornton UK LLP
	Brenda Powell	(BP)	Senior Procurement Officer (for item 4, minute no. 84/20)
	Rob Gibson	(RG)	Corporate Systems Manager (for item 7, minute no. 87/20 and item 8, minute no. 88/20)
	Sam Byrnes	(SB)	Senior IG Officer (for item 6, minute no. 85/20 and item 8, minute no. 88/20)

81/20	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Neil Smurthwaite (Interim Accountable Officer) and Martin Pursey (Head of Contracting and Procurement).	
82/20	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest. 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.	
83/20	**MATTERS ARISING FROM THE MEETING HELD ON THE 18 JUNE 2020**	
	DECISION: The minutes of the Audit Committee meeting held on the 18th June 2020 were **RECEIVED** and **ADOPTED** as a correct record. **Actions** Action 71/20 concerning the process of submitting committee annual reports to the Audit Committee was ongoing. A meeting was being arranged to complete the required work.	

	All other actions from the last meeting had been completed.	
84/20	**CONTRACTING REPORT**	
	BP presented the Contracting Report to the committee for its assurance. : **Completed Tenders** The tender process for the GP Support Intermediate Care Beds (Ingwood) contract had been completed between meetings. This was a short term contract awarded as part of the COVID-19 response. The contract would come to an end on the 15th October 2020. The award had been made in May 2020 Two procurements had been undertaken on behalf of the Integrated Care System: Training Provision for Social Prescribing (Link Workers) and Voluntary Care Sector employees and volunteers. **Current and Open Tenders** The COVID-19 Enhanced Beds tender had been closed and approval to proceed to contract award was being awaited. The CCG had received one tender submission for the GP Support: COVID-19 Beds contract by the closing date. The CCG was waiting for a waiver to be signed and then it would be a single tender process under Regulation 32. In response to question, it confirmed that the submission received was not from the existing provider. The Dermatology and Seamless Home from Hospital Services procurements were underway. **Proposed Tenders** A procurement process for Continuing Health Care - Domiciliary Care Providers would commence early in 2021. This was an ongoing tender for five years. The CCG regularly reopened the procurement window for domiciliary services quarterly or six monthly dependent on the number of new providers in the market. **Acute Health Care Contracts** BP advised that the acute contracts would continue until March 2021. This was a correction to the report which read March 2020. Comments and questions were invited: ▪ In response to a question concerning the Seamless Home from Hospital (SHfH) service procurement, BP confirmed she would check with the service lead to as whether there were any changes in intention following the publication of new guidance. *[Follow the meeting the service lead confirmed they had received the new guidance concerning patient transport and there was no impact on the SHfH procurement.]* ▪ In response to a question concerning GP Support – COVID 19 Beds at 2.13 in the report, BP confirmed this was a new procurement and one provider had responded to the market test. The procurement was currently awaiting approval to proceed. ▪ Concerning the Contract Register, BP explained that as authorisation for the contracts had come later than usual, late June, the contracts had also been issued	**BP**

	late, resulting in their being more outstanding contracts on the register than would be expected at this point in time. Since publication, nine of the Continuing Health Care contracts had been escalated due to lack of provider response and fifteen had been signed and returned to the CCG. Four optometry contracts had been returned and one for Information Management and Technology (IMT) services. ▪ In response to a question, BP explained that there were ongoing negotiations concerning the contract with Brackenbed View Nursing Home regarding the number of beds the CCG wanted to procure. The committee recognised there would be a risk should the provider pull out, particularly so with winter approaching. BP confirmed that she would obtain an update from the contract lead. LS responded that the CCG had a very clear strategy in place concerning its intermediate beds provision and that there had been some very specific issues concerning the provider and the signing of the contract was symptomatic of this. Additional intermediate bed capacity had been identified as such there was no risk should the provider pull out of the contract. *[Following the meeting it was confirmed that the 2020/21 contract with Four Seasons for Intermediate Care (IMC) beds has been agreed. In addition, a lot of progress has been made in relation to other issues linked to both the provision of IMC beds and the therapy support into these beds. The contract includes an updated service specification and an agreed set of criteria to strengthen the admission process into the beds as well as a quality focussed Service Development and Improvement Plan.]* BP was thanked and left the meeting at this point. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** for assurance the content of the report, appendices and progress to date.	**BP**
85/20	**MANAGEMENT OF CONFLICTS OF INTEREST POLICY UPDATE**	
	AOC presented the Management of Conflicts of Interest Policy for approval following review. A new section was provided for insertion strengthening the CCG's arrangements for managing conflicts of interest when entering into joint activities, enterprises or arrangements that involved the shared or joint allocation, utilisation and accountability for financial and other resources, including HR appointments. Amendments were also proposed to reflect changes in CCG staff roles and responsibilities within the CCG's Governance Team following the retirement of the Head of Corporate Affairs and Governance. The policy continued to comply with statutory guidance and best practice. PR explained the insertion of an additional section at 5.3 was intended to ensure the CCG's arrangements for the management of conflicts of interest when entering into joint or shared arrangements with other organisations were as robust as possible. He explained that the paragraph had been drafted by him and JM. He noted that he did not think it was appropriate for non-executives to be preparing such documentation but it was required in this case due a lack of sufficient governance expertise within the CCG at the required level. He also noted that the process had been hampered by a failure of delivery by others who had provided support. The committee recognised the additional weight of responsibility this placed on the other committee members in terms of scrutinising the proposed amendment. He also explained that the section provided the basis for providing the appropriate guidance and governance concerning joint or shared activities which would be an ongoing process during the life span of the arrangement. JM indicated that the challenge was not a lack of contribution from Senior Managers who	

	were conflicted, and what the CCG was lacking was governance experience at this level for something which was unusual. He advised the committee that there were some additional words being considered for inclusion in the Accountable Officer's contract which might be considered as a further amendment to the policy. Comments and questions were invited: ▪ It was noted that "management" should have read "managed" at 2.10. ▪ It was explained that the statement at 2.10 confirmed that risks presented by shared posts in terms of decision making could be mitigated through robust policies and their application. ▪ In response to a question, it was explained that the approved policy would be circulated to staff who were required to familiarise themselves and comply with the requirements of the policy while undertaking work for the CCG. ▪ There was support for the new section. An offer of support with regard to the future development of the policy had been made by the CCG's auditors. PR recognised there were other possible sources of support also. ▪ It was noted that the CCG's conflicts of interest arrangements were audited every 12 months. ▪ It was recognised that, should the CCG go beyond a shared Accountable Officer, there would need to be a more universal review of the CCG's governance arrangements. ▪ In response to a question, JM explained there would be a tripartite agreement with regard to the management and policies that the individual would need to adhere to when undertaking work for the different organisations. The employment contract set out the nature and operation of the relationship and JM suggested it might usefully be shared with Governing Body members at a later date. ▪ GM advised that there was an increased focus on the Value for Money conclusion and governance arrangements in new audit code for 2020/21. **DECISION:** The committee **APPROVE** all proposed amendments and the policy as a whole. In concluding the item the committee noted that internal audit had offered to support the review of the implementation of the new arrangement and this was accepted. The committee also noted that there was a need for additional governance human resources which might be provided via the provision of additional personnel and/or the provision of additional training and support.	
86/20	**INFORMATION GOVERNANCE POLICY BOOK**	
	SB presented the CCG Information Governance Policies and Policy Book for approval following review. The IG Team had brought together all of the policies into a single book for ease of use and to eliminate unnecessary duplications. A high level summary of proposed policy amendments had been supplied at 2.5. As part of the review, the policies had been reviewed by the Senior Management Team (SMT) and Information Management and Technology colleagues. Comments and questions were invited.	

	▪ The value and usefulness of bringing the policies together was recognised. ▪ The committee recognised that the Audit Committee was only responsible for some of the policies in the book and that those for which it was not responsible would need to go to the relevant committees for approval. ▪ It was agreed that "and legislation" would be added to Chapter 1, 2.3 (Information Security) at the 6th bullet. ▪ For ease of understanding, there was a suggestion that links to the glossary be added. ▪ In response to a question, it was confirmed that the policy described roles and responsibilities against the CCG's current staffing structure which may be subject to change in the future. ▪ There was a suggestion that NHSX be added to those parts where the policy recognises it responding to guidance from, for example, NHS England and NHS Improvement. **DECISION:** The Audit Committee **APPROVED** the Information Governance Policies Book and the policies for which it was responsible subject to the above amendments and suggestions. In determining the above the committee recognised that that other committees would be required to approve the policies within their remits.	
87/20	**EMERGENCY PLANNING RESILIENCE AND RESPONSE ANNUAL REPORT 2019/20**	
	RG presented the Emergency Planning Resilience and Response (EPRR) Annual Report 2019/20 for the committee's assurance and decision. The following key points were highlighted: ▪ Section 4.3 - an overview of CCG actions during the COVID lockdown. ▪ The updated Annual Work Plan for 2020/21 ▪ Section 2.1 – the CCG's Emergency Planning Framework ▪ Section 8.0 – concerning the EPRR Annual Assurance Process. The required process in 2020 had been amended as detailed in the report. It was recommended the committee delegate authority to the CCG's Interim Accountable Officer to complete this process on behalf of the Committee and CCG. Comments and questions were invited. ▪ In relation to annual EPRR assurance process, LS commented that NHS England (NHSE) were seeking to ensure that CCG's had sufficient arrangements in place and were these were pragmatic and realistic given pressures and timescales. ▪ The Chair drew attention to the National Audit Guidance for committees on finance reporting and management during COVID-19 which included useful comment on risk and emergency planning. AOC was asked to circulate following the meeting. ▪ The committee recognised that for very understandable reasons the annual report included activities beyond the end of the financial year. It was suggested that some explanation concerning this be somewhere in the report. ▪ The committee asked that learning from exercises be included in future reports. ▪ The committee also asked that consideration be given to how the CCG is responding to the cyber security threats prevalent when people are home working. RG assured the committee that work was taking place in this regard including by the IG Team.	**AOC**

	DECISION: **The Audit Committee:** 1) **NOTES** the arrangements in place to support Emergency Preparedness (EP) including the 3 yearly review of the CCG's EPRR Framework 2) **DELEGATED** to the Interim Accountable Officer responsibility for assuring themselves of the robustness evidence gathered prior to the statement of assurance being submitted to NHSE by the Interim Accountable Officer (Accountable Emergency Officer) In delegating the above authority, PR asked that RG confirm with him when the assurance statement had been submitted.	**RG**
88/20	**GOVERNANCE ASSURANCE DASHBOARD**	
	SB presented the IG section of the Governance Assurance Dashboard drawing attention to the following key points: ▪ The CCG submitted its Data Security Protection Toolkit for 2019/20 on the 17 August 2020. The CCG had met all required standards. Due to the extension of 2019/20 submission deadline, the new toolkit for 2020/21 was not yet available. The anticipated release date was 1 October 2020. The IG Team had already prepared its annual workplan and activities were already underway. The October baseline submission was no longer required. The annual submission date for the toolkit continued to be 31 March 2021 but this may be subject to change. ▪ The IG Team had completed the Audit Yorkshire Covid checklists and a number of actions were being picked up in the team's work plan for the year. RG presented the remainder of the report drawing attention to the following: ▪ The CCG's performance concerning Freedom of Information requests in quarter 2 was much improved. All requests which had been late due to COVID-19 had been responded to. No complaints had been received. ▪ The Governing Body would undertake a review of the Governing Body Assurance Framework (GBAF) at its development session on 1 October 2020. Consequently, it had been decided not to present the GBAF to committees in September and October. All risks had been reviewed and reported to the CCG's Senior Management Team (SMT) in early September. Comments and questions were invited. ▪ Positive comments were made concerning the successful completion of all Data Security Standards. ▪ The rates of compliance on statutory mandatory training were noted to have improved; although, it was recognised further improvements were required. JM spoke about Governing Body compliance. He explained that all non-clinical members who were able to access the system and the CCG's two senior officers were up-to-date with their training requirements. He reminded the meeting that clinical members had been stood down from CCG activity for a period but provided assurance that their compliance would be picked up with individuals from 1 October 2020.	

	▪ It was noted that lessons learned from the Subject Access Request complaint were being taken forward. ▪ It was noted that "complaint" on p258 (third bullet) should read "compliant". **DECISION:** The Audit Committee **NOTED** the content of the Governance Assurance Dashboard.	
89/20	**AUDIT YORKSHIRE**	
	a. Internal Audit Progress Report JH presented the Internal Audit progress report. The following key points were highlighted: ▪ Six audits had been completed in 2019/20, five of which had received "high" levels of assurance opinion. The remaining audit was a Controls Improvement Audit (Stage 1) which would be followed up by a Stage 2 report. ▪ Details of audits in progress or being planned for 2020/21. ▪ Changes to the audit plan requested since the last meeting. ▪ The use of percentages to report against planned days. ▪ An agreement with LS that the Financial Systems and Management Audit recommendations would be placed on hold due to the revised financial regime currently in place. Comments and questions were invited. ▪ There was a request that COVID-19 be taken into account as part all audits during 2020/21. PR added that this was in-line with National Audit Office guidance. ▪ In response to a question, JH confirmed that Care Home Sustainability would be the focus of the Provider Quality Management and Provider Sustainability Management audit in-year, and that other providers would be a focus of work during 2021/22. ▪ In response to a question, JH confirmed that all of six of the 2019/20 audits were completed between February 2020 and May 2020. JM indicated an interest in the delivery and outcomes of the next round of audits in the context of changed ways of working. ▪ Concerning the recommendation on "Rent Reviews" as part of the Primary Care Co-Commissioning Audit, it was asked whether marking it complete might result in the issue not being resolved completely. LS provided assurance that rent reviews were a standing item in discussions with NHS England and the Commissioning Primary Medical Services Operational Group. ▪ In response to a question, JH confirmed that Audit Yorkshire had been tasked with undertaking a piece of work concerning the transition to a joint Accountable Officer during the committee members' private meeting with audit colleagues. ▪ It was noted that at p302 "there have been" should have read "there have been no".	

	DECISION: The Audit Committee: 1. **APPROVED** changes to the Audit Plan for 2020/21. 2. **RECEIVED** and **NOTED** the contents of the report. **b. Anti-Crime Progress Report** RT presented the Anti-Crime progress report drawing attention to the following key points: ▪ Changes in response to COVID-19 - The frequency of the quarterly Counter Fraud Newsletter had been increased to fortnightly, specifically addressing COVID-19 related fraud risks and changes in guidance. This had now been revised back to monthly. - Additional mandate and phishing training would be provided to the CCG's Finance Team. The majority of alerts issued in the last two quarters had been in relation to these types of fraud. ▪ Updated information concerning a fraud referral. ▪ Updates from the NHS Counter Fraud Authority (CFA) concerning: Alterations to Communications Delivery and the introduction of Government Functional Standards for Counter Fraud which would replace the NHS CFA standards. It had been understood that the April 2021 self-assessment would be against NHS CFA standards but in late September 2020 it had been confirmed that the 2021 self-assessment would be against the new government standards. The Counter Fraud Work Plan for 2020/21 had been designed on against the NHS CFA standards; prior to the publication of the new standards in June. As such, it was noted that there may be areas of non-compliance in 2021 but that the CFA had confirmed that it would take the change into account. 80% of the previous standards mapped across to the new standards. Specific changes included 4.4.2 concerning outcome based metrics and 5.1 concerning multi-levelled risk assessment. ▪ The provision of a link to the NHS CFA Strategic Intelligence Assessment 2020. Comments and questions were invited: ▪ The outcome of the 2019/20 self-review tool was noted to be positive. ▪ Further information concerning the fraud referral was provided in response to questions. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** the contents of the report.	
90/20	**ANNUAL AUDIT LETTER**	
	LS confirmed there were no changes to the reports received by the committee at it June 2020 meeting. **DECISION:**	

	The Audit Committee **RECEIVED** the Annual Audit Letter for Assurance.	
91/20	**EXTERNAL AUDIT PROGRESS REPORT AND SECTOR UPDATE**	
	As the newly appointed External Auditors to the CCG, GM confirmed they were delighted to have been appointed and were looking forward to working with the CGG's Senior Management Team and members of the Audit Committee. In terms of work to date, three introductory meetings had taken place with NS and LS; PR as Audit Chair; and JH to obtain an internal audit perspective. PM drew attention to the following keys points from the Audit Progress Report and Sector Update: ▪ Progress on Audit Deliverables. ▪ The National Audit Office consultation on the Code of Practice relating to Value for Money (VFM). A revised approach was expected to be published but a greater level of VFM work was anticipated. ▪ The Chief Accountants Workshops run by Grant Thornton for its clients usually in February. ▪ A report published by the King's Fund concerning mental health and Primary Care Networks and emerging opportunities. The report provided recommendations including those to improve the offer in Primary Care. ▪ A report produced by the Healthcare Financial Management Association concerning system wide resource consumption. Comments and questions were invited. ▪ LS confirmed that the audit of the Mental Health Investment Standard 2019/20 would need to be added to the audit plan. GM explained that detailed audit guidance was still outstanding as was the audit deadline. Discussions were taking place with NHS England and NHS Improvement. He confirmed Grant Thornton were keen to do this piece of work. Commencement was unlikely before the end of December. ▪ GM advised that other Audit Committees used the sector update as a checklist to ensure that the organisation has or is responding to the latest issues and recommendations. ▪ LS reported that there were items at the Quality, Finance and Performance Committee concerning the CCG's Mental Health Investment Plans for 2020/21 and that the Primary Care Network plans in relation to recruitment, including mental health practitioners, were being submitted the following day. ▪ In response to a question regarding fee variation, GM confirmed that at the point of tender the new National Audit Office code and detailed guidance was not available. The expected change in approach would require an additional level of work and therefore a variation in fee would be required. A proposal would be provided to LS at their next meeting. LS and PR indicated they would speak about this outside of the meeting. ▪ LS asked for the sector update to be circulated in non-pdf format so that the external links could be accessed. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** the content of report and sector update.	
92/20	**AUDIT COMMITTEE WORK PLAN 2020/21**	
	The amendments as set out were noted. The Chair also highlighted that the Internal Audit work on the Accountable Officer transition would need to come a future meeting. Comments and questions were invited.	

	DECISION: The Audit Committee **APPROVED** the 2020/21 Workplan as amended.	
93/20	**ITEMS FOR GOVERNING BODY AND/OR OTHER SUB-COMMITTEES**	
	DECISION: The Audit Committee **AGREED** that the following items would be drawn to the attention of the Governing Body: - Revised Management of Conflicts of Interest Policy - Revised Information Governance Policy Book	
94/20	**REFLECTIONS ON THE MEETING**	
	Committee members were happy with how the meeting's business had been transacted.	
95/20	**DATE AND TIME OF NEXT MEETING:**	
	DECISION: The members of the committee **NOTED** that the next meeting would take place as follows: **Audit Committee** **25 February 2021, 2pm** *[Venue subject to confirmation]*	
96/20	**AUDIT COMMITTEE SELF-ASSESSMENT ACTIONS: UPDATE**	
	DECISION: The Audit Committee **NOTED** and **CONSIDERED** progress made in delivery of the actions.	
97/20	**AUDIT YORKSHIRE EFFECTIVENESS SURVEY RESULTS**	
	The overall results were noted to be very positive. It was confirmed that there was a false positive that should be disregarded. Also, that another respondent was being asked about a negative response they had registered. JH confirmed that he would report back on this to the next meeting. *[Subsequent to the meeting, the above was confirmed to have been a further false positive]* It was asked that a plan be put in place to support committee members in areas where their responses had indicated a gap in knowledge or awareness. **DECISION:**	**JH** **JH**

	The Audit Committee 1. **NOTED** the results of the survey 2. **DISCUSSED** any less positive feedback and proposed actions	

Item 13 b

NHS Calderdale Clinical Commissioning Group

Minutes of the Quality, Finance and Performance Meeting held on Thursday 24 September, 2.00pm – 5.00pm, via Microsoft Teams

FINAL MINUTES

Present:	Dr Farrukh Javid	(FJ)	GP Governing Body Member **(Chair)**
	Neil Smurthwaite	(NS)	Interim Accountable Officer
	Lesley Stokey	(LS)	Interim Chief Finance Officer
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Dr Caroline Taylor	(CT)	GP Governing Body Member
	John Mallalieu	(JM)	Lay Member (Finance)
	Alison MacDonald	(AM)	Lay Member (PPI)
	Rob McSherry	(RM)	Registered Nurse
In attendance:	Debbie Robinson	(DR)	Head of Primary Care, Quality and Improvement
	Yvonne Hoorman	(YH)	Principle Contract Manager
	Debbie Graham	(DG)	Head of Integration and Partnerships
	Debbie Winder	(DW)	Head of Quality
Presenters:	Rob Gibson	(RG)	Corporate Systems Manager (for item 12)
	Tim Shields	(TS)	Head of Performance (for item 11)
	Gill Poyser -Young	(GPY)	Designated Nurse Safeguarding Children, Children Looked After & Care Leavers (for item 6)
	Kate Bell	(KB)	Equality Lead (for item 7)
	Jen Mulcahy	(JM)	Project Lead (for item 9)
	Rhona Radley	(RR)	Deputy Head of Service Improvement (for item 9)
Observing:	Denise Cheng-Carter	(DCC)	Lay Advisor, Governing Body
	Rob Atkinson	(RA)	Secondary Care Specialist, Governing Body
	Janice Wootton	(JW)	All Age Mental Health Programme Manager
	Paul Carter	(PC)	Patient Experience & Complaints Officer
Minute Taker:	Zoe Akesson	(ZA)	Senior Administrator, Corporate Services

042/20 APOLOGIES FOR ABSENCE **Action**

Apologies were received from Martin Pursey, Head of Contracting and Procurement.

043/20 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 https://www.calderdaleccg.nhs.uk/register-of-interests or from the CCG's headquarters.

044/20 MINUTES OF THE QUALITY FINANCE AND PERFORMANCE MEETING HELD ON 25th JUNE 2020

DECISION:
The minutes of the meeting were **RECEIVED** and **ACCEPTED** as a correct record.

045/20 MATTERS ARISING

There was no update to the action No 030/19 around participation in the E.coli data collection. The action was carried forward to the next meeting.

046/20 ANNUAL REPORT FOR LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) PROGRAMME APRIL 2019 - MARCH 2020

PW presented the annual LeDeR report for 2019-20. The report consisted of an overview of the current LeDeR programme, the CCG engagement and delivery of the reviews along with an overview of local area work that had been undertaken as part of the programme. The following key points were noted;

- PW highlighted that the review programme was not funded so reviewers were either existing CCG staff or from partner organisations.
- Completion of the reviews was challenging, with over 60 key lines of enquiry. The CCG's ability to complete these had been added to the risk register.
- The report described the organisation's specific learning from the completed reviews, making connections back with transforming care work and how it would influence commissioning decisions in relation to this population.
- The report highlighted the key objectives for this year; dealing with the backlog of cases of review, recruiting further reviewers and strengthening links into learning with the local action group and Transforming Care Partnership.

With regards to the current position, PW explained that all cases from the backlog during the pandemic were now allocated a reviewer and that additional reviewers have been secured from Social Care, SWYPFT and CHFT. An agreement had been received from NHS England on a rapid review process, allowing flexibility to only go to a full review where it was absolutely necessary. Funding for additional support to help with the reviews was also available if required.

Comments and questions were invited.

- In response to a question around critical cases being picked up sooner, PW described how the local area contact would scan for anything significant on notification and if anything came to light the individual providers would be contacted and asked to act upon it.
- JM was pleased to see the priority for an 'easy read' version and suggested the inclusion of the post-publication update around reviewers.
- There was an observation made on the number of deaths of people with a learning disability in Calderdale. PW explained that the number of notifications was reliant on people notifying deaths through the central portal.
- In response to a question around the impact of COVID on this vulnerable cohort, PW informed the Committee that the CCG had participated in a national review of approx. 100 deaths during the COVID period, which included one of our cases. The high level recommendations that come from the review would be reflected upon and be part of this year's work.

DECISION:

The Committee **RECEIVED** the report and **NOTED** its contents. The Committee **CONFIRMED** that it was assured that the CCG was engaged with the LeDeR programme and **APPROVED** the annual report for publication.

047/20 CHILDREN LOOKED AFTER AND CARE LEAVERS ANNUAL HEALTH REPORT

In presenting the report GPY explained that the new service had been in place for the last 2 years, the report demonstrated some of the work they were now undertaking differently and provided 2 cases studies. GYP highlighted the following points;

- The number of children coming in and out of care remained around 300 and the initial health assessments and review health assessments for the last year were delivered within the given timescales.
- The number of children placed in Calderdale from other areas was having a major effect on local health providers, especially the acute services. The issue had been raised with the Local Authority to ensure partners were considered in relation to safeguarding issues and the adverse effects on the rest of health service.
- GPY informed the Committee that the service was responsible for care leavers up to the age of 25 years. Young people were written to on a regular basis to let them know the team was available. Although the offer was not always taken up, the team was there to help navigate the health system if they required support.
- Engaging older young people in health assessments was difficult and consideration had been given to lowering the KPI next year to 90% however during COVID young people have engaged virtually. This was successful and then team may look to taking this way of communication forward in the future.
- During COVID the team was redeployed apart from a GP who remained one day a week to do adoption medicals. All young people and care leavers up to 25 years were sent information about support groups and advice on how to keep safe. The team returned in May and virtual initial health assessments took place on the entire cohort for that month. This worked well and it was felt this should be offered in future to help this age group engage quicker.

The report reflected the value of putting the designated function of the leadership of the Children Looked After back into the CCG. It gave a level of confidence around independence and a view of what should be done from a health perspective for these children, which was evident not only in the high performance around the indicators but the development work that was also taking place.

The Committee extended thanks to GPY for her dedication to the safeguarding team during her career with the NHS and wished her a happy retirement.

DECISION:

The Committee **RECEIVED** and **NOTED** the content of the report confirming that it was **ASSURED** that the CCG was fulfilling its responsibilities as a statutory partner in maintaining the health needs of children looked after and care leavers

048/20 EQUALITY AND DIVERSITY UPDATE INCLUDING THE EQUALITY DELIVERY SYSTEM (EDS2) REPORT

Equality and Inclusion Strategy
KB provided the Committee with an update on the new draft Equality and Inclusion Strategy, which was in its final stages and would be taken through the Senior Operational Group and Senior Management Team (SMT) meetings for sign-off, with the aim to publish by mid-October.

For the last 2 years the equality objectives focussed on young people from the

LGBT community. For the next 2 years, the focus would be on the BAME communities and carers. The team was developing detailed action plans to support the delivery of these objectives in partnership with a multi-agency steering group.

Due to the impact of COVID on vulnerable communities, the team was working with staff and community briefs to support key areas of work such as Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the ICS BAME Network. A brief survey was carried out for attendees on the Equality Health Panel. On the whole people liked the panels and wanted them to continue. A number of recommendations on how the panels might work, how they could be improved and delivered would be shared with SMT.

EDS2 Report
The focus was on patient access to GP practices for Lesbian, Gay, Bisexual and Transgender (LGBT) children and young people and wheelchair service users and their experience. The team was self-assessed as being 'developing' for this goal but the panel upgraded the team to 'achieving'.

The following comments were received from the public and the relevant teams were informed;

- to work more with hard to reach groups
- in relation to the wheelchair services review, people felt they did not receive timely feedback
- translation and interpreting service provision should be improved to enable better access to mental health services for BAME communities, asylum seekers and refugees.

Comments and questions were invited.

- In response to a question about the grading panel, KB responded to say that despite been upgraded she felt that they were still developing and would continue to work at pace.
- An observation was made that the Calderdale Health Forum was not on the GP websites. KB would follow up and advise Primary Care colleagues.
- DW informed the Committee that the team had been approached as a system to consider piloting EDS3, showing commitment to develop this agenda, influence and contribute to change in a positive way.

DECISION:

- The Committee **RECEIVED** and **NOTED** the report. The Committee was **ASSURED** that the CCG was meeting its legal and regulatory duties.

049/20 STABILISATION, RESET AND PLANNING

A paper was presented to the Committee providing an update on the stabilisation, reset and planning work that was taking place. It described the national expectations for the CCG from Phases 1 to 3 and included an overview of the winter reset work.

DG highlighted the following key points;

- The system had identified 17 priorities, which teams were progressing and exception reporting was taking place at the A&E Delivery Board on a monthly basis.
- There were 4 key actions around care home discharge and ensuring the ability to be able to deliver rapid response for community offers. These were going

through a rapid appraisal assessment to understand any mitigating actions in relation to resource and possible barriers and an agreement had been made with the Local Authority to use uncommitted Better Care funds to deliver these priorities through winter.
- The CCG was asked to submit a number of submissions relating to activity, mental health, continuing healthcare, workforce and finance, which have been met and sometimes exceeded.

RR along with JW, the new Programme Manager for All Age Mental Health, provided an update on the huge amount of work happening around mental health and the effects of COVID on wellbeing, providing assurance around the link with reset and the Mental Health Investment Standards. An All Age Mental Health, Learning Disabilities and Autism Programme had been developed. Work was ongoing with colleagues from business intelligence, contracting and finance to create a rest document that would link together the national and local priorities providing assurance on how these could be best achieved for the programme going forwards.

Questions and comments were invited.

- The Chair reminded the Committee that 5-6 weeks ago patient expectation and dealing with backlog was a priority however now it was not possible to remain at the same level of activity due to increasing number of COVID cases. The Committee reflected on the realism required during this time and that decisions would involve a high degree of flexibility as we change our response again.
- PW highlighted the importance of the health and wellbeing of staff from the impact of a second wave and winter. The Committee recognised the need to include this in the reset conversations with providers to check they are doing everything to equip staff for the next 6 months and reflect in the reset document as it is just as important as the processes.
- In response to a question around keeping the public informed, DG responded explaining that a huge amount of communications activity was happening at the moment linking up local with national messaging. An elective communications group was set up representing all local organisations, generating broad scale communications to General Practice and for the website. Through working with CHFT, more complex messages were now being sent to specific patients and a buddy system had been set up so patients have someone they could communicate with on a regular basis. There was also communications being developed around urgent care to support our population through winter and targeted work was taking place with Primary Care Networks who are high utilisers of A&E.

DECISION: The Committee **RECEIVED** and **NOTED** the update**.**

050/20 CARE HOME COVID 19 RESILIENCE PLAN

A paper that was taken to Adult and Social Scrutiny Board on 16th July 2020 was shared with the Committee. The paper, developed in partnership with the Local Authority, described the support that had been provided to all Calderdale care homes at a point in time, a view to setting up a Care Home Programme Board and a new future model.

The paper detailed how care homes have been supported during the COVID period in relation to additional financial support, tactical meetings that put in wrap around support if required, involvement from partners, implementation of the Enhanced Care in Care Homes DES which goes live on 1st October 2020 and the offer of IPC training and testing support.

With regards to the future development, RR described the work underway around a planned programme approach between health and social care. The first meeting of the commissioning development board for care homes had taken place where the aligning the market for care homes, sustainability of the workforce and maximising resources was discussed.

Questions and comments were invited.

- JM raised winter resilience and the need to consider scenario planning in relation to another wave of COVID. There was an understanding from the Committee that plans would have to have a degree of fluidity on responding.
- CT raised the point that enhanced care in care homes is about the whole care sector; historically learning disability care homes were not linked in the same way but they would now do so in an equitable way going forwards.

DECISION: The Committee **NOTED** the update.

051/20 QUALITY AND SAFETY REPORT (INCLUDING DASHBOARD)

Introducing the report, DW pointed out that the report continued to highlight the quality work carried out by the team and how this had been maintained and kept in proportion during the COVID outbreak. The following key points were raised;

- **Calderdale & Huddersfield NHS Foundation Trust (CHFT)**
  A never events report had been received from the Trust. It was a very robust investigation report that incorporated human factors and the action plan would be monitored through the joint sub-group. The team have also asked for increased assurance on their management of CAS alerts, asking for them to be managed at both a directorate and organisation level. DW informed the Committee that there is an Associate Director of Patient Experience in post, whose portfolio includes responsibility for complaints and engagement. This was an additional post to the Assistant Director for Patient Safety and Experience. The quality team were looking forward to working with the new post holder, with a view to seeing an improvement in complaints.

- **South West Yorkshire Partnership NHS Foundation Trust (SWYFPT)**
  The report contained an update on issues and governance breaches in relation to the way staff were working in a response to COVID. This has been considered as part of the actions to try to address this.

- DW informed the meeting that the team was now working in a more integrated way with providers, receiving invites to attend acute providers' internal quality meetings, giving an increased intelligence, surveillance and assurance.

- **Process for Sign- off of New Pathways for Clinical Guidelines**
  A process for developing new pathways for clinical guidelines was presented to the Committee for approval. Acting as the interface between primary and secondary care, the CCG wanted to provide assurance these were being appropriately governed. Although it was noted the paper was still in draft format, the Committee agreed the process in place.

Comments and questions were invited.

- In relation to the dashboard, an observation was made around the percentage of non-elective #NoF patients still showing red. In response DW informed the meeting that the Quality team continued to seek assurance on this and it was

being discussed at CHFT's Clinical Quality Board.

- A question was raised around the assurance that all groups understand their part in the process for the approval of clinical guidelines pathways. DG informed the Committee that the process was aimed at 2 groups (Acute Interface and Elective Groups) so clinicians would be made aware. Where there are a number of questions it would go back to the original clinicians until all satisfied. A routine update and any learning back would be included in future quality and safety reports.

DECISION:

The Committee **RECEIVED** and **NOTED** the report including the quality and safety information to provide assurance regarding its main providers, plus the Friends and Family Test guidance.

The Committee **APPROVED** the process for sign off of new pathways and standard operating procedures.

052/20 FINANCE, CONTRACTING AND PERFORMANCE REPORT

052/20-a FINANCE

LS highlighted the key messages from the finance section of the report.

The forecast was based on Month 5 information but forecasted to Month 6. The net overspend was £3.8m against the allocation given for this period of which £2.3m was COVID related costs. LS explained that the allocation process is based on overspend, the CCG had received £2.6m back up to Month 4, equating to a £1.2m forecast pressure in relation to August and September. Currently, the CCG had claimed £4m of COVID costs.

In terms of the current position, there had been no significant change from the beginning of the year;

- There was significant underspending on acute services but this was starting to return. Spend on non-contracted activity for providers not on the national framework was increasing;
- Mental Health had more non-contracted activity;
- Prescribing was still showing an overspend;
- The overspend continued in terms of delegated allocations and running cost, due to the allocation being under what had been planned for;
- Other reserves were showing a pressure due to NHSE basing this year's allocation on the areas which last year were underspent.

Financial Planning

The CCG was provided with an allocation from 01/10/20 and was required to submit a draft ICS level financial plan by 05/10/20. It was noted this information was not available at the time of writing the paper. Many of the business rules such as the Mental Health Investment Standards and block payment arrangements that the CCG had been operating under remained in place.

There was a large reduction in allocation this year. CCGs have been given an individual allocation (based on national analysis) and access to 3 separate ICS allocations for growth, COVID and top-ups. It was noted that the Hospital Discharge Programme sits outside this process and the CCG would continue to claim as normal.

Whilst waiting for guidance, CCGs had been asked to plan however there is now a gap between the allocation and what was originally planned for. Work was underway for both CCGs and providers to review and refine expectations within a very challenging timescale.

Questions and comments were invited.

The Committee acknowledged the huge challenge going forward to meet national expectation and thanked LS for her transparency. The Committee was confident that SMT would continue to report on the gap and if the position started to deteriorate it would be brought to the Committee's attention along with any implications this may bring.

There was a short discussion on scenario planning but is was felt that as the budgets were so volatile and subject to change it was not worthwhile to prepare scenarios on predictions, this would have to be done once budgets were confirmed.

052/20-b CONTRACTING

YH highlighted the key messages from the contracting section of the report.

Acute
The national block contract arrangement continued. There were consistent themes visible in the monitor reports received from the providers. Activity was down but there was a notable increase in A&E attendances and more non face-to-face out-patient activity across all providers including the smaller acute providers. It was visible from CHFT's reports that it was using the national advice and guidance, linking back to the stabilisation and reset work mentioned earlier in the meeting.

Independent Sector
With regards to independent sector national contracts, an information notice had been published as the contract was due to expire at the end of December 2020. YH pointed out that this was for local commissioners and NHS Trusts to agree what the contracts should look like. Clarity was being sought on the scope and how this would work. Further guidance would be available at the end of October and an update on how this work had progressed would be given at December's Committee meeting.

Mental Health
Both the national targets had been met in Month 4. There was an increase seen in out of area placements for both acute and PICU beds. The waiting times for one to one therapy had increased to 31 months. The team was checking with SWYPFT for a breakdown of how this information was being counted and would be picked up as part of the mental health reset work. The system psychology review was ongoing and there was a plan in place to support patients whilst on the waiting list.
In relation to the ASD waiting list trajectory, this was off-track due to the impact of COVID. There was a new trajectory in development and an update would be provided at December's Committee.

YH concluded her section of the report confirming there were 3 open procurements; COVID Positive Beds, The Seamless Hospital and Dermatology.

There were no further questions.

052/20-c PERFORMANCE

TS highlighted the key points to note from the performance section of the report.

The latest data revealed the fuller impact of COVID, highlighting 2 main issues; constraints with capacity (either closed or reduced) and demand (either patients cannot or will not come to the service).

Last year's Long Term Plan asked for a greater focus on mental health. In response, the CCG started discussions on reporting internally but were interrupted due to COVID. This had now been brought back into focus following the development of the reset plans and TS asked the Committee if they felt it would be useful to have mental health indicators as a separate item on future Committee agendas. The Committee agreed and this would be added to the work plan.

A dashboard, providing system assurance at a regional level, had been developed and shared with the Committee for awareness. The quarterly assurance meetings would continue with NHSE but these would now be at 'place' with all health and care partners and the new dashboard would be a feature of that discussion along with other elements around leadership, quality and finance. The first review meeting between NHSE, CHFT, CCG and CMBC was scheduled for 23rd October 2020.

There were no further questions.

DECISION: The Committee **NOTED** the Finance, Contracting and Performance updates.

053/20 CORPORATE RISK REGISTER

The Committee received the risk register position statement for risk cycle 3 2020-21. RG highlighted the key points from the report;

- 2 critical risks scoring 20
- 7 new risks were added to the register, 6 of which scored12.
- R187 was raised at SMT regarding the underachievement of the 18wk performance. The owner of the risk had changed to DG, who provided an update. It had been static for 1 risk cycle and more data would be available for the next meeting.

Comments and questions were invited.

JM highlighted that the new risks were around challenges of COVID in primary care and the changing model of General Practice. There were no comments raised for the Commissioning Primary Medical Services Committee conversation.

DECISION: The committee **REVIEWED** the CCG risk register and the management of the quality, finance, performance and CPMSC risks. The Committee **APPROVED** the CCG risk register for reporting to Governing Body.

054/20 MENTAL CAPACITY ACT AND DEPRIVATIONS OF LIBERTY SAFEGUARDS POLICY

In presenting the policy, LT pointed out that the male centric language in point 6.2.2 had been amended. There was a plan to review the policy in light of the liberty protection safeguards but due to a national delay on implementation the policy had been revised to ensure it was up to date. The only revision was point 7.5.3, which highlighted the CHC responsibilities for court protection DOLS applications.

The Committee acknowledged the amendments around language and correct legislation and felt that the policy was clearly written.

DECISION: The Committee **APPROVED** the policy for publication.

055/20 WORK PLAN

The mental health indicators (refer to point 052/20-c) would be a separate item on the agenda and the work plan would be updated to reflect this. It would be reviewed at a suitable point later in the year.

056/20 MINUTES AND HIGHLIGHT REPORTS

The Committee received the following minutes and reports for reference and assurance;

- Highlight report from the A&E Delivery Board 11th August 2020.
- Highlight report from the Integrated Commissioning Executive 9th July 2020.
- Minutes from the Partnership Transformation Board 27th January 2020.
- Minutes from the South West Yorkshire Partnership Foundation Trust Quality Board Meeting 19th June 2020.
- Minutes from the Medicines Advisory Group 25th June 2020.
- Minutes from the Patient Experience Group 19th December 2019

There were no further comments.

DECISION:
The Committee **RECEIVED** and **NOTED** the minutes and reports.

057/20 MATTERS FOR THE;

- **Governing Body -** routine papers including reset / high level planning paper.
- **Senior Management Team -** NA
- **Partnership Transformation Board -** NA
- **Local Medical Committee -** NA
- **Calderdale Primary Medical Services Committee -** NA

058/20 ANY OTHER BUSINESS

FJ asked for the submission of papers to be 24hrs earlier due to having 2 main committees on the same day. This problem was recognised in other committees, where it was agreed the meetings would be rescheduled.

059/20 DATE AND TIME OF THE NEXT MEETING

The Committee **NOTED** that the next meeting would take place as follows:
Thursday 17 December 2020, 2.00 – 5.00pm, MS Teams

Item 13 c

NHS Calderdale Clinical Commissioning Group

Minutes of the Commissioning Primary Medical Services Committee Meeting held on 15th October 2020, 3pm, Held virtually by Microsoft Teams

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

FINAL MINUTES

Present	John Mallalieu	(JM)	Governing Body - Lay Member (Chair of the Committee)
	Alison MacDonald	(AM)	Governing Body - Lay Member (Patient & Public Involvement)
	Dr Rob Atkinson	(RA)	Governing Body - Secondary Care Specialist
	Dr Steven Cleasby	(SC)	Governing Body - GP Member (CCG Chair)
	Dr James Gray	(JG)	Governing Body - GP
	Neil Smurthwaite	(NS)	Interim Accountable Officer
	Lesley Stokey	(LS)	Interim Chief Finance Officer
In attendance			
	Neil Coulter	(NC)	Senior Primary Care Manager - NHS England/Improvement
	Emma Bownas	(EB)	Senior Primary Care Manager
	Helen Hunter	(HH)	Chief Executive, Healthwatch, Kirklees and Calderdale
	Cllr Tim Swift	(TS)	Representative of Calderdale Health and Wellbeing Board
	Debbie Robinson	(DR)	Head of Primary Care Quality & Improvement
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Zoe Akesson	(ZA)	Senior Administrator

There was no public in attendance.

22/20 APOLOGIES FOR ABSENCE **ACTION**

There were no apologies received.

23/20 DECLARATIONS OF INTEREST

The Chair informed the meeting that GP members had conflicts of interest in items 7, 8 and 12. The proposed approaches for managing these conflicts were set out below;

Item 7 - the Finance paper asked for agreement to set up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals. JG and SC had a **direct financial interest** in the item as general practice contract holders in Calderdale. The Chair felt the GPs contributions to the finance paper were valuable and proposed that they take part in discussion but did not take part in the decision making.

Item 8 - the Estates paper set out some proposed principles referred to as 'Golden Rules' that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. JG and SC had a **direct financial interest,** as practices could be impacted positively or negatively by the proposed gateway principles. Again, it was felt that contribution to the conversation would be helpful but the GPs were asked not participate in the decision.

Item 12 - the PMS premium funding investment for 2020-21 paper asked for agreement to a proposal for investing the funding at PCN level. JG and SC have a **direct financial interest,** as their practices would potentially receive funds via the proposal. The GPs had not received the paper, would be asked to leave the meeting at this point and would not take part in the discussion or decision.

There were no further declarations of interest. The Committee agreed with the management of the conflicts.

The Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/register-of-interests or from the CCG's headquarters.

24/20 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

25/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 23rd JULY 2020

The Committee reviewed the minutes of the last meeting on 23rd July 2020 and **APPROVED** these as an accurate record of the meeting.

26/20 ACTIONS AND MATTERS ARISING 23rd JULY 2020

The Committee reviewed the action log. There was one outstanding action (13/20) for HH to establish the reason why patients believed they were unable to contact their surgery during the pandemic. Since the last meeting Healthwatch had prepared and shared a report on Calderdale's response to the pandemic, to which the CCG was preparing a formal response. The action was closed.

27/20 DECISION NOTICES

A Notice of Decisions from July's Committee was made available to the public via the website. The Committee **APPROVED** the notice.

The Chair informed the Committee that a single item meeting took place with core committee members with regards to establishing a process for urgent decision making. The Committee approved the urgent decision making process on 3rd September 2020 and the note reflecting the decision made at that point was made available to the public via the website.

28/20 HEAD OF PRIMARY CARE REPORT

In presenting the update DR highlighted the following key points.

There is a significant national and local focus on delivering a successful flu campaign this year due to concerns around the potential impact of influenza infection on top of existing and growing COVID-19 pressures this winter. A West Yorkshire and Harrogate Flu Board has been established which is receiving bi-weekly updates from CCGs on their flu plans, the target for both patients and staff, the expansion of the

programme later in the season to those in the 50-64 year old age group subject to vaccine supply and after existing eligible groups have been prioritised.

The Committee was asked to note the position with regards to the Additional Roles Reimbursement Scheme (ARRS) for Calderdale PCNs. It was noted that this had already been reported to NHSE due to timescales around returns. DR notified the Committee that there was likely to be some further funding made available from the WY ICS to support PCN development and the CCG was waiting for further details. In relation to NHS111, DR advised the meeting that the contractual requirement for appointment per 500 registered patients per day available for direct booking by NHS 111 had been extended.

Finally, work is due to start in October by internal audit on the Primary Care Commissioning Review. The specific area of review for this year is Commissioning and Procurement of Primary Medical Services.

Comments and questions were invited.

- In response to a question around the availability of flu vaccines for the 50-64 year old age group, NS assured the Committee that confirmation had been received from NHSE that there was stock available and this would be rolled out in a phased release. The deployment would be through the national procurement route for both Pharmacy and General Practice. He went on to say that if problems did occur there was a good route to feed into the regional and national flu meetings.

- In relation to the risk highlighted in the paper that all practices may not be able to maximise use of the APEX tool, DR responded to say the CCG along with the LMC and PCNs were ensuring that all practices were made aware of the tool and the great benefits that could be gained from using it.

- There was an observation made that the first contact practitioners were proving popular however some community practitioners such as paramedics had not yet being added to the additional roles scheme to ensure the system was not destabilised. SC agreed it was good to see clinical support in the system and asked about the utilisation of appointment slots and measuring the efficiency of these services. In response, EB said that there were plans to look at the impact and demand but also gain a better understanding of what these new roles could bring and how they would contribute to proactive care.

- NS added that since writing the report there had been movement on digital and good progress had been made with Calderdale agreeing as a system to have the availability of an additional functionality, making it easier to communicate by providing a balance between face-to-face, digital and on line.

DECISION

The Committee **RECEIVED** the paper and was **ASSURED** with the content, noting the significant activity undertaken in Primary Care.

29/20 CONTRACT REPORT

MP drew the Committee's attention to the following points in the report;

There was an update on the contracting position and solutions around future aligning of the GP online and video consultations into a new framework. Learning taken from

this would be used to look at aligning any future procurement from a joint functionality perspective. The report described elements set out in the Network DES 2020-21 and the concept of auto-enrolment for GPs. There was an update on the incorporation applications received by the Committee with the novations for Boulevard and Springhall Group Practice now being complete. There was a section on the national medical performers list, which the CCG along with NHSE colleagues have to ensure is maintained and vetted on a regular basis.

MP concluded by providing an update on a complaint received last year about a decision the Committee made on PMS premium funding. Paused due to the pandemic, this was now being picked up again and would be dealt with through the formal dispute resolution process. LS added that the CCG had followed the process as requested by NHSE but asked NC for any advice he could provide from an NHSE perspective in relation to equitable funding. NC agreed to look into this.

ACTION: MP to share details of the PMS funding complaint with NC who would look into this and provide advice/feedback from an NSHE perspective. **MP/NC**

Questions and comments were invited.

- SC raised GP online and video consultations and the importance of using in practice. DR informed the Committee that maximising the function of the 2 systems was discussed at the GP Leadership meeting where it was agreed that each PCN would agree on one system so that all practices maximise the same one and learn together. NS added that WY ICS Digital has been successful in a bid to look at web site access and review best practice. This should dovetail with the work being done locally and result in a positive direction of travel from all partners; ensuring patients receive the same offer of GP access anywhere in Calderdale.

DECISION

The Committee **RECEIVED** and **NOTED** the content of the report.

30/20 FINANCE REPORT

In presenting the report, LS reminded the Committee that the CCG was working under a very strict financial regime. The budgets had been issued for the first 6 months of the year, which were less than what the 6 month equivalent of the CCG's plan was for this year and in light of this the CCG was reporting a net overspend of £349k until the end of September.

The allocation for delegated primary care for the first 4 months was £232k leaving a net pressure of £117k for August and September. Overspends were as a consequence of not being able to move budgets around. The biggest variance was due to changes in contracts and overspends against PCNs.

October to March budgets were issued at the end of September. The CCG had a confirmed allocation of £15.7m with some allocations for specific DESs of £195K, which would give a total of £15.9m. The CCG's total net confirmed allocation for the first 6 months was £31.7m, which was not far off its initial plan for the year of £31.8m. This was positive news, with a confirmed allocation to deliver the plan for this year. The CCG are asked to submit their plan to NHSE by 22nd October 2020, once approved it will be shared with the Committee.

With regards to the PMS premium, following the Committee's decision equitable

funding would be in place from 01/10/20. This year there was a confirmed reserve budget of £580k and the full year adjustment will be available from 2021/22 with a budget of £666k.

Changes made to the PMS contract last year resulted in an increase in the reserve budgets equating to £710k. A recommendation was put to the Committee for their agreement to deploy these reserves and make appropriate investment in primary care in relation to Winter and COVID pressures. Conscious of the timing, decisions may need to be made swiftly so in order to facilitate that LS recommended one or more separate additional meetings of non-conflicted members' takes place to approve investments of the £710k reserve and report to the next formal committee of the decisions. All other normal process would be followed such as the QIA and EQIA process around rapid decision making.

Helen Hunter left the meeting.

Questions and comments were invited.

- The GPs acknowledged they were conflicted but emphasised the importance of clinical input around deciding the most effective way of utilising this resource. DR assured the Committee conversations were taking place. Each scheme being considered is explored informally with both the LMC and Clinical Directors and there is a named clinical lead either an Associate or GP Governing Body clinical lead for each of the schemes.

JG and SC left the meeting whilst the decision took place.

DECISION

The Committee **APPROVED** setting up an additional virtual meeting in private with non-conflicted members to approve any discretionary investment proposals.

The Committee **NOTED** the 2020/21 financial position on Primary Medical Services delegated budgets and the indicative allocations for 2020/21October to March.

JG and SC re-joined the meeting.

31/20 ESTATES REPORT

DR presented a report that proposed some Golden Rules that all submissions for premises development proposals in Calderdale must meet before being considered for investment support. In addition, the paper outlined new guidance to PCNs to commence work on estates in conjunction with workforce planning. Since the group met, further guidance had been issued for commissioners and officers were working through the implications.

The paper reminded the Committee that at its meeting on the 23rd July 2020 it agreed to the establishment of a small sub-group to develop this work. The paper presented the work of the group and sought the Committees views on the Golden Rules to see if they were workable. These would be communicated out to practices so they understood the process they are working towards.

The Chair asked the Committee for their views and comments.

- JM emphasised the need to define the submission process for practices ensuring they have clarity on how to evidence. DR confirmed there were a number of

documents the CCG could direct them to such as the Commissioner Guide and the Expectation to PCN Guidance and by starting conversations early could advise where to find the best advice.

- A question was raised about the new guidance incorporating the changes in the way care is delivered in light of COVID and if the needs of the population had been refreshed. DR responded by explaining that practices should have considered their existing arrangements as part of the process. Practices would be challenged to ensure they have considered how they supported patients previously. DR reminded the Committee that this was only the first gateway and if successful at this point it would then go to NHSE for their scrutiny and overall decision.

JG and SC left the meeting whilst the decision took place.

DECISION:

The Committee **APPROVED** the Golden Rules**.**

The Committee **NOTED the** content of the report and the requirements of PCNs, Clinical Directors, and the CCG (as part of the wider system) to commence work to ensure there is sufficient accommodation for professionals recruited under the Additional Roles Reimbursement Scheme involving workforce and estates planning.

JG and SC re-joined the meeting.

32/20 RISK REGISTER POSITION STATEMENT

RG presented the information relating to the third risk cycle 2020-21.
There were 7 risks in total, 4 new risks scoring 12 and 1 marked for closure. All 6 open risks were between 8 and 12 therefore no significant risks to report.

Comments and observations were invited.

- In response to a question relating to R1629 about additional roles, it was explained to the committee that this was not about the professionalism of the people but recruiting them into an environment that they might not be familiar with and likewise the environment not familiar with them and the consequences of that. By putting it on the risk register it made the Committee alive to this.

- In relation to R1628 maximising funding available, LS assured the Committee that a lot of work was happening with PCNs to maximise plans and develop templates.

- JM suggested splitting R1630 vaccination of population, as there would be different inputs to managing this. Although accountable for it as a whole, some parts of the risk could be managed and splitting would show the level of risk differently.

DECISION

The Committee **REVIEWED** the risk register and the management of the CPMSC risks.

The Committee **APPROVED** the register for reporting to Governing Body.

33/20 NOTICE OF URGENT DECISIONS

DR informed the Committee of 3 urgent decisions that had been made. The committee members were reminded that on the 3rd of September 2020 they considered and approved the process for making urgent decisions that were required in relation to matters of such urgency, and relating to the management of COVID-19, that they will not wait until the next scheduled meeting of the Committee and therefore warrant the use of urgent decision process.

Since then 2 practices have submitted applications under this process, both for a 3 month delay in providing face to face services from one of their respective branch surgery premises.

An application from Hebden Bridge Group Practice advised that "*It is not physically possible at present to safely socially distance and protect both patients and staff in the Luddendenfoot Branch Surgery. As a result this location will not be providing face to face appointments. Additional access has been made available to these patients.*" This application was approved.

A further application from another practice had been agreed in principle subject to further conditions and clarification. The Local Medical Committee was consulted for a view on both applications. The decision notices on these applications would be published on the CCGs website.

Comments and questions were invited.

- A question was raised about keeping patients informed of what was happening. DR explained that practices are asked to communicate clearly with patients and to provide the CCG with evidence of their patient engagement and responses around this.

DECISION

The Committee **NOTED** the updated.

34/20 WORKPLAN

The work plan was reviewed and there were no comments.

DECISION

The Committee **AGREED** the work plan.

SC and JG Left the meeting

35/20 PMS PREMIUM INVESTMENT 2020/21

The Chair noted that the conflicted individuals were not present for this item.

DR outlined the paper that sought approval of the investment of the PMS premium funding for 2020/21. It recommended that PMS premium monies are distributed to practices via PCNs based on weighted list size at the 1st April 2020 and that this is topped up to £3php from reserves.

DR assured the Committee that clinical input into this proposal, had been via the Local Medical Committee and also the Clinical Lead for Primary Care, both parties confirmed their support for the approach being proposed.

The PCNs and practices would be asked to consider the 4 objectives below when using this funding;

- Reducing inequalities to accessing general practice services
- Managing and meeting all on the day demand
- Ensuring practices as part of PCNs are able to remain resilient over winter
- Target acute care, prevention and screening of those who's physical and mental health is most at risk

In previous years, funding had been targeted at additional clinical prescribing capacity only and its clear from patient feedback and practices alike that there is a need to take a more flexible approach this year to enable those at the front line to determine how best to invest the funding to maximise the general practice response over winter.

Comments and thoughts were invited.

- The Committee agreed to this investment approach.

- LS was comfortable with the financial recommendation of £3 per head which would take the investment pot to the full year effective of what the PMS premium would be for next year and the difference would come from the reserves.

- There was a short discussion around skills and being able to tailor to their PCNs. The Committee was informed that conversations were happening about methods and approach. There is multi-disciplinary support in place from the CCG to help PCNs deliver such as the APEX Insights and Population Health Management work, which will give a better understanding of their population.

- The skills and funding should improve access, however if it fails to do so the CCG would need to re-think how it would do it for next year. The CCG understands the risk and that it may take longer to develop.

Cllr. Tim Swift left the meeting

DECISION

The Committee **NOTED** the content of the report.

The Committee **APPROVED** the proposal for investment of the PMS premium funding for 2020/21 as detailed in the report.

36/20 DATE AND TIME OF NEXT MEETING IN PUBLIC

The Committee **NOTED** that the next meeting would take place on Thursday 21st January 2021, 3.00 – 5.00pm, via MS Teams

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Minutes of the meeting held in public on Tuesday 6th October 2020

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
Neil Smurthwaite	**NS**	Deputy Chief Officer, NHS Calderdale CCG
Dr Steve Ollerton	**SO**	Chair, NHS Greater Huddersfield CCG
Dr Khalid Naeem	**KN**	Chair, NHS North Kirklees CCG
Carol McKenna	**CMc**	Chief Officer, NHS Greater Huddersfield CCG and NHS North Kirklees CCG
Dr Jason Broch	**JB**	Chair, NHS Leeds CCG
Tim Ryley	**TR**	Chief Officer, NHS Leeds CCG
Dr Adam Sheppard	**AS**	Chair, NHS Wakefield CCG
Jo Webster	**JW**	Chief Officer, NHS Wakefield CCG
Associate members		
Dr Charles Parker	**CP**	Chair, NHS North Yorkshire CCG
Amanda Bloor	**AB**	Chief Executive, NHS North Yorkshire CCG
Apologies		
Dr Steven Cleasby	**SC**	Chair, NHS Calderdale CCG
Matthew Groom	**MG**	Assistant Director, Specialised Commissioning, NHS England
In attendance		
Esther Ashman	**EA**	Programme Director, Commissioning Futures
Rod Barnes	**RBa**	Joint Senior Responsible Officer, Urgent and Emergency Care
Stephen Gregg	**SG**	Governance Lead, Joint Committee of CCGs (minutes)
Sarah Halstead	**SHa**	Specialised Commissioning, NHS England
Ian Holmes	**IH**	Director, WY&H HCP
Anthony Kealy	**AKe**	Locality Director WY&H, NHS England & NHS Improvement
Pat Keane	**PK**	Joint Senior Responsible Officer, Urgent and Emergency Care
Jonathan Webb	**JWb**	Director of Finance Lead, WY&H Health and Care Partnership
Keith Wilson	**KW**	Programme Director, Urgent and Emergency Care

Item No.		Action
86/20	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the 'virtual' meeting, including 2 new CCG Lay members to their first meeting - Ruby Bhatti of Bradford District and Craven CCG and John Mallalieu of Calderdale CCG. Members of the public were able to watch the livestream of the meeting. Apologies were noted. **Chair's update** The Chair noted that we continue to operate in a challenging environment, with COVID infections rising across the country and localised restrictions across WY&H. Partners across the NHS were planning for the restoration of essential services, balancing the competing requirements of non-COVID and COVID services. The Chair expressed thanks to all staff across NHS, care services and other public services for the hard work that they continued to do.	
87/20	**Questions and deputations**	
	The Chair advised that as the meeting was being held virtually, members of the public had been invited to send questions in advance. One had been received: **Question:** In Simon Steven's letter of 31st July to CCG Accountable Officers and others, he noted: "Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system". Rob Webster, Chair of the WY&HHCPB, has previously been quoted as stating: "Moving to one CCG for WY&H would risk undermining our approach and our relationships with our local authorities, who are equal partners. We have no intention of doing so". How does the Joint Committee see these two positions being reconciled? It was agreed that a response would be provided under agenda item 91/20 'Commissioning futures'. A written response would also be prepared and posted on the Joint Committee webpage.	
88/20	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. There were none.	
89/20	**Minutes of the meeting in public – 7 July 2020**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 7 July 2020.	
90/20	**Actions and matters arising – 7 July 2020**	
	The Joint Committee reviewed the action log.	
	The Joint Committee: Noted the action log.	
91/20	**Joint Committee governance**	
	SG presented the update, which formally reported the appointment of Ruby Bhatti and John Mallalieu as new CCG lay members to the Joint Committee. Work was ongoing to review the role of the Joint Committee PPI Assurance Group in the light of the Commissioning Futures work programme.	

Item No.		Action
	The revised MoU for Collaborative Commissioning and Joint Committee work plan had been agreed by the West Yorkshire CCGs. The main changes were the delegation of new commissioning decisions to the Joint Committee and changes in Committee membership, with North Yorkshire CCG becoming an associate member. The Committee reviewed the significant risks to the delivery of its work plan. Seven risks were scored 12 or above after mitigation. In response to a question from RB, SG confirmed that risks to the delivery of the Cancer and Planned Care programmes resulting from COVID were reflected in the risk framework.	
	The Joint Committee: a) **Noted** the appointment of 2 new CCG lay members to the Joint Committee. b) **Noted** that the new MOU and work plan had been agreed by all West Yorkshire CCGs and a final copy signed by CCG Accountable Officers. c) **Noted** the risk management framework and the actions being taken to mitigate identified risks.	
92/20	**Mental Health, Learning Disabilities and Autism – Commissioning of Assessment and Treatment Units**	
	Helen Hirst presented an update on proposals for commissioning West Yorkshire and Barnsley Learning Disability Assessment and Treatment Units (ATUs). HH highlighted that this was part of a wider direction of travel towards greater collaborative commissioning between commissioners and providers. The report set out a proposal for a new care model for the future commissioning of ATUs, which went beyond the inpatient model to consider the whole pathway for people with learning disabilities in need of enhanced care and support. The report noted the revised engagement timeline and KC outlined the approach, which focused on engaging with people who had accessed care in ATUs, their carers and staff. A number of engagement mechanisms were being used. HH emphasised that today, the Joint Committee was being asked to support the direction of travel. Formal approval for the proposed approach to commissioning ATUs would be brought to a future meeting of the Joint Committee, once engagement had been completed. JM supported the approach and highlighted the need for clarity about the provider-managed risk model that was proposed. NS confirmed that the approach was designed to strengthen the management of financial risks across the whole care pathway.	**HH/KC**
	The Joint Committee: a) **Endorsed** the proposal to extend the workplan of the programme to commission a new care model for people with a learning disability. b) **Supported** the proposed approach of provider-managed risk, subject to the further work of provider organisations Directors of Finance and CCG Chief Finance Officers.	
93/20	**Commissioning Futures**	
	Esther Ashman presented an update on the Commissioning Futures programme, which was based on our successful model of place-based working. The approach was being developed in collaboration with partners across the health and care system, including providers and local authorities. It was based on principles of collaboration and integration, with a strong focus on prevention.	

Item No.		Action
	There were three levels of commissioning, each tailored to local population need and focused on improving population health: • commissioning in each place, developed and delivered collaboratively as a system in that place. • commissioning in partnership across the ICS, but delivered separately in each place to a common specification/set of outcomes and standards. • commissioning done once in partnership across WY&H. Work was only done at WY&H level if it added value to our places. All 3 levels required close partnership working across the whole health and care system. A set of financial principles was being developed, which aimed to share financial risk across the system. A proposed operating model would come to a future meeting of the Joint Committee for approval. This would build on the areas already covered by the Joint Committee work plan. In response to the question raised under item 87/20, JW said that the uniqueness of our places meant that a single CCG for the ICS was not the right model for WY&H. Our strong collaborative approach had been shown to deliver results, for example through the WY&H Healthy Hearts and stroke programmes. JM noted the clear message that 'one size fits all' did not work for WY&H. He highlighted the need to articulate this message clearly and simply and ensure that everyone in our places understood and supported the approach. The Chair added that the proposals put our WY&H places at the centre of Commissioning Futures.	**EA/JW**
	The Joint Committee: a) **Noted** the update on the Commissioning Futures programme and **agreed** the proposed next steps in developing the operating model.	
94/20	**Urgent and emergency care - Yorkshire and Humber-wide programme for implementing NHS 111 First.**	
	Pat Keane presented the report. NHS 111 First was a national programme which built on learning from COVID-19 about the high use of 111 by the public for advice and signposting. The aim was to build on this by encouraging people to phone 111 as an alternative to 'walking' unheralded into Emergency Departments (ED), reducing ED footfall and tackling COVID-19 social distancing challenges. PK emphasised that the aim was not to prevent people from attending ED, but to make it easier for them to access quickly the right support in a planned and managed way. This included direct booking a time slot in ED if appropriate. The aim was to maximise the use of digital solutions to offer a range of alternative services outside of hospital settings. A national specification set out the key aims, actions and outcomes for the implementation of NHS 111 First This was an integrated offer which included a number of alternative pathways, for example through GPs, pharmacists and mental health advice services. Close collaboration with acute hospitals and YAS aimed to make sure that all services were fully integrated. This would maximise the benefits of delivering 111 at scale, integrated with the local services in each place. In Yorkshire and Humber we are working jointly across 3 ICS footprints with YAS (the 111 provider). KW outlined the detailed work being carried out in West Yorkshire and Harrogate to enable effective local implementation across places and programmes. The approach would be launched nationally on 1st December but we were currently doing 'soft launches' to test systems. A major communication and engagement programme was planned, focused on trying to ensure that people accessed the right care at the right time.	

Item No.		Action
	SO noted the benefits of an integrated approach across 111, ED and primary care supported by better signposting across the system. Efficient data flows would be important in enabling this. TR asked how we were tackling the challenges of encouraging behavioural shift and how we would gauge whether the model was working. PK outlined work to capture data on patient flows and understand why people were accessing services. KW noted that we know that people are using 111 more and have developed a strong narrative about where people should go. It was acknowledged that more work was needed to encourage behavioural shift. JB emphasised the importance of understanding people's underlying needs as opposed to the services that they were accessing. KN highlighted the role of 111 call handlers in signposting people and the need for them to be fully supported and trained.	
	The Joint Committee: a) **Noted** the national specification for NHS 111 First and the process for local implementation through a Yorkshire and Humber Programme Oversight Group.	
95/20	**Urgent and emergency care - Yorkshire and Humber framework for the integrated commissioning of services provided by Yorkshire Ambulance Service**	
	Pat Keane presented the report, which explained that Yorkshire Ambulance Service (YAS) provided integrated urgent and emergency services across the Yorkshire and Humber geographical footprint, which also contained Humber Coast & Vale and SY & Bassetlaw ICSs. A framework had been developed to strengthen the coordination of planning and commissioning integrated urgent and emergency services provided by YAS. The aim was to balance the advantages of operating at scale across the region with the need to be responsive to the needs of local places. PK set out how the approach dovetailed with the Commissioning Futures approach, with commissioning taking place at the appropriate level across the system. NHS 111 was presented as an example of how this might work in practice. The Integrated Commissioning Framework was underpinned by a set of agreed principles, behaviours and values and an operating model. The approach would combine collaborative working with clear accountability. Rod Barnes outlined the benefits of having a common set of priorities across the 3 Yorkshire and Humber ICSs. The approach enabled better strategic engagement with commissioners and ensured strong links into local places. JW agreed that the approach fitted well with the Commissioning Futures direction of travel. JM emphasised the benefits of greater consistency and integration and the ability to share good practice.	
	The Joint Committee a) **Noted** the development of the Yorkshire and Humber framework for integrated commissioning of Integrated Urgent and Emergency Care Services provided by Yorkshire Ambulance Service. **b) Supported** the proposed next steps	
96/20	**Any other business**	
	There was none.	

Next Joint Committee in public – Tuesday 12 January 2021, 11am – 1pm.