Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Appointment of CCG Accountable Officer**	**Agenda Item No.**	1
Report Author	Jen Mulcahy, Programme Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair	**Responsible Officer**	Dr Steven Cleasby, CCG Chair

Executive Summary							
Please include a brief summary of the purpose of the report	To inform the Governing Body of the appointment to the role of Accountable Officer for the CCG, uniting health and care services within the borough.						
Previous consideration	**Name of meeting**		**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: a) **RECEIVE** this report and **NOTE** that following NHSE approval, the current Calderdale Metropolitan Borough Council (CMBC) Chief Executive has been appointed as the Accountable Officer for Calderdale CCG as part of a shared role with CMBC with effect from 16th October. b) **RECOGNISE** the leadership provided by the current Interim Accountable Officer, Interim Chief Financial Officer, and the CCG's Senior Management Team during the intervening period.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications							
Quality & Safety implications	Not applicable						
Engagement & Equality implications	Not Applicable						
Resources / Finance implications	To be confirmed in line with timescale.						
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	X	
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**					
Legal / CCG Constitutional Implications	Tri-partite agreement between the CCG, Calderdale MBC and the individual being established	**Conflicts of Interest**	The CCG's conflicts of interest policy has been updated and approved by Audit Committee. Any Conflicts arising from				

			this report will be manged in line with the CCG Management of Conflicts of Interest policy.

1. Introduction

1.1 This paper informs the Governing Body of the appointment to the role of Accountable Officer for NHS Clinical Commissioning Group.

2. Background

2.1 The CCG's previous Accountable Officer left the CCG on the 15 April 2020. Following conversations held between the CCG's Chair and NHS England (NHSE), the Governing Body, having evaluated all options, made the decision, in private, to work with its Local Authority (CMBC) on a joint role for Accountable Officer on the basis that this provided the most viable option to: enable Calderdale to retain its identity and build on existing strong relationships and support the West Yorkshire Health and Care Partnership's emphasis on subsidiarity.

2.2 CMBC's Cabinet discussed Health and Social Care Integration on 1 June 2020 in private and recommended approval of the CCG's preferred option for their Accountable Officer to become a joint post with the Council's Chief Executive.

2.3 At its meeting in private in July, the Governing Body agreed that in light of the work to date and the proposed assurance arrangements outlined, that sign off of the appointment by the Remuneration/Nominations Committee should be delegated to the Chair and Deputy Chair of the Governing Body.

3. Appointment of Accountable Officer

3.1 Subsequent to the recruitment process by Remuneration and Nomination Committee and sign off by the Chair and Deputy Chair of the Governing Body, a completed nomination form was submitted to NHS England (NHSE). The Chief Executive Officer of the NHS wrote to Robin Tuddenham, CMBC's current Chief Executive on 14th September to confirm his appointment with effect from 16th October, 2020.

3.2 This appointment will ensure that commissioning and the leadership of primary care services, such as GP practices, continues within Calderdale and that the closer partnerships between the Council, NHS Calderdale CCG, Calderdale and Huddersfield NHS Foundation Trust (CHFT) and the community and voluntary sector continue to have significant impact on people's lives in the borough.

3.3 The combined post will be jointly funded by Calderdale Council and NHS Calderdale Clinical Commissioning Group.

4. Recognition of interim arrangements

4.1 During the intervening period between the previous Accountable Officer leaving in April and the new arrangements being established, the role has been filled on an interim basis by the current Chief Financial Officer/Deputy Chief Officer, Neil Smurthwaite. The role of Chief Financial Officer has been undertaken on an interim basis by the current Head of Finance, Lesley Stokey. The Governing Body should like to note its thanks to Neil, Lesley and the CCG's Senior Management Team for the contribution made during a time of unparalleled pressure on the NHS.

5. Recommendations

5.1 It is recommended that the Governing Body

a) **RECEIVE** this report and **NOTE** that following NHSE approval, the current Calderdale Metropolitan Borough Council (CMBC) Chief Executive has been appointed as the Accountable Officer for Calderdale CCG as part of a shared role with CMBC with effect from 16th October.

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

Item 4a

NHS Calderdale Clinical Commissioning Group

Public Section of the Governing Body Meeting held on Thursday 23rd July 2020 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
	Neil Smurthwaite	NS	Interim Accountable Officer
	John Mallalieu	JM	Deputy Chair, Lay Member (Finance and Performance)
	Lesley Stokey	LS	Interim Chief Finance Officer
	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 Peter Roberts	PR	Lay Member (Audit)
In attendance	Denise Cheng-Carter	DCC	Lay Advisor
	Iain Baines	IB	Director of Adult Services, Calderdale Metropolitan Borough Council
	Andrew O'Connor	AOC	Senior Corporate Governance Officer (Minutes)
	Sarah Antemes	SA	Head of Commissioning Continuing HealthCare, Mental Health, Learning Disabilities (for item 4, Minute No 38/20)
	Lucy Walker	LW	Quality Manager (for item 4, Minute No 38/20)
	Bev Hanson	BH	Manager, Calderdale Retreat Care Home (for item 4, Minute No 38/20)
	Luke Turnbull	LT	Designated Nurse, Adult Safeguarding (for item 7, Minute No 41/20)
	Gill Poyser-Young	GPY	Designated Nurse, Children and Young People Safeguarding (for item 7, Minute No 41/20)
	Jill Dufton	JD	Engagement Manager (for item 9, Minute No 43/20)
	Jenna McGuiness	JMc	HR Manager, North of England Commissioning Support Unit (for item 10, Minute No 44/20)
Observing	Steven Reed	SR	Communications Officer
	Simon Lightwood	SL	Communications Manager
	Kate Bell	KB	(for item 8, Minute No 42/20)
	Sarah Mackenzie-Cooper	SM-C	(for item 8, Minute No 42/20)

35/20 APOLOGIES FOR ABSENCE **Action**

The meeting noted that clinically active members of the Governing Body continued to be stepped down from Governing Body activity. As such GP Members, Dr Caroline Taylor, Dr Farrukh Javid and Dr James Gray were not in attendance. The meeting was quorate in accordance with the standard quoracy arrangements agreed by the Governing Body at its meeting on 23 April 2020 for the period of the standing down.

Apologies were received from Deborah Harkins (Advisor to the Governing Body, Director of Public Health, Calderdale Metropolitan Borough Council).

36/20 DECLARATIONS OF INTEREST

There were no declarations in interest.

The 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.

37/20 MINUTES

a. Public Section of the CCG Governing Body Meeting held on 23 April 2020

DECISION:

The minutes of the public section of the Governing Body meeting held on 23 April 2020 were **RECEIVED** and **ADOPTED** as a correct record.

Matters Arising

The two actions arising from April's meeting had been completed.

38/20 PATIENT STORY

SA, LW and BH were welcomed to the meeting.

LW explained that she had been redeployed as the Clinical Lead for the extra capacity beds established at the Calderdale Retreat Care Home as part of the system response to Covid 19. She went on to share her experience whilst redeployed to The Retreat and the care journey of a particular patient and their family.

SA explained that the story was just one example of how additional community facilities had helped to provide patient centred end-of-life care to individual their families.

BH addressed the Governing Body sharing their reflections on hosting the Covid Isolation Unit at The Retreat and those of other Calderdale based care homes:

- Patients admitted to The Retreat received the best experience of care at all time, from daily living to end-of-life care. This had been made possible by partners and commissioners coming to together as one.
- Positive changes during the response to Covid 19:
    - Improved documentation from external professionals with full and in-depth

assessments affording people the best start on their care journey.
    - Placement agreements and authorisations for payment arriving within hours of the placement followed by prompt receipt of payments.
    - Improved access to GPs, District Nurses, Community Mental Health Services, Speech and Language Therapists, Physiotherapists helped to keep residents healthy and better able to fight off other viruses and infections.
    - Relieved of the usual pressures, BH was able to focus on ensuring that everyone at The Retreat was healthy, happy, supportive and safe
- The most important learning was said to have been derived from the greater joint working. There had been an improved understanding of one another's roles in the delivery of social care. The usual barriers had been removed and the impact in terms of service deliver was "exceptional".
- The biggest lesson: if we can work more closely together, great things can be achieved.

SC recognised that what had been achieved in Calderdale since the onset of Covid-19 had been nothing short of miraculous and demonstrated that the existing direction of travel toward greater integration and partnership working was the correct one.

Questions and comments were invited.

The following key comments were made:

- Patient centred care was recognised as a key factor in the delivery high quality services to patients and their families.
- The process of establishing the provision at The Retreat had provided experience of the practical requirements had been shared beyond Calderdale.
- The willingness of CCG staff to take on these roles voluntarily was recognised and tribute was paid to the staff. BH was thanked for the support she had given to CCG staff during the period of the redeployment.
- That the learning acquired from this period needed to be built on in readiness for the winter.
- IB said he had never been prouder of the joint efforts of individuals and teams across Calderdale. Tribute was paid to all staff working tirelessly to deliver high quality care during the response.

SA, LW and BH were thanked for their attendance.

DECISION:

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

39/20 ACCOUNTABLE OFFICER'S REPORT

NS presented the Accountable Officer's (AO) report explaining that the content reflected the significant amount of work taking place locally, regionally and nationally. He explained that the CCG was entering a difficult planning phase in terms of continuing the response to Covid-19 while preparing for winter and agreeing services and budgets for the remainder of the year. Attention was drawn to the following:

COVID 19 – Outbreak Governance, Test and Trace

Attention was drawn to the outbreak governance and test and trace arrangements in place locally, set out at 2.4, for the Governing Body's assurance and information. A copy of the local outbreak plan was provided at Appendix 3. The health and care sector continued to be as busy as it had been during the initial response.

COVID 19 – Health Inequalities

Outbreaks were noted to be in distinct demographic areas and consultation was being undertaken to help understand needs and shape the offer of support. Attention was drawn to the piece of work that the Integrated Care System (ICS) had commissioned in this area as described at 2.4.3.

Commissioning Developments

Attention was drawn to:

- The ongoing work in support of the Open Minds Partnership at 3.1;
- The ongoing improvements in the delivery of the Posture and Mobility Service at 3.2;
- Work undertaken by Calderdale and Huddersfield NHS Foundation Trust (CHFT) to support the continuation of cancer services at 3.4. Calderdale was performing comparatively better due to prioritisation and partnership working.

Military Stress Test

As part of the ICS across West Yorkshire, the CCG, with partners, had undertaken a military stress test, presenting as a place, in response to different scenarios. Calderdale had received positive feedback on its preparedness.

Questions and comments were invited

- In response to a suggestion that the Improving Access to Psychological Services (IAPT) survey also be taken into account as part of the stabilisation and reset planning, PW confirmed that, once the Healthwatch Covid survey data had been received, the two would be looked at together and that AM could speak with members of her team about this.
- In response to a question, NS confirmed that all staff would continue to work at home as default until at least January 2021. All staff were required to complete risk and work station assessments in order that the necessary support and resources could be provided. Work had also been undertaken to ensure staff who have needed to use the office space at Dean Clough could do so safely. The CCG was continuing to work closely with staff to ensure people were supported during this period. Particular thanks were given to the membners of Staff Forum.
- NS took on board suggestions made concerning the reinstatement of some face-to-face meetings when conditions allowed it, on the basis that some types of business benefit from physically coming together.
- In response to a question, NS confirmed the CCG and partners were in the process of developing what people might expect when they have been referred in order to manage expectations. This work was ongoing.
- In response to a question, NS confirmed that, based on staff performance to date, he was confident of maintaining staff focus and commitment following the shift to working from home and that the evidence indicated people “stepping up” to the challenge rather than “away”.

DECISION:

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

40/20 COMPLAINTS ANNUAL REPORT 2019/20

PW presented the Complaints Annual Report 2019/20 which had been received at the last Quality, Finance and Performance Committee (QFPC) meeting. She drew attention to:

- An increase in the number of complaints in-year resulting from the introduction of a new system to record lower level complaints.
- Assurance that, wherever possible, learning is gathered in fed into the organisation.
- An improvement in response timescales due to changes in sign off processes.
- Contacts with complainants having been maintained throughout the national pause. The complaints process had recommenced.

Comments and questions were invited

- An in-depth discussion was confirmed to have taken place at QFPC with particular attention given to how the CCG had maintained contact with individuals affected by the pause.
- The CCG's complaints process was recognised to support the CCG as a learning organisation. More examples of this in future reports were invited,
- The report was recognised to comprehensive and reflected the robust processes in place.
- SC assured the Governing Body concerning the robustness of the CCG's complaints process based on their involvement during the year.

DECISION:

The Governing Body **NOTED:**

1. complaints received about services commissioned by Calderdale CCG during 2019/20;
2. categorisations by provider, category, level and response timeframe.

41/20 JOINT SAFEGUARDING ADULTS AND CHILDREN ANNUAL REPORT 2019/20

LW and GPY were welcomed to the meeting.

PW presented the Safeguarding Adults and Children Annual Report 2019/20. The following points were highlighted:

- The report was presented in a new, more concise format for 2019/20 with links to sources of further information.
- It provided an overview of the work and activity taken place at the CCG, in partnership with the Adults and Children & Young People's Safeguarding Boards and at an ICS level.
- The CCG's Safeguarding function had received an internal audit opinion of **HIGH** assurance against the NHS Accountabilities Framework.
- The work that had taken place across the ICS under Clare Robinson's leadership was with regional peers to establish about how Safeguarding can support the West Yorkshire programmes and how a "do once, share once" approach might implemented was noted to be particularly positive.

GYP and LT were invited to share their highlight from reporting year:

- GYP reflected positively on the shaping of the Health Assurance and Insurance Group (HAIG) (Slide 13). The audits regularly being undertaken were highlighting gaps in communications between agencies and identifying examples of good practice. The group was providing assurance to the Safeguarding Children's Partnership. An independent scrutineer who had attended a meeting had been highly assured by the group's progress.
- LW drew attention to slide 9 and the importance of partnership working in terms of the safeguarding agenda and the work the Quality Assurance Sub-Group of which he was the Chair. The performance framework had been revised during the year and, while there was

more to do, it had clarified priority areas for response pointing towards greater partnership working and the concept of making safeguarding personal.

PW concluded by drawing attention to slide 29 and the Strategic Objectives for 2020/21. She assured the Governing Body that the Safeguarding function was concerned with, alert to and planning with partners for a potential surge in demand resulting from the Covid-19 lock down.

Comments and questions were invited.

- PW's assurance that plans were being made to deal with any post lockdown surge were welcomed.
- The report was recognised to be comprehensive providing the Governing Body with an overview of outcomes and achievements, required assurances, work at a regional level and priorities for the next 12 months.
- RM welcomed the filling of vacancies with the Safeguarding Team. PW confirmed that induction arrangements were being put in place for the appointees.
- In response to a question, PW confirmed that one of the key pressures for the team involved translating national guidance into local practice and putting in place arrangements to assess the implications of operationalising the changes. The changes to the Deprivation of Liberty Safeguards were given as an example. She confirmed that risks would appear in the CCG's Corporate Risk Register with mitigations discussed at a Senior Management Team (SMT) level.
- IB reflected positively on the strength of the local safeguarding partnership and safeguarding boards.

DECISION:

The Governing Body:

1. **RECEIVED** the report;
2. **NOTED** its contents;
3. **CONFIRMED** that it is assured that the CCG was fulfilling its responsibilities as a statutory partner in safeguarding work and activity.

42/20 PUBLIC SECTOR EQUALITY REPORT 2020

PW presented the Public Sector Equality Duty Report 2020 which had been published at the end of March 2020 following approval by QFPC under delegated authority from the Governing Body. The reports submission to Governing Body had been delayed due to Covid-19. It was felt that the discussion of the report was particularly relevant due to the equalities issues that had emerged during the response to Covid-19. Attention was drawn to the following.

- The report was provided in a new, more concise format with links to further sources of information.
- It set out information concerning the duties the CCG was required to follow.
- That a better understanding of equalities issues supported better commissioning decisions.
- The examples of activity undertaken to deliver equalities objectives.
- That the number examples submitted by providers which had increased year on year. This was significant in terms of their meeting the equalities duties.
- The next steps set out in the report had been written Pre-Covid. These would now require some reflection and amendment based on the learning that had emerged in terms of its impact on the BAME communities.

Comments and questions were invited

- PR welcomed the report and noted the huge amount of work that had taken place. He suggested the work published by CIPD (Chartered Institute of Personnel and Development) might be used to help support the CCG's planning following the onset of Covid-19. PW recognised the importance of maximising the available resources and ensuring that the CCG had the right connections.

DECISION:

The Governing Body **RECEIVED** the report for assurance following its approval by the Quality, Finance and Performance Committee on 20 March 2020.

43/20 PATIENT AND PUBLIC ANNUAL STATEMENT OF INVOLVEMENT 2019/20

PW presented the Patient and Public Annual Statement of Involvement 2019/20 for approval. The report provided a summary of all the engagement activity undertaken by the CCG during the year including some that undertaken by the CCG's partners. It also provided details of CCG's planned activity for 2020/21. Attention was drawn to the following:

- The key themes that had emerged during the year and previous five years of CCG engagement at p13. Commissioning managers were asked to take account of when looking to commission new services.
- The structure of the report: who did we engage with; what did they tell us; what did we do; where can you find out more.
- Progress updates on previous engagement and consultation activity at p79.

JD was welcomed to the meeting. She drew attention to the following:

- The key role of the Engagement Champions and networks in delivering engagement activity in Calderdale and the contribution of partners to the report.
- The development of a new system wide engagement strategy during the year in partnership with the Local Authority, Voluntary Sector and Health Watch. The strategy would build on existing mechanisms, assets and resources and aimed to strengthen existing approaches to communication, engagement and co-production.
- The work undertaken with the Local Authority to reach Young People concerning their experience of using GP services including those who identify as LGBTQ. Following the engagement practices reviewed recommendations to identify potential improvements to services.

PW concluded by drawing attention to planned work in 2020/21 at p88. While the new system wide engagement strategy had not yet been approved through local governance arrangements the CCG was already working to the principles therein with key partners. The integration/alignment agenda would allow greater collective consideration of how to make best use of existing communications colleague and networks.

Comments and questions were invited.

- There was a request that the planned work for 2020/21 include consideration of how patients are responding to revised access challenges. This was agreed. **PW**
- PW invited AM to speak to JD concerning updates to activity in March and April.
- There was recognition of the excellent partnership working and stakeholder engagement, including work with hard to reach groups and sensitive groups, co-production and facilitation.
- The importance of the CCG and partners engaging with hard to reach groups concerning

their experience during the response to Covid-19 was recognised as being very important for future planning of services.

- In response to question concerning how the outcomes of engagement or consultation activities was fed back, PW confirmed that information was provided to those individuals and groups that had been involved and the team also maintained a "You said. We did" page on the website. Further work was taking place on making the information more accessible and suggestions were welcomed.
- PW proposed that an addendum to the Planned Work for 2020/21 be added following the meeting concerning the CCG's intentions around exploring people's experiences during Covid-19. The Governing Body agreed and asked that AM sign off the addition on behalf of the Governing Body. **PW**
- NS suggested that in terms of the key areas of work for 2020/21, the CCG needed to ensure that commissioning managers provide feedback on how the engagement and consultation activities shaped the final commissioned service. Moreover, that this needed to be better reflected in reports coming through for decision.

DECISION:

The Governing Body **APPROVED** the annual statement of involvement as an accurate account of engagement activity during the period so the report could be published subject to AM's agreement of an addendum to the Planned Work for 2020/21.

44/20 WORKFORCE REPORT

JMc presented the Workforce Report for the period 1 April 2019 to 31 March 2020 including workforce data for the period 1 April to June 2020 with an emphasis on Covid related activity. Attention was drawn to the following:

- Over the 2019/20 financial year and first three months of 2020/21 sickness rates had fallen overall, particularly during the first quarter of 2020/21. Other West Yorkshire CCGs and other NECS supported CCGs in the North East had also seen a similar reductions. While the reasons for this was not clear, the increased flexibility in terms of working patterns was noted as a possible factor.
- The Employee Assistance Programme commissioned by the CCG had been recommissioned for a further 12 months.
- The CCG had signed up to the BAME Network Action plan as part of the ICS. The intention was to bring the CCG's response together into its existing Workforce Race Equality Strategy (WRES) which would go to SMT in August.
- There was very little workforce relations activity. One formal case had been successfully defended at tribunal.
- The national NHS staff survey results had been received in February. The onset on Covid-19 had delayed subsequent action planning in response to the results. The CCG's Organisational Development Manager would be working with SMT on developing an action plan.
- Planning was underway for the annual flu vaccinations programme. A combined approach of onsite and voucher/reimbursement schemes would be taken.
- The CCG had continued to make use of its existing mechanisms for communication and engagement with staff over the last three months as part of supporting staff well-being.
- The CCG had received significant support as an employer following the onset of Covid-19 from NECS Guidance and communications to managers had been developed throughout as well those directed at staff concerning working from home.
- The CCG HR Associate had supported the development of a Memorandum of Understanding (MOU) to facilitate the redeployment of staff in Calderdale and elsewhere around the region.
- Risk assessments for all the CCG's BAME staff had been completed. All staff were working from home and there was no increased risk which needed to mitigated. The CCG was now undertake individual risks assessments for all staff which would be completed by mid-August.

Comments and questions were invited

- NS recognised the improved level of support that the CCG had received from NECS since becoming the CCG's HR provider. Two areas of focus for the CCG that had been discussed included: the development of the CCG's organisational development plan through its appraisals process and delivery of additional training concerning unconscious bias.
- JM recognised that staff absence and turnover was low but asked that, if there was a change in these numbers, the Governing Body be assured that the return to work interviews and exit interview were take place and made aware of any emerging issues.
- In response to a question, NS confirmed that the CCG had been clear with staff about the need to continue to take leave for their well-being. JMc added that an assessment of the CCG's position would be undertaken over the next two months. The Government has introduced legislation allowing leave to be carried for two years. She suggested this would be postponing the inevitable and NECS would be exploring other options for recommendation to SMT.
- In response to the workforce relations matter reported, JM suggested that the Governing Body should be equipped with a reactive statement regarding such matters in the future.
- JMc confirmed that appraisal completion rate will be included in future reports. NS confirmed that the appraisals process had been suspended earlier in the year due to Covid-19 but these had recommenced with a focus on staff development needs.
- The staff absence data for 2018/19 and 2019/20 were noted to be polar opposites. NS explained that, with the size of CCG's workforce made any variation look significant when it was in fact the absences of 1 or 2 people affecting the picture.

DECISION:

The Governing Body **RECEIVED** and **NOTED** the CCG Workforce Report.

45/20 PEFORMANCE REPORTS

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

LS presented the Chief Finance Officer's report. Attention was drawn to the following key points

Finance

- The CCG was continuing to operate under a temporary financial regime.
- The original financial allocations for 2020/21 had been suspended. For the first four months of the financial year, the CCG had received £111.8m which was based on 2019/20 spending plus an inflationary uplift. This was £4m less than what would have anticipated under the normal regime. A process for claiming additional Covid-19 related costs was in place. The budget for the period April-July at 1.2 had been supported by the QFPC at its meeting in June 2020.
- Performance against the budget was set out at 1.3. There was a forecast £2.7 overspend compared to the allocation. The most significant costs were against the CCG's programme budget but also running costs and delegated primary care budgets.
- Following the month 2 submission, NHS England (NHSE) had provided the CCG with £1.3m leaving a £1.6m forecast overspend. Similar cost pressure reviews and award of adjustments were anticipated in the future. NHSE was working under the assumption that the CCG would break even by the end of the financial year. The principle pressures were in primary care, prescribing, Better Care Fund (BCF), and the CCG reserves.
- Covid-19 costs incurred to date were set out at 2.4. Costs were just short of £2.4m to date.
- Additional planning guidance was anticipated. The existing guidance from NHSE and NHS Improvement (NHSI) expired from the end of July. The CCG was currently working on the basis that the existing arrangements would role forward.

Contracting

- The principle impact of Covid-19 in relation to contracting was around the NHS Trust block payments arrangements. Nationally payment-by-results (PBR) had been suspended and block payments calculated for the first quarter of the year. This provided Trusts with a guaranteed income from CCGs with any additional costs being supplied directed by NHSE.
- Independent sector capacity was being procured nationally. As such the VCG was not currently contracting or commissioning independent sector capacity. Plans were in place as to how the capacity would be used as part of the re-set programme.
- Guidance was also in place for non-NHS , non-acute capacity. The issue for the CCG was ensuring there was sufficient capacity for the rest of its commissioning activities, including home and domiciliary care. Measures mirroring Local Authority arrangements had been put in place.

Performance

- The CCG continued to perform well in terms of A&E target performance (upper quartile, 94.8%).
- A great deal of work was taking place around planned care and diagnostics to establish how the backlog would be addressed and what a sustainable plan would look like. The CCG continued to perform well on cancer waiting times.

Comments and questions were invited

- The receipt of an adjustment from NHSE was welcomed.
- In response to a question, LS confirmed that NHSE had set some parameters regarding the timeframe within which retrospective allocations for Covid costs would be issued. Some audit capacity was being commissioned centrally and it was expected that CCG claims would be reviewed at a point in the future. As an internal process was in place to consider the reasonable of the submissions in anticipation of this.
- In response to a suggestion, LS confirmed that Internal Audit had been asked to look at benchmarking Covid related expenditure. It was agreed that the annual audit of financial systems would include a review of the additional costs. It was agreed that if the available benchmarking data showed the CCG as an outlier that further consideration be given to the matter. **LS**

DECISION:

The Governing Body **RECEIVED** the report **NOTING**:

- the new temporary financial regime for the period April 2020-July 2020.
- the forecast overspend for the period April-July 2020.
- new planning guidance due for the period August 2020 – March 2021.
- the Supplier Relief guidance
- the progress being made towards achieving the standards set out in the NHS Constitution.

b) Quality and Safety Report

PW presented the Quality and Safety Report. The routine quality dashboard continued to be suspended but was in the process of being reintroduced. Attention was drawn to the following key points:

- **Covid 19** – Rapid Impact Assessments (RIA) had been introduced for any new services that were being commissioning or varying. A review was built into the process and weekly reports were being received by SMT. Staff were considering opportunities where a more simplified screening tool could continue to be used in the future. The QFCC would be

asked to consider proposals in this regard in the future.

- **Care Quality Commission (CQC) Emergency Support Framework** - CQC routine inspections had been suspended due to Covid-19. It had published an Emergency Support Framework which detailed how it would operate for the next period. PW intended to ask that colleagues maintain contact with local inspection managers. The CQC were prioritising testing board assurance framework for infection prevention and control with hospitals and mental health providers. PW assured the Governing Body that the CCG was aware of all of its providers' position on this issue.
- **Infection Prevention and Control** – Section 10 was noted to set out what had been required of CCG's in terms of supporting training for local care home staff. Mobilisation of was noted to have been significant challenge. All care homes had received an offer of support, there had been a high uptake and there was an ongoing prevention plan in place.
- **Principles to deliver an Enhanced Universal Support Offer to Care Homes** – The principles developed to support the sector were provided at Appendix 1. The local Care Home Programme Board was considering how the impact of interventions would be assessed as well as participating in some evaluation at a regional level.

Comments and questions were invited

- IB recognised the challenge that delivery of the Infection Control Training had presented and the amount of work that had taken place. He thought Calderdale was particularly well placed to deliver due to the good local working relationships already in place.

DECISION:

The Governing Body:

1. **RECEIVED** the update on the following routine quality and safety information:

    - Local Care Direct Care Quality Commission inspection publication
    - Provider Quality Accounts

2. **RECEIVED** and **NOTED** the update on the work being undertaken by the Quality Team to ensure the quality and safety of our provider organisations continue to be reviewed and monitored during the Covid-19 Pandemic.

46/20 RE-APPOINTMENTS TO THE GOVERNING BODY

AOC presented a report concerning the recommendation arising from the meeting of the Remuneration and Nomination Committee on 23 February 2020 that Dr Caroline Taylor be reappointed the Governing Body for a third three year term of office. Dr Taylor's second term of office would come to an end on the 2 November 2020.

At the time of the committee's meeting, there had been no existing eligible candidates that had previously met the required standard through assessment to be invited to stand in an election and this continued to be the case. The options that had been available to the committee were to recommend reappointment or seek expressions of interest from the CCG membership. In recommending the former, the committee had considered the requirements of the CCG's constitution and available relevant health service guidance concerning matters of tenure, in particular, the importance of regularly and progressively refreshing board memberships; the principle any member appointed through election should regularly be reconfirmed through that process; and that a decision to reappoint beyond 6 years be carefully considered and justified. The rationale for the committee's recommendation was related as set out at 2.4.

Comments and questions were invited:

- JM confirmed that the paper was reflective of the committee's discussions. He clarified that, while there were no existing eligible candidates, who had already achieved the required standard through assessment as part of earlier recruitment exercises, to be considered, there may be suitable candidates should the CCG choose to seek expressions of interest. The CCG had last sought expressions of interest 2018. He explained that the key issue underlying the committee's recommendation was its recognition of the implications for the Governing Body and CCG of the decision to reduce the number of GP Governing Body Members from 7 to 4 from 1 April 2020. Specifically he committee felt that the change meant the Governing Body needed to retain experience and continuity of knowledge at a leadership level at this point in time. He emphasised that the recommendation was not intending to set a precedent but was responding to circumstance.
- Should the recommendation be agreed, NS advised the Governing Body that it should ensure that consideration is given in advance of the end of Dr Taylor's the third term in order to ensure that good governance practices are being taken into account. JM responded that good governance practice in terms of tenure indicated 2 terms plus 1 by exception, and that this recommendation should be understood as being "by exception".

DECISION:

1. The Governing Body **APPROVED** the reappointment of Dr Caroline Taylor to the Governing Body for a third three year term of office.

47/20 HEALTH AND SAFETY POLICY AND FIRE SAFETY POLICY

RG presented the Health and Safety and Fire Safety Policies for approval following review. There were no significant changes. The formatting of the documents had been brought in line with the corporate standard. Changes had also been made to reflect the post pf Head of Corporate Affairs and Governance no longer being part of the organisational structure.

Comments and questions were invited.

- It was suggested that assurance regarding the structural fire safety of the building be sought from the landlord. RG confirmed that the CCG had plans of the building showing fire safety features. Also, that he maintained and annually reviewed a fire risk assessment for the building first developed by NHS Property Service and was assured of the structural safety of the building. It was agreed that this needed to be reflected in the policy. **RG**

DECISION:

The Governing Body **APPROVED** the Health and Safety Policy and Fire Safety Policy, subject to the agreed amendment.

48/20 GOVERNING BODY ASSURANCE FRAMEWORK – UPDATE

RG presented the Governing Body Assurance Framework (GBAF) to the Governing Body following its six month review. Receipt of the report had been deferred from the April 2020 meeting due to Covid-19. The amendments to the GBAF and GBAF action plan were set out at Appendix 1. A root and branch review of the GBAF would take place during the Autumn.

Comments and questions were invited.

DECISION:

The Governing Body **CONFIRMED** that the GBAF provided sufficient **ASSURANCE** that:

1. The strategic objectives of the CCG were accurate;
2. The principal risks to the achievement of those objectives were identified;
3. The controls in place to mitigate or manage those risks were identified.

49/20 HIGH LEVEL RISK LOG AND REPORT - RISK CYCLE 2 2019-20

RG presented the High Level Risk Log and Report for Risk Cycle 2 2019-20. The following key points were highlighted:

- There were 2 critical risks (1493 and 62) on the register (scoring 20).
- Critical risk reports for the two critical risks had been provided at Appendix 2.
- With regard to critical risk 1493 (delays in transfer of care), QFPC had discussed whether this should continue as a critical risk when CHFT had reported lower activity levels. RG confirmed that this remained a high level risk to the system should demand return to a pre-Covid levels.
- There were 8 serious risks (scoring 15-16) on the register, 2 of which were new (1557 and 1558) as detailed at section 2.8 in the report.

Comments and questions were invited.

- JM confirmed the report was reflective of the position at the end of June 2020 and the discussions at QFPC.
- It was noted that risks to the organisation and within the system were subject to regular change at the present time and it was important for the Governing Body to maintain oversight of those changes.

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 2 of 2020-21. This was following a review of the risks at the combined Quality, Finance and Performance Committee meeting on 25 June 2020.

50/20 COMMITTEES

a) Audit Committee Annual Report

PR presented the Audit Committee Annual Report to the Governing Body for its assurance inviting comments and questions.

DECISION:

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

b) Minutes

i. Audit Committee held on 27 February 2020

DECISION:

The Governing Body **RECEIVED** the minutes of the Audit Committee meeting held on 27 February 2020.

ii. Auditor Panel held on (a) 20 February 2020 and (b) 14 May 2020

PR reported that, having gone through a robust procurement process in accordance with the CCG's usual procurement rules, the Auditor Panel had determined to appoint Grant Thornton Ltd to provide the CCG's external audit service. There had been no challenge and the appointment had been confirmed.

DECISION:

The Governing Body **RECEIVED** the minutes of the Auditor Panel meeting held on 20 February 2020 and 14 May 2020..

iii. Quality, Finance and Performance Committee held on 26 March 2020

DECISION:

The Governing Body **RECEIVED** the minutes of the Quality, Finance and Performance Committee meeting held on 26 March 2020.

iv. Commissioning Primary Medical Services Committee Decision Notice

A single decision had been made virtually by email.

DECISION:

The Governing Body **RECEIVED** the decision notice of the Commissioning Primary Medical Services Committee.

51/20 EXTERNAL MEETINGS

a) Minutes of the West Yorkshire and Harrogate Joint Committee of CCGs meeting held on 14 January 2020.

Comments and questions were invited

DECISION:

The Governing Body **RECEIVED** the minutes of the meeting of the West Yorkshire and Harrogate Joint Committee of CCGs held on 14 January 2020.

b) West Yorkshire and Harrogate Joint Committee of CCGs Annual Report 2019/20

DECISION:

The Governing Body **RECEIVED** the 2019/20 Annual Report of West Yorkshire and Harrogate Joint Committee of CCGs.

52/20 KEY MESSAGES FOR MEMBER PRACTICES

DECISION:

The Governing Body **AGREED** the flowing key messages for member practices:

- Re-appointment of Dr Caroline Taylor — Comms

53/20 DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

The Governing Body **NOTED** that the next meeting would take place as follows:

Governing Body Meeting
Thursday 22 October 2020,
2.00pm
Via Video Conference

Governing Body Meeting – 23 July 2020 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
CHIEF OFFICER'S REPORT	77/19	▪ Andy's Man Club to be the subject of a future Patient Story.	PW	Ongoing	Contact has been made. Discussions ongoing. (Update to GB on 23.01.20)
PATIENT AND PUBLIC ANNUAL STATEMENT OF INVOLVEMENT 2019/20	**43/20**	▪ Planned work for 2020/21 to include consideration of how patients are responding to revised access challenges. This was agreed.	PW	COMPLETE	Added to plan of work for 2020/21 (19/08/2020)
PATIENT AND PUBLIC ANNUAL STATEMENT OF INVOLVEMENT 2019/20	**43/20**	▪ An addendum to the Planned Work for 2020/21 be added following the meeting concerning intentions around exploring people's experiences during Covid 19. The Governing Body agreed and asked that AM sign off the addition on behalf of the Governing Body.	PW	COMPLETE	Addendum agreed. Statement published. (19/08/2020)
CHIEF FINANCE OFFICER'S REPORT	**45/20**	▪ Annual audit of financial systems to include Covid related costs.	LS	COMPLETE	Action has been picked and built into plans. (01/08/2020)

HEALTH AND SAFETY POLICY AND FIRE SAFETY POLICY	**47/20**	▪ Fire policy to be amended to include assurance regarding the structural fire safety of the building be sought from the landlord	RG	COMPLETE	Policy amendment made and uploaded to the website. (02/09/2020)
KEY MESSAGES FOR MEMBER PRACTICES	**52/20**	▪ Re-Appointment of Dr Caroline Taylor	Comms	COMPLETE	Published on member Connect (23/07/2020)

Item 4b

NHS Calderdale Clinical Commissioning Group

NHS Calderdale CCG Annual General Meeting
held on Thursday 23 July 2019 at 6.00pm
via Video Conference

DRAFT MINUTES

Present	Dr Steven Cleasby	SC	Chair, GP Member
	Neil Smurthwaite	NS	Interim Accountable Officer
	John Mallalieu	JM	Deputy Chair, Lay Member (Finance and Performance)
	Lesley Stokey	LS	Interim Chief Finance Officer
	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 Peter Roberts	PR	Lay Member (Audit)
In attendance	Denise Cheng-Carter	DCC	Lay Advisor
	Iain Baines	IB	Director of Adult Services, Calderdale Metropolitan Borough Council
	Andrew O'Connor	AOC	Senior Corporate Governance Officer (Minutes)
			The meeting was also observed CCG Member practice representatives, partners and the public via an online stream.

54/20 WELCOME **Action**

SC welcomed those in attendance to the CCG's Annual General Meeting which was taking place virtually due to COVID-19. The impact of the pandemic on the work of the CCG and on people's physical, emotional and spiritual wellbeing across Calderdale was recognised, as was the strength and sprit of the local response. CCG, voluntary sector and public service staff and members of local communities were thanked for everything they had done in the preceding months.

Alison MacDonald (Lay Member, Patient and Public Involvement), Denise Cheng-Carter (Lay Advisor), and Professor Peter Roberts (Lay Member and Chair of the Audit Committee) had joined the Governing Body during the year as had Deborah Harkin (Director of Public Health, Calderdale Metropolitan Borough Council) who had joined the Governing Body as one its advisors.

Dr Helen Davies and Dr Majid Azeb had stepped down from the Governing Body from the 31 March 2020 but were continuing to work with the CCG in Associate roles supporting the CCG's community and primary care programmes respectively.

Further departures from the Governing Body in-year included

- Matt Walsh, former CCG Accountable Officer
- Paul Butcher, former Director of Public Health, CMBC, Governing Body Advisor
- Kate Smyth, Lay Member, Patient and Public Involvement

• David Longstaff, CCG Deputy-Chair and Lay Member, Audit

Everyone who had left was thanked for their contributions to the CCG and Governing Body.

The CCG's Interim Chief Officer, Neil Smurthwaite, was thanked for their work guiding the CCG through a period of leadership transition and through the challenges of the preceding months.

55/20 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

56/20 PRESENTATION OF THE CCG ANNUAL REPORT 2019/20

NS presented the CCG' Annual Report drawing attention to the following.

Primary Care

Calderdale's five Primary Care Networks (PCNs), established in 2019, were explained to be the vehicle via which local primary care was being delivered. Building on existing care services, the networks were helping to develop more proactive, personalised, coordinated approaches to health and social care with the aim of bringing about a change from reactively providing appointments to proactively caring for the people and communities they serve through the use of population health data.

The PCN system was explained sits in line with the wider aims of Calderdale Cares, a partnership approach with the aim of:

- Improving health outcomes
- Reducing health inequalities
- Encouraging greater independence
- Lowering the need for hospital based care

Within each of the five PCNs care was being brought closer to home by improving access at a locality level . In the past year this had included:

- putting the right staff in the right setting and co-ordinating services;
- making more services available closer to home, through a single point of contact;
- increasing GP capacity, improving access to services and reducing waiting times;
- improving communication, information and signposting and to other places people can get help;
- developing workforces that represent the communities they serve.

Right Care, Right Time, Right Place

Work on the reconfiguration of hospital services in Calderdale and Greater Huddersfield had continued during the year. The proposals would improve and achieve financial sustainability. The Strategic Outline Case for capital expenditure of £196.5 million was submitted by the Calderdale and Huddersfield NHS Foundation Trust (CHFT) to NHS England (NHSE) and NHS Improvement (NHSI) in April 2019 and approved in November 2019. Significant public, stakeholder and clinical engagement had taken place since 2012, and were continuing to ensure local people; key stakeholders and the Joint Health Scrutiny Committees were involved in the next steps. During 2019, members of the public and colleagues were involved in the

development of a Design Brief which would inform the development of future detailed design and construction schemes at both Huddersfield Royal Infirmary and Calderdale Royal Hospital.

Initiative and Success Stories 2019/20

Several initiatives which had been of particular significance were highlighted and shared from the content of Annual Report:

- The 'Lets Get a Grip' antibiotic campaign
- The Open Minds Partnership
- The Find Your Brave Calderdale Children and Young People's ASD Summit 2020
- The Calderdale and Kirklees Wheelchair Service
- Supported living flats

Further information concerning these is available in the CCG published Annual Report.

Beyond our border

The CCG has been involved in a great deal of work across the area covered by CHFT.

A major success was the improvements made in the timeliness of Cancer Treatment. Improvements in delivering primary care services had impacted positively on GP referrals for cancer screening. As a result, The CCG had been recognised as a high performing system by the West Yorkshire & Harrogate (WY&H) Cancer Alliance.

The CCG had also continued to show its influence on a regional scale, and remained a major player in the WY&H Health and Care Partnership, embracing regional projects for the benefit of local people, including:

- The Healthy Hearts improvement Project
- West Yorkshire and Harrogate policy for cataract surgery
- West Yorkshire and Harrogate 'Looking out for our neighbours' campaign
- 'Do once and share' approach

Looking after our people

A major priority for the CCG concerned taking care of its staff. The CCG's Staff Forum had continued to promote and lead a wide range of activities to support the physical, social and psychological wellbeing of all staff. Highlights from the past year included:

- Over £199 raised through the year for local and national charities - Andy's Man Club and the British Heart Foundation;
- Promoting local, regional and national health campaigns
- Encouraging staff to take their weekly Wellbeing Half Hour – time out during their working week to focus on a mental or physical wellbeing activity;
- Taking steps to promote sustainability – including supporting the national 'Clean Air Day';
- Maintaining positive relationships with each other through the always popular monthly "coffee, cake and catch-up" sessions and our new Garden 'Swap Shops'.

CCG staff were thanked for their dedication and hard work.

Looking forward

NS concluded his presentation by addressing the CCG's responsibility, as a spender of public funds, to work in way that had a positive effect on local people's lives and

supports the creation of healthy and resilient communities. Attention was drawn to the sustainability section of the Annual Report and how the CCG discharged this responsibility. Attention was also drawn to the changes in working practice and communications driven by the requirements of the response to COVID-19 which had the potential to deliver more effective and accessible service along with positive environmental impacts now and in the future.

57/20 PRESENTATION OF THE CCG ANNUAL ACCOUNTS 2019/20

LS presented the Annual Accounts for 2019/20 drawing attention to the following:

- The CCG had delivered its financial plan and its statutory financial duties including increasing its in year surplus by £1,017,000. This was a significant achievement as the CCG had a challenging plan to deliver savings and a break even position as well as having committed to making investments in mental health and posture and mobility services.
- How the CCG had spent it £337.2m budget including an analysis of its main area of spending on acute services (£168m)
- Financial plans for 2020/21. Initial spending plans had been submitted in January 2020 had been suspended and the NHS was operating under a temporary financial regime. Further guidance was awaited from August 2020 onwards.

58/20 PRESENTATION OF THE CCG ANNUAL STATEMENT OF INVOLVEMENT

PW presented the CCG's Annual Statement of Involvement explaining that it:

- Highlighted key engagement activities
- Demonstrated the CCG's commitment to patient and public involvement engagement
- Provided assurance concerning legal and statutory requirements
- Demonstrated the involvement of a diverse range of people
- Demonstrated partnership working
- Provided an opportunity to look back at the progress made on previous engagement and consultation that took place between 2016/18

She then went on to highlight and share the following:

- The CCG had involved just over 2,000 local people in the year 2019/20 and the emerging themes would be taken forward to drive all future work.
- The 35 pieces of engagement activity undertaken by the CCG and partners reported on in the report.
- The inclusion in the report of updates on engagement activities previously undertaken by the CCG and its partners between 2016 and 2018 including engagements on autism services and Right Care, Right Time, Right Place.
- Future areas of work including Hospital services; Primary care engagement and consultation; Primary Care Networks (PCNs) and localities; Equality Objectives 2020/21; Community Services and the West Yorkshire and Harrogate Health and Care Partnership.
- Opportunities for local people to become involved in the CCG's engagement work. More information can be found at calderdaleccg.nhs.uk/get involved.

59/20 CONCLUSION OF THE MEETING

SC thanked everyone who contributed to the Annual General meeting and those members of public and partners who had watched the live stream on the internet for their attendance and support.

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Accountable Officer's Report**	**Agenda Item No.**	5
Report Author	Neil Smurthwaite, Interim Accountable Officer	**Public / Private Item**	Public
GB / Clinical Lead	-	**Responsible Officer**	Neil Smurthwaite, Interim 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**		**Meeting Date**				
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body **RECEIVES** and **NOTES** the content of the report.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

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	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risks**	None identified.
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 As we enter the autumn with winter sneaking up on us we are continuing in a period of unknown. New levels of COVID restrictions have been implemented, as we are starting to see the rise in the number of both positive cases and hospital admissions. As a place we continue to show great partnership working as pressures mount and through the annual winter preparedness work we are as ready as we can be.

2.0 Covid Updates

Elective Reset (Lead Manager; Debbie Graham, Lead Clinician; Steven Cleasby)

- Work continues at pace on the safe reset of elective activity, which is being led by clinicians at Calderdale and Huddersfield NHS Foundation Trust (CHFT), Steven Cleasby and Steve Ollerton. The focus is primarily on: referral support systems, reviewing patients waiting for a first appointment, and communicating and supporting patients awaiting follow-up appointments.

WY Transformation Programme (Lead Manager; Debbie Graham)

- The CCG has established a process to ensure connectivity between the West Yorkshire programmes and the CCG. An exception report will be completed monthly to understand progress against each of the programmes, and to identify any areas of risk or lack of visibility.

Open Minds Partnership (Lead Manager; Rhona Radley, Lead Clinician; Caroline Taylor)

- The next meeting of the Wider Open Minds Partnership takes place on 20th October 2020. This brings together the Local Authority's Emotional Health and Wellbeing Taskforce, and Open Minds core mental health partners (commissioners and providers). This wider cooperative of local authority, NHS, education, voluntary and third sector organisations aims to foster a stronger partnership approach to delivering improvements in emotional health and wellbeing services for children and young people. Meeting quarterly, the combined group will meet digitally to focus on the impact of COVID on children and young people (CYP) returning fully to education, the delivery of the NHS Long Term Plan CYP mental health commitments and the remaining areas for improvement from the Calderdale Local Transformation Plan.

- The Autism Spectrum Disorder (ASD) Steering Group has continued to meet during the COVID-19 pandemic. The group has carried out an in-depth review of progress to date on 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 (building on ways of working established through the Open Minds Partnership), involve children, young people and their families in shaping the group's actions and provide support at the earliest opportunity regardless of whether a diagnosis has been made.

Covid Testing (Lead Manager; Rhona Radley)

- The satellite testing centre at King Cross currently offers COVID-19 antigen testing for essential workers (and members of their household) who are symptomatic. This is an appointment only service and it operates on Monday afternoons, Wednesday all day & Friday afternoons. This has proved a valuable service for essential workers and has been

able to respond swiftly to local need and supported front line staff returning to work as fast as possible.

- We are continuing to provide a proactive approach to test asymptomatic care home staff/residents (not on the national testing scheme) and GP practice staff through a drop and collect approach on a fortnightly basis (approximately 700 tests per week).

- In addition to the satellite testing site at King Cross, we also have a number of mobile testing units (MTUs) deployed across the borough; Mixenden, Todmorden and Copley. We also have a local test site operational at Asda in Pellon which operates from 8-8pm, 7 days a week. It is expected that this will be available until the New Year.

- NHS Test and Trace was introduced in June 2020 and is a key role in containing future outbreaks of COVID-19 and our Calderdale Outbreak Prevention and Control Plan outlines the steps our public health teams and partners are taking in Calderdale to prevent, and contain, local outbreaks of COVID-19. Local outbreaks are currently being managed through existing arrangements via the local infection prevention and control teams, with good relationships already in place with Public Health England.

- In terms of antibody testing, again a process is being rolled out to hospital and practice staff in Calderdale. This was firstly introduced to general practice and from the beginning of August will be further rolled out to 4,000 Care Home staff across Calderdale and Huddersfield

General Practice Update

- From 1st October 2020 all Calderdale GP practices are now offering face to face appointments where clinically required, at one or more of their sites. This means patients will be seen at their normal practice buildings where required, following a clinical assessment. Greater use of remote and digital options for appointments will continue, to protect both patients and staff, however it is clear that further work needs to be done by, and with, GP practices to understand where reasonable adjustments need to be made.

- Calderdale CCG and the Local Medical Committee recently agreed Principles for General Practice: Third Phase Response to COVID. These principles recognised the need for general practice to provide patient-centred care, ensure accessibility for all and to reduce the inequalities that have widened during the first phase of COVID-19. These principles reflect the feedback we are hearing about GP services, and patient access models and methods for securing appointments within individual practices must be in line with these principles.

- In each of the five Primary Care Networks in Calderdale, work is ongoing to understand how best to meet the needs of the communities they serve. Although in its infancy, this approach together with close collaboration with our Local Authority colleagues who have established relationships within communities to share public health messaging and improve health outcomes, will ensure that access meets the needs of the population they serve. The development of the patient and community voice is key to this, so that we may understand how we ensure services are accessible, and meet and improve health needs.

- In all this communication is key. A GP communication group has been established and will work to develop multi-language and multimedia messaging around updates to general practice services. This programme of communication began with the clear messaging to the public that General Practice remains open, and to inform people that face-to-face GP appointments are available at their own GP practice, where there is a clinical need. GP practices have also been provided a communications toolkit to assist with spreading the

messages and updates at a practice level. Work is underway to ensure that practice websites are clear and simple for patients to use the online options to receive care, where appropriate and to clearly explain how services are working.

3.0 Governing Body Assurance Framework (GBAF)

The Governing Body needs to be assured that the principal risks to delivering its strategic objectives are captured and that there are sufficient controls in place to mitigate against these risks materialising or manage those risks. These principal risks are set out in the GBAF which is reviewed on a six monthly basis. In March 2020 it was intended for the GBAF to have a full systematic review undertaken including a discussion on appropriateness of the current strategic objectives. This discussion was to be led by Internal Audit during the Governing Body Workshop on 2 April. Due to COVID-19 this was postponed. The next six monthly review of principal risks was due to take place in September 2020 with the framework being presented for assurance at the Governing Body meeting on 22 October 2020 however the discussion on strategic objectives planned for 2 April took place at the workshop on 1 October replacing the six monthly principal risk review.

4.0 Flu Vaccination Programme 2020

In light of flu and COVID-19 co-circulating this winter the flu programme is more vital than ever. Providers are asked to focus on achieving maximum uptake of the flu vaccine in existing eligible groups.

West Yorkshire and Harrogate Integrated Care System (WY&H ICS) have established a Flu Board which is receiving bi-weekly updates from CCGs on their flu plans.

The national aspiration is to deliver 75% uptake of flu vaccination to all existing patient cohorts:

a) Over 65 year olds
b) At risk under 65
c) Pregnant women
d) Pre-school children aged 2 and 3
e) School children reception to year 7

As part of the wider planning for winter this season flu vaccination will be additionally offered to:

- Health and social care workers employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as personal assistants, to deliver domiciliary care to patients and service users

- Household contacts of people on the NHS shielded patient list will be offered the vaccine opportunistically, with the aim to offer to all identified

Frontline health and social care workers should be offered a vaccine this year - target 100% offer.

The following actions have been undertaken from a Calderdale wide response to the programme:

- The setting up a local flu group to share good practice and identify concerns around delivery of the flu campaign to aid plans for mitigating risks and improve system

understanding. The group has met 3 times since August and has representation from GP practices, community nursing, school immunisation team, midwifery, public health team from Calderdale MBC, community pharmacy, PHE Screening and Immunisation Team. Calderdale CCG is represented by the Flu Lead, Medicines Optimisation Team, Quality team and the Communications Team.

- Work is being done with the local authority street engagement team and neighbourhood teams in areas of high BAME population and where there are wider health inequalities e.g. North Halifax.

- Calderdale practices have been asked to share their flu plans with the CCG. About half of practices have provided an overview of their plans which includes provision of additional flu clinic dates than previous years.

- The Local Medical Committee (LMC) and Community Pharmacy West Yorkshire have issued a joint statement to practices and pharmacies encouraging collaborative working between both providers to deliver a successful flu campaign. This may include signposting to each other where vaccines supplies are low or using prescription messages promoting vaccination for harder to reach cohorts such as the at risk under 65s.

- The CCG is maintaining a live flu plan for the Calderdale system which is used to track progress on delivery and record risks as they are identified. This is used to update the WY&H ICS Flu Group.

- Calderdale CCG Senior Management Team receives a bi-weekly update on flu uptake using information from practices clinical system. This allows tracking of progress in delivery for each patient cohort

5.0 Right Care Right Time Right Place Update

The Calderdale and Kirklees Joint Health Scrutiny Committee met on 25th September to receive an update report on the reconfiguration timeline and programme of work for hospital services at Calderdale and Huddersfield NHS Foundation Trust. The report covered the progress made regarding public and colleague involvement in the development of the Design Brief for the estate investment at CRH and HRI, shared the key themes identified and outlined the next steps to continue to involve members of the public and colleagues in the development of the plans for service reconfiguration in Calderdale and Huddersfield. The report also provided an update on progress in developing community care provision including changes to access to the provision of primary and community care services as a result of the pandemic.
Link to report:
https://democracy.kirklees.gov.uk/documents/g6552/Public%20reports%20pack%2025th-Sep-2020%2013.30%20Calderdale%20and%20Kirklees%20Joint%20Health%20Scrutiny%20Committee.pdf?T=10

6.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

6.1 The Joint Committee met on 1st October 2020. The key decisions summary from the meeting was not available at the time of publication. It will be circulated as either a later update to the paper or between meetings of the Governing Body for its information.

7.0 Recommendations

7.1 It is recommended that the Governing Body **RECEIVES** and **NOTES** the content of the report.

Name of Meeting	Governing Body Meeting	**Meeting Date**	22/10/2020
Title of Report	**Healthwatch Calderdale Covid-19 Engagement report**	**Agenda Item No.**	6
Report Author	Jill Dufton, Senior Engagement Manager	**Public / Private Item**	Public
GB / Clinical Lead	Alison MacDonald, Patient and Public Involvement Lay Member	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary				
Please include a brief summary of the purpose of the report	Healthwatch Calderdale Covid-19 Engagement report 'health and care experiences of people living in Calderdale during Covid-19 outbreak'. The purpose of the engagement was to gather views, experiences and ideas from people living and working in Calderdale who have direct experiences of health and care services during these unprecedented times and the impact that Covid-19 may have had. The Healthwatch report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities, black and ethnic minority groups. The document also presents the views of health and care staff living and working in Calderdale Healthwatch Calderdale lead on the delivery of this report, whilst working in partnership with the CCG, Calderdale Council and voluntary and community organisations working across the area. The Healthwatch report has asked key health and care commissioners and providers to respond to a series of questions, to offer assurance about how this feedback is being considered by each organisation. The CCG recognises the importance of this report and would like to give assurance that we will act on the information and provide an organisation response to the report and apply the knowledge in the improvement of Calderdale's health and care services as we continue to work through these uncertain times together.			
Previous consideration	**Name of meeting**	Senior Operational Group	**Meeting Date**	14/09/2020
	Name of meeting	Senior Management Team	**Meeting Date**	13/10/2020
Recommendation (s)	It is recommended that the Governing Body: 1. **NOTE** and **CONSIDER** the Healthwatch engagement reports 2. **NOTE** the CCG response letter			

	3. **NOTE** that the response letter will be published on the CCG website once Healthwatch have received the formal response.						
Decision	☐	**Assurance**	☒	**Discussion**	☒	**Other**	Click here to enter text.

Implications	
Quality & Safety implications	The health and wellbeing of the people of Calderdale is at the centre of everything we do as an organisation, and we are fully committed to listening and taking into consideration the views of the people we serve. A key part of upholding our legal requirement is to ensure we have taken the time to consider all insight and feedback. We will ensure that the information presented in the report becomes an integral part of our existing quality assurance and quality improvement processes the CCG has in place with all providers. We will use the detail in the report in our scrutiny of service information submitted by our providers, and in analysing the quality metrics we receive to ensure that the quality of the services we commission meet the expectations of those using them.
Engagement & Equality implications	Along with our partners, Calderdale CCG are developing the Involving People Strategy, which will help us to work effectively with organisations across our area and work together to engage with people effectively and involve them in our work. The Healthwatch report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities, black and ethnic minority groups. The document also presents the views of health and care staff living and working in Calderdale. Despite this, we in the CCG recognise that further engagement is required to address the gaps in the report's findings, so that we can be confident that the range of health and care services available in Calderdale is accessible to, and representative of, all the people they serve. The health inequalities that impact our communities also impact our staff. We are committed to working in partnership with our providers, partner organisations, staff, public, patients and carers and by understanding and reflecting on all the responses received to the report we will ensure this work remains a priority for the CCG.

<table>
<tr><td colspan="2">Resources / Finance implications</td><td colspan="6">There are no financial implications</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</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>Section 242 Health and Social Care Act, NHS Constitution, Equality Act.</td><td colspan="3">Conflicts of Interest</td><td colspan="3">Any conflicts of interest arising from this report will be managed in line with the CCG Management of Conflicts of Interest Policy.</td></tr>
</table>

Healthwatch Calderdale Covid-19 Engagement report

1. Introduction

1. The purpose of the engagement was to gather views, experiences and ideas from people living and working in Calderdale who have had direct experiences of health and care services during these unprecedented times and the impact that covid-19 may have had.

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

3. We also needed to understand:
   - How people were accessing, gathering and using information about Covid-19 and the way health and care services are working
   - Where people are facing difficulties or barriers in accessing both routine and urgent care, and how these could be overcome

2. Detail

1. Healthwatch Calderdale lead on the delivery of this report, whilst working in partnership with the CCG, Calderdale Council and voluntary and community organisations working across the area.

2. The Healthwatch report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities, black and ethnic minority groups. The document also presents the views of health and care staff living and working in Calderdale

2.3 The Healthwatch report has asked key health and care commissioners and providers to respond to a series of questions, to offer assurance about how this feedback is being considered by each organisation.

2.4 The questions asked are below:
   - How will your organisation use the information in this report to make sure that services are more responsive, prepared and effective if Covid-19 remains a significant threat to public health or we experience a second wave of Covid-19 infections?
   - How will your organisation use this information to ensure that services meet the needs of local people whilst we live with Covid-19 in the recovery phase, including Covid-19 specific care and routine health and social care?
   - There is a real danger that the Covid-19 outbreak will significantly increase health inequalities, and there is evidence that this has already begun. How will your organisation use this information to ensure your services are designed to mitigate the risk of widening inequality by taking into account the ways in which some people will bear multiple impacts both in the short and long-term?
   - How will your organisation use this information to shape and mould ongoing delivery of your services?
   - As a result of listening to the feedback from the public, what will you stop, restart, let go, adopt & adapt?

2.5 The CCG recognises the importance of this report and would like to give assurance that we will act on the information and provide an organisation response to the report and apply the

knowledge in the improvement of Calderdale's health and care services as we continue to work through these uncertain times together.

3. Next Steps

3.1 The next steps will be:

- Acknowledge and receive the Healthwatch engagement report
- Ensure we take the time to consider all insight and feedback
- Formally respond to Healthwatch
- Work in partnership with our providers, partner organisations, staff, public, patients and carers to understand and reflect on all the responses received to the report
- Ensure this work remains a priority for the CCG

4. Implications

4.1 Quality & Safety Implications

4.1.1 The health and wellbeing of the people of Calderdale is at the centre of everything we do as an organisation, and we are fully committed to listening and taking into consideration the views of the people we serve. A key part of upholding our legal requirement is to ensure we have taken the time to consider all insight and feedback.

4.1.2 We will ensure that the information presented in the report becomes an integral part of our existing quality assurance and quality improvement processes the CCG has in place with all providers. We will use the detail in the report in our scrutiny of service information submitted by our providers, and in analysing the quality metrics we receive to ensure that the quality of the services we commission meet the expectations of those using them.

4. 2 Engagement & Equality Implications

4.2.1 Along with our partners, the CCG are developing the Involving People Strategy, which will help us to work effectively with organisations across our area and work together to engage with people effectively and involve them in our work.

4.2.2 The Healthwatch report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities, black and ethnic minority groups. The document also presents the views of health and care staff living and working in Calderdale. Despite this, we in the CCG recognise that further engagement is required to address the gaps in the report's findings, so that we can be confident that the range of health and care services available in Calderdale is accessible to, and representative of, all the people they serve. The health inequalities that impact our communities also impact our staff.

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

4.3 Legal / CCG Constitutional Implications

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

5. Recommendations

5.1 It is recommended that the Governing Body:

1. **NOTE** and consider the Healthwatch engagement reports

2. **NOTE** the CCG response letter

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

6. Appendices

1. Healthwatch Calderdale Covid-19 Engagement report 'health and care experiences of people living in Calderdale during Covid-19 outbreak'.

2. Healthwatch Calderdale Covid-19 Staff report

3. Healthwatch Calderdale Covid-19 appendices

4. CCG response letter

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

August 2020

Healthwatch Calderdale

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We are aware that this document may not be the most accessible version for some people in our community. If you require a version that can be viewed via a screen reader please click the report here.

Contents

Our work at a glance

Health and care services changed dramatically and with little or no prior notice during the Covid-19 outbreak. In an unprecedented and constantly changing situation, services had to respond and adapt rapidly. As the United Kingdom was put into a 'lockdown' situation, people were asked to only leave their homes for essential journeys. However, throughout this time, people still needed to seek health care, support or treatment for various issues.

Our role at Healthwatch Calderdale is to listen to and make sense of what members of the public tell us about their experience of using health and care services, then use that knowledge to make health and care better for everybody. As Covid-19 has resulted in enormous changes to health and care services, Healthwatch knew that we had to capture people's views, but that we would get the best results if we worked in partnership with Calderdale Clinical Commissioning Group (which plans and buys healthcare services for Calderdale), Calderdale Council and voluntary and community organisations in Calderdale. Working together means we can reach more people and makes sure we don't repeat elements of each other's work. To do this, we worked with the Calderdale Involving People Network.

To gather a full understanding of the experience of health and care services during the Covid-19 outbreak, over a period over of 12 weeks (end of May to end of August 2020) Healthwatch Calderdale and partners used a variety of different engagement approaches and tools including a survey and virtual focus groups to talk to people living and working in Calderdale.

We asked people to tell us their experiences of accessing health and care services during the Covid-19 outbreak, if they experienced any change to the service that they would normally receive and what those changes were. We also asked people to tell us what was good about the service they received, what didn't work so well and what would have made their experience better.

We asked people to share their experiences with us in creative ways such as stories, pictures, poems and word clouds.

We also asked staff to share their experiences of working and delivering a service during this time, and the responses from staff can be found in this linked report.

In total we received 393 survey responses from service users, their families and carers as well as health and care staff. A total of 103 people submitted feedback in other ways such as stories, drawings, focus groups and Snapchat.

Our 346 survey respondents made 543 visits to different health and care services. The majority of responses we received related to NHS care, in particular people's experience of accessing their GP surgery (253 contacts, 47%), pharmacy (82, 15%) and routine hospital care (83, 15%). Other service types commonly commented on were community services (39, 7%), 999 and 111 (30, 6%) and dentists (26, 5%). This means that the majority of feedback that was received related to experiences of GP surgeries. As GP surgeries are universally accessible and a first point of contact for many health interventions, this is not surprising.

The key themes that are mentioned repeatedly throughout our survey responses and other engagement tools are:

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

Feedback is mixed for all of these themes, with many people appreciating the necessity for change during the outbreak, but feeling that their experience could have been improved. Some respondents have made suggestions for how their experience could have been improved, which will hopefully offer some steer to health and care providers.

Where there are examples of different groups of people and communities experiencing care in different ways, this has been highlighted in the **Equality** section of the report. Specific attention is drawn to discrepancies in experience for Asian/Asian British respondents, people who were shielding due to age or disability, and people with caring responsibilities.

Specific questions were asked about the impact of Covid-19 and the lockdown period on people's wellbeing, and there is a discrete section that states that for almost all respondents, there has been a **mental health** impact. However, it is important to note that, for some, that impact has been positive, with people finding life easier in lockdown, and for others the impact has been negative, with a struggle to adapt to the changes in our way of life.

In the following report, we share details of the clearest and most common themes in our engagement work. In each themed section, we indicate if there is feedback specific to a particular type of service, and share the ideas and solutions suggested by members of the public. We have also produced a detailed summary of responses from staff members, which you can find in this report. To try to maintain our focus on these key themes, we have chosen to create a supplementary document of appendices which covers all the connected information. In the appendices is a detailed summary of feedback from the staff respondents to the survey.

We will share the findings of this report with the public via our website and with our partners. We will ask NHS and social care organisations to respond to us within 20 working days so we can help to make health and care services better for everybody. We want to ensure that positives in health and care during the Covid-19 outbreak are not lost and the negatives do not become the norm.

Key themes

Access to services

During the Covid-19 outbreak, many health and care services changed the way they interacted with and cared for people, for example by offering telephone and digital options rather than face-to-face appointments. Other services were closed, relocated or care and treatment was put on hold until in the short term.

640 comments were made that related to access to services; 19% of these were positive, while 51% were negative, 8% were mixed and 22% were neutral. Captured within the very broad theme of "access to services" were 3 key feedback areas; face-to-face contact and overall access of services, phone access, and service closures.

290 comments were made about face to face access to services; 19% of these were positive, 66% were negative, 4% were mixed, and 11% were neutral.

- 290 comments were made about telephone access; 23% were positive, 34% were negative, 12% were mixed, and 30% were neutral.
- 60 comments were made specifically about service closure; 62% of these were negative, 3% were mixed, 35% were neutral.

Adapting the way people accessed services was essential to protect the health and wellbeing of staff and the public. Some changes were welcomed and led to an improved access. Other changes led to difficulties for some people as they made access harder or more complex to navigate.

What worked well?

Some people found access generally easier and more efficient during this period and some mentioned that they preferred telephone access with their GP practice, saying that it was quicker, less time-consuming and removed the risk of getting Covid-19.

'It was all much more efficient, quicker service and as someone with a chronic illness and disability, it was much easier and better for ease and access'(GP services)

'I didn't have to take a sick child in the car sit and wait surrounded by other sick people and could do this from home. It was much better'(GP services)

'Telephone appointment with GP helped me more as I care for husband. Saved a trip to the surgery' (GP services)

Pharmacies appear to have been a lifeline for some people when they couldn't access their GP practice or when medication needed to be delivered.

'Chemist provided prompt home delivery service' (Pharmacy)

'Late opening hours as usual, but very reassuring to have an open chemist 7 days a week with later opening hours in these times' (Pharmacy)

'Eventually pharmacist contacted GP, and got me some temporary meds sorted and then eventually helped get me a meds review over the phone, but took a few days sorting out' (Pharmacy)

What didn't work well?

Lots of people had difficulties getting through to services by telephone which led to some frustration. For various reasons, some people struggled with telephone appointments, in particular if they couldn't explain their symptoms or if English was not their first language. With many people being asked to call rather than visit, phone lines were often reported as engaged or unanswered.

'not being able to get through on the phone, constantly engaged' (Hospital services)

'not sure always works over the phone because can't always explain what the problem is without someone seeing the babies' (District nursing services)

'Rang to check about a medical appointment, but it was all recorded phone message, and I don't speak English very well and don't know how to use a mobile phone options so couldn't get sorted' (GP services)

People reported that many services were closed and some didn't know where or how to access care, treatment or support from alternative places.

'GP told me she would look into if there was anywhere else that could provide the injection, but heard nothing since so feel like this was just said to me to get me off the phone' (GP services)

'Dentist being open, or someone to talk to, to tell me where to go and what to do' (Dental surgery)

Routine care was delayed; for example, people couldn't get pain-relieving injections, blood tests, B12 injections, dental check-ups and treatment, annual health checks or care worker visits at home. Some had appointments cancelled but were given no indication of when they might expect to receive another appointment.

'I needed a filling and couldn't get an appointment' (Dental surgery)

'I receive a pain injection every three months as the department was shut. I'm unable to receive my regular injection' (Hospital services)

'We were all shielding so my care workers and nurses couldn't visit me and my brother' (Social care services)

What would have made things better?

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

'it was harder to access the service in the new system as I wasn't prepared for it'(GP services)

'it worked well, but perhaps info about how it would work before…' (GP services)

Feedback relating to specific services

Telephone contact proved most difficult when people were trying to contact their GP practice

For some of the people who described their GP surgery as "closed", this was linked to the planned closure of the Park Community Practice in Halifax. This surgery closed at the end of March 2020; prior to this, all patients received a letter explaining where they could register following the closure. However, it would seem from some of the comments that respondents contacted Park Community Practice during the outbreak, unaware that it had closed, and then did not feel they could get access to care elsewhere. The impact of this has been reported particularly by 'Asian/Asian British: Pakistani' respondents, as Park Community Practice was located in the area of Calderdale with greatest ethnic diversity.

"GP was closed, and relocated to another surgery, and that was closed as well." (GP surgery)

"Our practice had shut down and moved elsewhere, which was quite some distance for us to travel, but we couldn't because the other location was also closed." (GP services)

Dental practices remained open but were only accessible by phone for telephone triage, and as such, there were several comments received about the closure of dentists and the lack of availability of urgent care. Whilst dental ill health is rarely life threatening, several respondents indicated they had been in significant pain without scope for it to be resolved.

Digital Access

Digital access to health and care has been crucial during the outbreak as a way for staff to continue to deliver their services to the people who need it. Ease of access to online options has varied, as patients were asked to interact in different ways with different services, and make these adaptations in a short amount of time. Most comments about digital access mentioned telephone calls, video calls and online appointments, and most of these comments were about digital access to General Practitioners (GPs).

180 comments were made that related to digital access; 25% of these were positive, and 25% were negative, 14% were mixed and 36% were neutral. In the case of comments about digital access, several people mentioned video appointments, but without expressing a positive or negative view.

Some respondents appreciated the technology driven appointments but many experienced issues with the transition from face-to-face to online care, and sometimes this prevented them from accessing the services they needed.

What worked well

Some people found telephone and video call appointments from the GP much more convenient. It often saved them time travelling to the practice and made it easier to fit into a busy schedule.

"I think telephone, skype, zoom style interaction could be safer and more efficient for many. Of-course it will not suit everyone but could save those at more risk from various infections." (GP services)

The use of technology to manage prescriptions has been valuable to many patients. Online prescription services were spoken about positively.

"There was a greater use of technology. The prescription was emailed to my pharmacy for collection and my sick note was emailed to me." (Pharmacy)

Providing technology to those that might not have it and teaching them to use it proved to be very valuable to many patients who otherwise would have been isolated.

"Yes, ACE gave me a tablet computer thing and showed me how to use it to contact people. I was able to talk to family and friends on video and this helped with my health, talking to others about it." (Community services)

What didn't work well

Accessing the digital services was a huge hurdle for a lot of people. Online services were not implemented in a planned and supportive way, putting many off who were daunted or ill equipped from even registering.

"I had called up in the past to ask for my grandmother's medicines to be reviewed as she was receiving too many and now has a surplus of the gaviscon and the pain killers. But when I called up this time the system has changed and everything has moved online. Which made it a lot harder to resolve the issue. And I was told I had to go online despite just asking for her to booked for a medicine review which was now overdue. So it was difficult and still needs to be resolved as I have not had an opportunity to sort things out." (GP surgery)

"As a response to Covid-19 I was not able to access GP services over the phone. The system has changed and needed me to go online for an appointment because it was non urgent for a mild eye infection. And I was too confused to even try and register" (GP surgery)

"Online services need easy access: one gateway into all services ... not multiple closed doors to new apps, having to register details all over again, like a series if hurdles to climb over ... then the system malfunctions." (comments about GP surgery, NHS 111 and pharmacy)

For some, a video call is not convenient, rather than being inaccessible.

"I would prefer a phone call rather than video appointments with GP, fit in much better with my busy lifestyle and I could describe my problem and it didn't require physical appointments" (GP surgery)

Other barriers to online services included language limitations, limited computer literacy and lack of access to a computer or suitable device. A lot of respondents expanded on their own experiences by stating that older relatives, or the elderly population in general, had struggled or would struggle much more than them to access these services.

"Could not get an appointment, had to set up an online account, which I could not do because I don't have access to a computer." (GP services)

"No face to face - elderly need that Drs reassurance and don't have face time / internet" (GP services)

"Camera/phone not very accurate or adequate. Probably due to my technical limitations." (GP services)

What would have made things better?

Many respondents suggested improvements to various online services based on their experiences.

"There must be an opportunity to have video calls to Healthcare Professionals (HP) where the patient has a computer. There must be many conditions/situations, where a simple phone call would not work, but a video link, so the HP could see the problem would suffice. This could be done via a triage system by call handlers." (Hospital services)

"It would be better if the hospital systems (online appointments) allowed you to make comments as to why you wish to reschedule and what requirements are needed, e.g. patient transport, etc." (Hospital services)

"To be given more calls from midwives given that we haven't been seen, visual tours or online sessions with midwives for prenatal hospital tours or classes" (Maternity services)

From all the feedback we have received respondents indicated that online services could be easier to access and navigate. Providing clear information on the services and an easy-to-understand pathway to booking an appointment would have made many experiences better.

Comments suggest respondents feel that the current portal and password system is confusing and varies greatly from practice to practice. Standardising the online registration process will help people register more easily. Patients would benefit from a single portal through which to manage their NHS and social care interactions, rather than registering for multiple online services. Communicating with social care teams or other health services these patients are involved with could be key to ensuring messages are relayed to them in an appropriate manner. A simpler IT infrastructure would make it easier to produce instructions for people to use IT systems, and this information could then be shared widely, with an offer of support.

It's essential to identify groups of people who may not have access to the internet, a computer or mobile phone, or a way to acquire skills to use online systems. These people could be left behind, and there should be assurance that there are alternative ways to make appointments beside online. Many practices had automated phone messages asking patients to register online for an appointment and provided no alternatives. Some of the most vulnerable patients find themselves struggling with online access, and should not be left isolated with inferior access as a result of limited understanding of, or access to, technology.

Feedback relating to specific services

The majority of issues people faced with online services and digital access related to GP practices. The sudden switch from face to face or telephone appointment booking confused many people. There was no time to adjust and for those without technology and IT skills, the switch to digital was an impossible task.

Arranging a hospital appointment online was challenging for some who needed to find a way to communicate changes to their needs during this time; for example, requesting a reschedule due to patient transport was not easy.

For women using maternity services, additional calls with midwives would have been appreciated by expectant and new mums, who were impacted by reduced face to face contact. Mums value virtual tours and online classes or sessions, and would like to see more of these during this time.

Communication

In the space of a few months, the Covid-19 outbreak has significantly changed the way health and social care professionals communicate with patients, families and colleagues. Whilst effective communication was always a crucial part of health and care services, it has now become even more important. In the fast changing and challenging environment of the Covid-19 outbreak, communication is paramount in ensuring people feel safe, alleviating anxiety and providing information. Many of the comments about communication in our survey results indicate that people struggled with communicating with health and care services during this period.

144 comments were made that related to communication; 7% of these were positive, while 64% were negative, 10% were mixed and 19% were neutral.

People indicated that there were communication challenges around arranging appointments, service changes, the absence of a real person with whom to communicate, anxiety, the fragmentation of services and barriers (as discussed in the **Equality** section in more detail).

What worked well

A small number of people found the increased access to General Practitioner (GP) services via telephone very positive, particularly in terms of the process, ease of contact, advice given, responsiveness and supportiveness.

'The processes have been put in place quickly and communication is excellent. (all over the phone)' (Hospital services)

'...easier to contact doctors' (GP services)

Others commented more generally stating that communication was 'good', and many people were able to accept that alternative means of communicating with them, such as by phone or online, were necessary due to the unprecedented outbreak situation. They were satisfied with this arrangement for patient and staff interactions.

What didn't work well

People were unhappy regarding the general lack of communication from health care services and asked that someone make contact with them to offer updates. Some felt that they had not been furnished with adequate information regarding changes to services made as a result of the Covid-19 outbreak and what they could expect when visiting a service during the outbreak:

'Wasn't told much by receptionist about changes I'd see in surgery' (GP services)

'A phone call, an email, a text message or a letter - just to keep me updated, instead of ignoring all forms of contact made by myself' (District nursing services)

'If someone had written to us, or sent a voice message or text or something to let us know'. (Hospital services)

Some people did not feel they had been adequately informed that their GP surgeries were closed for face-to-face contact. Others were unsure of what different services were offering, what changes had been made or who to contact.

Some were dissatisfied about an absence of information regarding Covid-19 and the changes it brought in general.

'Yes, this virus and lockdown is very bad, but we need to be given more information and support to understand'. (Pharmacy services)

'Communications need to get better, so people know what is going on'. (Service not specified)

For some the changes in how the services communicated with people induced anxiety, worry and, in one instance concerns, about safety.

'All phone messages, very confusing and worrying'. (Dental services)

'All this change is very confusing and puts lives at risk, not good'. (GP services)

'Lack of ability to speak to anyone has simply increased my concern. I was made to feel a nuisance for calling, and that should not happen' (GP services)

For others the changes caused frustration and difficulties, mainly around being unable to get through to the full range of health services by telephone due to lines being constantly engaged.

Many people reported they had received inadequate information from the hospital around their planned care. Some had not received information that stated their appointment had been cancelled or received very late notice from the service of the cancellations. If some people hadn't checked whether a planned appointment was going ahead, then they would not have been told the appointment was cancelled.

'I could have been informed earlier of the cancellation, poor communications'. (Hospital services)

'If someone had rang me or even texted me earlier to say because of Covid-19 appointments had been cancelled.' (Hospital services)

'I rang to check my mum's appointment and was told it was cancelled…' (Hospital services)

Some respondents have been left with no details as to when a rescheduled appointment could be expected, or when a closed service would be re-opened.

'I have an appointment in September at a West Yorkshire hospital (I think Bradford) but I don't know if it will be delayed. I would like some information so I know what to expect'. (Hospital services)

‘No alternative, no explanation of when we would be seen. Not good enough communication about when to expect an appointment’. (Hospital services)

‘I had to ring and ask why and when I could have another appointment, but they told me they couldn’t say when’ (Hospital services)

People who were happy with phone and video consultations often noted that the appointment times for GP contacts were not exact enough. They were not told about the exact time the health professional would ring and some patients waited extended periods of time to receive telephone contact.

“I don’t mind the telephone consultations. But it would be better if you had an exact time that they would ring.” (GP services)

“I don’t mind the online thing or over the phone, so long as it works, but it often doesn’t because you don’t know when someone is going to ring and if you will be able to answer the phone in time before it stops ringing.” (GP services)

‘2nd appointment was over an hour late and I wasn’t kept informed. (If I had been in the health centre I could speak to receptionist)’ (GP services)

There were also comments about people experiencing difficulty navigating NHS services; notably individuals who did not know where to turn for help.

‘For CRH (Calderdale Royal Hospital) some way of knowing who you could contact and how’ (Hospital services)

A prominent request across feedback for all service types is to speak to a real person rather than having no option but to rely on technology to relay information. Some respondents felt a real person aided and improved communication providing greater reassurance and non-verbal cues, whilst others simply expressed a preference for face-to-face contact.

‘If someone had been able to see me or give my son advice over the phone of what to do.’ (Dental services)

‘Being able to talk to someone to help explain some of the things to do’. (GP services)

‘It would have been better to have someone at the end of the phone who could help and redirect the call to the right place or offer other advice’. (GP services)

People expressed frustration regarding the fragmentation in the NHS and between the NHS and council services, and gaps in their communication with each other.

'…NHS, Council, Hospital, all need to start talking to each other, system is a shambles.

'…Parts of the system need to start talking to each other. There is no communication between different bits and so it all becomes crazy.'

Some respondents also reported issues with communication to professionals, specifically that it was very difficult generally to obtain a response to questions, that prescription requests had not been fully actioned or dose changes were made to prescriptions but with no explanation given to the patient as to why. Others reported that they did not receive adequate information from GP surgeries about the need for a medication review. One person also felt uncomfortable speaking to staff in public areas about medical matters; this required people to use louder voices than usual due to having to maintain social distancing.

What would have made things better?

People wanted to see improved communication from health and care services in general; this included better quality information being sent out to the public, some individual contact with people receiving routine care, and someone with whom they could discuss their queries.

A frequent suggestion for improvement was to be able to communicate with a real person. Some people would have been satisfied with speaking to a real person over the phone whilst others stated they wanted face-to-face contact.

People also stated that being able to get through to services by phone would have improved the situation.

Gaps in communication have led to delays, and respondents have requested more timely contact and clear explanations.

'Medication was not delivered on time, was told was required to complete a meds review, but no one told me and I couldn't get sorted with surgery.' (GP surgery)

One person stated that improvements could have been made to the communication around the hospital discharge of an elderly person:

'Just a simple / brief summary of and changes or important messages would have been very helpful' (Hospital services)

Finally, several people commented on the lack of integration between services and stated that services working together would have improved their situation greatly.

Feedback relating to specific services

In primary care services, the majority of the feedback about communication with GPs concerned access to services, the wish to speak to a real person, confusion around the changes and a lack of communication from surgeries to patients. One out of hours GP was mentioned as having given a 'very good assessment and very helpful advice'. Other positive feedback concerned straightforward access to appointments and sympathy and practical advice.

People commented both positively and negatively regarding the communication of pharmacies during the Covid-19 outbreak. One person stated that it would have saved them time if the pharmacy had explained that there was an option to collect medication instead of having it delivered and another that the pharmacy had phoned ahead of a medication delivery to allay someone's anxiety.

Feedback specifically about dentists concerned the lack of interpreting, slow or lack of response on the part of dentists to patient queries, closures and unsympathetic attitudes.

'If the patient got a quick response from her dentist and if that dentist provided an interpreter, she might get a better care and avoid suffering from pain for two months'. (Dental services)

Feedback about communication between staff and patients at Calderdale and Huddersfield NHS Foundation Trust who provide hospital services was largely positive. A specialist nurse was described as 'supportive and helpful', and A&E staff were respectful.

'A/E worked very well and staff were very careful of my father but at 91 years of age, confused, blind and hard of hearing - he had no one with him - which I understand but when he was discharged home there was no hand over or paperwork to say what had happened or more importantly what needed to happen e.g. changes in medication.' (Hospital services)

In the community, we received positive feedback about the District Nurse service with respondents saying this is a 'good' service:

'Good, prompt service, got questions answered and problems sorted' (District nursing)

Physiotherapy also received a positive mention, specifically around the attitude of the practitioner and the support given.

One person provided positive feedback on service Child and Adolescent Mental Health Services (CAMHS).

'Our experience of CAMHS during this period has also been very supportive and the telephone communication has been excellent from them'. (Mental health services)

However, the experience of mental health crisis care was mixed. It was described by one person as 'engaging with the person involved and his carers' whilst another respondent stated the 'Crisis Team would not engage'.

Gateway to Care received several positive comments. It was described as 'very responsive and supportive', 'well organised and proactive' and offering a number of different options.

Quality of Care

Approximately 70 pieces of feedback were provided that related to quality of care; 59% of these were positive, while 27% expressed negative views, and the remaining 14% were either mixed or neutral.

Although not always expressed explicitly in comments across the survey there is a sense of gratitude to health and care professionals trying to deliver good quality care in very challenging times.

Issues included delays in support for pregnant mums, difficulties getting medication or medical checks, lack of support for people needing support from carers at home, and problems accessing dental services.

What worked well

Some people found it easy to access their GP, and felt that their GP was person centred and supportive.

'I didn't wait long for my appointment and my GP are really good and helpful and always supportive' (GP surgery)

'Person centred and patient my child has Autism so became anxious but the gp worked well and spoke primarily to me engaging as minimal as possible with my child' (GP surgery)

Others who had outpatient appointments which were changed to phone appointments were still happy with the way this was arranged and delivered.

'Due to have clinic follow up at hospital contacted by hospital prior to a pre-arranged Cardiology clinic follow up to check I was OK to have a phone call instead of visiting hospital. Received phone call at date & appointed time to discuss with the clinic nurse.' (Hospital services)

Some patients were also reassured by the changes that were made to the delivery of hospital services and warfarin clinics to protect them from contracting Covid-19.

'phone call was all that was needed; transport was good; service at PD Unit was fantastic - shown straight into a room and remained there right until transport came to take me home' (Hospital services)

'I've also carried on with Warfarin checks during lockdown but held as usual at Broad Street. I've felt really safe having these done.' (Hospital services)

There was also some positive feedback about how adaptable and flexible a range of services have been, from emergency medical care to social care and support services.

'Very thankful to have been offered emergency treatment at this time. I had been told by my dental manager not to attempt to pull it as it was a big rooted tooth, also i take a strong blood thinner and DIY not an option' (Dental services)

‘The carers have been able to take our son on walks and to the cycling sessions arranged by the local authority, that have replaced the usual summer scheme.’ (Social care services)

‘Residential care home where dad lives, the staff have been wonderful and very caring’ (Social care services)

What didn’t work well

Some people didn’t get the routine support they wanted from their GP, such as blood pressure checks and adequate pain management, while one person felt that the service the GP provided for an elderly complex patient was just a tick box exercise, not the proper assessment that that was needed.

‘Wasn’t able to take blood pressure which I was concerned about.’ (GP services)

‘The fact I was in so much pain and because I wasn’t able to get the proper treatment and pain killers I needed…I think they could have opened up for more types of minor treatment such as mine. The private clinic were able to do the procedure. If I hadn’t have had it treated privately I would have ended up needing an operation’ (Hospital services)

‘I think general practice worked the least well - not that it was a bad service it just didn’t fit the needs of a very elderly complex patient who did not have Covid-19 and just needed a full holistic assessment it seemed very “tick box move on to the next”’ (GP service)

There was also negative feedback from people trying to access dental services, referrals for treatment were slow, it was hard to find information about how to access dental services, and interpreters were not always provided when needed.

‘Dentist was not sympathetic, I phoned Friday 15th May in extreme pain. He said he would refer me to emergency dentist (but there were a lot of people in the same situation as me). I phoned back on Monday 18th asking if I had been referred, it was only then that emergency dentist rang me (immediately) and she was lovely, explaining and advising’ (Dental services)

‘I had extremely bad toothache and I did not know which way to turn. I appreciate the problems that dentists have but the way I was treated was not good’ (Dental services)

Maternity services also got some negative feedback because of changes to the service, this led to problems when measurements were taken later than normal, and some mums were left feeling like they just had to get on with it on their own.

‘Measurements started late - problems picked up later than they should as a result’ (Maternity services)

‘As my third pregnancy I can compare well, this pregnancy I have been ‘left to it’ and won’t be seen until 28 weeks I can imagine for first time mums this is very scary.’(Maternity services)

What would have made things better?

All of the examples people shared of good quality of care reference flexible and person-centred support and there are examples of this in all different types of health and care services, yet there isn't consistency across providers.

It's clear that people have felt a great deal of fear across the outbreak period, and that good quality care addresses those fears, and helps people to feel confident in the plan for their care.

Pregnant women who are unable to visit the hospital where they will give birth due to the current restrictions, requested virtual tours of the ward or birth centre they will be using, along with introductions to the staff they will meet and the procedures that will be used.

'I also as yet cannot visit the hospital I'm expected to give birth in which is unfamiliar to me which adds to my apprehension' (Maternity services)

Feedback relating to specific services

There was positive feedback about A&E being quieter than normal.

'The fact that A&E was so much quieter was amazing but that comes down to the public using it wisely in future.' (Emergency care)

From the comments received people felt the service at Gateway to Care had improved, but it was queried whether this might be due to the way the service is responding during the Covid-19 outbreak.

'Gateway to care seem a very well organised and proactive service - it seemed very easy and straight forward to get things put in place - without lots of red tape - not sure if it is always like this or just due to the Covid-19 response' (Social care services)

Equality

Survey responses have indicated there are specific issues and barriers that are being faced by some groups who experience greater health inequalities. The comments made in the survey indicate there are differences in the experience of people who are from the South Asian communities, older people, people with disabilities, and carers.

The following section gives a summary of the specific concerns raised by respondents from these groups, and some details indicating where people from particular groups have had disproportionate experiences by comparison to others.

Race and Language

In the responses received from South Asian residents, there is clear reference to a sense that they have been abandoned by health and care services during the Covid-19 outbreak, with some comments referencing the higher risk of Covid-19 for Black, Asian and Minority Ethnic (BAME) communities.

"Too many people not being helped from the Asian community and being ignored. Not good as it results in needless 999 calls, needs sorting out." (Social care services)

"Asian community has had poor deal as usual, why? Do our lives not matter?" (GP services)

The data indicates that people who stated their ethnicity as 'Asian/Asian British: Pakistani' are more likely than other ethnic groups to state that services have "closed" during the outbreak. It suggests there is a real sense amongst the community that they have been shut out of services across this time. In some of these comments, respondents say the service was "closed" despite online/telephone access being available. This conveys the feeling that the online and telephone services do not equal proper access, and may limit people from this community seeking assistance with their health.

Several of the practical difficulties that have been experienced by BAME communities are linked to English not being the first language of some community members. People have reported difficulties with making sense of the clinician in their telephone appointments and understanding telephone messages.

"See GP face to face for diabetes. Had to have a telephone call. I felt because my English is not priority language I struggle more." (GP services)

"No good for me, I don't speak English very well so couldn't understand what the messages were saying." (GP services)

Some respondents had to rely on family members to act as translators or organisers to make sure they could speak with a clinician and coordinate receiving prescriptions.

"She doesn't speak English so had to ask my sister to ring because medicines not arrived." (Pharmacy services)

Communication between staff and patients was a key issue reported by Asian/Asian British respondents to the survey, and although language barriers were highlighted, most comments were about not being able to get through to their GP practice by phone. Although answerphone messages provided instructions, this was not seen as a substitute for being able to speak to a person directly, and people reported feeling like they did not have the information or understanding they needed after making phone contact.

"They need to have some real people answering the phone to help people go to the right place." (GP services)

There were also comments about limited access to IT equipment, such as smart phones, and limited knowledge of how to use these amongst people who do not have English as a first language.

"Had to do all online. Ok for me, but for my wife who can't speak English or use a computer it was all down to me." (GP services)

Age and Disability

Feedback directly related to age and disability has been grouped in this report because many older people and disabled people were instructed to "shield" during the height of the Covid-19 outbreak. This means they were told to stay in their own homes and avoid all social contact outside of their household, and as such, there is some cross over in their experience of health and care.

Some of those who were shielding reported difficulties with making contact with health services; phone lines were not always answered, and they were unable to attend premises in person, so were sometimes left without any access to care.

"We were shielding and could not get hold of anyone on the phone." (District nursing services)

"I understand they were very busy at the time but do feel that the normal elderly / ill were not looked after as they should have been - partly because the GPs were trying to protect them by not visiting but the knock on was that they were not getting a full picture." (GP services)

"A less-able bodied / older person without any support (or mobile phone) shouldn't have had to visit to find out their new methodology (which wasn't working anyway)." (GP services)

People with a disability struggled to get reasonable adjustments made to new temporary Covid-19 related processes. This meant the delivery of their care was not reflective of their needs, and in some cases, created physical health impacts. This included an expectation that people were able to access online information and services, when for some older people or people with disabilities, this was not accessible.

"Was isolating, on shielding list, contacted their GP who even though isolating said they had to go to a doctors surgery in Ripponden when they live in Elland. No wheelchair access transport available. Was told as they were not housebound before Covid-19 they were not allowed a home visit." (GP services)

"As I said before nothing easy to use [online access] if you cannot see well"

"Had to stand outside in a queue until called in. I have physical disabilities and find it difficult to stand. No provisions are made for this." (GP services)

However, for some, new ways of work improved their experience of accessing care, and the survey responses offer examples of people with disabilities who have valued online and telephone access.

"It was all much more efficient, quicker service and as someone with a chronic illness and disability, it was much easier and better for ease and access" (GP services)

Some people who were shielding were fearful to access health and care due to the Covid-19 risk.

"Also did not want to risk going to the hospital when Covid-19 infection rates were high." (Hospital services)

When looking at the data on access to services for people with disabilities, there are many references to those people not being able to access routine care for the management of their long term health conditions. In some cases, peole told us this is due to the absence of face to face care for routine reviews that cannot be completed by phone.

The high incidence of comments that we received about telephone access from people with disabilities, particularly to GP surgeries, indicates that respondents had needed and attempted to access care during the outbreak, which they had then struggled to receive.

Unpaid Carers

For many unpaid and family carers, the Covid-19 lockdown period was a very busy time, as many cared for people were shielding at home. Some reported that there was improvement in the joined-up delivery of care, with different agencies communicating with each other, which meant that their job as a carer was more straightforward.

"Professionals and services seem better joined up and more effective at prioritising important and targeted cases, this helps to relieve some of the pressure on carers who may not be identified (due to not being part of volunteer group or a registered carer)." (Hospital services)

However, in most of the comments specifically about caring, barriers to communication were clearly stated as a significant factor in how well support had worked.

"We had to leave the room when the nurses were in the house and that was worrying because my mum doesn't speak English." (District nursing services)

"Husband (stroke patient) wasn't part of telephone appointment in the way he would be if we were there in person. I (wife) always speak for him at appointments as he doesn't engage, but he's there and will communicate sometimes. Phone call means he isn't involved so it falls to me (wife) to do more for him." (GP services)

What might make things better?

There were very few suggestions about what might address some of the inequalities issues raised here.

One respondent indicated that there should be more readily available access to interpreters, particularly for Urdu.

Some of the people who responded who had disabilities indicated that greater awareness for professionals of the impact of their disabilities would improve their experience.

The most commonly requested change was about the offer of clear information, provided in accessible formats and community languages, that relates specifically to the local services.

Although it was not explicitly stated as a suggestion, some people were very clear that they benefitted from face to face engagement with a clinician, particularly those who do not speak English as their first language, or who have disabilities that link to communication difficulties. They wished to retain face to face appointments as a possible option for accessing care.

Other equality data

There are some other elements of the data that suggest that people with different demographics have experienced health and care in different ways during the Covid-19 outbreak.

- Significantly more men than women stated that a service was “closed” when online and telephone access was available.
- Women made significantly more comments about the quality of the care that they have received than men, with around 75% of those speaking positively about the quality of care, and stating how grateful they were for the assistance they received.
- People in receipt of benefits reported key issues around telephone access to services; of the comments made about this, over 75% were negative, most commonly stating waiting for the phone to be answered or for someone to call them back as the problem.

Mental Health

Survey responses have indicated that there were specific impacts upon peoples' mental health throughout the Covid-19 outbreak.

In the following section, there is a summary of the specific concerns raised by respondents from these groups.

Mental health implications of Covid-19 outbreak

In the responses received from service users and carers, there is indication that the most significant mental health impact from the Covid-19 outbreak is the effect upon peoples' general mental health and wellbeing. Some people responded that the Covid-19 outbreak had a positive impact upon their mental health and wellbeing.

"I am lucky I had the company of my husband, a big garden, plenty of crafts and baking to do so I was always busy. I was happy"

"Less going out has led to more relaxing home time although miss the bacon butties."

However, some people reported that they were feeling increased stress, anxiety and pressure in their personal circumstances and some expressed feelings of being depressed when their mental health is typically good.

"I have good mental health most of the time. The worry about my risks of becoming very ill or dying due to Covid-19 escalated. I am very low and feel anxious. Not having anyone to discuss my worries with has been detrimental."

"Already being treated for depression the outbreaks has created more pressure for me as both a career and a vulnerable person and I became more stressed and down"

"I have struggled working from home with increased work output. I have needed to start anti-depressants"

People shared experiences of difficulties sleeping and insomnia since the start of lockdown.

"Some difficulty sleeping at times. Worried about my 97 year old mother who I haven't seen for more than 12 weeks"

"I can't sleep I may only get 4 hours of sleep a night. I feel as though my head is about to explode"

In particular, females and people who indicated that they have a disability highlighted that they had been impacted by increasing stress, anxiety and worry.

Caring Responsibilities

In the responses received from service users and carers, there is clear reference to the additional caring responsibilities people encountered during the Covid-19 outbreak. Some people reported that their caring responsibilities had increased and others were worried about vulnerable family members with whom they had very little contact.

"As a family, we have suffered throughout the pandemic. We are now full-time carers which meant little time to spend on our other children's home schooling. We are also coping with lost jobs and businesses that have been destroyed. There have been some very dark days."

"It has been a huge challenge caring for my son who has a severe learning disability. The loss of his routine led to increased anxiety and aggressive behaviour. As a consequence, half the family moved into separate accommodation. Being the main carer for my son at home has been very stressful, and at times I've felt unable to cope."

"On a personal level looking after two parents in their 90's one of whom is very frail and has had to have numerous contacts with health and social care services - navigating those services during lockdown has been very stressful and worrying that we have done all we should for my father"

People who indicated that they have caring responsibilities felt that their mental health was impacted negatively by the increasing caring responsibility and tasks they encountered, especially with vulnerable people. This was also the case for females who were working from home and had primary school aged children to care for.

Education, Jobs and Finances

One of the main reported causes of poorer mental health was the additional worry and stress over educational needs, job retention and strains upon finances.

"I had little time to spend on our children's home schooling"

"I had a new job that I couldn't start due to lockdown and then I had an online interview that I couldn't take part in due to being sick. I'm now unemployed and claiming Universal Credit and am depressed as I am isolated and have no job."

"I am working full time from home, a single parent, with 2 teenagers. I feel stressed by work which is as busy as ever and feel I ignore the kids. Work seems more pressure than usual."

Some feedback suggested that the ability to work from home or work differently during the Covid-19 outbreak has provided a positive impact for people on their work and life balance.

"It has actually got easier as time has gone on, and the current situation has become more normalised. However, I do not have the worries about finances, an unstable home life, or pressures around childcare/caring for a family member that are very present and wearing in some households."

"I am working from home which has taken some adjusting to the work / life balance - learning to stop working at the end of the day. However after the initial madness of the first few weeks - work calmed down and I find it much less stressful working from home - no travel / rushing from one meeting to another - all done now via Microsoft teams video calls".

In particular, male respondents reported that their mental health was impacted by financial pressure and also having concerns around home schooling their children.

Isolation

People who live alone spoke in detail about their experiences of isolation and loneliness. Survey respondents also commented on a lack of social life increasing feelings of being isolated from extended family members and friends. Females were more likely to talk about isolation as were people who claimed state benefits.

"I live alone, so the no interactions have been hard. I have no motivation to do things and just wallow when not working"

"I suffer from mental health problems and being stuck at home was terrible for me. I couldn't see any friend's and this made things worse for me"

"Not being to play with my mates was lonely, not being able to go to school, not being able to go visit friends and relatives."

Some people have increased the amount of contact they have had with their family and friends via digital access and using mobile apps. This has improved their mental health and wellbeing during this time and also provided a support network.

"I live alone but keep in touch by WhatsApp Video, that has helped. I think without it I would feel lonely"

Mental health support

Lots of respondents questioned where they could contact or attend in person to receive mental health support during the Covid-19 outbreak. Many people already receiving mental health support from community services felt as though they had been abandoned and their mental health suffered as a result.

"Lockdown affected me quite badly. I am outgoing type, and suddenly having to stay at home was very difficult, and not knowing where to go for support etc made it even worse."

"I suffer multiple health problems, and struggle with walking, and so being locked down made it worse for me, my mental health was at breaking point and I had no idea where to go and what to do because everywhere was closed and online. Not everyone knows how to use a computer or go online."

"I have anxiety and depression (diagnosed clinically prior). I am on medication. I have reviews of medication which was done via telephone. I felt unsure this was the right thing for me. I feel unsupported in the community."

"My psychiatric and psychology care were delayed and feel was left to struggle"

"Being isolated, vulnerable and not being able to contact anyone to help me, with all the changes to services and no one being available to talk to.

Report limitations

As is often the case when launching and sharing generic surveys about health and care services, we have received significantly more feedback about NHS care and treatment than social care support. This is largely due to the much smaller numbers of people who access social care, but those who do are likely to have far more significant needs.

We are keenly aware that there is little feedback in survey responses and stories that relates to residents living in care facilities, and we know that these residents may have had life changing experiences, either through contracting Covid-19, or with significantly reduced interaction with their families and friends.

We have not received any responses from people who have talked about care they received following a hospital admission and a Covid-19 positive diagnosis. This is not hugely surprising, as the number of people hospitalised with Covid-19 from Calderdale has been low, but it is a significant gap in terms of how health and care has been experienced in the pandemic. However people who responded to the survey may not have been hospitalised and may have chosen to self-care or contact their local GP or Pharmacy services.

We also have received little feedback from people who were in the midst of significant health intervention, such as cancer treatment.

When reviewing our equality monitoring information, there are a few gaps in the number of respondents with particular demographics. Most respondents to the survey described themselves as heterosexual, which means we will not have gathered a broad understanding of the impact of sexuality on experience of health and care during the pandemic. Similarly, we have received very few responses from ethnic minority communities, except for Asian/Asian British: Pakistanis.

There were no survey responses in which people stated that they were trans.

Next steps

We will publish this report on the Healthwatch Calderdale website and share it with all partners involved in the project as well as local NHS and social care organisations:

- Calderdale & Huddersfield NHS Foundation Trust
- Calderdale Clinical Commissioning Group
- South West Yorkshire Partnership NHS Foundation Trust
- Locala
- Yorkshire Ambulance Service
- Pennine GP Alliance
- Calderdale Local Medical Committee
- West Yorkshire and Harrogate Health and Care Partnership
- Local Dental Committee
- Calderdale Health and Wellbeing Board
- Members of Parliament for Halifax and Calder Valley
- Local councillors
- Calderdale Council inc. social care, care homes etc

We ask NHS and social care organisations to respond in writing to the following questions within 20 working days (upon receipt of this report) as per the timeframe set by the Health and Social Care Act 2012 and The Arrangements to be made by Relevant Bodies in respect of Local Healthwatch Organisations Directions 2013. *

- How will your organisation use the information in this report to make sure that services are more responsive, prepared and effective if Covid-19 remains a significant threat to public health or we expereicne a second wave of Covid-19 infections?
- How will your organisation use this information to ensure that services meet the needs of local people whilst we live with Covid-19 in the recovery phase, including Covid-19 specific care and routine health and social care?
- There is a real danger that the Covid-19 outbreak will significantly increase health inequalities, and there is evidence that this has already begun. How will your organisation use this information to ensure your services are designed to mitigate the risk of widening inequality by taking into account the ways in which some people will bear multiple impacts both in the short and long-term?
- How will your organisation use this information to shape and mould ongoing delivery of your services?
- As a result of listening to the feedback from the public, what will you stop, restart, let go, adopt & adapt?

* Gov.uk. (2013). The Arrangements to be made by Relevant Bodies in respect of Local Healthwatch Organisations Directions 2013. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/184970/The_Arrangements_to_be_made_by_Relevant_Bodies_in_respect_of_Local_Healthwatch_Directions_2013.pdf

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

August 2020

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Contents

Our work at a glance

This report is to be viewed in conjunction with our service users and carers engagement report. For further information and to find out about our next steps please click here.

Health and care services changed dramatically and with little or no prior notice during the Covid-19 outbreak. In an unprecedented and constantly changing situation, services and their workforce had to respond and adapt rapidly. As the United Kingdom was put into a 'lockdown' situation, people were asked to only leave their homes for essential journeys. However, throughout this time, people still needed to complete their roles as keyworkers.

Our role at Healthwatch Calderdale is to listen to and make sense of what members of the public tell us about their experience of using health and care services, then use that knowledge to make health and care better for everybody. As Covid-19 has resulted in enormous changes to health and care services, Healthwatch knew that we had to capture people's views who worked in health and care services throughout the lockdown period, but that we would get the best results if we worked in partnership with Calderdale Clinical Commissioning Group (which plans and buys healthcare services for Calderdale), Calderdale Council and voluntary and community organisations in Calderdale. Working together means we can reach more people, and we don't repeat elements of each other's work. To do this, we worked with the Calderdale Involving People Network.

To gather a full understanding of the experience of staff working in health and care services during the COVID-19 pandemic, Healthwatch Calderdale and partners used a variety of different engagement approaches and tools such as a survey, focus groups and telephone consultations. We also asked people to share their experiences with us in creative ways such as stories, pictures, poems and word clouds.

In total we received 49 survey responses from health and care staff members. The responses were from a number of organisations including NHS, local authority, social care and the third sector.

Overall, the comments are divided as follows:

- Very positive: 15
- Moderately positive 58
- Moderately negative: 52
- Very negative: 32

The feedback we received indicates 4 main themes, they are:

- Staff wellbeing;
- Service delivery;
- Cleanliness, hygiene and infection control;
- Digital.

Staff wellbeing:

We received 54 responses in relation to staff wellbeing, the topics covered by respondents include personal, emotional reactions to lockdown, adapting to a work/home life balance, pressure relating to demand on services and impact on mental health, among others.

What was good?

Much of the positive feedback focused on supportive colleagues within workplaces.

"The CCG has been excellent, allowing all staff to work from home and facilitating home working with the installation of Microsoft Teams. Although it was initially very busy with many service users needing some additional help, I felt very supported by managers with almost daily catch-ups."

"Well protected by immediate management with regards to personal health concerns." (Care home employee)

"Everyone has been very supportive, hard-working, and dedicated to looking after patients and each other. NHS is like a family, always there for each other." (Hospital employee)

What could have worked better?

Many of the negative responses related to people's emotions and feelings throughout the lockdown period.

"I Felt very lonely at the beginning and the workload has been overwhelming in terms of managing updates from PHE (Public Health England) and other sources." (Registered Manager of a care home)

"The general feel of attitudes towards social care during this pandemic has led to staff feeling second rate to NHS staff and an "after-thought" in the overall effort." (Care home employee)

"At times very worrying, no PPE, working long hours, risk of infections, and seeing people going off sick." (Care home employee)

"I found myself feeling guilty for saying no to working extended hours, so I just did it, but then felt torn between my family commitments; I found this emotionally draining at times." (Third sector worker)

Service delivery

We received 79 pieces of feedback relating to service delivery from people working in health and care services throughout the Covid-19 outbreak. Respondents spoke to us about how their organisations adapted to delivering services remotely, support offered to staff working from home, impact on working hours and supply chain challenges, among others.

What worked well?

People commented that staff and patients adapted quickly and positively to the changes required. This was highlighted as the reason organisations were able to continue to deliver services during lockdown and protect the public.

"We changed the focus of our work - stopping some things and starting working on other things." (Third sector worker)

"We decided to close the home to non-essential visitors from Thursday 12/03/2020 when the first positive case was detected in Calderdale. We believe that the reduction in visitors to the home, even just for a week, has enabled us to maintain a Covid-19 free status." (Care home worker)

"Patients acknowledging that they do not need to see the same GP all the time." (GP worker)

What could have worked better?

Staff told us that gaining a balance between home life and work has been challenging for delivering services as usual. People also raised concerns around supply chains, partnership working, communication as well as the impact on organisational finances.

"I've been putting in more hours." (NHS worker)

"We have come up against increased prices for PPE (personal protective equipment) across the board. We have been able to get some stock from the LA (local authority), but their stocks are also limited. We have been able to access testing for residents and staff on a need by need basis to begin with, but we have not received our kits for whole home testing. We have seen a

*decline in older people coming into the home from their own homes and had to furlough staff due to a reduction of residents in the home. This has also put the home under financial strain." (*Care home worker)

*"Chaotic organisation of services wider across Calderdale e.g. child immunisations." (*General Practice worker)

*"Our service for people with learning disabilities (adults) closed. However, the pressure the families faced meant we had to find a way to continue to support them. Staff and volunteers had their own challenges at home, but they rose to the occasion to support others when needed. It sometimes meant a phone call, doing a delivery etc. Our clients all have learning disabilities so they were on the shielding list. It was confusing to start with, I think without staff/volunteers to provide families with information they would have struggled to find it on government websites, which are too confusing to navigate. Many relatives of our clients are old and not IT savvy." (*Third Sector worker)

Cleanliness, hygiene and infection control:

We received 58 comments related to sourcing and using Personal Protective Equipment (PPE), along with problems socially-isolating at work or being asked to work while displaying Covid-19 symptoms.

What worked well?

"Using the extra PPE equipment and changing into uniform at work and then removing it before we leave." NHS worker

"Management were also operating a taxi service for staff members who didn't live in walking distance to reduce the amount of public transport that was used by staff. We did this for approximately 8 (weeks)." Care home worker

"The manager installed a handwashing sink in the entrance of the home for staff and other visiting professionals to use when they entered the building. Handwashing posters were erected at all handwashing sinks within the home. Hand hygiene and Infection Control questionnaires were handed out to staff prior to the initial lockdown." Care home worker

What could have worked better?

"… Contact tracing was a letter sent out to patients arriving 10 days after they could have been exposed - telling patient to isolate for 14 days - bit of a joke since for 10 days they could have been out and about. 3 members of my team have had Covid-19 - not once were we told officially. A small handful of staff, but not all, were told they would be ok and no need to isolate. PPE

regs seem to change with the supply. I know of 10 staff who contact Occupational Health with symptoms all told to come into work - all have direct patient care." CHFT worker

"At times very worrying, no PPE, working long hours, risk of infections, and seeing people going off sick." NHS worker

"We could have worked from home but were told it wasn't an option unless we had to isolate. We were not socially distanced." Admin in secondary care

Digital access

We collated 66 comments about digital access, people spoke to us about utilising technology at home to continue service delivery, issues with resolving IT and lack of equipment. Many comments were positive, with a few ideas for improvement.

What worked well?

There were many positive comments about how organisations embraced technology.

"Good. Quick rollout of technology has helped me stay connected with colleagues. I've found that I still feel connected to colleagues, and a sense of camaraderie remains." CCG employee

"Reduced unnecessary travel to meetings which can now be done online. Allowed faster and better online communication." Local authority employee

"Rapid implementation by General Practice of new ways of working including remote video consultation." GP worker

What could have worked better?

People responded that there was a reluctance to use digital technology, opthers commented that IT issues remained unresolved or taking longer to fix, others spoke of difficulties accessing systems remotely.

"Online (Zoom) support, where they had previously been reluctant. Different skillset facilitating online and not appropriate for more high-intensity support. That's taken place via phone. Workers (are) dealing with intense calls." Third sector

"Having to email a generic email and await responses before work could continue on some tasks - e.g. supplier set up - not being able to speak to a person to action a request." Third sector

Further feedback:

We gave people the opportunity to make a comment about anything additional they would like to add about working throughout the Covid-19 outbreak. The highest volume of comments related to stress, anxiety and pressure (14 comments); followed by caring responsibilities (5); isolation, working from home and worried about family (all with 4 each).
In relation to stress, anxiety and pressure comments are as follows:

"Anxiety and depression have both been affected positively and negatively - WFH reduces impact of work, but isolation and concerns about the world and loved ones have been hard. Longer term impacts as we reduce lockdown and try and navigate the world and the impact post Covid-19."

"This has been the worst experience of my career, the weight of responsibility for resident and staff wellbeing has been overwhelming

"Thought I couldn't do the job anymore when we were losing so many as they become part of your "family". Was short tempered at home, vivid dreams and trouble sleeping."

"Due to the strain within the department and lack of support I'm currently off work."

Some had a more positive experience: working outside of normal roles or being deployed into different services was seen as a challenge they embraced.

Other themes with more than 10 comments:

- Building and facilities, 33 pieces of feedback;
- Partnership or strategic work, 14 pieces of feedback;
- Access to services, 13 pieces of feedback.

Building and facilities:
One person commented: "Increase in agile working to keep numbers in buildings down and also helps reduce costs of parking etc for staff."

Many expressed how organisations' support for working from home had lessened the pressure they felt about childcare and home schooling.

Partnership or strategic work:
"Our experience of external agencies in Calderdale has been very positive, we have all grouped together to make sure no clients have gone without food, gas and electric."

"Multi practice working due to 'Hubs'. Greater appreciation for our working practices."

Access to services:
Some felt reliance on technology made reaching vulnerable people difficult, saying, adding it was difficult for some vulnerable people to overcome the virtual barrier to access online support groups.

Improvements or ideas for the future:

Staff wellbeing: Home or flexible working were options put forward to support staff in the future, along with greater communication with people working away from colleagues.

"Access to MS Teams means that previous barriers to WFH (working from home) have been reduced and will hopefully impact on the presenteeism cultures. The adjustments to support WFH will have a longer-term impact on some disabled staff as it will be harder to refuse reasonable adjustments which include WFH or other IT based solutions."

Service delivery:
Testing and sourcing equipment needed:

"The testing process has been extremely frustrating. For 2 weeks there were significant difficulties accessing symptomatic resident swabs. Staff and the home faced difficulties early in lockdown accessing basic food supplies and transport (actually had to use Beelivery to buy staff bread and milk). PPE was being actively diverted away from care homes into the NHS, this made ordering masks very difficult for small providers." Care home employee

Supply chain difficulties:
"Lack of PPE available, difficult to source required equipment."

A number of comments related to the child immunisation programmes, indicating the changes (health visitors supporting vaccinations) was a positive outcome once organised properly.
One medical worker said they wanted *"confirmation of what is the right thing to do"* going forward.

Communication:
"I suppose anything can be improved, but providing more information, and closer working with GP's and other providers to stop people turning up at

A&E." CHFT worker

Cleanliness, hygiene and infection control:

Communication:
"Clarification on the infection control grant why can we not spend it on PPE. No clear guidance. Are CCG going to explain to carers who drive (why) they get nothing but people who get the bus can get a free ride by taxi?" Care home employee

"Still not always enough information sharing and some 'local' procedures taking over from Government guidelines difficult to know which you should be following."

Testing:
"Care home support and testing - joined up approach, working more collaboratively."

Digital:
Training challenges, resolving IT issues and differing IT systems between organisations were highlighted as an area for improvement along with better communication. Some workers asked for better access to equipment, including two screens, printers and their own laptop.

"…More training is still required for care staff to use this technology more pressure and stress given to homes in this department."

"Provide training for Microsoft Teams to carers. All health professionals to use the same system; we have two laptops one for Local Care Direct for SALTS and nurses and yet the doctors use a different system - we are carers not IT technicians."

Comments relating to specific identified services:

CCG learning from different care home employees:
"Stop bombarding us with paperwork instead telling us to do this and do that. Support us and ask us. I find if you say anything bad to CCG everyone knows about it and you become the bad apple… Train your social workers to understand funding maybe send them on courses. So many times we were being asked to take residents through Covid-19 at a reduced priced. We are not charities and have overheads to pay being asked to reduce a price which is cheaper than home is an insult."

"CCG having a business plan to support care homes in this time of a pandemic Now everything is easing off, do not be adding more paperwork on to us we still haven't recovered from this."

"Added audits from the CCG. CCG threatening to remove residents if we did not comply with sending someone into our home who was not tested for Covid-19 for inspection."

Local authority, CQC and wider health network:
From care home worker: *"Infection Control Lead Sandra Beaumont has been outstanding; Calderdale Contracts team have been extremely supportive- especially Bernie and Tina. CQC have been very supportive of providers, the Emergency Support Framework from CQC was helpful and offered some structure."*

Care home: *"Calderdale and CQC have been very supportive and I have felt like they are just at the other end of the phone."*

Care home worker: *"The excellent Quest nurses, LA staff and my own staff who still came to work day after day knowing the people we were losing."*

NHS worker: *"Local authority and health using different IT systems for conference calls made it difficult for colleagues to join meetings. Also considering clients may not have up to date technology so therefore adapting and using teleconferencing systems."*

Public Health England:
Registered Manager of a care home: *"Felt very lonely at the beginning and the workload has been overwhelming in terms of managing updates from Public Health England: PHE and other sources. Guidance has been issued at twenty to 11 on a Friday night-completely overhauling PPE guidance. Centralised guidance with a checklist of what needs to be done would be really helpful-for example guidance has not been clear about what risk assessments might be needed, approach to furloughing, RIDDOR reporting etc."*

Pharmacy: *"Social distancing measures in place in local pharmacy when collecting prescription. Pharmacy doors closed, and spoke to pharmacist through a protected viewing window. The service was very prompt and professional."*

The health and care experiences of people living in Calderdale during the Covid-19 outbreak - appendices

August 2020

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Contents

Appendix 1: Methodology

To gather a full understanding of the experience of health and care services during the COVID-19 pandemic, Healthwatch Calderdale worked with a range of engagement partners to seek feedback from residents of Calderdale in different ways. With such a pertinent and current topic up for discussion, we felt it was essential that we offer the opportunity to engage with us in the way that best suits the individual and that we offer the facilitation to do this.

Healthwatch Calderdale was supported by Calderdale Clinical Commissioning Group, through the Calderdale Engagement Network links. This ensured that the engagement did not duplicate work being delivered elsewhere. A range of organisations had an opportunity to contribute and provide resources.

The approaches used were:

Experience survey

We developed a survey to help us understand how changes to care during the COVID-19 pandemic have impacted members of the public. The survey asked these key questions about individuals' experiences:

- Service(s) used/attempted to use
- Date of contact with service(s)
- If you were not able to access a service, why were you not able to access the service?
- Tell us more about the changes you experienced
- What was good about the service you received or delivered?
- What did not work so well?
- What would have made your experience better?
- Thinking about the changes to your health and care services, are there any changes you would like to become a permanent part of the service in the future
- Tell us more about your mental health during the COVID-19 pandemic

A full equality monitoring form was also conducted as part of the survey. This ensured we gathered a representative sample of views from the public and identified any inequalities to access or delivery of care.

We also created a survey, to ask specific questions to staff working during the Covid-19 pandemic who provided care for the public. The key additional questions were:

- Service(s) where you work
- What is your experience of working for your service during the COVID-19 outbreak?
- Are there any examples of good practice from the COVID-19 outbreak that you would like to share?

The survey has been widely promoted across the Calderdale area. Partners from the Calderdale Engagement Network have shared this through their communication routes including their service users. The online survey link has been publicised on

social media through tailored targeted marketing campaigns. This has encouraged diverse and under-represented groups to complete the survey.

Two Calderdale Engagement Champions (trained and supported by VAC) have been working with particular groups with protected characteristics to assist in completion of the surveys; they have targeted people with disabilities, and people from Calderdale's South Asian communities.

A copy of the survey, the distribution and communication plan, and a list of engagement partners involved in the work can be found at Appendices 7,8 and 9.

Capturing stories

Alongside the survey on the Healthwatch Calderdale website, there is a list of creative ways in which you can share your COVID-19 health and care experiences. Staff designed specific tools to provide ideas for how people could share their stories. For example, a word search and a postcard to your future self. Other requests included sharing artwork, poems and other creative pieces that they have completed at this time.

Some specific resources were designed for children and young people, such as designing your own emoji, or sharing a lyric or sentence with us that was significant in the pandemic.

We also shared a more traditional case study template, in case people wanted to tell a fuller version of their experience, rather than putting it in to the survey. We promoted the opportunity to leave a review of your care experience on our website. We know that some services have adapted in a way that people have really valued, and it's good to be able to share that publicly, along with understanding where people have struggled to get access.

Again, these tools have been promoted through social media and on our website.

Working creatively with community groups

Where we know some communities face additional barriers when sharing feedback about care experiences, we have continued to work creatively with community groups. We have maintained ongoing contact with services such as St Augustine's, who support asylum seekers and refugees. We've reached out to organisations supporting people with learning disabilities to do video call activities. We've used our connections at one of the local Mosques to ask people to share 1 line of their experience with us, in a format of their choice for example, audio recording, in their preferred language. We have also experimented with different digital tools for engagement. For example, a group of around 30 young people linked with us and shared their views using Snapchat

Appendix 2: Demographics

Service users and representatives of person needing care

We had a total of 346 responses from services users and representatives of people requiring either NHS or social care during the Covid-19 outbreak. Of these 212 people were service users and the remaining 134 responses were from representatives (family, carer, advocate) of people who had required NHS or social care.

The gender of respondents was as follows:

Gender	Number of participants
Female	159
I describe my gender in another way	2
Male	105
Blank	80
Grand Total	**346**

Figure 1: Gender of respondents - service users and patient representatives

In terms of age range, respondents comprised the following groups:

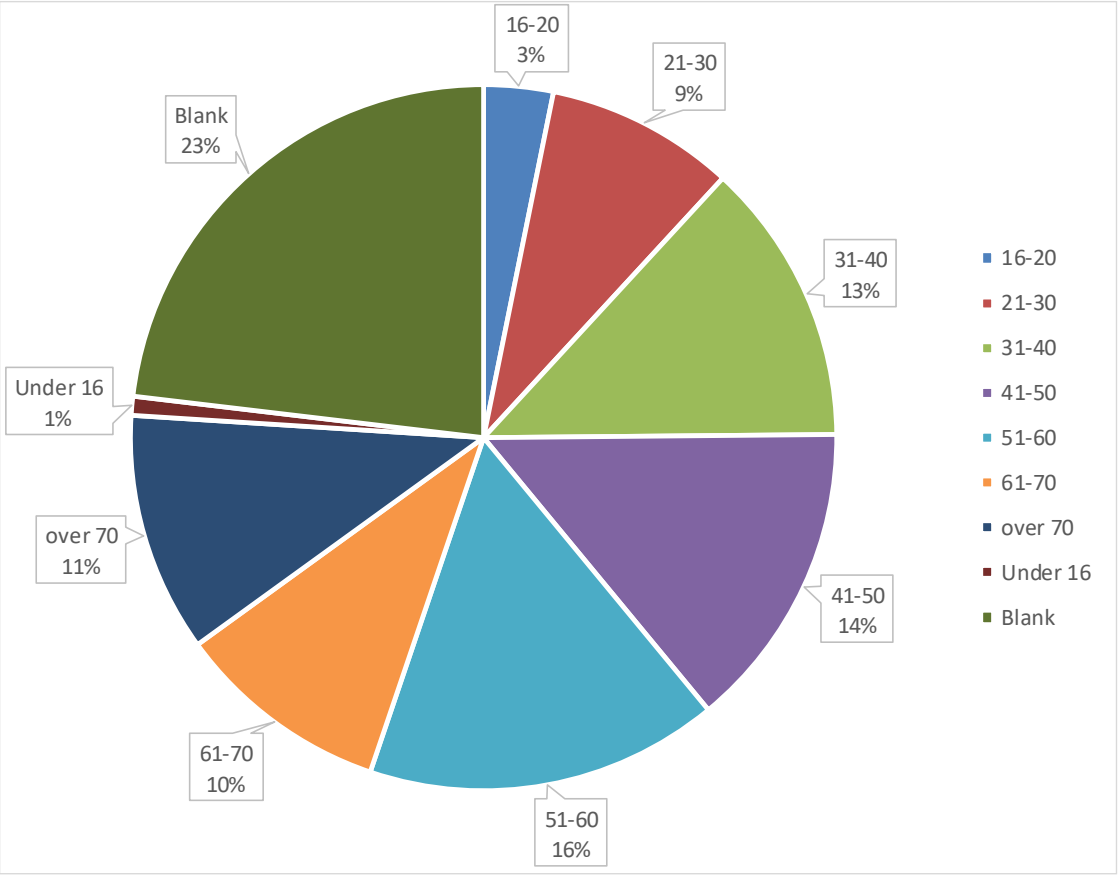


Figure 2: Ages of respondents - service users and patient representatives

Only a small number of the respondents (4%) were children or young people (aged up to 20). It was recognised that the survey was not the most appropriate way of engaging with this group. Therefore, experiences from individuals in this age range were collected by other means (stories, songs, informal chats on social media, pictures, poems, word clouds).

Survey participants came from many areas of Calderdale, though some postcode areas were more widely represented in the data than others:

Postcode area	Number of respondents by postcode area
HD4	1
HD6	24
HX1	63
HX2	57
HX3	83
HX4	11
HX5	18
HX6	15
HX7	15
OL14	29
Blank	30
Grand Total	**346**

Figure 3: participants by postcode area: service users and representatives

81% of these respondents had needed to contact a health service during the Covid-19 outbreak, whilst only 9% people reported needing to contact care services (social care, residential home, nursing home). 58% people reported problems contacting health and/or care services.

The most frequently contacted services in order of contacts were: General Practitioners (GPs), hospitals, pharmacies and community services (for example district/community nurses, maternity services).

Service name	Number of visits
Adult Social Care	9
Ambulance/111/Urgent care	30
Blank	99
Children's Social Care	1
Community services	39
Dentist	26
Disregarded	11
GP	253
Hospital	83
Mental Health Service	13
Optician	5
Other	2

Pharmacy	82
Grand Total	**653**

Figure 4: Number of visits per service

The graphs to follow show the number of contacts per month during the Covid-19 outbreak for each service type.

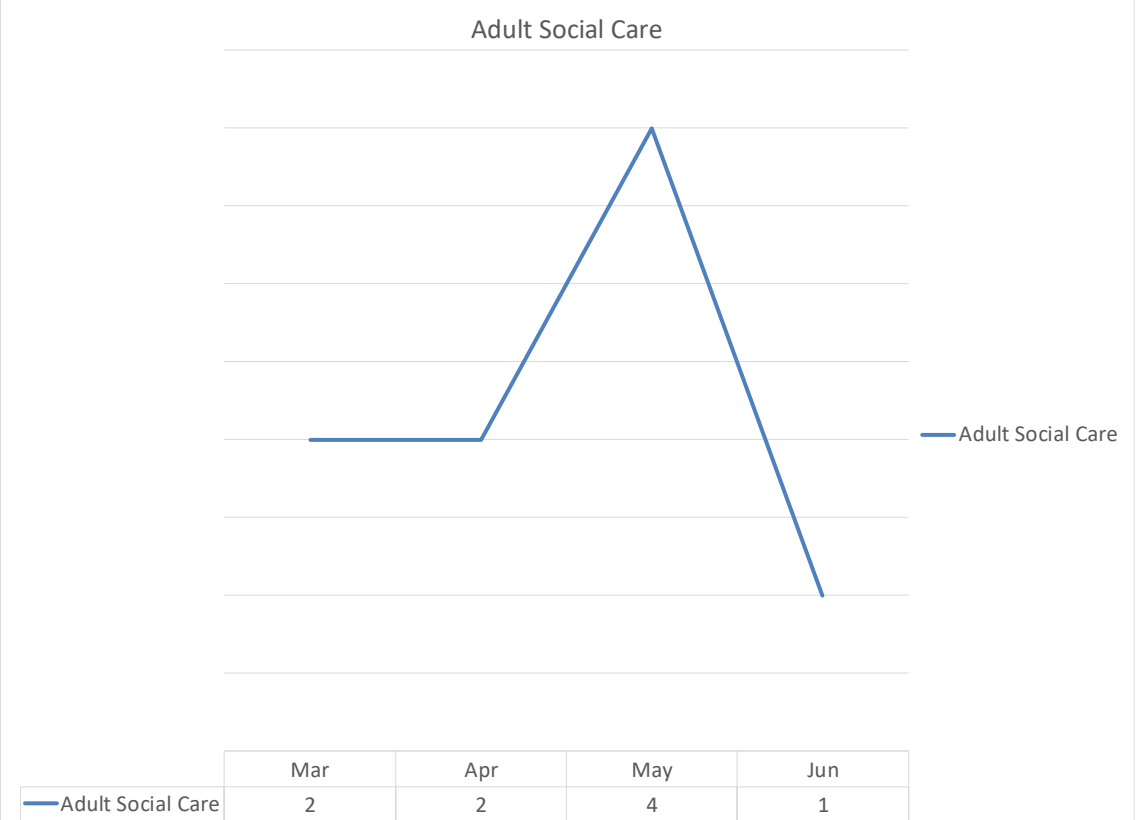
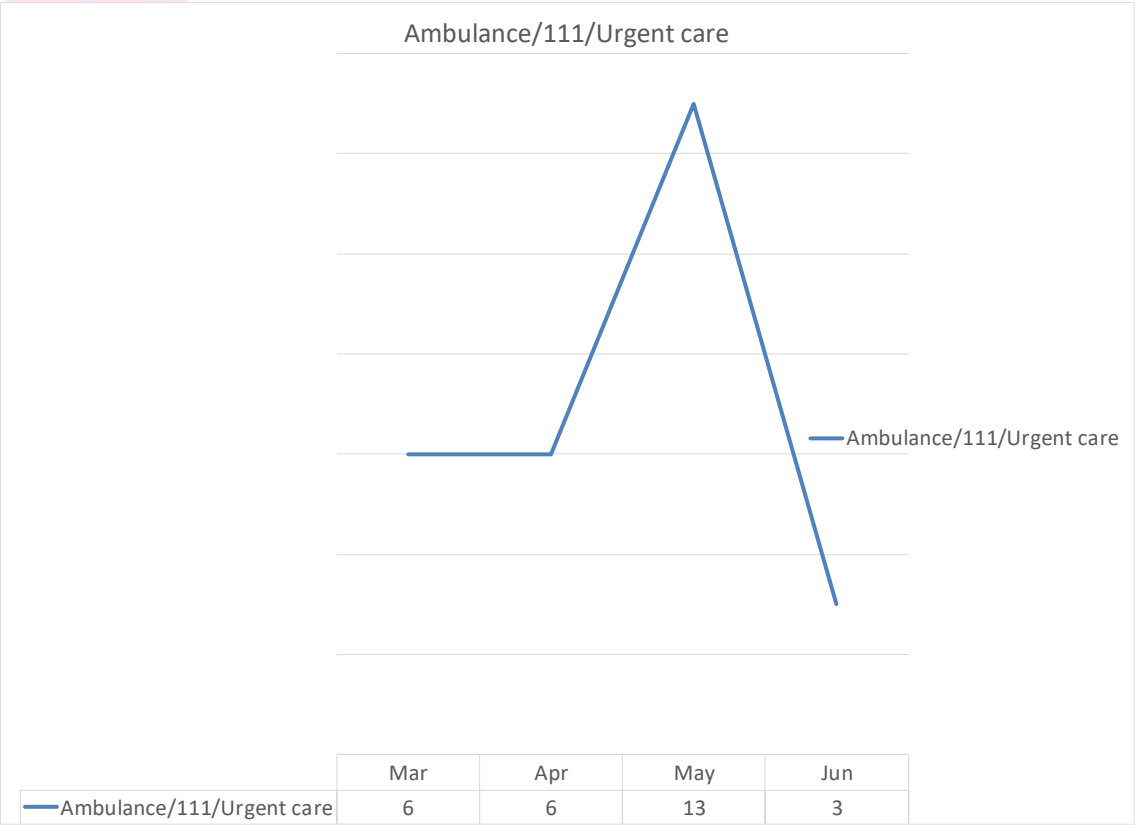
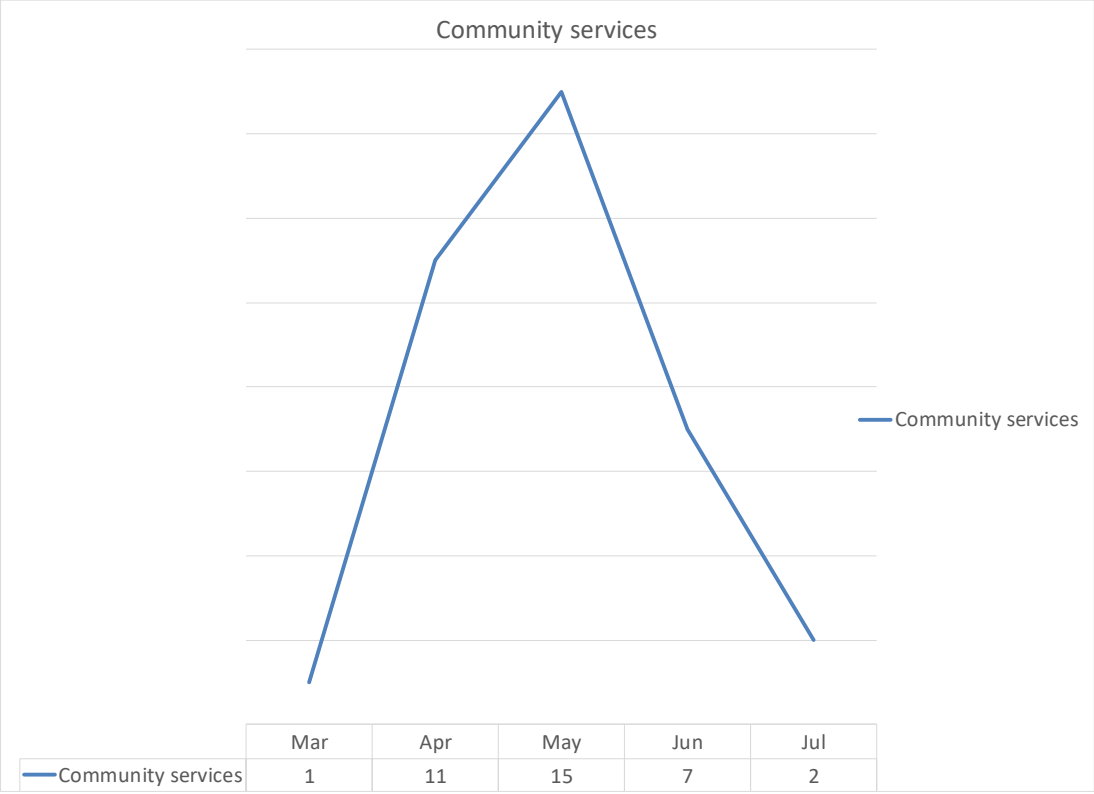


Figure 5: Adult social care contacts



	Mar	Apr	May	Jun
Ambulance/111/Urgent care	6	6	13	3

Figure 6: Ambulance/111/Urgent care contacts



	Mar	Apr	May	Jun	Jul
Community services	1	11	15	7	2

Figure 7: Community services contacts

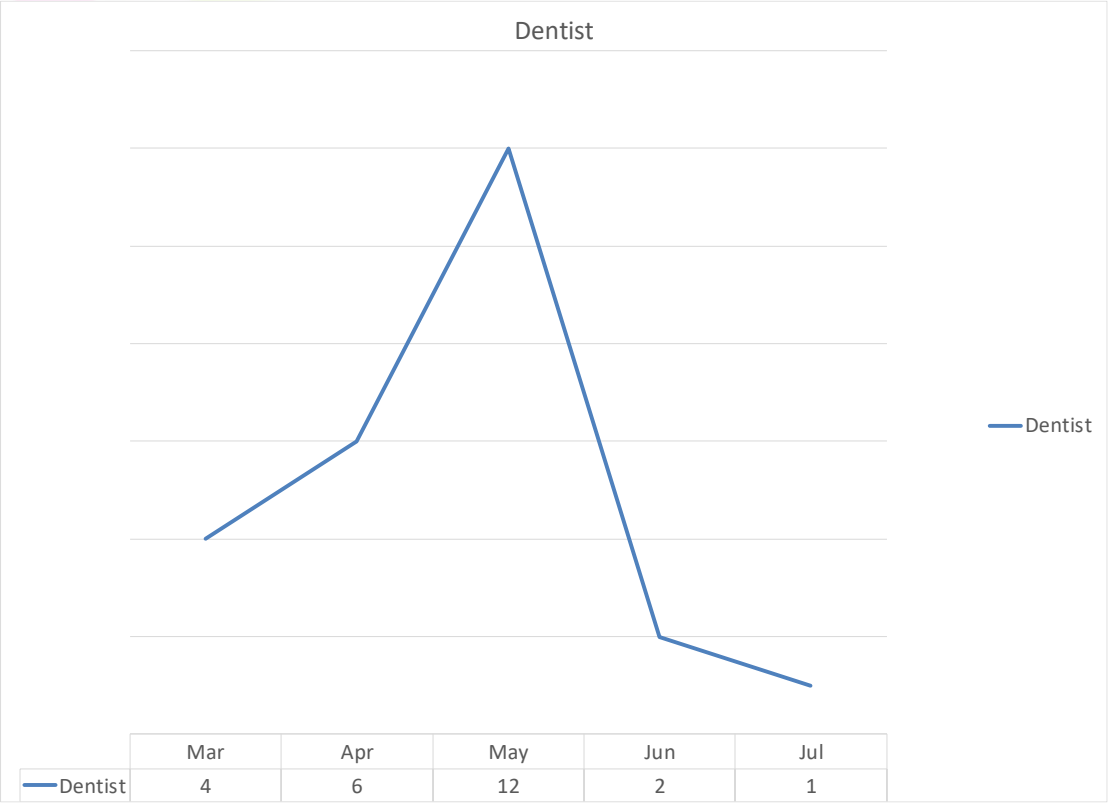


Figure 8:Dentist contacts

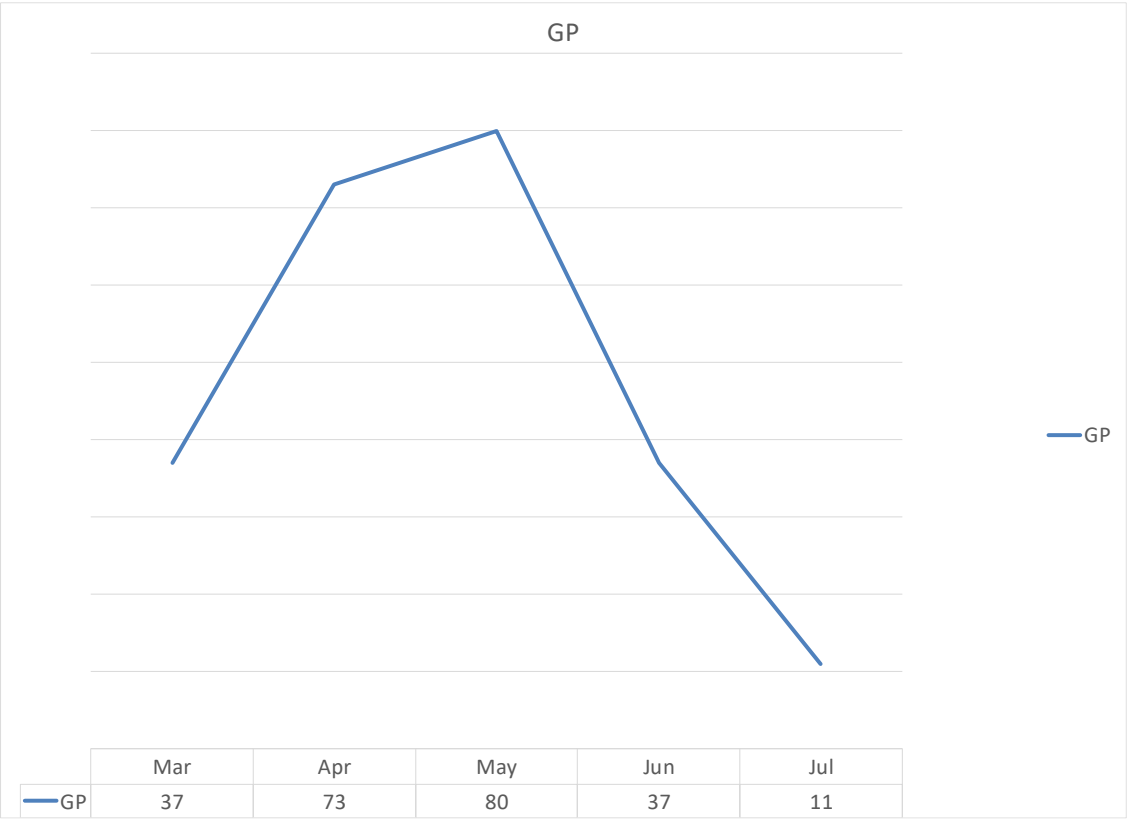


Figure 9: GP contacts

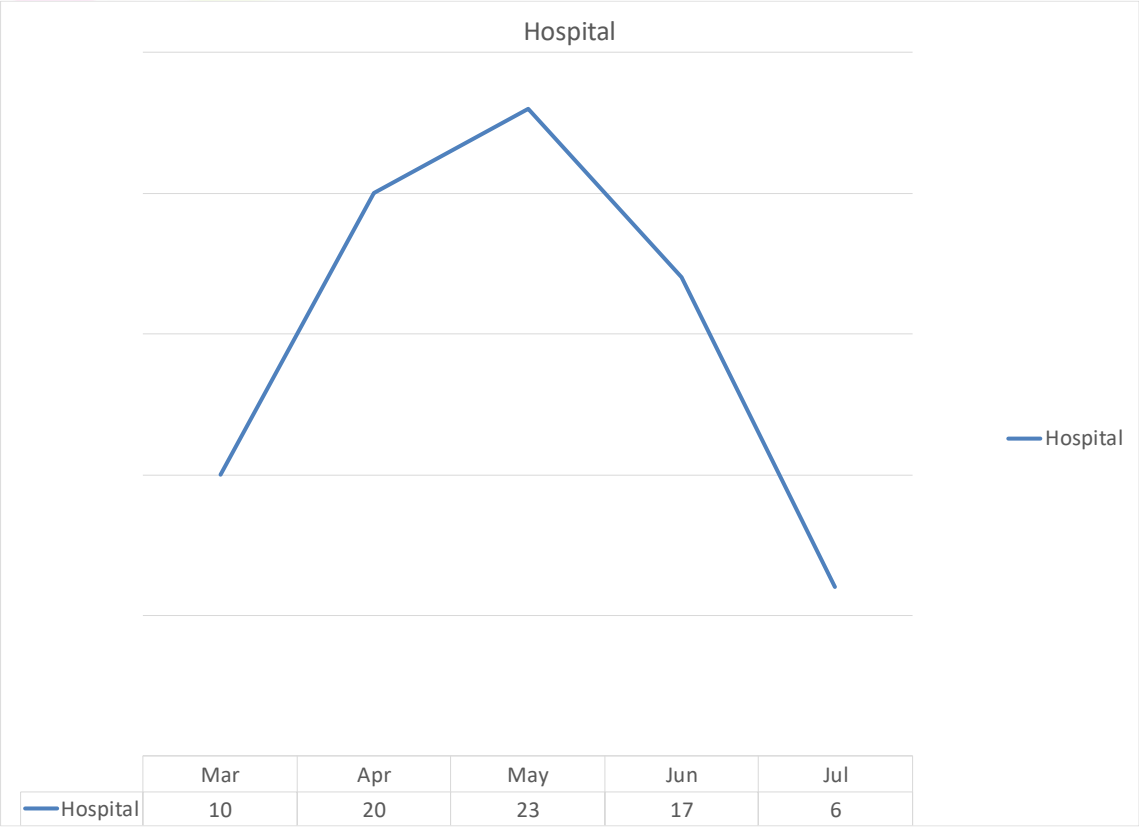


Figure 10: Hospital contacts

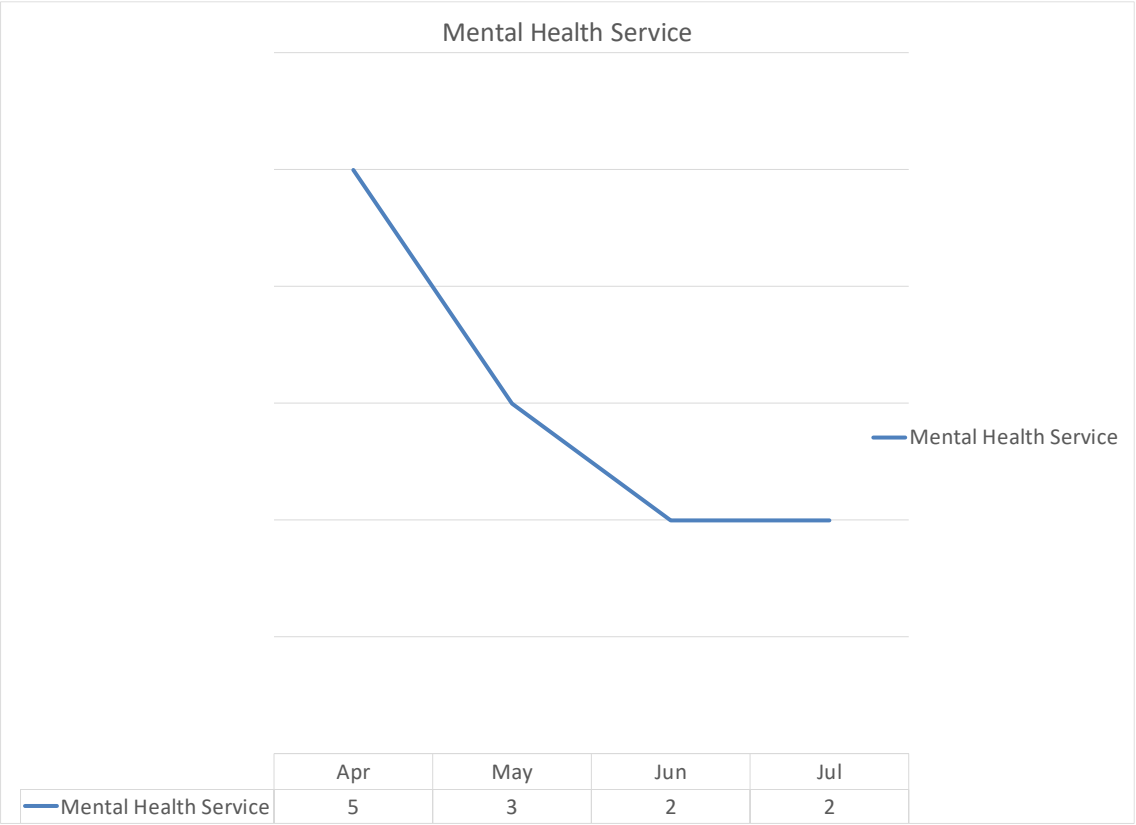


Figure 11: Mental health services contacts

Figure 12: Opticians contacts

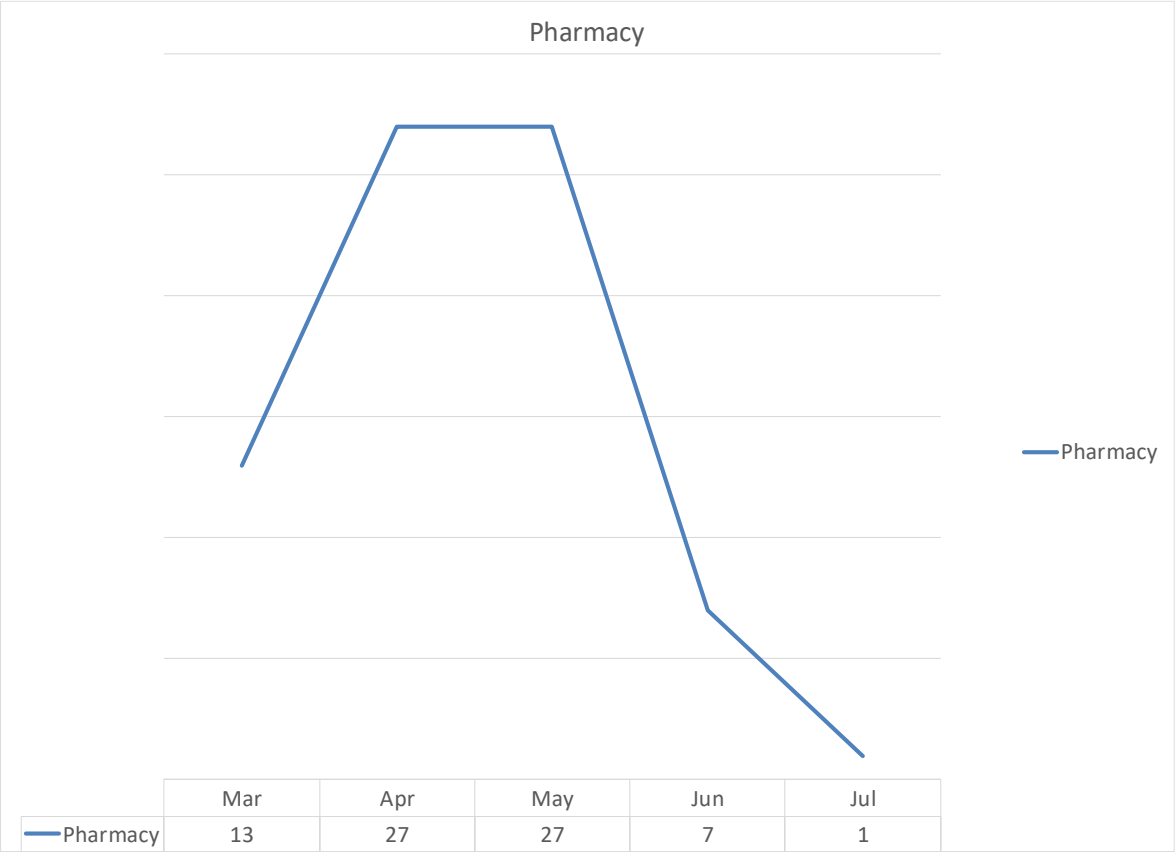


Figure 13: Pharmacy contacts

Women were far more likely to contact services (61% of total contacts) than men (23% of total contacts) or people who described their gender in other ways (0%). Women accessed adult social care, ambulance/111/urgent care, community services, dentists, GPs, hospitals and pharmacies more frequently in the period than men or people who described their gender in other ways.

Services used	Female	Male	Describe gender in other way	Blank	Grand Total
Adult Social Care	8	1	0	0	9
Ambulance/111/Urgent care	19	7	0	3	29
Blank	9	24	1	54	88
Children's Social Care	0	0	1	0	1
Community services	28	9	0	2	39
Dentist	17	6	0	3	26
Disregarded	9	2	0	0	11
GP	177	60	0	16	253
Hospital	60	11	0	12	83
Mental Health Service	5	8	0	0	13
Optician	1	4	0	0	5
Other	1	1	0	0	2
Pharmacy	54	16	0	12	82
Grand Total	**388**	**149**	**2**	**102**	**641**

Figure 14: Service contacts by gender

Men were more likely to access mental health services (61%) and opticians (80%) than women (39% and 20%) respectively and people who described their gender in other ways (0%).

In terms of age, the age range of people who made most overall service contacts were people aged 41 to 50. This group made the highest number of contacts in terms of hospitals and pharmacies. People aged 31-40 made the most community services contacts. This can be explained by the fact that a large number of visits to community services were for maternity related appointments. Those in the age ranges 51-60 made more GP visits than those in other age ranges.

Service	Age range									
	> 16	16-20	21-30	31-40	41-50	51-60	61-70	<70	Blank	Grand Total
Adult Social Care	0	0	1	0	1	1	6	0	0	9
Ambulance/111/ Urgent care	0	2		3	8	7	4	2	3	29
Blank	1	2	3	4	5	6	4	8	55	88
Children's Social Care	0	0	0	0	1	0	0	0	0	1
Community services	0	0	9	13	3	6	4	2	2	39
Dentist	0	1	4	1	3	7	4	4	2	26

Disregarded	0	1	0	2	1	4	2	1	0	11
GP	1	24	24	37	43	57	26	25	16	253
Hospital	0	3	3	5	24	17	8	11	12	83
Mental Health Service	0	0	1	4	7	0	1	0	0	13
Optician	0	2	1	1	0	0	1	0	0	5
other	0	0	0	1	0	0	1	0	0	2
Pharmacy	1	2	6	12	24	6	8	11	12	82
Grand Total	**3**	**37**	**52**	**83**	**120**	**111**	**69**	**64**	**102**	**641**

Figure 15: Service use by age range

There were also differences in how many service contacts were made by people from different ethnic groups. People from white ethnic groups were far more likely than those belonging to other groups to contact GPs, ambulance/111/Urgent Care Centres and hospitals. The table below shows this in detail:

Ethnic group	Asian	Black or Black British: African	Other	Other ethnic groups: Arab	Prefer not to say	White	Blank	Grand Total
Service								
Adult Social Care	1	0	0	0	0	8	0	9
Ambulance/111/Urgent care	3	0	1	0	0	21	4	29
Blank	16	0	0	0	2	15	55	88
Children's Social Care	0	0	0	0	0	1	0	1
Community services	14	0	0	0	0	23	2	39
Dentist	8	0	1	3	0	12	2	26
Disregarded	3	0	0	0	0	8	0	11
GP	40	1	1	0	7	187	17	253
Hospital	4	0	0	0	1	65	13	83
Mental Health Service	4	0	0	4	0	5	0	13
Optician	4	0	0	0	0	1	0	5
Other	0	0	0	0	0	2	0	2
Pharmacy	14	0	0	0	0	56	12	82
Grand Total	**111**	**1**	**3**	**7**	**10**	**404**	**105**	**641**

Figure 16: Service access by ethnic group

In terms of place of birth, the majority of respondents were born in the United Kingdom (66%). 10% stated they were born elsewhere, specifically Bangladesh, Kashmir, Nigeria, Pakistan, Poland, Sudan, Sweden, The United Arab Emirates and Zambia.

Place of birth	Number of respondents
United Kingdom	229
Other	36
Prefer not to say	1
Blank	80
Grand Total	**346**

Figure 17: Place of birth of respondents

As far as religion was concerned, Islam was the most frequently mentioned religion (29% of respondents). 24% of respondents stated they had no religion and 20% of participants stated they were Christian.

Religion	Number of respondents
Islam	99
No religion	82
Christianity (all denominations)	68
Prefer not to say	14
Hinduism	1
Judaism	1
Blank	80
Grand Total	**346**

Figure 18: Respondents by religion

Of all respondents, 45% were white, 29% were Asian, 6% were other ethnic groups: Arab, 1% were black and 0% were any other ethnic group. 23% of respondents did not answer this question and 2% preferred not to state their ethnic group. These figures are rounded to the nearest whole.

General ethnic group	Specific ethnic group	Number of respondents
White	White: English, Welsh, Scottish, Northern Irish, British	140
	White: Irish	5
	White: Other	12
Asian	Asian or Asian British: Bangladeshi	6
	Asian or Asian British: Chinese	1
	Asian or Asian British: Indian	6

	Asian or Asian British: Pakistani	86
Other ethnic groups: Arab	Other ethnic groups: Arab	2
Black		1
Any other ethnic group	Any other ethnic group	1
Blank		80
Prefer not to say		6
Grand Total		**346**

Figure 19: Respondents by ethnic group

In terms of disability, 67% of respondents did not consider themselves to be disabled. A total of 31% of respondents stated they were disabled and a further 2% preferred not to say.

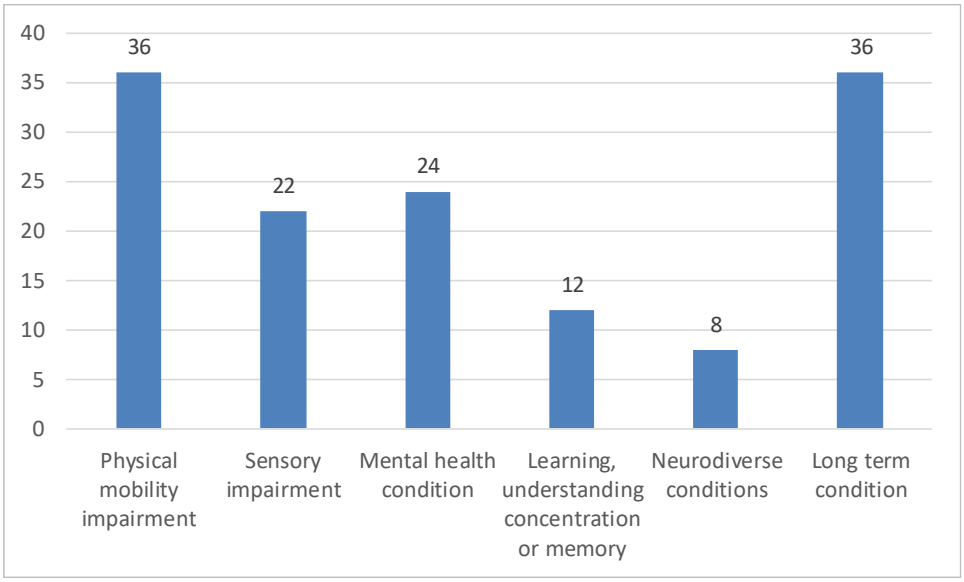


Figure 20: Respondents by disability

With regard to sexuality, respondents categorised themselves as follows. A total of 264 respondents provided an answer to this question.

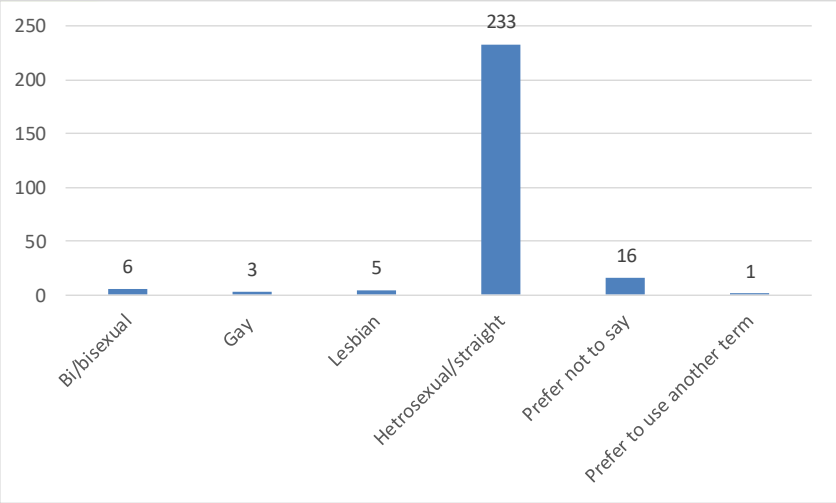


Figure 21: Respondents by sexuality

One person considered themselves to be trans and 4 people preferred not to answer this question.

With regard to carers, 25% of respondents stated they were carers, whilst 51% said they were not carers.

Carer	Number of respondents
Yes	85
No	177
Prefer not to say	4
Blank	80
Grand Total	**346**

Figure 22: Carers among respondents

A total of 26% of participants stated that they were parents or primary carers to children.

Parent or primary carer	Number of respondents
0-4	34
5-9	18
10-14	25
15-19	12
Not applicable	144
Prefer not to say	9
Blank	104
Grand Total	**346**

Figure 23: Parents or primary carers to children among respondents

Of the respondents, 3% were pregnant or had given birth in the last six months.

Pregnant	Number of respondents
No	245

Prefer not to say	2
Yes	11
Blank	88
Grand Total	**346**

Figure 24: Number of respondents who were pregnant/had given birth in last 6 months

In terms of benefits, 27% of respondents stated that they were receiving one of the following types of benefits:

- Universal Credit
- Housing benefit
- Income Support
- Pension Credit Guarantee Credit Element
- Child Tax Credit
- Incapacity Benefit/Employment Support Allowance
- Free School Meals
- Working Tax Credit
- Council Tax Benefit

49% stated that they did not receive the above listed benefits, 0.5% of participants preferred not to answer this question and the remaining respondents left this answer blank.

Staff

We had a total of 51 responses to the survey from health and care staff working in Calderdale. Three participants did not provide Healthwatch Calderdale with consent to use their data anonymously and to share the project's findings with other organisations. One respondent did not work in Calderdale. These responses have therefore been excluded from the analysis of staff data.

In terms of gender, 29 responses came from female staff members (62%), 7 from male staff (15%) members. A further 11 participants (23%) did not answer this question. Male respondents stated they worked either for the Clinical Commissioning Group (CCG) or Calderdale and Huddersfield NHS Foundation Trust (CHFT). Female respondents worked for a wider range of organisations.

The age ranges of respondents were as follows:

Age range	Number of respondents
21-30	2
31-40	11
41-50	12
51-60	10
61-70	1
over 70	0
Blank	11
Grand Total	**47**

Figure 25: Age range of staff respondents

Respondents worked in postcodes HX1 to HX7 as well as in HD3. The largest number of respondents came from people working in the HX3 postcode area.

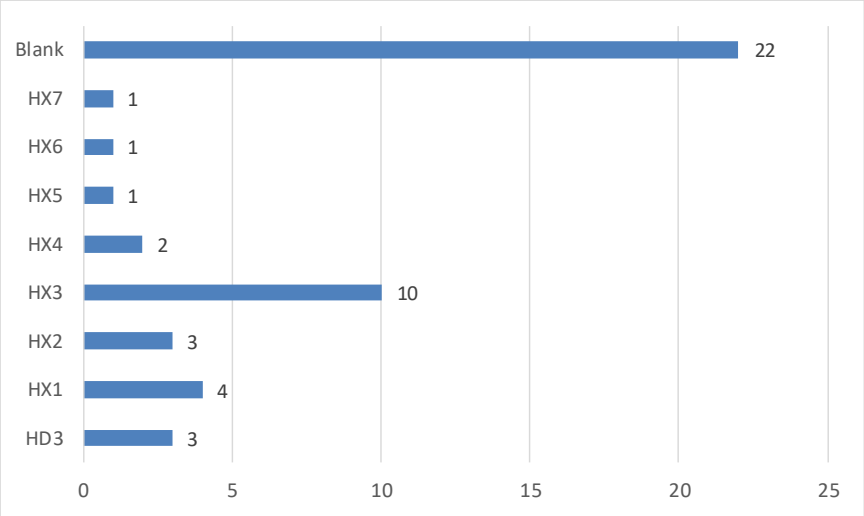


Figure 26: Staff by postcode worked in

CCG staff represented the largest numbers of responses, followed by care home and CHFT staff.

Service name	Number of respondents
Blank	1
Care home	9
CCG	14
CHFT	9
Disregarded	3
GP	4
NHS not specified	1
Primary Care Network	1
social services	1
SWYFT	1
Voluntary sector organisation	3
Grand Total	**47**

Figure 27: Number of staff respondents per service

The ethnic groupings of the respondents were as follows:

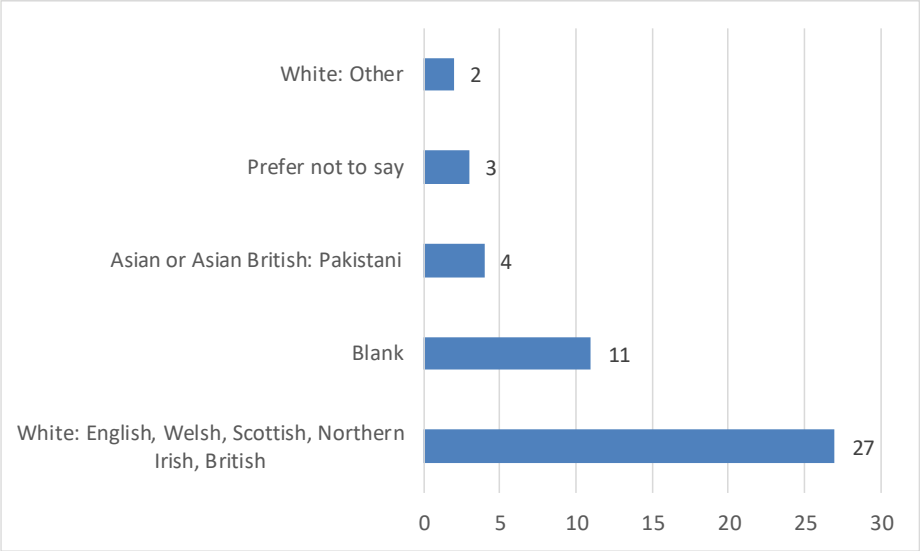


Figure 28: Respondents (staff) by ethnicity

Of these all Asian or Asian British Pakistani respondents were male. The remaining male respondents were White English, Welsh, Northern Irish, British.

Religion	Number of respondents
Buddhism	1
Christianity (all denominations)	17
Islam	4
No religion	9
Other	2
Prefer not to say	1
Sikhism	2
Blank	11
Grand Total	**47**

Figure 29: Respondents (staff) by religion

A total of 35 respondents were born in the UK (74%), 1 participant was born in Poland (2%) and 11 respondents (23%) declined to answer. These answers are rounded to the nearest whole number. The main religion of respondents was Christianity (36%). 19% of participants said they had no religion. One person (2%) stated their religion as other and specified this to be humanist.

In terms of disability, 4 respondents (11%) stated that they were disabled. Mental health conditions (2 respondents) and neuro diverse conditions (1 respondents) were the only disabilities specified.

With regard to sexuality, most respondents were heterosexual/straight (64%), 6% were lesbian and 2% preferred not to say. 28% of respondents chose not to answer this question. There were no respondents who stated that they considered themselves to be trans.

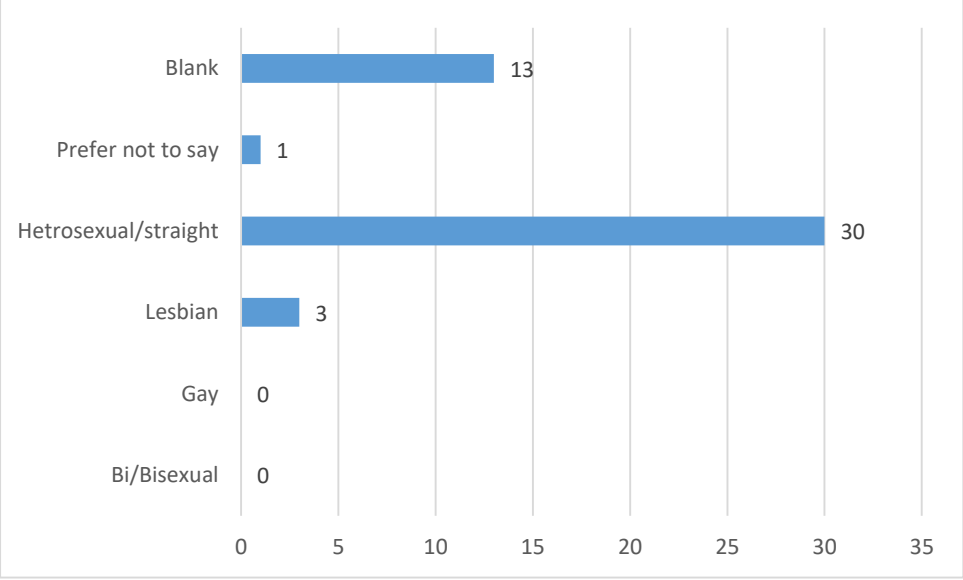


Figure 30: Respondents (staff) by sexuality

A total of 21% of respondents were also carers. 55% stated that they did not provide unpaid care/support to someone who was older, disabled or had a long term condition and 23% of

participants left this answer blank. These answers are rounded to the nearest whole number.

A number of staff respondents were also parents or primary carers to children (30%):

Parent or primary carer	Number of respondents
0-4	2
5-9	2
10-14	6
15-19	4
Not applicable	13
Prefer not to say	3
Blank	17
Grand Total	**47**

Figure 31: Parent of primary carers among staff respondents

There were no staff members who identified themselves as being pregnant or who had given birth in the last six months. 77% of participants stated they were not pregnant and a further 23% left this answer blank.

15% of respondents were in receipt of one the following benefits Universal Credit, Housing Benefit, Income Support, Pension Credit Guarantee Credit Element, Child Tax Credit, Incapacity Benefit/Employment Support Allowance, Free School Meals, Working Tax Credit. 62% of respondents stated they did not receive these benefits and the remainder (23%) did not indicate whether or not they received benefits.

Appendix 3: Creative feedback from children

CYP%20report%20FINAL.pptx

Appendix 4: Creative feedback from adults

Stories%20FINAL.pdf

Appendix 5: Mapping of Calderdale engagement work

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
1	Healthwatch Calderdale (leading a partnership engagement piece for Calderdale, including CCG)	End of May	End of August (break point end of July)	No – also Kirklees	Understanding people's experience of accessing health and care services during the Covid-19 pandemic	Survey – shared widely by Calderdale engagement partners Story telling resources	Helen Hunter Karen Huntley	Yes
2	Calderdale Council	Late summer		Yes	Calderdale Conversations – focus for the whole council on talking to Calderdale residents to seek their views on how Calderdale recovers, post-Covid, and on the climate emergency	Varied – but likely to be open questions put to members of the public in a variety of ways and settings	Mike Lodge	Yes
3	Calderdale Council – Public Health	April	Ongoing	Yes	Learning about the ways in which your experiences of Covid-19 are different if you are from a	Telephone interviews Group discussions via Zoom Leaflet drop, engaging with	Kate Horne Shebana Sadiq Sail Suleman	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
					BAME community, including information about risks, lifestyle, physiology, etc… To work with key businesses and services , deliver key messages , work with faith organisation with collegaues	business, residents key stakeholders, email and telephone		
4	Calderdale Council – Public Health	July		Yes	Engagement work with communities to help us understand how effective Test and Trace can be, whether people will adhere to requests to isolate		Jess March	
5	Calderdale Council – Communities	April	Ongoing	Yes	Meeting is to help coordinate the response	Sowerby Bridge Covid 19 Voluntary	Graham Gibbons	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
					between the Council and the voluntary Sector. Meetings started in April and take place every 3-4 weeks and are ongoing.	Sector support meetings – Zoom meetings between the Council and the voluntary sector groups supporting people through the Covid Crisis.		
6	Calderdale Council – Communities	Mid July		Yes	To talk about how Covid 19 has impacted on relationships between groups of people.	Council's Cohesion Team - is supporting the Belong Network with a research project for Covid-19 and Cohesion. This will involve online/ virtual discussion groups	Sail Suleman	
7	Calderdale Council – Communities	August	Ongoing	Yes	The meetings have been on hold due to Covid but are restarting. The boards focus is partnership regeneration	Town Development Boards – Council led - occur regularly every 8 weeks in the main townships.	Graham Gibbons	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
					between the Council, businesses and voluntary organisations. Not Covid specifically but encompass a wide variety of projects and local priorities and representation from the community			
8	Calderdale Council – Communities (including Himmat, Halifax Central Initiative)	July	Ongoing	Yes	Supporting employment opportunities with BAME/EU communities, focused particularly on young people	Zoom, face to face (social distancing)	Asif Hussain	Yes
9	Together Housing			No – other areas where Together Housing have properties	Gathering residents' views on how Together Housing has delivered support during Covid-19		Mark Patterson / Linsay Severn	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
10	Disability Partnership Calderdale	July	End of August	Yes	Gathering experiences of disabled people whilst out shopping in Calderdale	Survey / comms plan	Julie Stott	Yes
11	South West Yorkshire Partnership NHS Foundation Trust (SWYT)	ASAP	End of August	No – also Wakefield, Kirklees & Barnsley	Experience of using services during COVID19	Online, paper survey, discussion groups	Dawn Pearson	Yes
12	Calderdale and Huddersfield NHS Foundation Trust (CHFT) 1 staff engagement piece 1 public engagement piece	May 2020	Staff survey 31st May Patient survey 13th July	No - also Huddersfield	To learn from people's experience of delivering (staff) and accessing (patients and public) services during Covid19 and to help us provide 'Business better than usual' as we move forward. In both surveys we asked for ideas of how we should deliver services in the	Internally - We have had a large number of meetings with staff groups across all clinical and non-clinical areas and external partners including CCGs, local authorities etc. Externally – We published a survey on our website, promoted it on	Internal - Rebecca Sharpe / Nicola Bailey External – Claire Sibbald	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
					future as well as requesting feedback on peoples experience.	Facebook and twitter, sent text messages to circa 24,000 patients and emails to 1000 patients, volunteers and Trust members. We also sent the information and link out to several community groups and organisations via both Calderdale and Huddersfield CCGs and Healthwatch also promoted it.		
13	Locala			No – Kirklees predominantly	To learn about people's experiences of accessing Locala services during Covid-19.	"Doing things differently" survey	Emma Dickens	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
14	North Halifax Partnership	Will take place over the next few months		Yes	Community listening approach, focused on "reimagining communities". The focus will be "what make a good life in North Halifax"	Conversations with residents in the area	Tina Burke Rachel Swaby	
15	Upper Valley Test and Trace Community Pilot	Early July		Yes	Understanding more about people's Covid experience	Survey shared through social media and Upper Valley organisational links	Colin Hutchinson Jenny Shepherd	
16	WomenCentre	Early June	End of August	No – also Kirklees	Women in Lockdown Project capturing the Covid-19 experiences of women, so that these can be used in creative ways, such as dance and poetry	Survey/case study template/online workshops	Emily Druce Emma Townend	
17	VAC (leading a partnership of local VCS	Late summer	By end of 2020	Yes	Under the Health Inequalities Funding bid,	Community reporters approach – sharing stories	Dipika Kaushal Hayley Trowbridge	

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
	and statutory organisations)				gathering an understanding of how North Halifax and Central Halifax have been impacted by Covid-19 to enable the design of valuable interventions	of lived experience		
18	Voluntary and Community Sector Alliance	Early July	31st July	Yes	Calderdale VCSE Mental Health Impact Survey to establish how voluntary sector organisations are being impacted by changes in people's mental wellbeing and managing themselves	Online survey	Jayne Leech	
19	Maternity Voice Partnership (MVP)	Late July	28th August	No – also Kirklees	Understanding more about women's experience of accessing maternity	Online survey	Anna at Calderdale and Huddersfield MVP	Yes

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
					services during the Covid-19 pandemic			
20	Harnessing the Power of Communities (West Yorks)	April	End of May	No – across West Yorkshire	Understanding how the delivery of services in the voluntary sector has changed during Covid-19, and how sustainable that is	Survey	Jo-Anne Baker	Yes
21	Autism Engagement (West Yorks)	July	End of August	No – across West Yorkshire	Gathering the views and experiences of people living with Autism through this Covid-19 period, and before	Survey	Shelley Russell	
22	Planned Care (West Yorks)	Late summer		No – across West Yorkshire	Gathering an understanding of how people want to access planned hospital care in the post Covid-19 NHS set up	Mixed methods – still being developed	Christine Hughes / Catherine Thompson	

	Lead organisation delivering engagement	Start date	Completion date	Calderdale only?	Focus of the work	Methods	Key Contact	Happy to share findings?
23	Cancer Research UK		Unknown	No – across the UK	Gathering an understanding of how people receiving cancer treatment, diagnosis and care were impacted by the pandemic	Unknown	Complete report at this link	See report

Appendix 6: 'I' statements Long Term Plan

- I care about the NHS
- Listen to me
- Care about me and respect me
- See me as a whole person
- Support me to better care for myself and be there for me when I have problems
- Don't keep me waiting
- Encourage and assist me to use digital technology but don't let that replace all human contact
- Share my information with each other and work together to deliver my care
- Understand that if I have a mental health condition, I am typically having a poorer care experience
- Understand that if I am from a BAME community, I typically have less knowledge of upcoming initiatives, technologies and terminologies
- Look after the people who care for me

Appendix 7: List of partners and places contacted for engagement

- Residents of Calderdale - from young to old
- Health and care workers in Calderdale
- Healthwatch Calderdale
- Calderdale Clinical Commissioning Group
- Calderdale Metropolitan Borough Council
- Calderdale Disability Partnership
- St Augustine Centre
- Lead the Way
- The Stroke Association (Calderdale branch)
- Voluntary Action Calderdale
- Local mosques
- South West Yorkshire Partnership NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Locala
- St Augustine's Centre
- Lead the Way
- Healthy Minds
- Calderdale NAS
- Specialist Autism Services
- Sisters United
- Wheelchair Enabling Society
- Disability Support Calderdale

- Calderdale Forum 50+
- Staying Well Calderdale
- YODA (Young Onset Dementia & Alzheimer's Peer Support Group)
- Halifax & Calder Valley MS Society
- Different Strokes Calderdale
- Brunswick Centre
- Valley of Sanctuary
- Halifax Blind Society
- Calderdale Deaf Association
- Unique Ways
- Imagineer
- Unmasked Mental Health
- The Hive Halifax
- Calderdale Carers
- WAC (Women's Activity Centre)
- Calderdale Women Centre
- Alzheimer's Society
- Andy's Mans Club
- Memory Lane Café
- The Artworks
- Society for Neurodiversity (S4ND)
- Noah's Ark Centre
- The Phoenix Shed
- Calderdale MS Society
- Living Well Calderdale
- Calderdale Smartmove
- Healthy Mums Calderdale
- Light Up Black and African Heritage Calderdale (Light up Bahc)

Appendix 8: Survey

Your health and care experiences during the Covid-19 outbreak - Calderdale and Kirklees

We want to hear from people who have needed or worked in health and/or care services during the Covid-19 outbreak, so we've created this survey to ask people for their stories. There are lots of questions on this survey but you'll only be asked some of them, depending on your experiences.

Our job at Healthwatch is simple. We're here to help make health and care work better for everybody. During this challenging time of Covid-19, this role has never been more important.

Healthwatch Calderdale and Healthwatch Kirklees are gathering feedback regarding local people's experiences of accessing and working for health and care services during the Covid-19 outbreak. We are doing this in partnership with Calderdale Clinical Commissioning Group (which plans and buys healthcare services for Calderdale), Calderdale Council and voluntary and community organisations in Calderdale, and we are supported by the North Kirklees and Greater Huddersfield Clinical Commissioning Groups.

If you have made contact with, tried to contact or worked for any health or care services during the Covid-19 outbreak, please fill in our survey. Whatever your experience, we want to hear from you.

Health and care services have had to quickly change the way they work and deliver services in response to Covid-19. Whilst health and care staff are doing everything they can to keep us well during this crisis, there might be things that can be improved. There may also be positive changes to your care.

By filling in this survey you can help services to understand how you feel about the changes made to health and care services and the issues that are affecting you. It's our job to listen to people's experiences, then share their views with those who can do something about it.

We want to ensure that the positives in health and care during the Covid-19 outbreak are not lost and the negatives do not become the norm.

Everything you tell us will be anonymous – but we believe your feedback will help us shape future health and care and make a positive difference.

This survey will be open until 28th August 2020

Thank you!

* 1. **Consent:**

I give my consent for Healthwatch Calderdale and Healthwatch Kirklees to use my data anonymously and to share the project's findings with other organisations, such as the Clinical Commissioning Groups and Councils

- [ ] Yes
- [ ] No

* 2. Are you

- [ ] The person who needed a health and/or care service?
- [ ] A family member, carer or representative of a person who needed a health and/or care service?
- [ ] The person who works for the health or care service? Please tell us which service you work for

3. Which area do you live in?

- [ ] Calderdale
- [ ] Kirklees

What is the first part of your postcode? E.g. HD1, HX6, WF12

4. Which area do you work in?

The purpose of this question is to collect general overarching feedback about services in general rather than to provide specific services with direct feedback.

If you do not wish to answer this question, please leave it blank.

- [ ] Calderdale
- [ ] Kirklees

5. What is your experience of working for your service during the Covid-19 outbreak?

6. Are there any examples of good practice from the Covid-19 outbreak that you would like to share?

- [ ] Yes
- [ ] No

If you have answered 'yes' to this question, please tell us about the good practice

7. Have you needed to contact any of the following health services during the Covid-19 outbreak?

(Hospitals, GPs, Maternity Services, Dentists, Pharmacies, Opticians, Community Based, Urgent Care Centres, Emergency Care)

Please answer either 'yes' or 'no' to this question by ticking one of the boxes below:

☐ Yes

☐ No

8. Have you needed to contact any of the following care services during the Covid-19 outbreak?

(Social Care, Residential Homes, Nursing Homes)

Social care services help, care and protect vulnerable people from harm. They include information and advice services, home care, day care, safeguarding services and short term support services for example to aid recovery after discharge from hospital or for respite.

Please answer either 'yes' or 'no' to this question by ticking one of the boxes below:

- ○ Yes
- ○ No

9. Please tell us the names of the services you contacted **and** the dates on which you contacted them on. If you can't remember the exact date, just tell us the approximate date.

For example:

GP: end of March 2020

Hospital: Maternity: early April 2020

Hospital: Pain management service: 1st April 2020

Adult social services: 15th April 2020

Community services: District nurse: from 21st April

10. Were you able to access the service/s?

- [ ] Yes
- [ ] No

If no, please tell us why you were not able to access the service

11.The Covid-19 outbreak has resulted in many changes to the way health and social care is delivered. Were any changes made to the service you received or delivered during the Covid-19 outbreak?

- [ ] Yes (please tell us the name of the service/s below)
- [ ] No
- [ ] Don't know

Please tell us:

- the name of the service/s

12.Please tell us more about the changes you experienced, for example what was different? How was it different?

13.What was good about the service you received or delivered and what worked well for you?

14.What did not work so well?

15.What would have made your experience better?

16.Thinking about the changes to your health and care/the service you deliver, that you have experienced during the Covid-19 outbreak, are there any changes would you like to become a permanent part of the service in future?

17.Is there anything else you'd like to tell us?

Your mental health

We are interested to understand what impact the Covid-19 outbreak has had on your mental health. Whether the effect has been positive or negative, please tell us your experience.

18. To what extent has the COVID-19 outbreak impacted your mental health?

- [ ] No impact at all
- [ ]

Some impact

Significant impact

Very significant impact

19. If you would like to tell us more about your mental health during the Covid-19 outbreak please do so here

Some information about you

It's really important to Healthwatch Calderdale, Healthwatch Kirklees and our partners that we try to understand whether certain groups of people with specific characteristics are having similar experiences, so we can tackle any inequalities that we see in the way that health services are provided.

If you feeling comfortable doing so, please answer some or all of the questions in this section.

20. What is your gender?

Male

Female

I describe my gender in another way - please specify in box below

21. How old are you?

Under 16

16-20

21-30

31-40

41-50

51-60

61-70

over 70

22. Which country were you born in?

- [ ] United Kingdom
- [ ] Prefer not to say
- [ ] Other (please specify)

23. Do you belong to any religion?

- [ ] Buddhism
- [ ] Christianity (all denominations)
- [ ] Hinduism
- [ ] Islam
- [ ] Other (please specify)
- [ ] Judaism
- [ ] Sikhism
- [ ] No religion
- [ ] Prefer not to say
- [ ]

24. What is your ethnic group?

- [ ] Asian or Asian British: Indian
- [ ] Asian or Asian British: Pakistani
- [ ] Asian or Asian British: Bangladeshi
- [ ] Asian or Asian British: Chinese
- [ ] Black or Black British: Caribbean
- [ ] Black or Black British: African
- [ ]

Mixed or multiple ethnic groups: White and Black Caribbean

Mixed or multiple ethnic groups: White and Black African

Mixed or multiple ethnic groups: White and Asian

White: English, Welsh, Scottish, Northern Irish, British

White: Irish

White: Gypsy or Irish Traveller

White: Other

Other ethnic groups: Arab

Any other ethnic group

Prefer not to say

25. Do you consider yourself to be disabled?

Yes

No

Prefer not to say

26.Do you have any long-term conditions, impairments

or illnesses? Please tick any that apply

- [ ] Physical mobility impairment (such as using a wheelchair to get around and/or difficulty using your arms)
- [ ] Neuro diverse conditions (such as autism, ADHD and/or dyslexia)
- [ ] Sensory impairment (such as being blind/partially sighted or deaf/hard of hearing)
- [ ] Long-term condition (such as cancer, HIV, diabetes, heart disease, epilepsy etc.)
- [ ] Mental health condition (such as having depression or schizophrenia)
- [ ] Prefer not to say
- [ ] Learning, understanding, concentration or memory (such as Down's Syndrome, stroke or head injury)
- [ ] Other (please specify)

27. Are you a carer?

Do you provide unpaid care/support to someone who is older, disabled or has a long-term condition?

- ( ) Yes
- ( ) No
- ( ) Prefer not to say

28. Please select the option that best describes your sexual orientation

- [ ] Bi/bisexual
- [ ] Gay
- [ ] Lesbian
- [ ] Heterosexual/straight
- [ ] Prefer not to say
- [ ] I prefer to use another term (please specify)
- [ ]

29. Do you consider yourself to be a Trans* person?

*Trans is an umbrella term used to describe people whose gender is not the same as the sex they were assigned at birth

- ( ) Yes
- ( ) No
- ( ) Prefer not to say

30. Do you/get anyone you live with any of these types of benefits?**

Universal Credit, Housing benefit, Income Support, Pension Credit - Guarantee Credit Element, Child Tax Credit, Incapacity Benefit/Employment Support Allowance, Free School Meals, Working Tax Credit, Council Tax Benefit

**We are asking this question to help us understand if being on the lower income affects experiences of health and care services

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

31.If you are a parent/primary carer of a child or children, how old are they? (If you have more than one child, please tell us your youngest child's age)

- 0-4
- 5-9
- 10-14
- 15-19
- Prefer not to say
- Not applicable

32. Are you pregnant or have you given birth in the last six months?

- Yes
- No
- Prefer not to say

Thank you for completing our survey. We really appreciate you taking the time and sharing your experiences.

If you want to know more about what happens as a result of sharing your views with us, visit the Healthwatch websites for Calderdale or Kirklees; we'll share any updates on there.

If you'd like to hear more from us, please head to our contact page on the websites and use our form to request more information.

Visit www.healthwatchkirklees.co.uk or www.healthwatchcalderdale.co.uk

Appendix 9: Communications plan

The Impact of Coronavirus (COVID-19) on the experience of health and care services
Communications plan

Context

In these times of unprecedented change, brought about by Covid-19 lockdown, to the way people live their lives, and the way that health and social care services are provided, it is essential for our health and care systems to understand how these changes are impacting the people of Calderdale and Kirklees.

It is clear how much good will is being shown by individuals and communities in our local area, and how positively they feel about the efforts that are being made by key workers in health, care, schools, shops, warehouses, and many more. We want to understand what the public wants to celebrate about the people who are serving our population during this pandemic, what changes they have seen that have improved their experience of health and care, and whether there have been concerning or difficult experiences.

The organisations that deliver engagement work with communities in Calderdale and Kirklees have committed to work in collaboration to pull together useful, valuable information about how people's experiences of health and care services have changed during the Covid-19 pandemic. We hope that this will indicate to us what is working well, and where there are challenges, gaps and barriers that are impacting on people's wellbeing.

Aim

The overall purpose of the project is to work in partnership with stakeholders across Calderdale and Kirklees, to deliver a co-ordinated set of communication activities to a range of target audiences to gather public experiences of health and care services.

Communication principles

All communications and engagement activity carried out by partners will be:

- Accessible and inclusive – to all our audiences
- Clear and concise – allowing messages to be easily understood by all
- Consistent and accountable – to ensure that messages are clear and reliable
- Flexible – ensuring communications and engagement activity follows a variety of formats, tailored to and appropriate for each audience
- Open, honest and transparent – we will be clear from the start of the conversations what aim is, the reasons why and ultimately, how changes could be made
- Targeted – making sure we get messages to the right people and in the right way
- Timely – making sure people are kept updated on a regular basis

- Two-way – we will listen and respond accordingly, providing feedback to audiences on a regular basis

Objectives

- Engage with the public around their experiences of health and social care in Kirklees and Calderdale at this time
- Capture how communities are working together and supporting one another throughout this time
- Increase brand awareness of Healthwatch Calderdale and Healthwatch Kirklees
- Encourage the public to respond to our survey/resources
- Start conversations and inspire creative user generated content to capture stories of Covid-19 lockdown circumstances

Strategy

To influence the way that health and care services will be delivered in the future, based upon public voice and experiences.

Audiences

- General public within Kirklees and Calderdale localities who are using health and care services
- People who are socially isolating
- People who are shielding
- Vulnerable members of our communities
- People with protected characteristics
- Children and young people
- Voluntary and community groups
- Staff from all health and care services including hospital, community and primary care
- MPs and councillors

Messages and Channels

Target Audience	Key messages	Delivery Method
General public who are using health and care services in Calderdale and Kirklees	- Say thank you to…. - Tell us your experience of xxxxx - If you could talk directly to the NHS what would you say? - If you could talk directly to xxxxx what would you say?	Raise awareness of the engagement through: • Social media channels • Direct messaging via social media * • Paid social media advertising*

	- What are your experiences of the NHS and social care during lockdown? - Answer our survey about the NHS and social care	• Partner websites and newsletters • CCG membership • Third Sector contacts • Outreach groups • Direct with our communities via community representatives at the council • GP practice patient participation groups • Partners to cascade via their networks and partners websites and social media
People who are socially isolating and shielding	• Say thank you to…. • Tell us your experience of xxxxx • If you could talk directly to the NHS what would you say? • If you could talk directly to xxxxx what would you say? • What are your experiences of the NHS and social care during lockdown?	• Send directly to community volunteer groups to request sharing via befriending calls and deliveries • Social media channels • Newspaper • Word of mouth • Shareable postcards to post through doors - direct mail |* • Pharmacy delivery bags
Vulnerable members of communities and people with protected characteristics	• Say thank you to…. • Tell us your experience of xxxxx • If you could talk directly to the NHS what would you say? • If you could talk directly to xxxxx what would you say? • What are your experiences of the NHS and social care during lockdown? • Resources in alternative languages	• Gatekeepers to communities • Social media targeted groups • Religious leaders • Outreach contacts • Enter and view contacts
Children and young people	• Tag @HWKirklees in your lockdown TikToks	• TikTok • Instagram

	• Complete our family resources about NHS and social care in lockdown • Tell us how your children feel about the NHS and/or social care services in Kirklees/Calderdale • Are you a young carer? Tell us about your NHS and social care experiences throughout lockdown	• Young volunteers • Youth forum contacts to cascade via their usual channels • Email young carers groups •
Staff and providers	• Calling all NHS and social care workers in Kirklees/Calderdale. • Tell us what it is like working throughout this Covid-19 pandemic	• Emails • Staff briefings • Internal bulletins • Staff Intranets • Cascades at meetings through managers • Social media channels
Voluntary and community groups, key partners and stakeholders	• Please share our NHS and social care survey with your contacts	• Outreach contacts via email • Personal discussions • Board organisations email • Targeted social media direct messages • Hard copy surveys
MPs and local councillors	• Say thank you to…. • Tell us your experience of xxxxx • If you could talk directly to the NHS what would you say? • If you could talk directly to xxxxx what would you say? • What are your experiences of the	• Email

	NHS and social care during lockdown? • Answer and share our survey about the NHS and social care in Kirklees/Calderdale	

Timeline

Action	Date period
Resource planning and creation	18th – 22nd May 2020
Survey and resources go live	27th May 2020
Social media launch	27th May 2020
Request partners and stakeholders share the information	25th – 29th May 2020
Direct contact on social media followers	27th – 29th May 2020
Ongoing evaluation of social media messages and imagery	1st June - 17th July
Evaluation of survey and specific target audiences required	1st of each month

Resources required

- Surveys
- Staff video
- Images
- Press release
- Story telling templates / case study templates
- Toolbox for partners including copy for emails, tweets, images, websites, newsletter, internal staff intranet
- Website page with collection of resources
- Email copy for outreach contacts, MPs, Councillors, direct messaging
- Hard copy surveys
- TikTok account creation
- Pharmacy bag leaflet/postcard
- Direct mail – Royal mail £500 per 8,000 homes
- Press release
- Social media advert
- Rio

Evaluation

Communications channels, messages, survey numbers and audiences will be evaluated on a regular basis, resulting in changes to the communications plan. Full evaluation of the communications plan will be based upon meeting the communications objectives.

Evaluation method	Date / timings
Key messages	Every 2 weeks
Channels	Every 2 weeks
Direct mail/adverts	Timings based upon return on investment
Social media statistics	1st of each month
Survey response numbers	1st each month
Targeted audiences based on survey responses	1st each month
Complete communications statistics	Close of project

Evaluation of communication objectives

Objective	**Evaluation method**
- Engage with the public around their experiences of health and social care in Kirklees and Calderdale at this time	- Total number of responses to survey, case studies, storytelling resources returned - Social media statistics
- Capture how communities are working together and supporting one another throughout this time	- Qualitative data analysis
- Increase brand awareness of Healthwatch Calderdale and Healthwatch Kirklees	- Social media analytics - Response to news article
- Start conversations and inspire creative user generated content to capture stories of Covid-19 lockdown circumstances	- Number of user generated content received - Quality of user generated content
- Encourage the public to respond to our survey/resources	- Survey responses - Social media reach and engagement

Item 6 Appendix 4

NHS Calderdale Clinical Commissioning Group

Title
Address line 1
Address line 2
Address line 3
Town/city
Postcode

Date: DD/MM/YYYY

Dear Title,

NHS Calderdale CCG welcomes the publication of the Healthwatch Calderdale Covid-19 Engagement report *health and care experiences of people living in Calderdale during Covid-19 outbreak.*

We would like to thank Healthwatch Calderdale for leading on the delivery of this report, while working in partnership with the CCG, Calderdale Council and voluntary and community organisations working across the area.

The health and wellbeing of the people of Calderdale is at the centre of everything we do as an organisation, and we are fully committed to listening and taking into consideration the views of the people we serve. We would like to thank everyone who has taken time to be part of this engagement and share their experiences of health and care services during a very strange and difficult time for us all.

The report shows that people have had mixed experiences accessing health and care services, both in-person and through digital means. The work undertaken by Healthwatch Calderdale also highlights issues in communication healthcare staff and patients, and the quality of care delivered. In regards to respondents mental health the report suggest that experiences have been mixed, with many people struggling due to the impacts of the Covid19 pandemic, and others seeing an improvement in their emotional wellbeing during lockdown.

We are grateful that some people have acknowledged and appreciate the need for change during this time. However, we are also aware that some people's experiences could have been better. People's views really matter to us, and we use the information put forward in this report to improve current health and care services in Calderdale, and to inform those planned and implemented in the future

The Healthwatch report brings together in total over 400 responses from services users, their families and carers, across a range of demographics including young people, people with learning disabilities, black and ethnic minority groups. The document also presents

the views of health and care staff living and working in Calderdale. Despite this, we in the CCG recognise that further engagement is required to address the gaps in the report's findings, so that we can be confident that the range of health and care services available in Calderdale is accessible to, and representative of, all the people they serve.

Moving forward

Before the Covid-19 pandemic hit Calderdale, the demand for health and care services was greater than available capacity. Given this, we know that our previous model of delivering health and care services cannot meet the demand in a post-covid society, and we need to ensure that we make the best use of, what are likely become, very scarce resources.

This pre-pandemic scenario had already generate a good deal of transformation activity in both hospital and community, more integration of service offers, new models of both elective and urgent care, strengthening links with our third sector and plans for hospital reconfiguration. Our current reset activity is focused on how we ensure this transformation continues, but in the new context of the need the ensure the safety of our patients and staff through reduced capacity for face to face care, and more reliance on technology.

We need to balance Covid and non-Covid demand, and the risks and benefits of restarting health and care services. We will have to recover from the emergency at the same time as dealing with an ongoing emergency.

We continue to look at each element of our reset, where that is; mental health, out-patients, or urgent care individually to learn from the pandemic and create a new normal. The intelligence gathered as part of this engagement process is invaluable to every area of the CCG, as we have outlined below.

Our approach to quality

In terms of quality of care, we will ensure that the information presented in the *health and care experiences of people living in Calderdale during Covid-19 outbreak* becomes an integral part of our existing quality assurance and quality improvement processes the CCG has in place with all providers. We will use the detail in the report in our scrutiny of service information submitted by our providers, and in analysing the quality metrics we receive to ensure that the quality of the services we commission meet the expectations of those using them.

The CCG's Quality team contains a number of clinical staff who prioritise patient experience and in the monitoring of existing contracts and procurement of new services. The intelligence gathered during this engagement process will support their role in identifying needs, both specific and general, and addressing inequalities in outcomes.

Our approach to commissioning services and contracting

During the COVID-19 pandemic the CCG's contracting team responded in-line with government issued guidance in relation to NHS contracting and payment, in order to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract.

The contracting team has followed this guidance as well as any service specific guidance that was issued subsequently, in relation to payment and in addition to minimise the burden of formal contract documentation and contract management processes.

Our approach to improving services

As Calderdale's health system emerges from the Covid-19 pandemic, an Elective Care Restart (ECR) Group has been established to work towards re-mobilising elective care services across our local health system. A number of processes have been reviewed which will address some of the areas of concern raised in the Health watch report.

With significantly reduced secondary care capacity and a duty to reduce the risk of harm, a referral backlog review was commissioned by the ECR Group for all referrals waiting over 22 weeks and with no appointment assigned. Calderdale completed a backlog review, with a small group of GPs carrying out a peer review of referrals. Each speciality backlog review was carried out jointly by a lead hospital clinician and a lead GP and ensured people's needs are clinically reviewed and they are on the correct waiting list, any learning has been collated and will be shared across Primary Care in a series of interface sessions run over Microsoft Teams.

CHFT have also reviewed patients waiting for surgery against a series of national Priorities that were agreed by each specialty, helping those in most need get access to the limited theatre resource.

Since the pandemic there has been a significant increase in calls into the appointment centre at Calderdale Royal Hospital from patients waiting for an appointment. To ensure we reduce the risk of patients coming to harm, a non- clinical buddy role was introduced. The buddy is to keep in contact with urgent and routine follow up patients that are overdue an appointment and have been clinically assessed and awarded a priority (P) rating. They will be responsible for keeping patients informed of their appointment status along with gathering information which will assess deterioration and prevent harm to patients.

Our approach to supporting people's mental health

The enforced 'lockdown' imposed as a result of the Covid-19 pandemic has had a negative impact on many people's emotional health and wellbeing, and a number of new services have been launched during this time to provide extra support. Many mental health services commissioned by Calderdale CCG can be accessed over the telephone, online and through social media, and more recently people are being seen face-to-face.
The information presented in the *health and care experiences of people living in Calderdale during Covid-19 outbreak* report will help the CCG's Service Improvement

team to work with services to ensure support can be accessed in a range of ways. Further engagement is planned with black and ethnic minority communities across Calderdale to explore how mental health support services can be made more accessible.

Our approach to primary care

One of the key areas of the *health and care experiences of people living in Calderdale during Covid-19 outbreak* report was the perceived accessibility of primary care services, mainly GP practices, during the first wave of the Covid-19 pandemic. The report will serve as a vital resource in shaping GP services as we continue to live with the presence of COVID-19 in our communities, partnered with the need to address existing and new health needs of our population.

The scale and speed of change in the way people accessed general practice, from making an appointment to having more alternatives than face to face, has been unprecedented and has provided challenges for patients and clinical and non-clinical general practice staff alike. Whilst there have been advantages for some in increasing methods of access and ways with which appointments can be delivered, it is important to remember that one size does not fit all. This is clearly stated in the report.

As delegated commissioners of general practice we will use the information gathered as part of this engagement process to:

- Ensure that no-one is disadvantaged as a result of changes to the way people access GP services access, people are supported in using digital services.
- Digital access is simplified, where possible, through reducing the number of log-ins and passwords required.
- Communication of changes to services and updates on general practice are clear and available through a variety of sources.
- That health inequalities across Calderdale are not exacerbated as a result of these changes.

Calderdale CCG and the Local Medical Committee recently agreed Principles for General Practice: Third Phase Response to Covid. Within these principles we recognised the need for general practice to provide patient-centred care, ensure accessibility for all and to reduce the inequalities that have widened during the first phase of Covid -19. These principles reflect the conclusions within the Healthwatch report, and patient access models and methods for securing appointments within individual practices must be in line with these principles.

In each of the five Primary Care Networks in Calderdale, work is ongoing to understand how best to meet the needs of the communities they serve. Although in its infancy, this approach together with close collaboration with our Local Authority colleagues who have established relationships within communities to share public health messaging and improve health outcomes, will ensure that access meets the needs of the population they serve. The development of the patient and community voice is key to this, so that we may understand how we ensure services are accessible, and meet and improve health needs.

The information within this report will help mould services at Primary Care Network and individual practice level, and will be a springboard for future developments within the GP leadership across Calderdale. It is our intention as commissioners to share this report with each practice as well as the leadership.

From reading the views of the public within the report it is clear that a variety of access methods and ways to receive an appointment are essential. We have already begun conversations with GPs relating to phone accessibility. Although required at the time, we also recognise that restricting the number of settings in which face-to-face appointments with clinicians were available has been a barrier to some in accessing care. All Calderdale GP practices are now offering face to face appointments where clinically required, at one or more of their sites. This means patients will be seen at their normal practice buildings where required, following a clinical assessment.

Greater use of remote and digital options for appointments will continue, to protect both patients and staff, however it is clear that further work needs to be done by, and with, GP practices to understand where reasonable adjustments need to be made.

Since July 2020 some routine clinical procedures and reviews have re-started, including cervical screening, childhood immunisations, Learning Disability Healthchecks, and some long term condition reviews. General Practice is working hard to re-start the routine care that is vital for people's condition management and wellbeing whilst managing the urgent/on the day demand.

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

It is evident from the report that some patients did not feel fully informed around some changes to their medication. We will take this learning back to our practices to ensure any future changes to routine medications or review processes should be communicated effectively in a patient centred approach.

It is clear that communications around changes in services need to improve further in accessibility and reach. We have established a GP communication group and will work to develop multi-language and multimedia messaging around updates to general practice services. This programme of communication began with the clear messaging to the public that General Practice remains open, and to inform people that face-to-face GP appointments are available at their own GP practice, where there is a clinical need. GP practices have also been provided a communications toolkit to assist with spreading the messages and updates at a practice level.

Our approach to equality

Any changes to the design or delivery of our services are subject to an Equality Impact Assessment (EIA). EIAs form an integral part of our scrutiny process, and ensure that all of our key decisions are evaluated for their impact on all disadvantaged groups (including health inequalities) , and that actions are put in place to mitigate any identified risks. EIAs also help us to target our engagement activities and provide disadvantaged groups with a voice in shaping our services.

The CCG has written and agreed a reset action plan with specific work areas to deliver high impact preventative interventions that improve and recover patient health, focusing on those populations most at risk. In addition, the CCG has drafted a new Equality and Inclusion Strategy for the next three years, which acknowledges the detrimental impact of Covid-19 on some population groups including black and minority ethnic communities. It places a renewed emphasis on tackling health inequalities with system partners to address the poor health outcomes experienced by some of our most disadvantaged populations. The CCG has an equality objective for the next two years to improve access to primary care for people from black and minority ethnic backgrounds and carers. A multi-agency steering group, which includes representatives from our local communities, has already met to drive this work forward and we are in dialogue with St. Augustine's Centre in Halifax to improve access to primary care for refugees and asylum seekers.

The CCG also works with system partners each year to implement the Equality Delivery System (EDS2). The EDS2 requires the CCG to clearly evidence what action we are taking as a commissioning organisation to improve services and reduce health inequalities. We are actively involved in addressing health inequalities at a community level through our work in supporting the successful multi-agency bid for funding from the West Yorkshire and Harrogate Health and Care Partnership Health Inequalities Grant Fund. The CCG has an active role in supporting the delivery of the project, which aims to reduce the impact of covid-19 on the inequality in life expectancy through greater connectivity.

We work closely with local and regional partners across the West Yorkshire and Harrogate Health and Care Partnership. We regularly attend public health led regional meetings where we work in partnership with colleagues to address health inequalities and share best practice.

The health inequalities that impact our communities also impact our staff. We know from workforce data that some equality groups experience disadvantage and inequalities in the workplace. Now, more than ever, we need to involve and listen to our staff from different equality groups. We are currently exploring ways of improving staff voice for equality groups including establishing staff equality networks, which will offer a safe place for people with common lived experience to share experiences and influence organisational policy. We have also developed a new workforce equality objective to ensure the voices of diverse groups are included in leadership meetings and decision-making.

Our approach to engagement

Along with our partners, we at Calderdale CCG are developing the Involving People Strategy, which will help us to work effectively with organisations across our area and work together to engage with people effectively and involve them in our work. The strategy will create opportunities to build on existing approaches and explore the use of techniques for engaging with people, sharing knowledge and resources for the benefit of local people. We need to understand how we can best involve people, when people need to be, and want to be engaged.

As a CCG we also need to meet our responsibilities under the Health and Social Care Act 2012:

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

We will continue to strengthen our approach to communication and engagement with our population, maximising opportunities for meaningful conversation and co-production. Together with our partners across Calderdale we see the involvement of local people at the heart of the design, development and implementation of interventions that improve health and wellbeing. This is a critical element of delivery of our Wellbeing Strategy and Calderdale Cares – creating a new relationship with our unique communities (as described in Vision 2024).

We recognise the importance of this report but it's important to note that all engagement and consultation activity we do provides rich information and intelligence to support service development and design. By working through existing intelligence we can identify key emerging themes and also identify where there are gaps.

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

Once again, I would like to give my thanks, on behalf of NHS Calderdale CCG, for this invaluable report and all of the hard work that has gone towards it. I would like to assure you that we will act on the information and recommendations within the document and that, as I hope is clear from the information in this letter, will apply this knowledge in the improvement of Calderdale's health and care services as we continue to work through these uncertain times together.

Yours sincerely,

Penny Woodhead
Position

Change log:

EB's comments on Primary Care and Meds Management incorporated – 11:51, 12/10/2020

AB comments additions incorporated for service improvement section – 15:29, 12.10.20

SMT comments additional para incorporated – 10:00 13.10.20

Sentence referencing CHFT website with a link within the approach to improving services section deleted – 14:07, 14.10.20

Name of Meeting	Governing Body	**Meeting Date**	22/10/2022
Title of Report	Stabilisation, Reset and Planning	**Agenda Item No.**	7
Report Author	Debbie Graham, Head of Integration and Partnerships	**Public / Private Item**	Public
GB / Clinical Lead	Dr F Javid, GP Member	**Responsible Officer**	Debbie Graham, Head of Integration and Partnerships

Executive Summary							
Please include a brief summary of the purpose of the report	The purpose of the report is to provide members with assurance on activities being undertaken in relation to the NHS Stabilisation and Reset process, namely: ▪ Development of our system's winter reset ▪ Development of our CCG Reset Plan ▪ Development and submission of planning assumptions and other planning expectations						
Previous consideration	**Name of meeting**	CCG Senior Management Team		**Meeting Date**	20/09/2020		
	Name of meeting			**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: 1) **RECEIVES** and **NOTES** the contents of report; 2) **IDENTIFIES** any areas for further assurance; 3) **REQUESTS** regular updates on reset and planning.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications	
Quality & Safety implications	The safety of both staff and patients remain central to the expectations set by NHS England / Improvement, and central to local implementation. Planning assumptions are built around what is feasible whilst maintain social distancing and infection, prevention and control requirements.
Engagement & Equality implications	Equality and engagement impact assessments will be completed for service changes and new pathways. A governance process has been designed for new pathways emerging from transformation of elective and non-elective pathways. Engagement work undertaken to assess the impact of Covid will be considered as it is completed, particularly the Healthwatch Covid engagement report for Calderdale & Kirklees and the awaited Covid impact assessment commissioned by Calderdale Metropolitan Borough Council.
Resources / Finance implications	A key strand of the work will be the development of underpinning financial plans that enable delivery of reset expectations. However, there remains a lack of clarity about the financial regime for the remainder of

		the financial year and this has resulted in an unmitigated risk at this point. The planning submissions include as assessment of our delivery of the Mental Health Investment Standard					
Has a Data Protection Impact Assessment (DPIA) been completed?		**Yes**		**No**		**N/A**	X
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**			Risk associated with delivery of elements of our winter reset and CCG reset plan are included in our corporate risk register on an individual basis, and they will be refreshed as the work progresses. New risks will be added as they emerge.		
Legal / CCG Constitutional Implications	None identified	**Conflicts of Interest**			Any conflicts of interest arising from this report will be managed in line with the CCG's Management of Conflicts of Interest Policy.		

1.0 Introduction

1.1 This report aims to provide members with assurance on activities being undertaken by the CCG in order to deliver national expectations around Reset and Recovery, and associated planning submissions.

1.2 As an organisation, and as a system, we have taken a joint and proactive approach to the planning round this year. We have worked on the basis that we plan for what we know and make data-led assumptions about what we do not know. However, we recognise that we are in unpredictable territory as we enter winter. As such we will continue to work together as a system, and refine and adjust our plans in the light of changing circumstances.

2.0 National Stabilisation and Reset

2.1 The National Stabilisation and Reset agenda has been undertaken in 3 phases, to the following timelines:

Planning Stages	Expectations
1. Old normal - Pre Feb 20	• NHS 5 Year Plan
2. March – June 20 – Reset and Stabilisation Phase 1	• Supporting the exponential increase in critical care capacity • Supporting safe and effective discharge to communities, to free up acute beds • Supporting 'vulnerable' people shielded from the virus, and other groups who are likely to be most affected by social distancing • Ensuring continuation of other essential areas of business
3. Bounce back - July – September 20 – Reset and Stabilisation Phase 2	• Continuing to provide critical and urgent care for Covid-19 patients, and their recovery and rehabilitation • Providing essential health and care services • Continuing to support people who are shielded and or vulnerable • Keeping health and care colleagues safe and well • Understanding the wider impact on different population groups • Co-ordinating our reset to the new 'normal'
4. Living with C19 – October 20- Dec 21- Stabilisation and Reset Phase 3	Recover services to pre-Covid level: and associated planning submissions • Elective care (out patients, day cases, procedures) • Diagnostics • Cancer • Non-elective • A&E • Mental Health; Children & Young People, perinatal care, annual health-checks, Improving Access to Psychological Therapies (IAPT), Mental Health Investment Standard (MHIS) • Learning disabilities; annual health-checks • Continuing health care • Workforce

3.0 System Stabilisation and Reset – our Winter Reset

3.1 The Calderdale and Greater Huddersfield system, under the auspices of the A&E Delivery Board, has developed a plan to navigate the system through the next 12 months. Given this period coincides with winter, the Board agreed to develop a Winter Reset Plan. The context for the plan is:

- A perfect storm - winter likely to be our most challenging yet; Covid-19 legacy, peaks, seasonal flu, other winter-related conditions – set within context of huge reductions in capacity (face-to-face care, support offers, beds etc) and social distancing, deepened health inequalities and financial pressure.

- The first wave had a disproportionate impact on; people living in deprived areas, Black and Ethnic Minority (BAME) populations, those in certain occupational groups, people with long term conditions, and those who have not accessed essential physical and mental healthcare during the pandemic.

- The huge economic/employment impact of Covid-19 on families and businesses, which will take exacerbate the impact of winter

- It is not a challenge for one part of our system. We have learned that we work best together - taking learning from the work we did together during the first pandemic peak

3.2 The Board talked to the system in order to agree plans; (Third Sector, Overgate Hospice, Calderdale Metropolitan Borough Council (CMBC), Kirklees Metropolitan Borough Council (KMC), Yorkshire Ambulance Service (YAS), Local Care Direct (LCD), Locala, South West Yorkshire Partnership Foundation Trust (SWYPFT), Calderdale and Huddersfield NHS Foundation Trust (CHFT), Kirkwood Hospice, General Practice, and West Yorkshire Community Pharmacy. This resulted in a set of priorities which were boiled down to identify the key success factors that would get us through winter. This resulted in an action plan.

3.3 The plan is structured around the 3 key characteristics of high performing systems developed by both the Care Quality Commission (CQC) and McKinseys.

1. Prevention and pro-active support to enable people to stay well and independent at home
2. Swift and appropriate access to care and support where people require a step-up, urgent or crisis response is needed
3. Step down support for people who need transitional or ongoing care; at home or in a temporary or new residence

3.4 The 17 key actions set out below were exception reported to the Board in September and all are progressing. However, 4 key actions were identified for particularly focus in terms of criticality (identified in bold below). The system is progressing the 4 key actions, and this is happening at pace in Calderdale, where we have already had discussions with CMBC about the prioritisation of unallocated Better Care Fund (BCF) funding.

1) Maximise support for vulnerable households and individuals, building on Covid architecture.
2) Support for unpaid carers
3) Strong wrap around multi-agency support to care homes
4) Access to menu of elective care offers
5) Ensure resilience in home care market
6) **Rapid access to step up/step down community support, reablement, admission avoidance and follow-up,**
7) **Appropriate Discharge to Access (D2A) and community bed capacity (Intermediate Care, Social Care Transitional beds, dementia beds)**

8) Clear and effective Directory of Services (DOS), deliver 111 First, with links to Single Point of Contact (SPOCs) /Gateway to care (GTC)
9) GPs treating all their on-day demand
10) Greatest year for flu uptake; staff and population
11) Community based frailty and services for those need Intravenous fluids
12) Protect A&E and hospital beds for those who most need them (minimising avoidable attendances and admissions) – Primary Care Network (PCN) data sets are being prepared showing variation in utilisation.
13) Access to appropriate End of Life Care (EOLC) (hospice care; beds, outreach, respite)
14) Timely access to 111 and 999 capacity
15) **Effective discharge, integrated discharge teams, delivery of new guidance, developing Trusted Assessors model and implementing Reason to Reside methodology.**
16) Effective Mental Health pathways from A&E, Children and Young People, Personality Disorders, Severe Mental Illness, Early Intervention in Psychosis, psychological therapies and Psychology
17) Development of community based stroke rehabilitation beds

4.0 CCG Stabilisation and Reset Plan

4.1 The CCG has developed its own Reset plan, covering national expectations from all three Stabilisation and Reset Phases. The Plan is attached as Appendix A.

4.2 All staff, in their teams, took part in a process to identify learning from Covid in relation to their own areas of work. The aim was to identify activities that; started in Covid and should continue given their value, and activities undertaken pre-Covid that was no longer fit for purpose. The work was shared with Senior Management Team (SMT) and teams were asked to work through implementation of proposals through their line management structures.

4.3 The plan is owned by the Senior Operational Group (SOG), and is exception reported to SMT. This process enables both forums to identify any remedial action needed to ensure progress.

5.0 Planning Requirements

5.1 Underpinning the implementation of phase 3, is the submission of activity and financial assumptions that underpin our reset proposals.

5.2 We have continued to take a system approach to submission of our planning and financial assumptions, with a regular planning forum established that includes both Calderdale and Greater Huddersfield CCGs, and CHFT. This enables us to have collective oversight of our plans, and the opportunity to ensure alignment, particularly in our discussions with NHS England (NHSE) and Improvement (NHSI).

5.3 The table below sets out an overview of our planning submissions, in advance of the final submission date which is due on 17 September.

Point of Delivery	Aim	Direction of Travel	Comments/Risk
Referrals	Restore access to services	Assumes progressive increase referrals from 52% in Sept to 90% in March	Effective demand plan for Calderdale – encourage resumption of access to services to ensure no disproportionate impact on inequalities/ BAME; equally do not overwhelm finite capacity in acute sector

Outpatients	Sept - 80% of last year's activity Oct - rising to 90%	Below 90% from Sept; 90%+ from Jan	Transformation of Out Patient Appointments (OPA) during Covid; use of technology overcompensates decline in face to face activity independent sector activity not included (await clarity from NHSE)
Inpatients (Day Case/ Elective)	Sept - 80% of last year's activity Oct - rising to 90%	DC - deliver 47% from Sept; 60% in March EL – deliver 50% from Sept; 60% in March	Capacity to be adjusted based on theatre/. Bed modelling at CHFT; review of new infection prevention and control guidance; case-mix and prioritisation will impact volumes IS activity not included (await clarity from NHSE)
Diagnostics	90% of last year's and endoscopy, aiming to reach 100% by October	Deliver 90+ for Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT), Non-obstetric ultrasound (NOUS) and colonoscopy	Additional capacity sourced by CHFT Review of infection prevention and control guidance Notable pressures with flexi sigmoidoscopy & gastroscopy
Non Elective	Restore access to services	0 length of stay (LOS) – 94%+ from Sept 1+ LOS – 84% from to 95% in March; some seasonality	Manage acute bed based will require effective demand management and discharge arrangements
A&E	Restore access to services	100% from Sept	Effective demand management across the system
Cancer	Restore full operation of all cancer services	Increase in volumes during remainder of year	Confident national standards can be sustained. Continue to work with the West Yorkshire & Harrogate (WY&H) Cancer Alliance to deliver service improvements aligned to best practice.
Mental Health (MH) – Children and Young People	Maintain the growth in the number of children and young people accessing care	Aim to deliver target (35%) by March	An internal programme of work has been developed to deliver expectations, and a full reset plan has now been completed. The programme spans; mental health, Learning Disabilities (LD) and autism A description of the rest and delivery of our Mental Health Investment Standards (MHIS) is set out below
MH - Perinatal	Deliver the ambitions set out in 5 Year Forward View (5YFV)	Aim to deliver target (176) by March	
MH - Annual Health Checks	Target of 60% of people on the SMI register receiving a full and comprehensive physical health check	Below target set by 5YFV.	

IAPT	IAPT services should fully resume	Aim to deliver threshold by March	
LD - Annual Health Checks	Target of 75% of people aged 14 and over with a learning disability on GP learning disability register should have had an annual health check within the last twelve months	Exploring potential to achieve target set by 5YFV. Agreement on SMT to do more work to deliver this target. (Q3 19/20 variance from plan was -4.6%, but Covid impact may be significant)	

5.4 In additional to the expectations set out in the table above, there are a set of expectations around; the reset of continuing healthcare services, mental health reset and delivery of the Mental Health Investment Standard and changing financial regimes, which are set out below;

6. Continuing Health Care (CHC)

It is expected that the CCG reinstates CHC assessments and 3 and 12 month clinical reviews of client eligibility for CHC from 01/09/20. It is also expected that; any NHS CHC referrals, reviews and assessments received between 19 March and 31 August 2020, and any that have been deferred during this period, will be completed by 31/03/21. In order to achieve these requirements the CHC team will be working closely with CMBC.

6.1 A plan for the delivery of this target has been developed in conjunction with colleagues in CMBC, and trajectories and timescales agreed. The main risk associated with the delivery of this target is having sufficient available workforce with the right skills to manage the deferred workload as well as new assessments and ongoing work.

6.2 Additional monies have been made available to CCGs to recruit temporary health and social care staff, and in Calderdale, agency staff have been recruited and will be in place week commencing 28th September. These staff will work as a team, with a clear monthly trajectory for the completion of the backlog. The aim is to complete by February 2021

Timescale	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021
Number of assessments completed	0	40	40	30	40	9	0
Total	159	119	79	49	9	0	0

6.3 CCGs are required to submit fortnightly national SITREPs (Situation Reports) to monitor progress against this target. The first submission was made14/09/20. Progress against targets will be monitored by the Head of CHC and Assistant Director, Operations Adult Services and Well Being at CMBC. Progress will be reported to SMT and the equivalent forum in CMBC

7. **Cancer Reset**

7.1 The local Calderdale Cancer Network will work with the WY&H Cancer Alliance to support the proposed third phase of work in response to the Covid pandemic.

7.2 CHFT have a programme of reset and stabilisation work for cancer where all tumour sites are being reviewed by the clinical and managerial teams to see how the "new normal" can be introduced, embedded and maintained. The focus is on all parts of the patient pathway from fast track referral through patient-initiated follow-up.

7.3 Below is the local response to the specific areas of development identified by the Cancer Alliance:

Reduce unmet need and tackle health inequalities by:

- Analysis of all cancer standards including diagnosis rates demonstrates that presently there is no significant change in the number of referrals being received as they return to pre-Covid levels.
- CHFT are building grade of tumour at diagnosis data into clinical systems.
- Review all cancer fast track referral pathways to ensure they include the latest evidenced based guidance. For example, the dysphasia pathway will incorporate the Edinburgh Dysphasia Score.
- Use of dermatoscopes to support the skin cancer referrals and an improved tele-dermatology pathway to ensure the patient sees the right clinician first time.
- Audit of all cancer diagnosed patients using the PAMs (Patient Activation Measure) score to look at different levels of patient engagement across different groups including BAME.

Growth in people requiring cancer diagnosis and/or treatment by:

- Accessing regional diagnostic support for trusts with limited consultant radiology support. Exploring a bureaucracy-free, collaborative approach, that provides cross cover when necessary.
- Seeking a better understanding of the Positron Emission Tomography (PET) scans position which was a constraint pre-Covid and will need resolving going forward

Responding locally to new innovations:

- Improve the lower gastro-intestinal pathway at the point of referral and how this will reduce the number of colonoscopies without adding unnecessary patient delays
- Video Capsule Endoscopy is available at CHFT and will be used where appropriate.

Maximise surgical treatment capacity:

- Surgical treatments undertaken within the private sector and in the "Super Green" area at Huddersfield Royal Infirmary (HRI).

Rapid Diagnostic Centre pathways:

- Expanded vague symptoms service including Haematology who are triaging referrals and redirecting patients.

Cancer screening programmes:

- Participate in the national programme rollout of Lung Health Checks
- Breast screening has resumed with plans to deal with additional demand

Personalised support:

- Patient Activation Measures are in place and Electronic Holistic Needs Assessment has been implemented as well as Patient Stratified Follow-Up in all cancer sites.

7. Mental Health Reset

7.1 All age mental health, learning disabilities and autism services quickly adapted their services in response to 'lockdown', with a switch to a primarily virtual service offer, and limited face to face interventions. Emotional health and wellbeing services in Calderdale engaged with a reset exercise identified challenges, learning and what requires changing.

7.2 A deep dive exercise of emotional health and wellbeing services reviewed referral and activity levels and identified, and they mirror the national picture:

- an initial reduction in referrals
- a short term reduction in use of inpatient beds
- as 'lock down' eased referrals increased and continues to various degrees across services
- an increased complexity of referrals and existing caseloads requiring more intensive support
- increased use of Mental Health Act 1983

7.3 Local hotspots include:

- Crisis and home based treatment pathway
- Inpatient beds
- Safe space – alternative crisis offer operated by Healthy Minds
- ASD referrals
- Psychology waiting list
- Increase in referrals to digital offers e.g. Kooth Counselling

7.4 As part of the our local reset and stabilisation plans, work is taking place to look at; previously identified priorities for mental health, learning disabilities and autism, the Long Term Plan expectations, NHSE reset implementation guidance, Integrated Care System (ICS) reset work, and Mental Health Investment Standard requirements and trajectories.

7.5 A mapping and gap analysis engagement exercise is planned to enhance the psychological wellbeing offer to the BAME community, a cohort most impacted by Covid. Learning from this exercise will be used to inform similar work to reduce health inequalities.

7.6 A work stream is being developed reporting to the Calderdale Collaborative Communities Group (CC2H), to enhance the prevention and early intervention offer. This will also consider the opportunities provided by the Direct Enhanced Service (DES) contract to further enhance the emotional health and wellbeing offers within PCNs.

7.7 Modelling work is ongoing to further understand the future demand and implications for service lines. This will take place across the emotional health and well-being system in collaboration with partners. An early draft will be available for the Quality, Finance and Performance Committee in September.

8. Mental Health Investment Standard (MHIS)

8.1 There is a clear expectation that CCGs should plan to deliver the MHIS in 2020-21. The standard is for the CCG to invest growth plus 1.7% more than 2019/20 expenditure levels. The additional investment should be targeted in specific areas as set out in the Mental Health Five Year Forward View.

8.2 The CCG submitted a draft plan at end of August showing that the CCG is planning to achieve the target, however there are a number risks to delivery of the target. The most significant risks are in relation to the lead-time for new investments, and the providers' ability to deliver

new services. The CCG has established a specific Mental Health Reset Group focussed on delivering the Mental Health Investment Standard in 2020/21 as set out in 7 above.

9. Financial Regime

9.1 The CCG has been operating under a temporary financial regime for the period April to September 2020. A new financial regime starts from October 2020.The CCG has now received information on allocations for the period October 2020 to March 2021. Consolidated ICS financial plans (draft) are due on 5th October.

10. Workforce Expectations

10.1 Planning expectations include the submission of system level 'Local People Plans', as requested in 'We are the NHS: People Plan 2020/21'. The WY&H plan is still being shaped before its submission on 21 September. Calderdale partners have been asked to contribute noteworthy examples of working together under the headers of:

- Looking after our people
- Belonging to health and care systems (particularly around BAME workforces)
- New Ways of Working and Delivering Care
- Growing for the future (recruitment, retention and deploying people across organisations)

10.2 Work continues over the next 2-3 months to develop a place-based People Plan for Calderdale, and we are currently awaiting a deadline from the ICS. This will also give us time to develop the Calderdale People Board (or equivalent).

11.0 Appendices

Appendix 1: CCG Reset Plan

Calderdale CCG Reset Action Plan – Phase 1 to Phase 3 (Version 3.0 agreed at SOG and SMT)

WY&H Agreed Priorities	Specific Calderdale CCG work areas	Leads(manager and Clinician),	To Involve
1. Continuing to provide critical and urgent care for C19 patients, and their recovery and rehabilitation	1. Continued support for Calderdale and Huddersfield NHS Foundation Trust (CHFT) **phasing of acute and critical** care beds	DG/FJ	YH
	2. Create sustainable **End of life Care** and bereavement support offers.	RR/HD	JC / HF / DW
	3. Develop and embed **Covid-aftercare Recovery and Rehabilitation** model (community, primary care, mental health) – build learning into future community model	AB/FJ	HW/RR/ EB / DW
2. Providing essential health and care services (recovery of critical and urgent care)	1. **A&E;** Use learning to refresh the future model and UTC development. Minimise avoidable attendances	DG/FJ	JP/YH / DW
	2. In-patient and critical care a) Support implementation of Royal College of Emergency Medicine (RCEM) Position Statement - C19: Resetting Emergency Department Care b) Model 'rebound' demand for our system and develop plans for winter 2020 c) Sustain current staffing, beds and capacity, and make use of independent sector and Nightingale hospitals	DG/FJ	JP/YH /PW
	3. Urgent Care a) Expand the 111 First offer and maximise 'hear and treat' and 'see and treat' pathways for 999 b) Develop Winter Reset plan	MP/FJ DG/FJ	JP/RR /DW

	4. **Elective care;** work with system to develop modelling to support phasing of a 'new normal' a) System work on approach to opening up Electronic Referral System and Clinical Assessment Service offers b) Plan volumes (activity and type) demand for future c) Analysis of service utilisation pre-C19 and current utilisation to understand changes in patterns d) Lock in benefits/rapid scaling of technology and other change through the Out-Patient Transformation Programme e) Linking with West Yorkshire and Harrogate (WY&H) work-streams - focusing on technology, triage and clinical advice. f) Restore elective activity to between 90-100% of pre pandemic levels by October • In September at least 80% of their last year's activity for both overnight electives and for outpatient/day case procedures, rising to 90% in October (while aiming for 70% in August); • This means that systems need to very swiftly return to at least 90% of their last year's levels of Magnetic Resonance Imaging (MRI)/ Computerised Tomography (CT) and endoscopy procedures, with an ambition to reach 100% by October. • 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August). g) Develop a week by week plan to optimise use of independent sector capacity h) Follow new streamlined patient self-isolation and testing requirement i) Trusts, working with GP practices, should ensure that, between them, every patient whose planned care has been disrupted by Covid receives clear communication about how they will be	AB//NT	DG/SC/YH/ VD/ DW/SL/JD

	looked after, and who to contact in the event that their clinical circumstances change. j) Communications Strategy to underpin the work		
	5. Maintenance and recovery of **cancer services** - particularly management of essential cancer surgery for adults. a) Restore the number of referrals for suspected cancer to at least pre-pandemic levels b) Ensure sufficient capacity in diagnostics and endoscopy, using the independent sector, community hubs and rapid access centres c) Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment. d) Expand capacity of surgical hubs to meet demand and deliver in a Covid secure environment e) Fully restart all cancer screening programmes f) Reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre- pandemic levels, with an immediate plan for managing those waiting longer than 104 days.	HW/NT	VD/PH /DW AB
	6. Maintenance and recovery of **screening services** with Public Health Team. Address the backlog of immunisations and cervical screenings	TBC	HW / EB / DW
	7. Ensure recovery of **stroke and cardiovascular** services	AB/NT	RR/HW/ YH
	8. Communication strategy to support restart of critical services	SL	
3. *Continuing to support people who are shielded and or vulnerable*	1. Continue to support the **Social Care hub**, learn and agree its future role as part of a community/Primary Care Network (PCN) model	DG/HD	
	2. Build on the process for identification and support of vulnerable people in order to move forward with Population Health Management	TS/EB	RR /DW/ JD/ KB

	3. General practice to continue to identify and proactively contact high risk patients, particularly shielded patients – assessing ongoing care and medication needs (in the event of a second spike)	EB/HF	
	4. Continue to support the **Volunteering Hub**, learn and agree its future role as part of the community/PCN model. o Recognise that the public response to the health and care sector during this pandemic is an excellent opportunity for recruitment of new people into the health and care workforce. o Continue to work with Voluntary Sector Infrastructure (VSI) Alliance on recovery and capacity building in third sector, and their future role in supporting the Volunteering Hub o Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.	DG/HD	JK /KB
	5. Engagement with people about their experience of services during Covid to use learning in our planning	PW	JK /KB
4. Keeping health and care colleagues safe and well	1. Ensuring local co-ordination of **PPE** supply Continue to follow good Covid-related practice to enable safe access to services and protect staff	Public Health	
	2. Ensuring local co-ordination of **testing** for staff	RR/LK	PH
	3. Developing a consistent offer for **staff health and wellbeing**. Clarity about **staff at increased risk** due to pregnancy or underlying health conditions o Deliver the commitments in the NHS People Plan for 2020/21 including urgent action to address systemic inequality experienced by some of our staff including BAME staff o Develop a local People Plan to cover the expansion of staff numbers, mental and physical support for staff, and setting out	NS	KB

	new initiatives to develop and upskill staff"		
	4. Capitalise on innovations and consider **digital by default** to protect workforce.	NS	
	5. Management processes and procedures are put in place to protect the **BME workforce**.	NS	TH / JK /KB
5. Understanding the wider impact on different population groups	1. Implement **'test and track'** plans to support Public Health plans; o Continue to follow Public Health England (PHE)/Department of Health and Social Care (DHSC)-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. o All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS.	RR/LK	PH/ SL/TS
	2. Ensure our system has access to robust **epidemiological information** and impact on population health and the long term impact and wider societal impact –with Public Health	TS with PH	
	3. Protect the **most vulnerable** from Covid with enhanced analysis and community engagement to mitigate identified risk in the community.	TS/PW	JK /KB / PC/ PH
	4. Strengthen leadership and accountability for **tackling inequalities**, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation.	NS/SC	
	5. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least	NS/SC	

	match the overall **BAME composition** of its overall workforce, or its local community, whichever is the higher.		
	6. Ensure data is complete and timely to support understanding and response to inequalities. All NHS organisations should proactively review and ensure the **completeness of patient ethnicity data** by 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September."	TS	
	7. Support system work to deliver high impact preventative interventions that improve and recover population health, focusing on population **groups most at risk** considering any safeguarding implications: a) children and young people; physical and mental health b) mental health of the population; bereavement support and suicide reduction c) BAME communities d) those at risk of violent crime and domestic abuse e) street homeless	 RR RR/JW KBe PW/GPY RR	 RR
6. Co-ordinating our reset to the new 'normal'	1. Learn and Reframe – design next steps for integrated **community model**; a) Agree new model, principles, outcomes b) Analysis of service utilisation pre-C19 and current utilisation to understand changes in patterns c) Develop future role of PCNs and the new normal primary care utilisation for our system, and support adoption of digital solutions in the sector d) Restart work on future community independent living model –	RR/NT	TS/DR/EB HD/YH/HF/ SCo/DW

	providing clarity on future commissioning intentions e) Enhance community services for crisis response and resume safe home visiting care for vulnerable patients that need it f) Community health services crisis responsiveness should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need ongoing rehabilitation and other community health services. g) Community health teams should fully resume appropriate and safe home visiting care for all those vulnerable/shielding patients who need them. h) Accelerate **preventative programmes** which proactively engage those at the greatest risk of poor health outcomes		
	2. Reset **Mental Health** System a) Restore and expand services e.g. Improving Access to Psychological Therapies (IAPT) and 24/7 crisis helplines b) Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. c) Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities. d) Validate system plans for mental health service expansion trajectories e) IAPT services should fully resume the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working f) Maintain the growth in the number of children and young people accessing care g) Proactively review all patients on community mental health teams'	RR/CT/JW	SA/LS/IB/JH

	caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with Serious Mental Illness (SMI) in the community; h) Ensure that local access to services is clearly advertised i) Use £250 million of earmarked new capital to help eliminate mental health dormitory wards j) Accelerate preventative programmes which proactively engage those at the greatest risk of poor health outcomes		
	3. **Learning Disability** Services a) Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission b) Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020. c) GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.) d) Accelerate preventative programmes which proactively engage those at the greatest risk of poor health outcomes	SA/CT CR	RR(CETRs)/ EB/IB/JH
	4. Develop overview of new **Care Home Support Programme** with CMBC as part of the integrated community model **(i) Strategic direction and commissioning (medium – long-term)** a) Develop Programme governance to support delivery of long term programme and links with CMBC Senior	RR/JM/HD RR/JM/HD	 JH/JM/ DW/HF/EB

	Responsible Officer (SRO) b) Develop strategic direction as part of Care Closer to Home (CC2H) c) Build in learning from assurance expectations for recent submissions (Care Homes and General Practice) d) GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes, and begin a programme of structured medication reviews. e) Develop enhanced care home model f) Develop clarity on end of life care offers to care homes and implement Advanced Care Planning g) Accelerate preventative programmes which proactively engage those at the greatest risk of poor health outcomes **(ii) Provider Development and Support (short and medium term)** a) Support CMBC to deliver national requirements for care home support and mutual aid b) Generate training the trainer offers to ensure the appropriate nursing/Allied Health Professional workforce c) Ensure effective Infection, Prevent and Support to care homes from the system with CMBC d) Develop primary care support offers in line with new guidance e) Develop clarity about the market position and work with CMBC in managing and supporting care market f) Develop clarity on the role of the voluntary sector to support the work	SA/HD/JM	SCo/JM/ CW /DW EB
	5. Create a new normal for **general practice**, learning from covid a) CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. b) All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video,	DR/EB/MA	CDs

	online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.		
	6. Lock in new ways of working related to **transfer of care** out of hospital to minimise delay, creating new offers; beds, and housing a) From 1 September 2020, hospitals and community health and social care partners should fully embed the discharge to assess processes. b) New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. c) The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital. d) Ensure a clear link with Care Home work e) (see CHC below)	HW/FJ)	SCo/SA /DW
	7. **Continuing Health Care** Systems a) Resume NHS Continuing Healthcare assessments from 1 September 2020 and work with local authorities using the trusted assessor model. b) Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.	SA (SC)	SCo/YH/LS
	8. **Infection Prevention and Control** – strengthen local system capacity a) Continue to follow PHE infection prevention and control guidance to minimise nosocomial infections b) Deliver an expanded flu vaccination programme c) Strengthen IPC system capacity	PW/DW	CW / HF/ RG

	9. Capturing and systematising **learning/innovation** during the C19 incident	PW	
	10. Development of a **financial strategy** to review planned investment and develop a model to support recovery priorities a) Draft summary plan using the issued templates. To be submitted 01/09/20	LS/AC	
	11. Commissioning Activities a) Describe alignment journey with CMBC b) Integrate Plans to streamline commissioning through a single Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) approach. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.	NS/DG	IB/DHa
	12. Reframe our approach to **contracting and procurement** over the next 12-18 months to support recovery	MP/YH	
	13. Ensure **workforce planning** activities (particularly future roles and work with our educational providers) are considered	NS/MGo	
	14. Ensure **support functions** are primed to enable delivery of the reset actions (Information Governance, Business Intelligence, IT, comms,, engagement, equality)	TS/PW	
	15. Ensure forums and ways of working effectively **support system recovery,** making changes as a result of C19 learning or from necessity	NS	

Name of Meeting	Governing Body Meeting	**Meeting Date**	22/10/2020
Title of Report	**Involving People Strategy**	**Agenda Item No.**	8
Report Author	Jill Dufton, Senior Engagement Manager	**Public / Private Item**	Public
GB / Clinical Lead	Alison MacDonald, Patient and Public Involvement Lay Member	**Responsible Officer**	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary

Please include a brief summary of the purpose of the report

The CCGs existing Public and Patient Engagement and Experience (PPE&E) Strategy was due to be refreshed and had been extended until the end of March 2020. 'The Involving People Strategy is a joint strategy with a shared set of principles for involving people across Calderdale – supporting the delivery of Calderdale Cares, Wellbeing Strategy and Vision 2024.

The strategy describes a narrative for involving people which sets out:

- An approach
- A set of principles
- A way of working that we can all use

Public sector organisations have different requirements for involving local people in the design, development and implementation of services. Building system wide engagement and communication so that the principles will be the foundation by which local people can expect to be involved by any organisation in Calderdale.

Previous consideration

Name of meeting	Health and Wellbeing Board (HWBB) development session	**Meeting Date**	20/02/2020
Name of meeting	HWBB delivery group	**Meeting Date**	28/01/2020
Name of meeting	CCG Governing Body development session with extended invite	**Meeting Date**	12/09/2019
Name of meeting	HWBB	**Meeting Date**	15/10/2020

Recommendation (s)

It is recommended that the Governing Body:

1. **APPROVE** the Involving People Strategy.
2. **APPROVE** governance structure for system wide engagement and communication across Calderdale.
3. **ADOPT** and **PUBLISH** the joint strategy and governance structure as a vision and shared set of principles and approach for involving people across Calderdale.

Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to

							enter text.

Implications							
Quality & Safety implications	This strategy is central in helping the CCG achieve its commissioning function by embedding the public voice into everything that we do. Our audit trail of evidence is strengthened by the information we gather and using this information we can demonstrate how the views of patients, carers/families and staff have influenced our commissioning decisions. This is a key part of upholding our legal requirement and ensuring we have taken the time to consider all insight and feedback. The information gathered also supports the completion of Equality and Quality Impact Assessments. This process provides assurance that we are talking to the people who may be impacted including our most protected groups.						
Engagement & Equality implications (including whether an equality impact assessment has been completed)	The Involving People Strategy is a shared set of principles for involving people across Calderdale. The strategy has been developed in partnership such as with Local Authority, VCSI Alliance, North Halifax Partnership and providers. It's been tested with public audiences such as Calderdale Health Forum (PRG network), C&YP via LA. The Equality Strategy is a key enabler which will support the Involving People Strategy to ensure we involve the diverse population of Calderdale and those groups protected by 'The Equality Act 2010'.						
Resources / Finance implications (including Staffing/Workforce considerations)	There are no financial implications						
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)		**Yes**		**No**		**N/A**	x
Strategic Objectives (which of the CCG objectives does this relate to?	• Achieving the agreed strategic direction for Calderdale • Improving quality • Improving value	**Risk** (include risk number and a brief description of the risk)	None				
Legal / CCG Constitutional Implications	Section 242 Health and Social Care Act, NHS Constitution, Equality Act.	**Conflicts of Interest** (include detail of any identified/potential conflicts)	N/A				

Involving People Strategy

1.0 Introduction

1.1 The CCGs existing Public and Patient Engagement and Experience (PPE&E) Strategy was due to be refreshed and had been extended until the end of March 2020. 'The Involving People Strategy *(Appendix 1)* is a joint strategy with a shared set of principles for involving people across Calderdale – supporting the delivery of Calderdale Cares, Wellbeing Strategy and Vision 2024.

1.2 The strategy has been developed in partnership such as with Local Authority, Calderdale Voluntary Sector Infrastructure Support Service (VSI Alliance), North Halifax Partnership and providers. It's been tested with public audiences such as Calderdale Health Forum (PRG network) and Children & Young People via Calderdale Metropolitan Borough Council (CMBC).

1.3 The strategy describes a narrative for involving people which sets out:

- An approach
- A set of principles
- A way of working that we can all use

1.4 Public sector organisations have different requirements for involving local people in the design, development and implementation of services. Building system wide engagement and communication so that the principles will be the foundation by which local people can expect to be involved by any organisation in Calderdale.

2.0 Detail

2.1 The strategy is intended as a framework to create a platform for the sharing of knowledge and information from both, services to communities and communities to services and alter the relationship services have with local people and local people have with services.

2.2 The strategy will create opportunities to build on existing approaches and explore the use of different techniques. Every community has resources and assets that are readily available from the people who live there, the organisations and associations who are based there and the services that are in place.

2.3 We have legal obligations which we need to publicise. We will need to describe our internal governance and assurance, create an action plan for Involving People to support the strategy. And describe our methods and approaches for involving people including how we reach our diverse population.

2.4 There are 3 enablers to support the strategy, which are

- Communication – firstly in relation to involving people but more widely in how and when we communicate with our audiences to prepare them for the conversations that will take place
- Patient experience – the stories we create and share
- Equality – making sure we hear from people and communities from all equality groups

2.5 The strategy will be supported by a communication plan which will wrap around and support involvement and ensure that Calderdale Cares can articulate the good work going on in Calderdale by sharing information and maintain communication with local people on progress.

2.6 We will update our get involved section on the website to mirror the style and content of the new strategy.

2.7 Engagement, communication and equality professionals will share knowledge / skills / resources and collaborate and coordinate on system-wide projects through the governance structure *(Appendix 2).*

3.0 Next Steps

3.1 The next steps will be:

- To publish strategy on our website
- Describe our legal obligations, our governance and assurance, methods and approaches. We have legal obligations which we need to publicise.
- Create an action plan for the involving people strategy
- Establish a group of engagement, communication and equality professionals to maximise the knowledge, skills and resources to co-ordinate and deliver any system-wide projects.

4.0 Recommendations

4.1 It is recommended that the Governing Body:

1. **APPROVE** the Involving People Strategy.

2. **APPROVE** governance structure for system wide engagement and communication across Calderdale.

3. **ADOPT** and **PUBLISH** the joint strategy and governance structure as a vision and shared set of principles and approach for involving people across Calderdale.

5. Appendices

1. Involving People Strategy
2. Governance Structure for system wide engagement, communication and equality activity

NHS
Calderdale
Clinical Commissioning Group

Contents

Acknowledgements

We would like to thank all the individuals and organisations who have contributed to the development of this strategy. Your contributions have helped to inform a shared set of principles for involving people across Calderdale.

This strategy will help to build Calderdale wide engagement and communication so that the principles will be the foundation by which local people can expect to be involved by any organisation in Calderdale.

About us: who we are and what we want to do?

]NHS Calderdale Clinical Commissioning Group (CCG) buys health care services for the population of Calderdale and Calderdale Council provides social care and public health services.. Our role is to provide health and social care services to local people.

We know by experience that the only way we can make sure the services we provide are right is through the involvement of local people.

We know that communities do not need services to live healthy and fulfilling lives and that we play only a small part in keeping people happy, healthy and well.

Along with other organisations who work in Calderdale we want to come together with local people to explore how we change the relationship we have with the public.

Together we are all 'Calderdale Cares'.

The task

Our task is to involve local people and make sure 'Calderdale Cares' is driven through the eyes, stories and narrative of local people who live and work in the area.

We know that many people are already involved in community life. We want to learn from and build on what is already happening. It is the formal and informal connections that already take place that can help services better understand involvement.

By joining the dots of this activity, local people's real life experiences and stories will start to create a picture of Calderdale that will help put local people at the heart of Calderdale's future.

Calderdale is full of kind, resilient, talented and enterprising people. We need to share examples of local initiatives through stories and show the skills and knowledge that already exist.

The relationship we have with each other will be the key to our success

Our aim is to make sure we value the relationships we have and continue to build on these. We can all create relationships that support meaningful conversations. We know that Calderdale can become a place where people;

- know what is going on
- know they have a voice and know how to use it
- know their voice has been heard
- feel involved in the decisions about their future
- are encouraged to dream, design and create a better future

Shouting about the good stuff

Calderdale needs to continue to be proud of its achievements. The more we shout about the good stuff, the stronger we become. Calderdale can do this;

- By sharing and telling stories and creating pictures and images and films
- Using creative ways to share messages using media, social media, local publications and public places
- Through celebrating our successes and achievements

Let's crank up the volume so everyone can hear how great Calderdale is and how proud we are to live and work here.

Working through the hard stuff

We know that not every conversation will be about the good stuff. We know that for some people life can be a challenge, but together we can create hope and identify solutions. By agreeing to talk openly and share we can all start to understand, listen and design services together so let's;

- keep channels of communication transparent and open
- provide information that everyone can read and understand
- speak our truth and listen to each other
- keep each other informed about how it's going
- give each other feedback both good and bad

Calderdale will be a place where everyone feels included and involved, Calderdale will be a place filled with hope for the future.

We are all part of the Calderdale story

Calderdale has, beauty, history, a strong sense of identity and culture. It is a great place to live and work. Together we can build on these strengths, facilities, resources and assets and create a healthy, happy Calderdale. This is the beginning of our journey to **'show'** and **'share' so we can**:

- **'Show'** who we really are
- Then shout about it and '**share'** with everyone

Calderdale has many stories which can describe:

- Local people's great energy for change
- Fantastic facilities, resources and assets, and
- Local people with the skills and knowledge to create a healthy, happy and well Calderdale

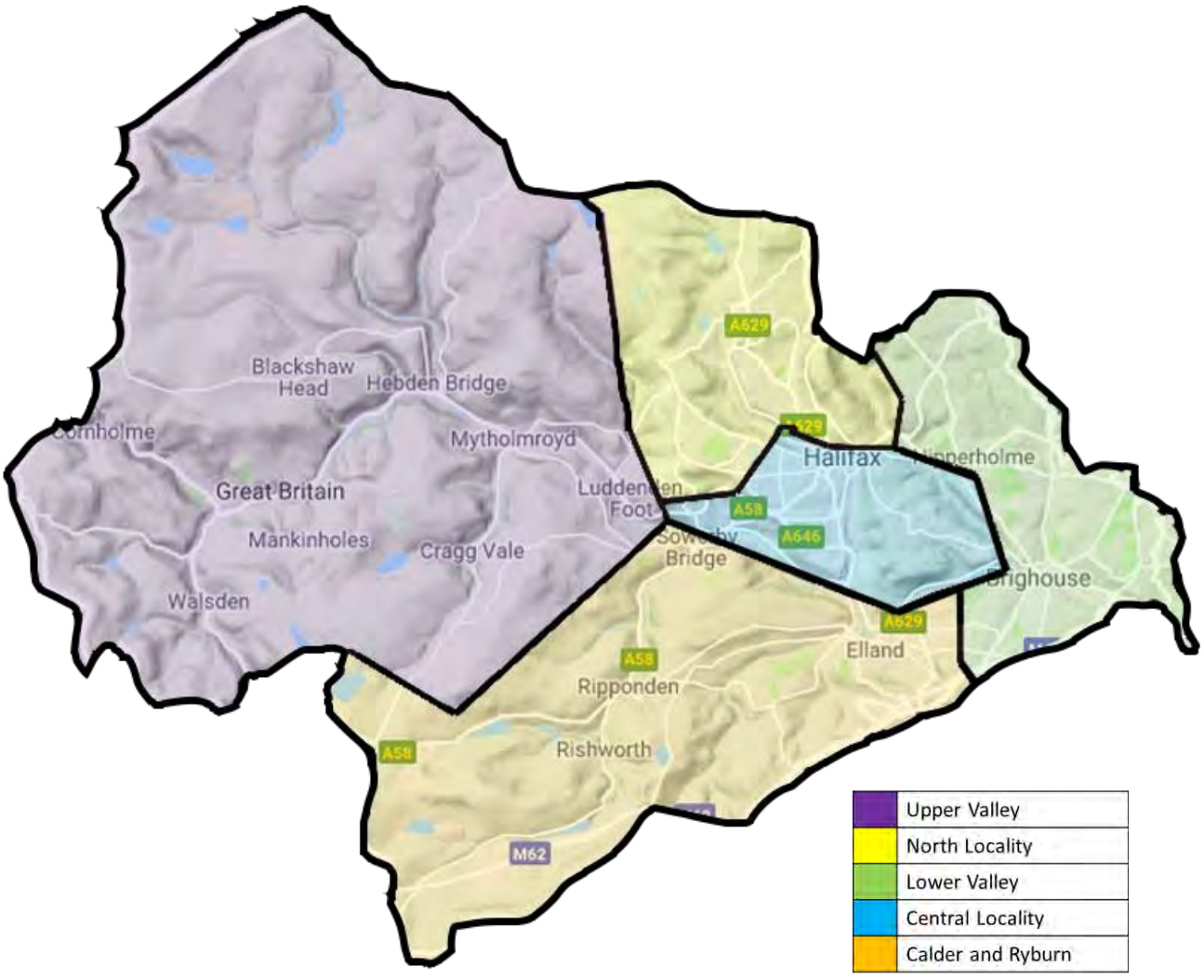
Calderdale 'A great place to live and work'

In 2024 Calderdale Council will celebrate its 50th anniversary. Founded in 1974, the council will reflect on what's already been achieved and local people will describe how far we have come in 50 years. In 2018 our NHS turned 70 and locally we reflected on and celebrated the achievements of our NHS service.

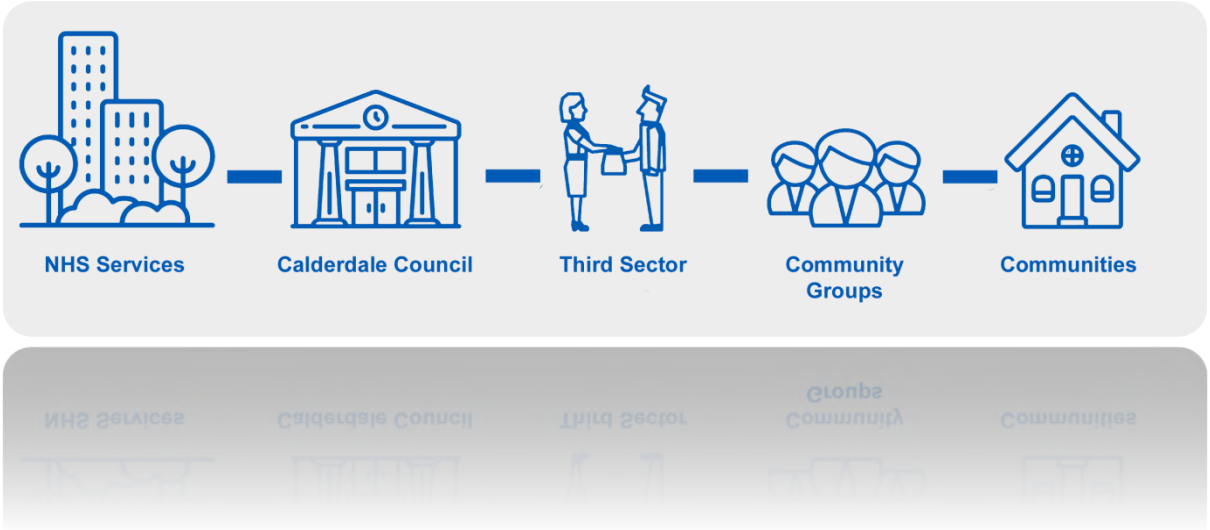
By 2024 Health and Social care services in Calderdale will be working together making sure local people get the services they need.

How your local services are starting to work together

Through Calderdale Cares services are starting to work in local networks covering a population of 30,000 - 50,000 local people. The locality areas are:



The services working together are:



- Calderdale Clinical Commissioning Group (CCG)
- Calderdale Council
- Pennine GP Alliance
- Calderdale and Huddersfield Foundation Trust
- Healthwatch
- Locala
- South West Yorkshire Partnership Foundation Trust
- West Yorkshire and Harrogate Health Care Partnership
- Voluntary and community sector

What else needs to be done?

We need to continue to work together with our communities so we can understand and celebrate the great things that have already taken place in local areas. We want to follow some simple steps to make this happen:

- Use what we already know about local services and continue to listen
- Create a story of 'place' with those who live and work in the area
- Understand what being involved means to people by working together
- Work with communities to create a vision
- Support conversations to take place

What will happen?

Our approach for taking this forward will be to:

- **Create the right conditions:** maintain and build on what we have, train staff and work with communities
- **Show and share:** Discover what is already working, and what is not
- **Exchange stories:** share and learn from each other and make the changes needed together

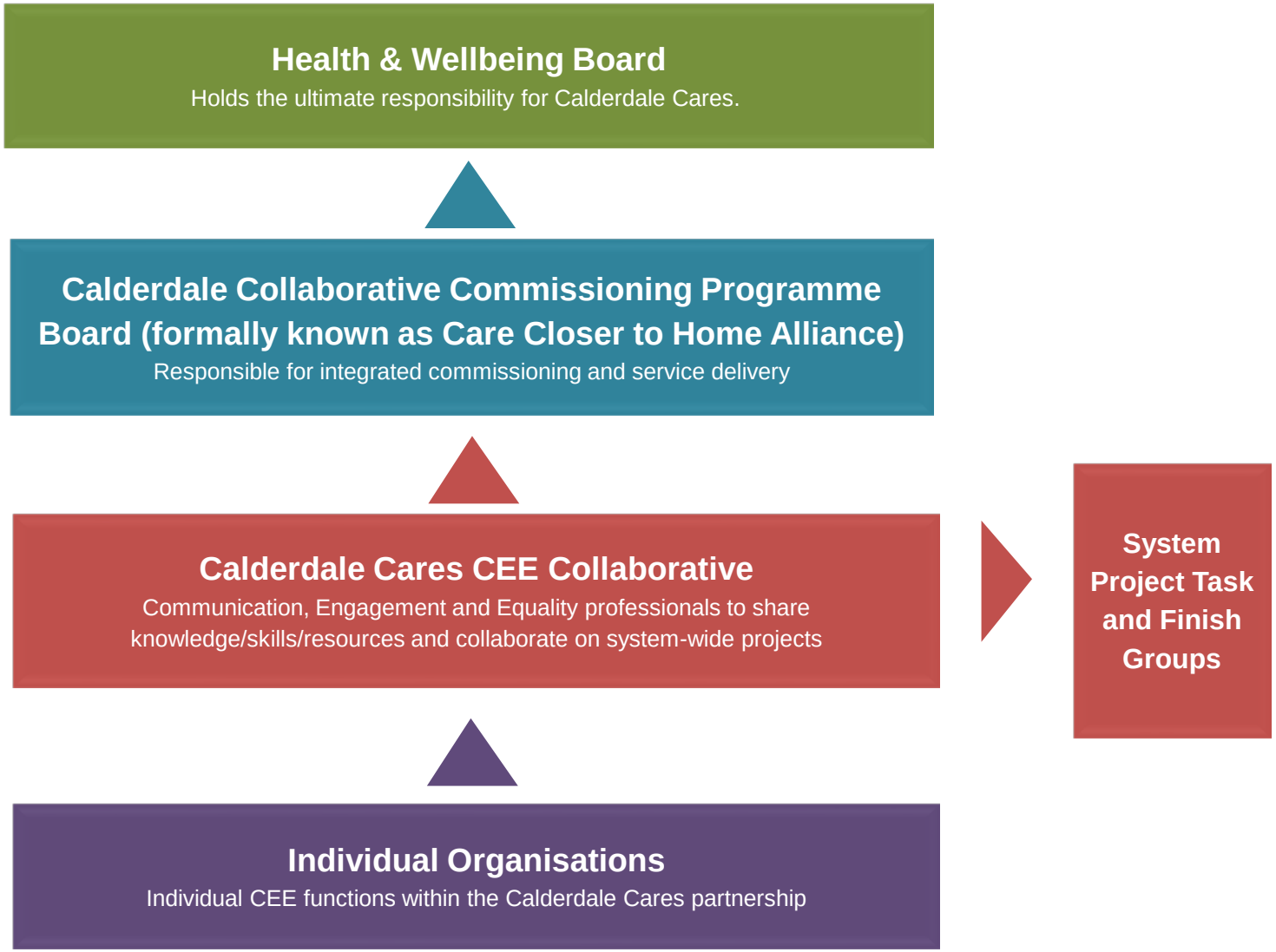
How will we know when we have got it right?

Communities need to tell us when we have got it right. We need to continually listen to feedback, respond to concerns and work together on solutions. This will include:

- Continuing to gather feedback
- Forums and gatherings to support open and transparent conversation
- Places for every individual to provide a view or comment
- Using technology and social media to reach people

When trust, cooperation and challenge are in place and people know they have a voice then we will know we are starting to get it right.

Governance


Health & Wellbeing Board
Holds the ultimate responsibility for Calderdale Cares.
Calderdale Collaborative Commissioning Programme Board (formally known as Care Closer to Home Alliance)
Responsible for integrated commissioning and service delivery
Calderdale Cares CEE Collaborative
Communication, Engagement and Equality professionals to share knowledge/skills/resources and collaborate on system-wide projects
System Project Task and Finish Groups
Individual Organisations
Individual CEE functions within the Calderdale Cares partnership

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Emergency Preparedness, Resilience and Response (EPRR) - Annual Update**	**Agenda Item No.**	9
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Interim Accountable Officer (Accountable Emergency Officer)	**Responsible Officer**	Rob Gibson, Corporate Systems Manager

Executive Summary							
Please include a brief summary of the purpose of the report	▪ To provide the Governing Body with summary of the CCG's activities in relation to emergency preparedness (EP) and business continuity throughout the year. This is in line with the Emergency Preparedness, Resilience and Response (EPRR) core standards which require that a report covering the emergency planning activity is produced at least once a year for the Governing Body. ▪ A more detailed report was received by the Audit Committee as part of its delegated role in scrutinising the Emergency Planning and Business Continuity functions of the CCG. ▪ The CCG is also required to complete a self-assessment of its compliance against the relevant EPRR core standards as part of the assurance process. The requirement for this years differs from previous years in that there is an expectation that all NHS organisations will already be undertaking reviews of their response to the first wave of COVID-19 and embedding learning into arrangements ahead of any possible second wave. Clinical Commissioning Groups area asked to submit a statement of assurance concerning this.						
Previous consideration	**Name of meeting**	Audit Committee	**Meeting Date**	24/09/20			
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body: ▪ **RECEIVES** and **NOTES** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year. ▪ **APPROVES** the CCG's Emergency Planning Framework (2020)						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications	
Quality & Safety implications	The Quality and Safety implications of Health Protection issues are reviewed by the Quality, Finance and Performance Committee as part of the the Infection Control and Prevention Papers
Engagement & Equality implications	None identified
Resources / Finance implications	All staff need to receive regular awareness raising training or skill development/refresher training

		commensurate with their roles in emergency planning and business continuity.					
Has a Data Protection Impact Assessment (DPIA) been completed?		**Yes**		**No**		**N/A**	x
Strategic Objectives	▪ Improving Quality and Safety ▪ Improving Governance	**Risk**			None identified		
Legal / CCG Constitutional Implications	▪ Civil Contingencies Act 2004 ▪ NHS Act 2006 (as amended 2012) ▪ NHSE EPRR Core standards	**Conflicts of Interest**			No conflicts of interest have been identified. Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.		

1.0 Emergency Preparedness, Resilience and Response (EPRR)

1.1 The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires NHS England (NHSE), NHS commissioners and providers to demonstrate that they can deal with such incidents whilst maintaining services to patients. In the NHS this programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

1.2 As a Category 2 responder, the CCG has a role in working with NHS partners and Calderdale Council both in planning and prevention and in responding to emergencies. The CCG fulfills this role in a number of ways including:

- Active participation in the local, system-wide and regional emergency planning fora;
- A senior manager on-call rota with Greater Huddersfield CCG;
- Participation in local, regional and system wide desk top and 'live' exercises;
- Coordination of the local health response, working with local emergency planning partners across the health and care system and supporting NHS England as required dependent upon the nature of incident;
- Review of existing plans to ensure that any learning is taken on board following exercises or incidents to improve our preparedness to respond to different categories of incident should we need to.

1.3 The Audit Committee has a delegated role in scrutinising the Emergency Planning and Business Continuity functions of the CCG. As part of this role, the committee receives regular updates on emergency planning activity as well as the annual self-assessment of compliance against the EPRR core standards, prior to submission to NHS England. There has been a change to this requirement for this year (see 3.0). A full report of the year's activities was received by the Audit Committee at its meeting on the 24 September 2020.

1.4 <u>CCG Emergency Planning Partnership Working</u>

The CCG is actively involved in local, system-wide and regional emergency planning arrangements. The main fora for coordination, joint working, planning and prevention are the:

Local Resilience Forum (LRF)
West Yorkshire

A&E Delivery Board
Calderdale and Greater Huddersfield

Local Health Resilience Partnership (LHRP)
West Yorkshire

Calderdale Council
(Emergency planning and community Safety Partnership structures)

Calderdale Health Protection Advisory Group
(CHPAG)

2.0 CCG Emergency Planning (EP) Framework (October 2020)

2.1 The CCG's Emergency Planning Framework (Oct 2020) (Appendix 1) sets out the roles and responsibilities of the CCG, the mechanisms by which it fulfils those responsibilities and the arrangements for working with partners across the health and care system. The Framework provides links to a suite of documents that provide further detail of the local emergency preparedness arrangements in place with partners. These are listed below:

- Surge and Escalation Plan (Calderdale and Greater Huddersfield)
- Calderdale and Greater Huddersfield Winter Plan
- West Yorkshire Emergency Incident Plan
- NHSE Operating Framework for Managing the Response to Pandemic Influenza (Dec 2017) and The Calderdale Health Protection Incident Response Framework (February 2020)
- Calderdale CCG Business Continuity Plan
- Calderdale CCG Pandemic Flu Plan
- Local emergency on-call pack

2.2 This document is reviewed every three years. During this current review there were no significant changes to the Framework. The Framework was noted at the Audit Committee meeting on 24 September 2020 and has been brought to this Governing Body meeting for approval.

3.0 Emergency Planning activity over the past year

3.1 The emergency planning and business continuity activity across the West Yorkshire Local Resilience Forum is informed by the risks identified on the West Yorkshire Community Risk Register and the national EPRR core standards. This in turn informs the review of the CCG's emergency planning arrangements and Business Continuity Plan and associated action plans.

3.2 There has been a continued focus on our emergency planning activity throughout the year – which included the area of cyber security at the very beginning of the year (see 3.5).

3.3 COVID-19

On 23 March 2020 the Government announced a full lockdown of the UK in response to the outbreak of COVID19 and the British population were instructed to stay at home. The CCG offices were closed with immediate effect and staff advised that they should work from home. Some of the actions undertook by the CCG as an overall response to this included:

- Provide all staff with the facility to continue working from home and introduction of MS Teams to allow for CCG business to continue virtually
- Establishment of a Gold SMT which conducted virtual meetings 3 times per week
- Establishment of a Silver Business Continuity Group consisting of team leaders meeting virtually 3 times per week
- An emergencies e-mail inbox single point of contact was set up in order to receive and cascade communications from partners including NHSE and Calderdale Council
- In terms of adult social care - increased cooperation and collaboration with the local authority
- Attendance at Gold and Silver system calls chaired by the local authority

- Provide regular reminders to staff through staff workshop and MS Teams on the risks associated from working from home including use of display screen equipment, electrical safety and IG issues such as phishing e-mails

At the time of writing this paper the CCG policy continues to be that staff should still work from home until further notice however the CCG recognises that there may be a need for a member of staff to work at Dean Clough. In such circumstances arrangements can be made for working from the office on a part time basis. The CCG office and Dean Clough building have been made COVID-19 compliant and the CCG has produced guidance informing staff on how to work safely in the office.

In addition individual risk assessments have also been completed by all staff. The aim is to allow staff to work safely and make sure their physical and mental health and wellbeing is supported, identify factors that may increase risk and assess the risks, reduce concerns for staff and support development of our recovery strategy. This risk assessment will also identify staff who may require access to the office.

3.4 **Emergency Planning Lead**

Due to a change in roles and responsibilities at the beginning of the year the Emergency Planning Lead for the CCG is now the Corporate Systems Manager.

3.5 **Training, exercises and planned events**

The CCG continues to take full part in the desk top and live exercises organised across the system to test existing plans against different scenarios. Due to the impact of COVID-19 and lockdown these exercises have been limited in number:

- Desk top exercise to investigate how Calderdale CCG, North Kirklees CCG, Greater Huddersfield CCG and Wakefield CCG are able to detect and respond to a staff member sharing commercially sensitive data with an unauthorised third party (February 2020). Risk assessments are currently being developed in collaboration with the Health Informatics Service (THIS) (active directory audit trail, data loss prevention software and on the use of approved USB devices) as a result of this exercise.

- Communcations exercise to test the efficiency of the communication arrangements for a team within a large service area of the CCG (February 2020). This exercise was run successfully with all team members being contacted and being able to escalate messages as required.

3.6 A further communications exercise is planned in the near future to test the functionality of MS Teams and the ability to contact all staff within the CCG at one time.

3.7 Normally the CCG participates in the Tour de Yorkshire every year however this year's event which was due to take place between 30 April and 3 May was cancelled due to the national lockdown.

3.8 **Business Continuity**

The CCG has a business continuity plan in place which is triggered if any incident occurs which has the potential to affect the smooth running of the organisation. Any actions identified as a result of incidents are carried out. Dean Clough experienced a problem with its gas supply on 16 December 2019 which meant that the office was without heating for a few hours during the morning. The Business Continuity Plan was triggered but the situation was resolved very soon afterwards.No actions were identified as a result of this incident.

3.9 The Business Continuity Plan had its annual review in August 2020. There were no significant amendments other than the inclusion of the use of MS Teams with staff working from home.

3.10 **EU Exit**

The UK left the EU on 31 January 2020 and entered a transition phase which will last for 11 months ending on 31 December 2020. Although the work undertaken by the CCG during last year in preparations for EU Exit was officially stood down by NHSE in January 2020 the CCG continues to retain the memory of all the elements that it has learned during this period e.g. issues around data flow, procurement etc.The CCG continues to monitor updates and requests for information/ situation reports from NHSE via its single point of contact. There are also weekly calls with the North East & Yorkshire Emergency Planning Team. At the writing of this paper there were no further updates on the plans for EU Exit from the regional emergency planning team.

4.0 EPRR Annual Assurance Process: reporting on compliance against the national Core Standards

4.1 There is a statutory requirement for the CCG to formally assure NHSE of its EPRR readiness. This is evidenced through the completion of the annual national EPRR core standards. In previous years these core standards have involved completion of a number of questions or core standards on emergency planning arrangements.

4.2 This year however the CCG is being asked to submit a statement of assurance covering the following three points:

a) The updated assurance position of any organisations that were rated partially or non-compliant in 2019/20 (*the CCG reported 'full' compliance in 2019*)
b) Assurance that all relevant commissioners and providers of NHS-funded care have undertaken a thorough and systematic review of their response to the first wave of the COVID-19 pandemic, and a plan is in place to embed learning into practice
c) Confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system

NHSE requests that the response is submitted via e-mail from the CCG's Accountable Emergency Officer by 31 October 2020. Work is currently being done on gathering the assurance for points b) and c).

5.0 Recommendations

5.1 It is recommended that the Governing Body:

1. **RECEIVES** and **NOTES** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year

2. **APPROVES** the CCG's Emergency Planning Framework (2020)

6.0 Appendix:

- Emergency Planning Framework (2020)

Emergency Planning Framework

Policy Ref: 024

Version/Status:	1.1 Draft
Responsible Committee:	Governing Body
Date Approved:	
Author:	Corporate Systems Manager
Responsible Lead:	Chief Officer
Review Date:	

Version History

Version.	Date	Author	Document Status	Commentary: (document development / approval)	Circulation
0.1	08/09/17	Head of Corporate Affairs and Governance	Draft	Initial draft	Audit Yorkshire and Chief Officer for comment
0.2	21/09/17	Head of Corporate Affairs and Governance	Draft		Audit Committee
0.3	28/09/17	Head of Corporate Affairs and Governance	Draft	Addition of NHSE roles and responsibilities, mutual aid arrangements	Governing Body
1.0	12/10/17	Head of Corporate Affairs and Governance	**FINAL**	Approved by Governing Body	Intranet, link for SMT
1.1	24/09/20	Corporate Systems Manager	Draft	3 yearly review – change of job title of Emergency Planning Lead	Audit Committee

Contents

1. Introduction

1.1 The NHS needs to plan for, and respond to, a wide range of significant incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease, major transport accident or chemical incident.

1.2 A significant incident or emergency is any event that cannot be managed within routine organisational arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or Local Authority.

1.3 Whilst NHS Calderdale CCG hopes that such incidents will not happen, the CCG is required to be prepared to respond and work with partners should they occur.

1.4 This Framework outlines how the CCG will meet the duties set out in legislation and associated statutory guidelines, as well as any other issues identified through regular risk assessments and testing of existing arrangements.

2. Statutory and Regulatory Framework

2.1 The Civil Contingencies Act 2004 aims to establish a consistent level of civil protection across the United Kingdom. The Act provides a national framework for organisations and agencies planning for local and/or national emergencies and explains how these organisations and agencies should work together, providing a framework to formalise joint working.

2.2 The Civil Contingencies Act 2004 (CCA) and the NHS Act 2006 (as amended by the Health and Social Care Act 2012)) requires NHS England, NHS organisations and providers of NHS funded care to demonstrate that they can deal with such incidents whilst maintaining services to patients. This programme of work is referred to in the NHS as Emergency Preparedness, Resilience and Response (EPRR).

2.3 The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies). Under the CCA, Category 1 responders are those at the core of any emergency response and who must comply with a full set of legal duties under the CCA 2004. This category includes NHS England, all acute trusts and ambulance trusts, Public Health England (PHE) and Local Authorities.

2.4 NHS England is responsible for providing national oversight, direction and co-ordination of the NHS response to health incidents and emergencies where appropriate.

2.5 **Clinical Commissioning Groups**

CCGs are classed as category 2 responders and therefore are placed under slightly lesser obligations than category 1 responders. They have a role in both planning and prevention and in responding to emergencies. CCGs work closely with partners and

are required to cooperate, support and share relevant information with other Category 1 and Category 2 responders.

3. Aims

3.1 The aims of this document are to ensure NHS Calderdale CCG acts in accordance with the legislative and regulatory framework, national policy and guidance by undertaking the duties listed below:

- To clearly define the governance arrangements for emergency planning, including responsibilities and lines of accountability throughout the organisation;
- To ensure that emergency plans and internal business service continuity plans have been established and are well communicated;
- To ensure that the plans address the consequences of all situations that might feasibly occur;
- To ensure that plans involve robust arrangements for the operational recovery from all such incidents;
- To ensure that all key stakeholders are consulted and collaborated with concerning their role in the plan and that they understand those responsibilities;
- To ensure that the plans are tested and are regularly reviewed;
- To ensure that funding and resources are available to respond effectively to major incidents;
- To ensure that NHS Calderdale CCG has access to up to date guidance relating to emergency planning;
- To ensure that staff receive emergency preparedness training that is commensurate with their role and responsibilities;
- To ensure that indicators demonstrating emergency preparedness and/or early warning of risk are used within contracts and service specifications;
- Work with partners to ensure that the whole system is monitored and tested regularly.

4. NHS England Responsibilities in Relation to Emergency Preparedness Resilience and Response (EPRR)

4.1 The generic EPRR role and responsibilities of NHS England are[1]:

- To set a risk based EPRR strategy for the NHS
- To ensure there is a comprehensive NHS EPRR system and assure itself and DH that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004.

4.2 **NHS England national**

At a national level the role of NHS England is to:

- Support the Accountable Emergency Officer to discharge EPRR duties

[1] NHS England Emergency Preparedness, Response and Resilience (EPRR) Framework 2015

- Participate in national multi-agency planning processes including risk assessment, exercising and assurance
- Provide leadership and coordination to the NHS and national information on behalf of the NHS during periods of national incidents
- Provide assurance to the Department of Health and Social Care (DHSC) of the ability of the NHS to respond to incidents including assurance of capacity and capability to meet National Risk Assessment (NRA) requirements as they affect the health service
- Provide support to DHSC in their role to UK central government response to emergencies
- Action any requests from NHS organisations for military assistance

4.2 **At a regional level,** the responsibility of NHS England (NHSE) is to:

- Ensure that each Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) has director level representation
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including ensuring the provision of surge capacity
- Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7
- Work with relevant partners through the LHRP & LRF structures
- Seek assurance through the local LHRP and commissioners that the Core Standards are met and that each local health economy can effectively respond to and recover from incidents
- Discharge the local NHS England EPRR duties as a Category 1 responder under the CCA 2004

5. CCG legal duties and responsibilities

5.1 As a category 2 responders, CCGs are defined as 'co-operating bodies' and are placed under slightly lesser obligations than category 1 responders. CCGs have a role to play in planning and prevention and in responding to emergencies.

5.2 CCGs work closely with partners and are required to cooperate, support and share relevant information with other Category 1 and 2 responders. The role of CCGs as set out in the NHS England Emergency Preparedness, Response and Resilience (EPRR) Framework 2015 is to:

- Fulfil the duties of a Category 2 responder under the Civil Contingencies Act (CCA) 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended):

  - Respond to reasonable requests to assist and cooperate
  - Ensure service delivery is maintained across the local health economy
  - Have a robust process in place for escalating significant incidents and emergencies to NHS England.

- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4)[2];
- Ensure contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity;
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards;
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident, the provider can inform the CCG 24/7. Locally this includes a shared emergency on-call rota across Calderdale and Greater Huddersfield CCGs;
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers;
- Be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative;
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness.

6. Underpinning principles for NHS EPRR

The underpinning principles apply to all commissioners and providers of NHS funded services:

a) Preparedness and Anticipation

The NHS needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) Continuity

The response to incidents should be grounded within organisations' existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

c) Subsidiarity

Decisions should be taken at the lowest appropriate level, with coordination at the highest

[2] Whilst the EPRR alert levels share common actions with the Operational Pressures Escalation Levels Framework (OPEL) they are not interchangeable and should be considered separately.

necessary level. Local responders should be the building block of response for an incident of any scale.

d) Communication

Good two way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public

e) Cooperation and Integration

Positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response.

f) Direction

Clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response.

The CCG's emergency planning and business continuity arrangements operate in line with the above principles.

7. CCG framework for fulfilling duties related to EPRR

7.1 Planning and Prevention

7.1.1 The CCG will work with partners through local, system-wide and regional emergency preparedness arrangements. The main fora for coordination, joint working, planning and prevention are:

- Local Health Resilience Partnership (LHRP) – West Yorkshire;
- A&E Delivery Board (A&E DB) - Calderdale and Greater Huddersfield footprint;
- Calderdale Health Protection Advisory Group
- Calderdale Council emergency planning and community resilience structures.

Local Health Resilience Partnerships

7.1.2 The role of the LHRP is to coordinate EPRR across the health system, to ensure continuity of patient services and effective engagement across local health organisations. They also support the health sector's contribution to multi-agency planning through Silver (Tactical) and Gold (Strategic) community and Local Resilience Forum (LRF) meetings attended by NHS England on behalf of the health sector. Key links are with LRF chairs; Public Health colleagues, Public Health England, Local Authority Chief Executives and EPRR teams and other senior EP officers.

7.1.3 LHRPs are not statutory organisations and as such accountability for emergency preparedness and response remains with individual organisations.

7.1.4 It is the responsibility of the CCG to be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative. Individuals attending should be executive representatives who are able to authorise plans and commit resources on behalf of their organisations. They must be able to provide strategic direction for health EPRR in their area. Individual members of the LHRP must also be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

7.1.5 The Head of Corporate Affairs and Governance will attend the LHRP as the CCG representative and will collaborate closely with Greater Huddersfield CCG to ensure a local coordinated approach.

The A&E Delivery Board (A&E DB)

7.1.6 The CCG works with partners to ensure service delivery is maintained across the local health economy through the A&E Delivery Board (formerly known as the System Resilience Group) comprises the key provider and commissioner organisations across Calderdale and Greater Huddersfield and has the role of ensuring a collaborative approach to maintaining the resilience of the system. The A&E DB focuses on current and future resilience across a 12-18 timeframe. The Board meets on a monthly basis and is chaired by the CCG's Chief Officer.

7.1.7 The A&E Delivery Board has oversight of the Surge and Escalation and the Winter Plans as well as the supporting communications plans.

7.1.8 These documents are reviewed and refreshed on an annual basis.

Calderdale Health Protection Advisory Group (CHPAG)

7.1.9 The role of CHPAG is to provide assurance to the Director of Public Health (Calderdale Council) about the adequacy of prevention, surveillance, planning, quality, safety and response to health protection issues. The meetings are held quarterly and the group has a lead role in the review and development of the Health Protection Incident Response Framework.

7.1.10 The membership is drawn from the CCG Quality and Primary Care teams, Public Health Team (Calderdale Council), screening and immunisations team (NHS England) and the Consultant in Communicable Disease Control, Public Health England.

Calderdale Council emergency planning and community resilience arrangements

7.1.11 The CCG is a member of the Calderdale Council Gold (Strategic) partnership group that meets on a quarterly basis and is co-chaired by the Chief Executive of the Council and the Chief Superintendent, West Yorkshire Police.

7.1.12 The The Head of Integration & Partnerships deputises for the CCG Chief Officer at these meetings as required.

7.1.13 The CCG also attends Local Authority Community Resilience meetings as required, takes part in Calderdale-wide exercises and is a key partner when an emergency response is required.

7.2 Emergency and Business Continuity Plans

7.2.1 A suite of documents contain further detail of the local emergency preparedness arrangements across the local health and social care economy. These are listed below:

- *Surge and Escalation Plan (Calderdale and Greater Huddersfield)*

  The Surge and Escalation Plan describes agreed operational processes through which the system will escalate and de-escalate activities to deal with increases in system pressure throughout the year.

- *Calderdale and Greater Huddersfield Winter Response Plan*

  The Winter Plan confirms additional specific arrangements related to the winter period; for example dealing with periods of extreme cold weather and ensuring business continuity plans are fit for purpose. The work also includes the development of winter communications plan.

- West Yorkshire Emergency Incident Plan and The Calderdale Health Protection Incident Response Framework

- On-call pack and Rota which sets out the 24/7 on-call arrangements (see 7.2.2)

- CCG Business Continuity Plan (see 7.2.4)

7.2.2 On-call arrangements

Each NHS organisation is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so each organisation must have an appropriate out-of-hours on-call system. Calderdale and Greater Huddersfield CCGs operate a Senior Manager 24/7 on-call arrangement to ensure that there is someone available to make strategic decisions on behalf of the organisation.

7.2.3 The arrangements, logging, escalation, communications and contact details are contained within the on-call pack which is reviewed and updated on at least an annual basis.

7.2.4 Business continuity plan

Business continuity arrangements have been developed for critical functions with due regard for risks posed to the CCG. CCG has adopted a corporate approach which outlines the response to the impacts of service disruptions for a variety of events. The Business Continuity (BC) Plan primarily focusses on the loss of one or more of the following components, identifying the minimum requirements to maintain and/or recover a critical function:

1. Staff
2. Premises
3. IT and Telephony
4. Resources

7.2.5 The BC plan sets out the arrangements to facilitate the maintenance and/or recovery of a critical function in a manner which identifies the maximum period of time that the function can be unavailable for based on the loss of one or more of the four components. Arrangements seek to provide an alternative to maintain service continuity. It also sets out:

- Roles and responsibilities
- Command, control and coordination arrangements
- Incidents experienced by other organisations and mutual aid arrangements
- The establishment and operation of an incident room
- Communications arrangements, including cascade arrangements and responding to media enquiries
- Recovery of the service
- Incident logging, reporting and procedures for lessons learned
- Consideration of staff welfare issues
- Mutual aid arrangements with Greater Huddersfield CCG and SWYPFT

7.2.6 Staff Welfare

NHS funded organisations must ensure staff welfare in general which includes anything done for the comfort and improvement of staff. The Senior Management Team must be aware of the potential for stress and/or fatigue to impact upon individual performance and decision making. They must ensure that they are mindful of their own and their team's levels of stress and fatigue and that effective arrangements are in place to minimise the potential impact.

7.2.7 The CCG's incident room procedures include consideration of provision of refreshments rest breaks and rotas, including for incident loggists, if the incident becomes protracted.

7.3 Provider Contracts

7.3.1 The NHS Standard Contract includes the appropriate EPRR provision and this contractual framework will be used wherever appropriate by the CCG when commissioning services. Contract monitoring and review will encompass the review of EPRR and there may be occasions where the LHRP uses the CCG as a route of escalation where providers are not meeting expected standards.

7.3.2 The CCG contracting and procurement team will seek assurance from commissioned provider organisations (including independent and third sector) that they have appropriate and effective internal business continuity plans in place.

7.4 Response

7.4.1 As Category two Responders under the CCA, CCGs must respond to reasonable requests to assist and co-operate with NHS England should any emergency require wider NHS resources to be mobilised. CCGs must have a mechanism in place to support NHS England Emergency Planners to effectively mobilise and coordinate all applicable providers should the need arise.

7.4.2 The CCG will work collaboratively with partners across the health and care system to maintain system resilience. The process by which this is carried out is contained within the Calderdale and Greater Huddersfield Surge and Escalation Plan and the Winter Plan. The A&E Delivery Board has oversight of the maintenance and effectiveness of the above plans.

7.5 Escalation arrangements

7.5.1 The command and control and Operational Pressures Escalation Levels (OPEL) are set out in the Surge and Escalation Plan.

7.5.2 The EPRR alert levels share common actions with the OPEL but should be considered separately. The EPRR alert levels, as set out in the NHS England EPRR Framework 2015, are set out below (see also appendix 1) and provide clear guidance on when an incident should be escalated to NHS England.

Incident Level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

8. Risk Assessment

8.1 Risk management is covered within the CCA 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

8.2 The risk register informs emergency and business continuity planning arrangements, ensuring that the CCG, its commissioned services and partner responders are prepared for the most significant risks.

8.3 The CCG utilises the West Yorkshire Community Risk Register in preparing its business continuity arrangements. The Business Continuity Plan provides an overview of the Very High and High risks which could lead to a service disruption. This is reviewed on an annual basis.

8.4 Any external risk may be required to be entered onto the Local Resilience Forum Community Risk Register if it is felt to pose a significant risk to the population. This action will be coordinated through the Local Health Resilience Partnership.

9.0 CCG Roles and Responsibilities

9.1 Governance and operational management arrangements

9.1.1 The diagram below sets out the governance and reporting arrangements for EPRR and business continuity at the CCG.

9.1.2 The **CCG Governing Body** has responsibility for approving the arrangements for emergency planning and business continuity[3]. The Chief Officer in his role as Accountable Emergency Officer (AEO) provides updates to the Governing Body on emergency planning, significant incidents and learning from incidents or exercises, as required.

9.1.3 The Governing Body has delegated scrutiny of the CCG's Emergency Planning and Business Continuity functions to the **Audit Committee**. This role of the Audit Committee will be supported by regular management updates on Emergency Planning and Business Continuity Matters through the quarterly Governance Assurance Report and on an annual basis as part of the NHS England EPRR assurance process. They will also be supported by Internal Audit reviews of emergency planning and business continuity arrangements as required.

9.1.4 The Quality, **Finance and Performance Committee** receives the minutes of the A&E Delivery Board and performance reports on actions to maintain system resilience.

9.1.5

9.1.6 The Senior Management Team approves the internal Business Continuity Plan, receives updates on emergency planning and business continuity matters, discusses on-call issues and arrangements, agrees actions to be taken forward following learning from exercises, incidents or requests from other organisations.

[3] NHS Calderdale CCG Constitution, Scheme of Reservation and Delegation (no.42), May 2017

Diagram 1: Governance and management arrangements

9.2 Individual roles and responsibilities within the CCG

9.2.1 The Accountable Emergency Officer

The Chief Officer is the Accountable Emergency Officer (AEO) for the CCG. They are responsible for:

- Ensuring that the organisation, and any sub-contractors, complies with the relevant EPRR statutory duties under the CCA 2004 and the NHS Act 2006 (as amended), The NHS England EPRR Framework, policy requirements and the NHS England Core Standards for EPRR;
- Providing assurance to the Audit Committee and Governing Body that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident;
- Providing assurance that the organisation has allocated sufficient experienced and qualified resource to meet these requirements.
- Ensuring that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supercede this;
- Ensuring that the organisation has a robust surge and capacity plan that provides an integrated organisational response and that it has been tested with providers and partner organisations in the local area;
- Ensuring that the organisation complies with reasonable requirements of NHS England, or agents of NHS England, in respect of monitoring compliance;
- Providing NHS England with such information as it may require for the purpose of discharging its functions;
- Ensuring that the CCG is appropriately represented by director level engagement with, and effectively contributes to governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

9.2.2 Corporate Systems Manager

The Corporate Systems Manager is the emergency planning lead for the CCG They are responsible for:

- Supporting the AEO in ensuring that that strategies, systems, training, policies and procedures are in place for emergency planning and business continuity including risk assessments as appropriate.
- Ensuring that the on-call pack is up to date and fit for purpose;
- Taking full part in the LHRP meetings as the CCG's representative;
- Representing the CCG at the Calderdale Council Silver meetings;
- Ensuring the production and implementation of the EPRR annual plan;
- Ensuring that the CCG complies with the NHSE assurance process;
- Ensuring that business continuity arrangements are in place, are fit for purpose;
- Liaising with CCG and other colleagues to develop a coordinated approach to the management of incidents, testing of plans and disseminating the learning. This includes attendance at internal/shared emergency planning meetings to monitor the delivery of the annual plan;
- Ensuring that plans and learning is disseminated to staff and that training is rolled out to staff as appropriate to their needs;
- Liaising with colleagues to ensure a joined up approach to system resilience and emergency planning.

9.2.3 Senior Management Team

- The members of the Senior Management Team are all part of the on-call manager rota.
- The roles of the Heads of Service in maintaining business continuity in their teams and responding to service disruption are set out in the Business Continuity Plan.

9.2.4

9.2.5 Incident room loggists

The CCG has a trained incident room loggist who is also qualified to train further loggists for both Calderdale and neighbouring CCGs.

10. Training

10.1 If staff are to respond to an incident in a safe and effective manner they require the tools and skills to do so in line with their assigned role.

10.2 Training is an on-going process to ensure skills and confidence in responding to incidents are to be maintained.

10.3 The training provided by Calderdale CCG, often in collaboration with neighbouring CCGs or other system partners, will focus on the specific roles and requirements assigned to the individual. Dependent on their responsibilities, the training will include wider organisational and multi-agency response structures and take the form of participating in multi-agency desk top or 'live' exercises.

10.4 The Standards for NHS incident training as contained within the Skills for Justice National Occupational Standards (NOS) framework will be referred to when identifying staff training needs.

10.5 Training needs as appropriate to individual roles will be identified through the risk assessment process and organised by the Head of Corporate Affairs and Governance as emergency planning / business continuity lead.

10.6 These include:

- Awareness raising of the CCG's business continuity plan for all staff on induction and on an annual basis either through a desk top business continuity exercise or 'live' business continuity exercise (every three years);
- Specialised training as necessary as identified through national/regional guidance or as a result of learning from exercises or incidents. (for example Strategic Leadership in Crisis and Loggist skills or for specific functions within the CCG such as the corporate services team)Specialist training for on-call managers relevant to their role

10.7 Training log

A training and exercise participation log will be kept for all on-call managers and will be provided as evidence of continuous professional development as well as informing any training needs analysis.

11 Testing of Plans

11.1 The CCG's internal Business Continuity Plan will be tested and reviewed on an annual basis as a desk top exercise, with a 'live exercise being organised every three years. The aims of these exercises are to:

- To validate the emergency planning or business continuity plans
- To test the systems and processes set out in the Business Continuity Plan
- To train staff and build confidence in their ability to respond to a real incident.

11.2 The communication and cascade plans will be tested every six months unless they have been effectively tested during an incident or as part of the annual desk top exercise. These exercises are to test the ability of the organisation to contact key staff and other NHS and partner organisations, 24/7. They should include testing the communications methods in use and be both during the in-hours period and the out-of-hours period on a rotational basis and should be unannounced.

11.3 The CCG will continue to play an active role in the multi-agency desk top or live exercises held by partners in health and at the local authority, as appropriate.

11.4 On occasion, a live incident occurs which requires the CCG to activate its business continuity plan and leads to a review and improvements in the existing plan. In such instances, this will replace the desk top exercise unless there is the view that a further exercise would be beneficial.

12 Lessons Learned

12.1 Ensuring that the lessons learned during such exercises and live incidents are captured and acted upon is key to the maintaining the resilience of the organisation and ability to respond to an incident in a managed way.

12.2 The process of hot debrief, cold debrief and production of exercise reports with recommended actions is set out in the surge and escalation plan and CCG business continuity plan.

12.3 Post incident reports will be produced following an incident affecting the CCG or local system.

12.4 The recommendations contained within post-exercise and post incident reports will be reviewed by the Risk, Health and Safety Manager for any local learning.

12.5 Updates on progress against the associated action plans will be reviewed by the SMT.

12.6 Any learning will be disseminated to CCG staff and partners across the health economy and local authority in support of continuous improvement in Emergency Planning.

13. NHS England Assurance Process

13.1 The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended).

13.2 The NHS Standard Contract Service Conditions require providers to comply with EPRR Guidance. Therefore commissioners must ensure providers are compliant with the requirements of the Core Standards as part of the annual national assurance process

13.3 The CCG must undertake a self-assessment of its compliance with the requirements of the Core Standards as part of the annual CCG assurance framework.

14. Review of Framework

14.1 This Framework will be reviewed every three years or more frequently due to changes in:

- National statutory, regulatory, policy requirements or guidance;
- Local policy, organisational functions, structure or staffing;
- CCG strategic objectives or processes;
- Key suppliers and contractual arrangements;
- Requirements due to learning from incidents, the testing of existing plans or risk assessments;

15. Dissemination of the Framework

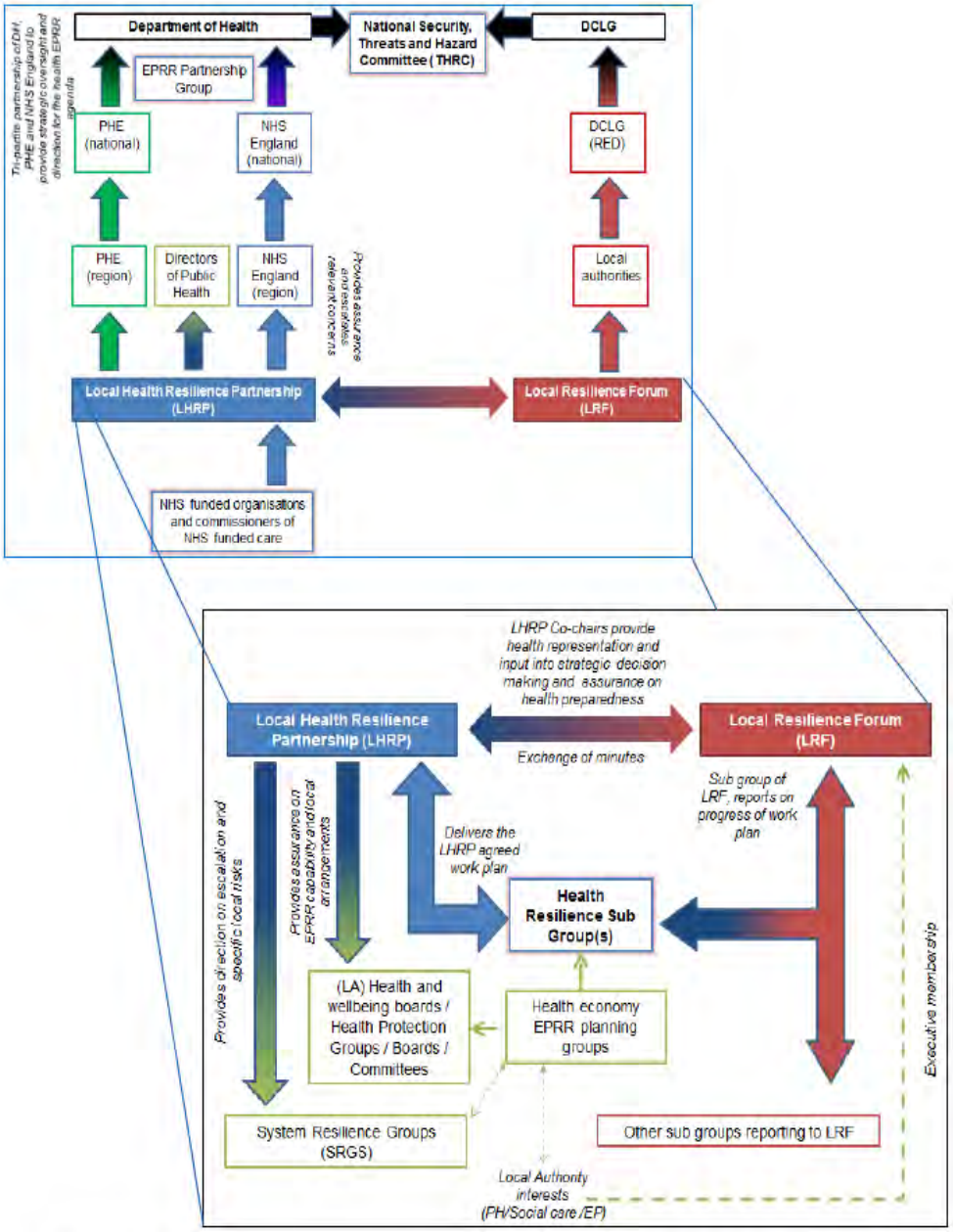
The Framework will be stored on the CCG intranet and disseminated to staff via the CCG's communication channels.

16. References and Underpinning Materials

- The CCA 2004 and associated Cabinet Office Guidance
- The NHS Act 2006 (as amended)
- The NHS Constitution
- The requirements for EPRR as set out in the NHS Standard Contract(s)

- NHS England EPRR guidance and supporting materials including:
- NHS England Core Standards for Emergency Preparedness, Resilience and Response
- NHS England Business Continuity Management Framework (service resilience)
- Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
- National Occupational Standards for Civil Contingencies
- BS ISO 22301 Societal security – Business continuity management systems

Figure One: **EPRR planning structure for the NHS in England**
Source: NHS England, Yorkshire & Humber.



Health resilience sub-groups may exist at LHRP level and also at a local health economy level to undertake strategic and tactical EPRR work.

Definitions[4]

Emergency Preparedness	The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.
Resilience	Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.
Response	Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.
Emergency	Under Section 1 of the CCA 2004 an "emergency" means "(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;* *(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;* *(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom*".
Incident	For the NHS, incidents are classed as either: ☐Business Continuity Incident ☐Critical Incident ☐Major Incident Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.
Business Continuity Incident	A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)
Critical Incident	A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.
Major Incident	A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency as above.

[4] NHSE, EPRR Framework, 2015

Appendix 3

NHS Calderdale CCG

Major Incident:

[*NAME*]

[*DATE* OF INCIDENT]

Post Incident Report

Incident Date:	
Incident Location:	
Date of Report:	
Report Author	
SMT	

Contents

1. Summary of incident	
2. Sequence of events (summary- full log available)	
3. Key observations	
4. Lessons to be learned	
5. Self-assessment against EPRR core standards [Does this affect our self-assessment against the EPRR core standards?]	
6. Actions to be taken forward	
7. Next Steps	

Action	Lead	Deadline	Comments

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Chief Finance Officer's Report**	**Agenda Item No.**	10 a
Report Author	Lesley Stokey, Interim Chief Finance Officer	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite, Interim Accountable Officer	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Officer

Executive Summary				
Please include a brief summary of the purpose of the report	**Finance** Key messages: • 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. • NHS England/Improvement has issued initial allocations for the period April 2020 to July 2020, this regime has rolled over into August and September 2020. • The CCG has received further guidance on allocations from October and is expected to submit a financial plan by 22nd October. • The CCG is currently forecasting an overspend against the initial allocations due to Covid costs and other cost pressures. • The CCG has received a retrospective increase in allocation following the submission of the Month 1-5 financial returns. **Contracting Key Messages** • To update the Governing Body on Month 4 of the 2020/21 contract position highlighting other issues where appropriate. **Performance** • To provide an update on progress against the NHS constitutional standards • To provide an insight into the 'core' mental health indicators currently published and update on the system dashboard being developed by West Yorkshire & Harrogate Partnership.			
Previous consideration	**Name of meeting**		**Meeting Date**	
	Name of meeting		**Meeting Date**	
Recommendation (s)	It is recommended that the Governing Body **NOTE**: ▪ the new temporary financial regime for the period April - September 2020. ▪ the forecast overspend for the period April – September 2020. ▪ new planning guidance due for the period October 2020– March 2021. ▪ the contacting update. ▪ the impact of COVID-19 on the progress being made towards achieving the standards set out in the NHS Constitution. ▪ 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.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications			
Quality & Safety implications	None identified		
Public / Patient / Other Engagement	None identified		
Resources / Finance implications	Detailed within the report		
Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**	1556 – Delivery of in year financial plan risk, 1557 – Delivery of CCG running cost requirements.
Legal / Constitutional Implications	None identified	**Conflicts of Interest**	Any conflicts of interest arising from this report will be managed in line with the CCG's Management of Conflicts of Interest Policy

1.0 FINANCE

1.1 Key Messages

1.1.1 This report updates the financial position as at month 6, 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.
- NHS England/Improvement (NHSE/I) has issued initial allocations for the period April 2020 to July 2020. These arrangements have been rolled over into August and September.
- The CCG has received further guidance in relation to October to March allocations. The CCG has to submit a financial plan by 22 October 2020.
- The CCG is currently forecasting an overspend against the initial allocations due to COVID costs and other cost pressures.
- The CCG received additional allocations of £3.3m for April-August against reported cost pressures.
- The CCG Quality, Innovation, Productivity and Prevention (QIPP) plan for 2020/21 is at risk due to the impact of COVID-19 and will be revising the QIPP plans as part of the October planning process.

1.2 2020/21 Temporary Finance Regime – Covid-19

1.2.1 In response to COVID-19, a temporary financial regime has been put in the place by NHS England (NHSE) and Improvement (NHSI) to cover the period 1 April 2020 to 31 July 2020. These arrangements have subsequently been rolled over into August and September with new arrangements in place from October. Original published allocations for 2020/21 have been reversed and allocations for this period have been based on 2019/20 outturn expenditure, uplifted for inflation and with some specific adjustments applied.

1.2.2 The revised financial regime and service changes in response to COVID-19 will have an impact on individual CCG financial positions and affordability of positions against allocations.

1.2.3 NHSE/I have implemented a block payment arrangement for acute NHS hospitals and the suspension of non-contracted activity charging. In addition the bulk of acute independent sector activity has been procured nationally. NHSE/I have made some adjustments to allocations to reflect this.

1.2.4 CCGs are expected to report additional COVID-19 expenditure within the year to date and forecast expenditure returns to NHSE. Where COVID-19 costs are deemed reasonable a subsequent retrospective allocation may be issued, subject to a review by NHSE/I.

1.3 Forecast position for the period July - September 2020

1.3.1 The CCG submitted its financial position to the end of September which is showing approximately £3.49m of pressures against the original allocation received for the period. The CCG has received additional allocation of £3.3m following the April-August financial monitoring submissions to NHSE/I. There remains a forecast overspend position of £0.2m.

1.3.2 A high level summary is shown in the table below:

High Level Forecast position M1-M6	Programme £'000	Delegated Primary Medical Services £'000	Running Cost £'000	Total £'000
Initial Allocation - Covid Regime	-150,466	-15,570	-1,792	-167,828
Latest Forecast for M6	153,341	15,919	2,058	171,318
Net overspend	2,875	349	266	3,490
Covid costs to date M1-M6	4,582	0	0	4,582
Other pressures (forecast M1-M6)	-1,707	349	266	-1,092
Total variance	2,875	349	266	3,490
Allocation adjustment M6	-2,791	-290	-221	-3,302
Net position	84	59	45	188

1.3.3 The makeup of these pressures can be seen in **appendices A-C** and summarised below:

- **Acute:** No longer showing an underspend due to an increase in the NCA (non-contract activity) and Independent sector expenditure which is not covered by the National purchasing arrangements.
- **Mental Health**: No longer showing an underspend as NCA activity has increased.
- **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 July. 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 overspend due to the Covid-19 cost included here in relation to Primary Care – in the main for Bank holidays and PCN related costs.
- **Primary Care – Delegated**: Showing an overspend as expecting costs to be in line with the original submitted plan.
- **Other / Reserves**: Showing an underspend as reserves have been released here following the additional allocations that we have received in months 1 to 5 to cover covid related costs. However there was a start pressure here as in 19/20 this budget delivered significant non recurrent savings and also from where we were able to increase our surplus in 2019/20 - which have not been taken into consideration in NHSE/I calculations of the revised allocations.
- **Running Costs**: The Allocation from NHSE 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. However as the CCG was already delivering a significant underspend on running costs in 2019/20 this methodology has presented the CCG with a further reduction against the planned 11.8% reduction. The CCG is therefore showing a cost pressure in relation to this target; however the pressure is still within our original planned reduced spending profile.

1.3.4 The guidance sets out that NHSE/I will review these pressures and make retrospective adjustments to allocations where they feel appropriate.

1.3.5 The CCG received additional allocation following the Month 5 submission to cover cost pressures incurred to date. The CCG received £3,302k additional allocation and the CCG allocated this between Programme £2,791k, Delegated Co-Commissioning £290k and running costs £221k. The remaining forecast pressures relate to month 6. The CCG submitted its month 6 finance reports in early October and is still awaiting feedback.

1.4 COVID-19 Cost Update

1.4.1 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 September.

Calderdale CCG Covid Expenditure Summary at 30th September 2020

	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6
Covid Expenditure	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
Hospital Discharge Programme - CCCG Commissioned	106	133	180	232	274
MH Services	10	11	11	23	24
Continuing Care Services	321	221	388	475	558
Prescribing	1	1	2	2	2
Community Based Services - Primary Care	400	529	513	569	608
Other Programme	46	45	106	105	157
Running Costs	4	4	4	4	4
Grand Total	**1,935**	**2,394**	**3,275**	**4,018**	**4,582**

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

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

1.5 New Financial Planning – October 2020 to March 2021

1.5.1 On August 20th, NHSE/I sent CCGs a briefing note on the expected financial arrangements for the rest of the financial year. The new financial arrangements consist of four envelopes of funding comprising:

A. **CCG allocations** – within which opening block contract values for services commissioned from NHS providers within and outside of the system will be nationally calculated;
B. **Directly commissioned services from NHS providers** – opening block contract values for specialised and other directly commissioned services will be nationally calculated;
C. **Top-up** – additional funding to support delivery of a breakeven position; and
D. **Non-recurrent Covid-19 allocation** – additional funding to cover COVID-related costs for the remainder of the year – Integrated Care System (ICS) allocation.

1.5.2 Under the new financial arrangements block payments to NHS providers will continue and national purchasing arrangements for the main independent sector hospitals remain in place.

1.5.3 CCGs have recently received new allocations for the remainder of the financial year and are expected to submit an organisational plan by the 22nd October.

1.5.4 In summary the national allocations and expenditure assumptions are as follows:

Calderdale CCG Month 7-12 CCG allocations	Original Allocations	Nationally modelled expenditure assumptions	Adjustment
Programme	156405	-149604	6801
Delegated Primary Care	15761	-15761	0
Running Cost	2058	-1933	125
Total	**174224**	**-167298**	**6926**

1.5.5 The national calculations assume that the CCG would have £6.9m surplus using the modelled expenditure assumptions. This surplus has been deducted from the CCG original allocation for this period leaving the CCG with an allocation of £167.3m.

1.5.6 The national expenditure model excludes cost in relation to the hospital discharge programme and costs in relation to additional CHC assessment activity, which will both continue to be claimed separately. It is expected that there will be additional allocations for specific programmes such as Primary Care Additional Roles for funding above the level included in baseline allocations. It is also expected that the CCG will be able to access part of the ICS COVID allocation and it is also anticipated that funding may be available for increases in independent sector activity which is not covered by the national procurement.

1.5.7 The CCG is expecting to be able to deliver a breakeven position subject to being able to access additional funding as set out above.

1.5.8 However, there is still consolidation of all CCG and provider plans across the ICS to understand the overall system financial plan. The CCG is in the process of developing a financial plan for submission on the 22nd October. The ICS is to submit a system level financial plan on the 20th October. Across the ICS, CCGs and providers are aiming to have draft plans completed by the 16th October.

1.6 Public Sector Payment Policy

The CCG has a target of 95%, and performance is currently between 92% and 99% across NHS and Non NHS invoices. **Appendix D** shows the public sector payment policy in more detail.

2.0 CONTRACTING UPDATE

2.1 Acute and Independent Sector providers

2.1.1 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.

2.1.2 Activity reporting indicates a significant reduction in activity as expected due to the impact of COVID-19. There has been a continued increase in non-face-to-face activity at all of our providers. GP referrals continue to be down compared to the same period last year and there has been a steady increase in the use of Advice and Guidance. A&E attendances and non-elective admissions have seen a steady increase across providers after the initial material reduction at the start of COVID-19.

2.1.3 Independent sector providers are continuing to support local systems in the delivery of clinical priorities.

2.2 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

2.2.1 An agreed contract value for 2020/21 was not finalised at the time that the COVID-19 guidance was published. Block payment values have been calculated by NHS England. 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 (Care Programme Approach) within 7 days of discharge was met in Month 4 (100%). The national target (60%) for Early Intervention in Psychosis (EIP) NICE approved care package within 2 weeks was also achieved in Month 4 (100%).

2.2.2. Calderdale CCG is now above planned trajectory for Acute and PICU (Psychiatric Intensive Care Unit) Out of Area (OoA) bed days at end of Quarter 1 2020/21, having been below trajectory for both at the end of Quarter 3 2019/20.

2.2.3 The Psychological Therapy service in Calderdale has a current waiting time of approximately 31 months for 1:1 therapy, which has risen from 24 months in January.

2.3 **Yorkshire Ambulance Service (YAS) 999 Ambulance**

2.3.1 Revised arrangements for NHS contracting and payment during the COVID-19 pandemic apply to the YAS contract as well. CCG level Contract reports for YAS 999 activity in Month 4 are not available at the time of writing this report, due to changes in the reporting process. Demand and performance data across the YAS footprint for Month 4 shows an average response time for Category 1 Calls of 6 minutes and 59 seconds, against a target of 7 minutes.

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

The Contract reports for IUC activity in Month 4 are not available at the time of writing this report, due to proposed changes in the reporting process. Validated WYUC activity shows 1,637 cases for Month 3 (Month 4 unavailable at time of report), a decrease of 389 cases compared with Month 2.

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

Performance in the service has been good despite the impact of COVID-19. Total new referrals reached 225 in July. For Calderdale there were 63 adult referrals with 32 of these being re-referrals and 20 paediatric referrals with 14 being re-referrals.

2.6 Procurements

Service description	Status	Contract start date	CCG Annual contract value
Covd-19 Temporary Additional GP Support Community Beds Ingwood	Contract Awarded	01.06.2020	£7,176 (per month)
Mental Health Helpline Service	Contract Awarded	01.05.2020	£219,177
West Yorkshire and Harrogate Health and Care Partnership Supporting Grief and Loss in the context of Covid-19	Contract Awarded	29.06.2020	Financial envelope: £150,000
West Yorkshire and Harrogate Health and Care Partnership Training Provision for Social Prescribing	Contracts Awarded	01.09.2020	Financial envelope: £104,000
Covid-19 Positive Enhanced Care Beds	Procurement underway	01.10.2020	£176,940 (6 months)
Dermatology Service	Procurement underway	01.04.2021	£350,000
GP Support: Covid-19 Beds	Market Test	01.10.2020	£15,568
Seamless Home from Hospital	Procurement underway	01.04.2021	£316,096
Continuing Healthcare Domiciliary Care	Contracts awarded	01.11.2020	Approximately £1m (multiple providers)

3.0 PERFOMANCE UPDATE

3.1 NHS Constitution

3.1.1 Overall performance against the key indicators of the constitution is captured in the tables below. Variances from the national standards are explored in the supporting narrative within this update:

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

Indicator Details	Latest Period	Target	Value	Change
A&E - % waiting under 4 hours	July 2020	95% and above	93.7%	⇓ -1.0%
A&E - No. waiting 12+ hours from DTA	July 2020	0	0	⇔

Cancer waiting times (monthly)
(Commissioner)

Indicator Details	Latest Period	Target	Value	Change
Cancer - % seen within 2 weeks (breast symptoms)	June 2020	93% and above	100.0%	⇔ 0.0%
Cancer - % seen within 2 weeks	June 2020	93% and above	98.9%	⇓ -0.4%
Cancer - % treated within 31 days	June 2020	96% and above	94.5%	⇓ -1.1%
Cancer - % treated within 31 days (Drugs)	June 2020	98% and above	96.0%	⇓ -4.0%
Cancer - % treated within 31 days (Radiotherapy)	June 2020	94% and above	97.4%	⇑ 0.7%
Cancer - % treated within 31 days (Surgery)	June 2020	94% and above	68.4%	⇓ -25.3%
Cancer - % treated within 62 days (Consultant Upgrade)	June 2020	No target	100.0%	⇔ 0.0%
Cancer - % treated within 62 days (Screening)	June 2020	90% and above	25.0%	⇓ -75.0%
Cancer - % treated within 62 days	June 2020	85% and above	73.5%	⇓ -14.7%

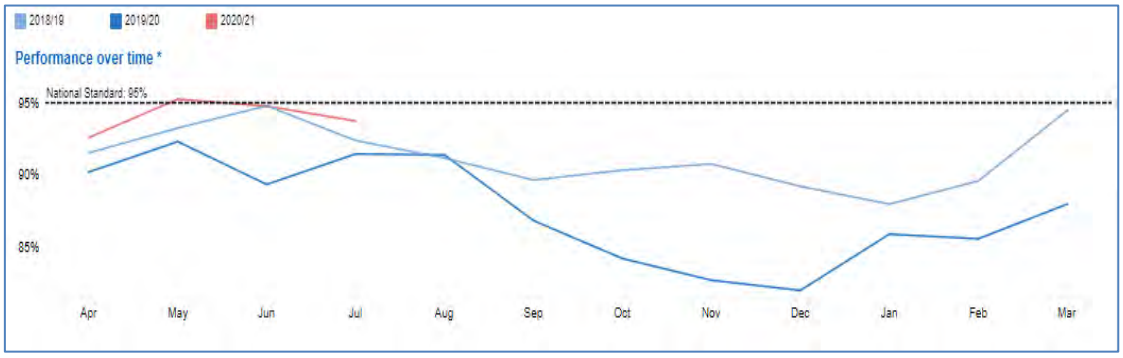
Elective care
(Commissioner)

Indicator Details	Latest Period	Target	Value	Change
Diagnostics - % waiting over 6 weeks	June 2020	1% and below	51.1%	⇓ -9.9%
RTT - % waiting over 18 weeks	June 2020	92% and above	N/A	
RTT - No. waiting over 52 weeks	June 2020	0	113	⇑ 140.4%

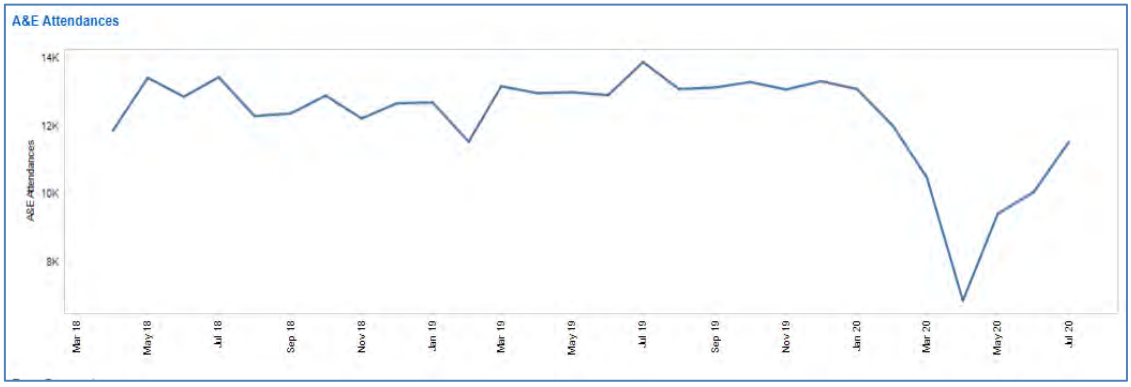
3.2 A&E - % waiting under 4 hours

3.2.1 A&E performance refers to the percentage of patients discharged, admitted or transferred within 4 hours of arrival at the A&E Department. Calderdale performance is aligned with the performance achieved by the local acute provider Calderdale and Huddersfield NHS Foundation Trust.

3.2.2 The chart below illustrates the monthly variation in A&E performance during the last 2 year years. The latest published figures on A&E performance for July indicates the local health and care system achieved 93.7%. Although below the constitutional standard (95%), this level of performance compares favourably with other systems placing Calderdale in the upper quartile both regionally and nationally.



3.2.3 As the 'lockdown' measures relaxed, the volume of attendances to A&E continues a sustained increase month on month – see chart below. As part of the reset for phase 3, plans are being developed that anticipate attendance to A&E to return to pre-COVID levels during Q3 2020/21. Key system challenges going forward will be the management of demand for A&E, managing the acute bed base at the front end (admissions) and back door of the hospital (discharges) and workforce capacity.



3.2.4 Winter

The A&E Delivery Board has developed a reset plan to support the system through winter. The context for the work is:

- A perfect storm - winter likely to be our most challenging yet; COVID legacy, peaks, seasonal flu, other winter-related conditions – set within context of huge reductions in capacity and social distancing (face to face care, support offers, beds etc.), deepened health inequalities and financial pressure

- First wave - disproportionate impact on people living in deprived areas, BAME population, those in certain occupational groups, people with long term conditions, and those who have not accessed essential physical and mental healthcare during the pandemic

- The huge economic/employment impact of COVID on families and businesses, which will take exacerbate the impact of winter

- It is not a challenge for one part of our system. We have learned that we work best together - taking learning from the work we did together during the first pandemic peak

The Board has talked to a range of partners in order to agree plans (Third Sector, Overgate Hospice, Calderdale Metropolitan Borough Council (CMBC), Kirklees Metropolitan Borough Council (KMC), YAS, Local Care Direct (LCD), Locala, SWYPFT, CHFT, Kirkwood Hospice and WY Community Pharmacy). There are 17 key actions in the reset plan and the A&E Delivery Board will monitor progress.

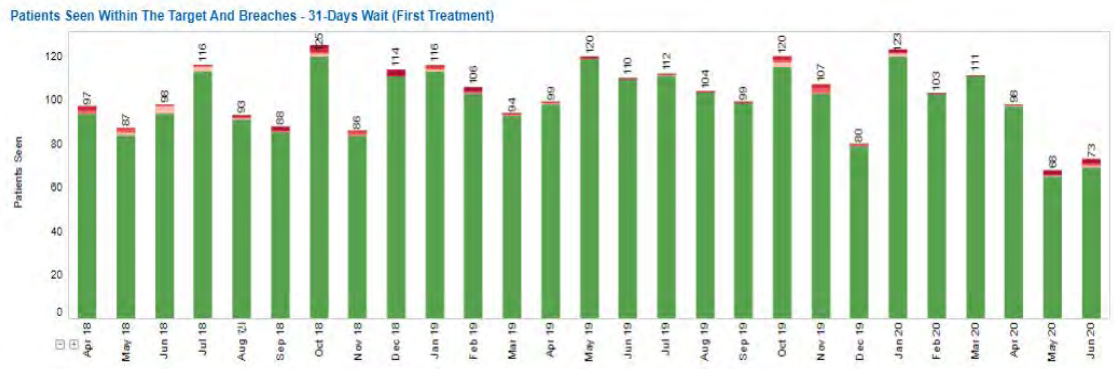
3.3 Cancer Waiting Times

3.3.1 Historically, Calderdale has demonstrated strong levels of performance against the cancer waiting time standards. However the impact of COVID can be noted in the latest published figures and there are a number of variations to note this month.

3.3.2 All breaches of the waiting times standard are reviewed by the Cancer Locality Group who coordinate actions to address the position. The Cancer Locality Group will also be looking at the actions required to ensure access levels return to pre-COVID levels during Q3 2020/21 and beyond and that performance levels are maintained. The volume of referrals onto cancer pathways is already returning back to pre-COVID levels but key the challenges remain including - encouraging patients to attend their appointments for treatment and maximising the capacity available to deliver safe services.

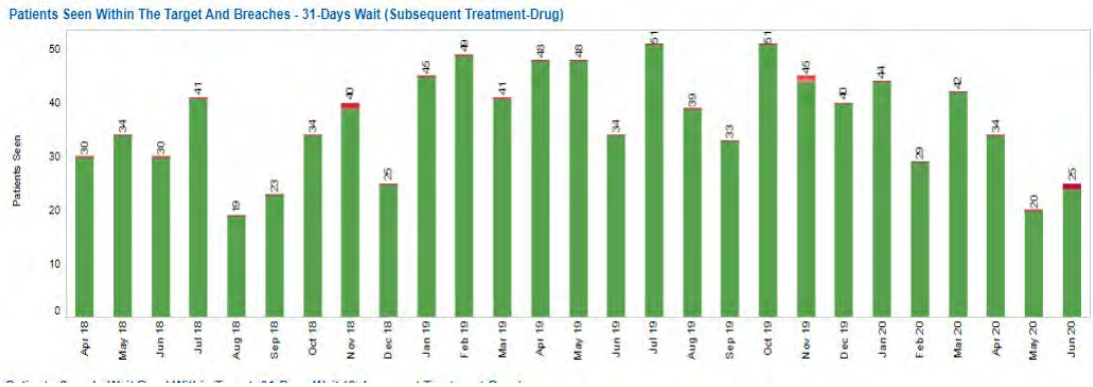
3.3.4 31 Days Wait (First Treatment)

Following a decision to treat, patients should expect to receive their first definitive treatment within 31 days. The standard to achieve is >96%. Performance in June was 94.5% (national position was 93.7%). The chart below illustrates the volume of patients seen within the target and the 4 patients who breached the waiting time standard due to capacity constraints with NHS providers.



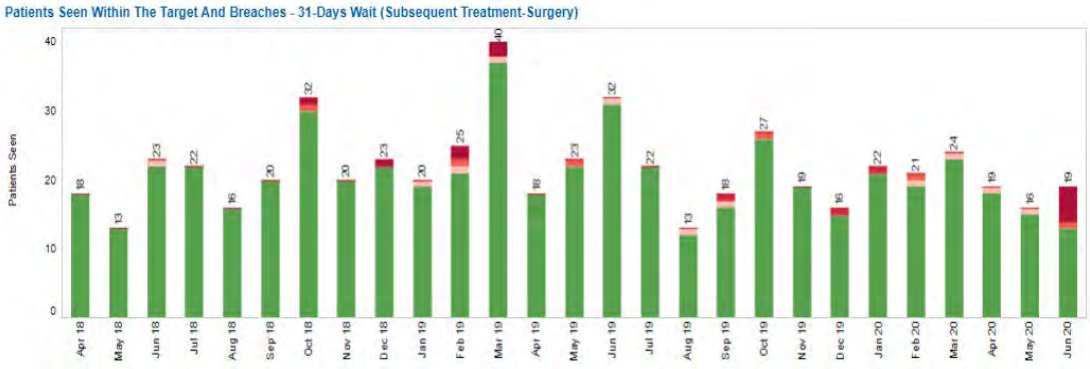
3.3.5 31 Days Wait (Drugs)

Patients who require a subsequent anti-cancer drug regimen should expect to do within 31 days. The standard to achieve is >98%. Performance in June was 96% (national position was 98.7%). The chart below illustrates the volume of patients seen within the target and includes 1 patient who breached the waiting time standard.



3.3.6 31 Days Wait (Surgery)

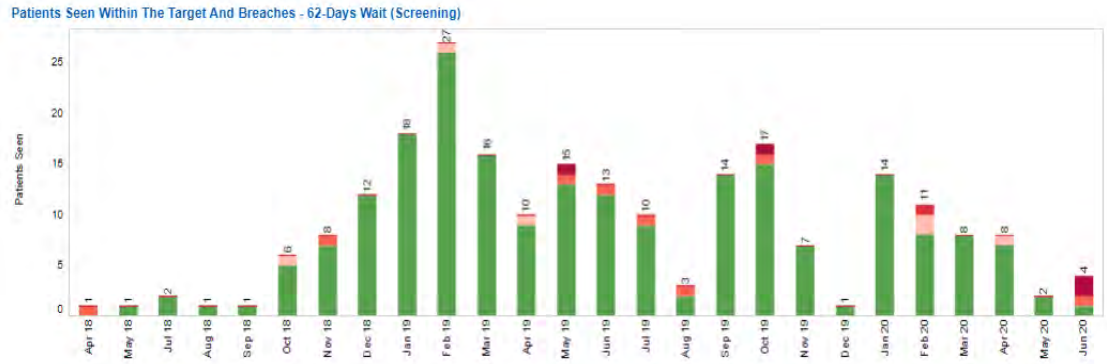
Patients who require a subsequent surgical treatment should expect to do within 31 days. The standard to achieve is >94%. Performance in June was 68.4% (national position was 86.7%). The chart below illustrates the volume of patients seen within the target and includes the 6 patients who breached the waiting time standard due to capacity constraints with NHS providers.



3.3.7 Cancer Screening

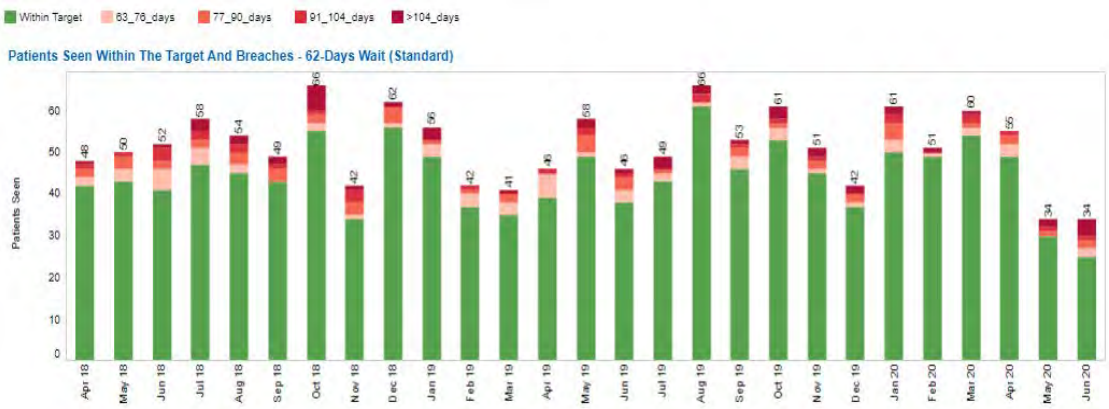
Following referral from a cancer screening service, patients should expect to receive their first definitive treatment with 62 days. The standard to achieve is >90%. Screening services were paused during the lockdown, hence the numbers reported in the chart below are low. Screening services have since reopened and we expect the numbers being reported on screening pathways to increase. Work between partners in Calderdale has commenced to support this.

Performance in June was 25% (national position was 12.9%). The chart below reflects the patients already referred post screening including 3 patients who breached the waiting time standard - 2 patients experienced delays due to capacity constraints with NHS providers and 1 was initiated by the patient.



3.3.8 62 Days

Following an urgent GP referral for suspected cancer, patients should expect to receive their first definitive treatment within 62 days. The standard to achieve is >85%. Performance in June was 73.5% (national positon was 75.2%). The chart below illustrates the volume seen within target and also includes 9 patients who breached the waiting time standard – 5 breaches were due to the complexity of the diagnostic pathway and the remaining 4 due to capacity constraints with NHS providers.



3.4 Elective Care

3.4.1 Referral to Treatment Times (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.

The report described the intention to field-testing these proposals with a number of care providers nationally in order to support an evidence-based decision-making process with regards to any changes in national access standards.

The field testing seeks to prove, or disprove, whether the new standards will have a positive impact on the management of access to elective care and patient experience. Twelve field sites (including CHFT) have been invited to test using the average wait for all patients on incomplete pathways as the headline measure of RTT performance.

3.4.2 Field Testing

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.

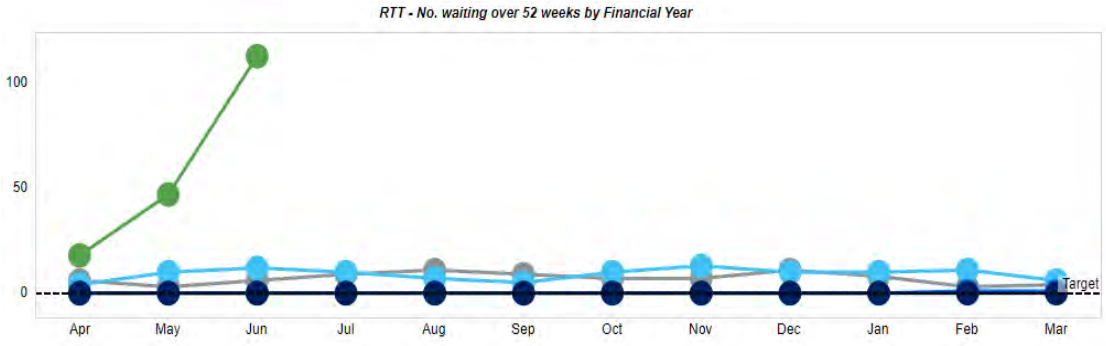
A new reporting and performance management regime commenced on the 1 August 2019 and the pilot was initially expected to last 4 months, but the development of the field test has been suspended during phase 1 and 2 of the COVID 19 response. We await further updates from NHS England on the next steps in phase 3 of the system response.

3.4.4 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 of Calderdale patients (113) waiting greater than 52 weeks and the specialties involved.

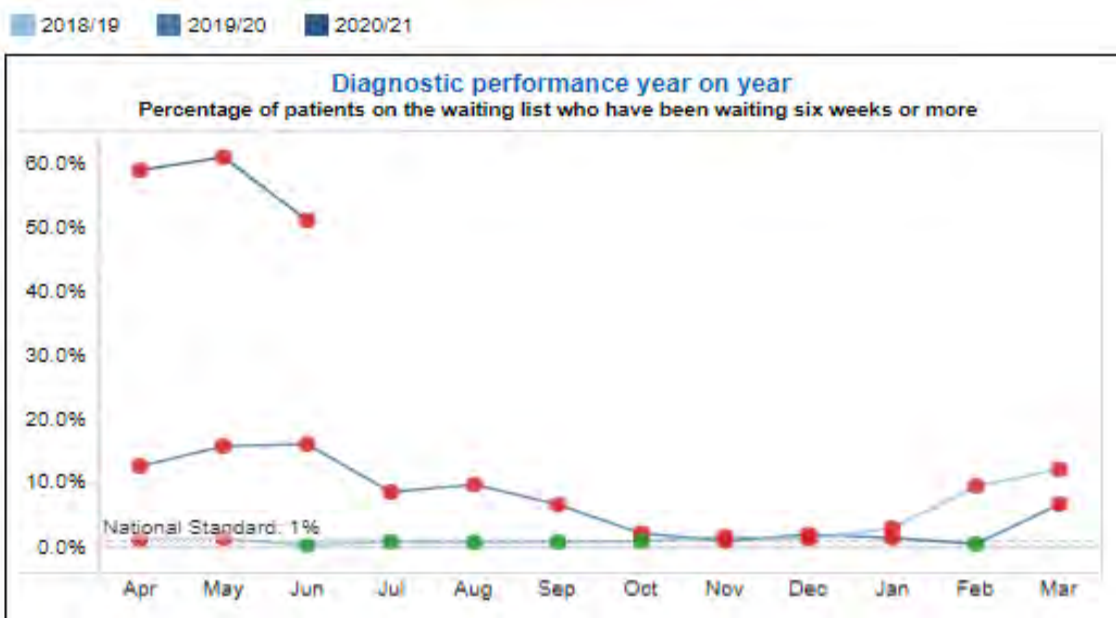


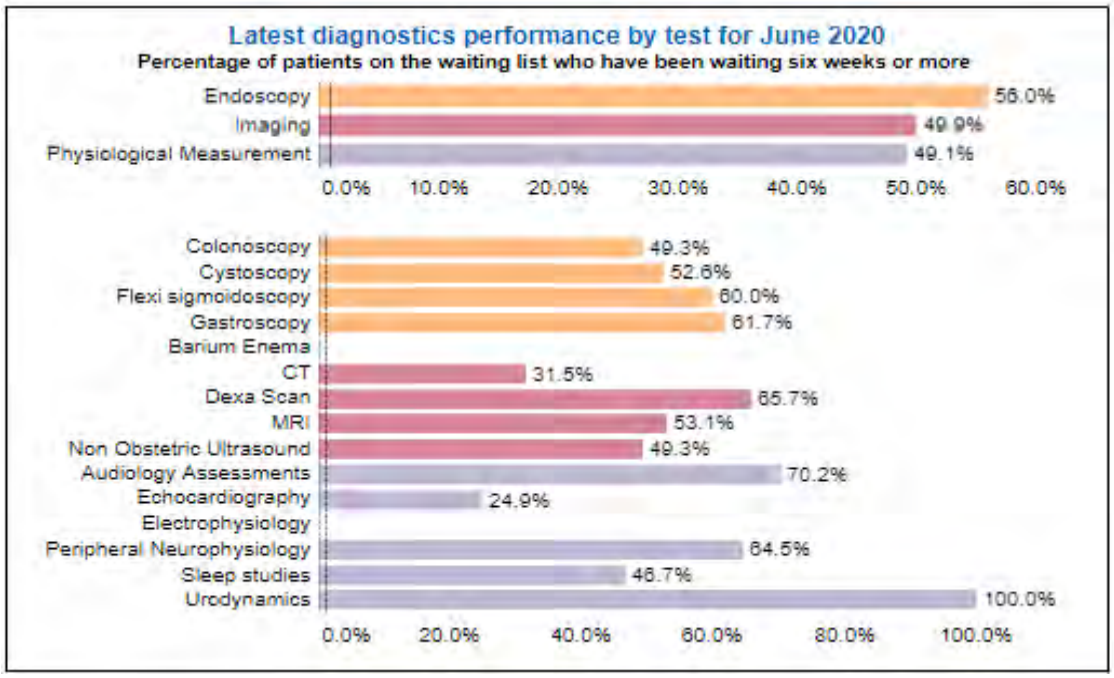
During the phase 1 of the NHS response to COVID, access to elective care was limited and patient treatment focussed on clinical prioritisation. As part of the NHS planning to reset access levels to services, modelling is being undertaken locally to maximise the volume of elective capacity that can be made available to safely treat patients according to clinical need and chronology.

3.5 Diagnostic Waiting Times

3.5.1 Patients referred for a diagnostic test should wait less than 6 weeks following their referral by a GP. The NHS Constitution requires no more than 1% of patient waits to breach this standard.

3.5.2 COVID has had a significant impact on overall performance in this area – see chart below. In June 51.1% of patients had waits greater than 6 weeks across all diagnostic modes. A similar picture was reported nationally (47.8%).





3.5.3 As with elective care, access to diagnostic testing was limited during the wave 1. Phase 3 of the reset is 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. There are plans in place to increase the volume of MRI and CT scans to 90% of pre-COVID levels during Q3 2020/21. However increasing capacity for endoscopy remains challenging.

3.6 Mental Health

3.6.1 The NHS Long Term Plan renewed the NHS commitment to pursue the transformation of mental health care in England. The implementation plan with a ring fenced budget provides a framework to monitor progress with this commitment at the local level.

3.6.2 The table below captures the latest position for the 'core' mental health metrics from the Long Term Plan. Metrics are available to support a range of areas including talking therapies, crisis intervention, health checks, dementia and out of area placements:

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
CYP access rate	21.9%	24.1%	26.5%	28.2%	29.7%	30.6%	32.1%	33.5%	35.0%	39.1%	43.0%		
CYP Eating Disorder Waiting time - Urgent			75.0%						0.0%			50.0%	
CYP Eating Disorder Waiting time - Routine			100.0%						95.0%			95.2%	
IAPT access rate	5.62%	5.27%	5.25%	5.46%	5.73%	5.66%	5.00%	4.52%	4.35%	3.19%	3.69%		
IAPT recovery rate	58.6%	59.6%	60.1%	57.2%	55.9%	53.8%	54.7%	56.1%	55.8%	53.8%	50.7%		
IAPT waiting times 6 weeks	93.0%	94.3%	94.0%	94.6%	97.8%	95.8%	96.1%	94.7%	93.2%	90.9%	94.1%		
IAPT waiting times 18 weeks	98.6%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
EIP waiting times - MHSDS		12.0%	27.0%	48.0%	72.0%	80.0%	90.0%	95.0%	93.0%	91.0%	71.0%		
EIP incompletes <2wks	0.0%	0.0%	50.0%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
SMI % achievement			26.4%			24.9%			23.3%			16.9%	
Out of area placement bed days (inappropriate only)	220.0	160.0	80.0	20.0	50.0	85.0	170.0	210.0	240.0	215.0	160.0		
Dementia diagnosis rate	64.9%	64.9%	65.7%	66.0%	65.9%	66.0%	66.9%	65.6%	65.2%	62.9%	61.2%	61.0%	59.9%
Perinatal Access	95.00	95.00	105.00	100.00	105.00	105.00	95.00	90.00	100.00	100.00	105.00		
Perinatal Access Rate	3.8%	3.8%	4.3%	4.0%	4.3%	4.3%	3.8%	3.6%	4.0%	4.0%	4.3%		

3.6.3 Going forward, performance will be assessed against the plans and trajectories being developed in these areas as part of phase 3 NHS reset. Updates will be provided the Quality, Finance and Performance Committee.

3.7 System Oversight and Assurance

3.7.1 Previous approaches to system oversight and assurance have been handled under the umbrella of the Improvement and Assessment Framework. This included a series of regular review meetings between NHS England and the CCG leadership team covering a range of indicators that covered quality of services, activity, finance and system leadership as well as any emerging issues. Each year, the overall progress the CCG had made during the year was given an assessment rating. The most recent rating for Calderdale was Good.

3.7.2 With the alignment of NHS England and NHS Improvement operating models, regional teams are coming together to develop a new approach to system oversight that will set out how to review performance and identify support needs across systems and places.

3.7.3 It is anticipated that the oversight regime will shift to a place based system review meetings that involve:

- the regional team
- system and place based leaders
- drawing on corporate and national expertise as necessary
- informed by a shared set of information covering;
  - performance against a core set of national requirements. These will cover quality of care, population health, financial performance and sustainability, and delivery of national standards
  - emerging organisational health issues that may need addressing
  - implementation of transformation objectives in the NHS Long Term Plan

3.7.4 Arrangements to support system oversight are currently transitional due to the impact of COVID. Attached as **Appendix F,** this is the latest system dashboard for the West Yorkshire and Harrogate Partnership. Much of the content is covered via the constitution and other updates to the Committee and will be used to inform regular reviews between Calderdale and West Yorkshire and Harrogate Partnership.

3.7.5 Updates on the development of the framework to support system oversight will be shared with the Quality, Finance and Performance Committee as well as insights from the system dashboard.

4.0 RECOMMENDATIONS

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

- the new temporary financial regime for the period April - September 2020.
- the forecast overspend for the period April – September 2020.
- new planning guidance due for the period October 2020– March 2021.
- the contacting update.
- the impact of COVID-19 on the progress being made towards achieving the standards set out in the NHS Constitution.
- 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

5.0 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 F – WY&H System Dashboard

Calderdale CCG Resource Allocation Summary as at 30th September 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 05 Forecast Outturn	Mth 05 Forecast Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS IN YEAR	(169,117	(28,268)	(28,268)	0	(169,117	(169,117	0	(169,117	0	(168,522)	(595)
ACUTE	81,763	13,627	13,640	13	81,763	81,808	45	81,808	45	81,797	11
MENTAL HEALTH	17,687	2,948	3,067	119	17,687	18,065	379	18,065	379	18,065	0
CONTINUING CARE	11,994	1,999	1,639	(360)	11,994	11,067	(926)	11,067	(926)	11,192	(125)
PRESCRIBING	17,622	2,937	3,085	148	17,622	18,266	643	18,266	643	18,261	5
PRIMARY CARE	2,969	494	494	0	3,036	3,449	414	3,449	414	3,424	25
DELEGATED CO-COMMISSIONING	15,860	2,653	2,653	0	15,860	15,919	59	15,919	59	15,919	0
COMMUNITY HEALTH SERVICES	7,886	1,324	1,294	(30)	7,872	7,833	(39)	7,833	(39)	7,853	(20)
OTHER	2,737	456	400	(56)	2,737	2,615	(121)	2,615	(121)	2,624	(9)
BCF	6,433	1,072	1,137	64	6,433	6,730	297	6,730	297	6,705	25
COMMISSIONING RESERVE	4,167	758	407	(350)	4,114	3,507	(607)	3,507	(607)	3,762	(255)
Grand Total	**(0)**	**0**	**(452)**	**(452)**	**0**	**143**	**143**	**143**	**143**	**1,080**	**(938)**

Calderdale CCG Running Cost Allocation Summary at 30th September 2020 — Appendix B

Centre Code / Name	Annual Budget (£)	In Month (£) Budget	In Month (£) Actual	In Month (£) Variance	Year To Date (£) Budget	Year To Date (£) Actual	Year To Date (£) Variance	Forecast (£) Outturn	Forecast (£) Variance	Month 5 Outturn	Month 5 Movement
ADMINISTRATION & BUSINESS SUPPORT	20	3	2	(1)	20	15	(5)	15	(5)	15	(0)
CEO/ BOARD OFFICE	271	45	39	(6)	271	317	46	317	46	318	(1)
IM&T	37	6	10	4	37	36	(1)	36	(1)	32	4
CORPORATE COSTS & SERVICES	75	13	13	0	75	87	11	87	11	87	(0)
EQUALITY AND DIVERSITY	20	3	3	(0)	20	17	(3)	17	(3)	17	(0)
PATIENT AND PUBLIC INVOLVEMENT	49	8	5	(3)	49	39	(10)	39	(10)	39	0
CONTRACT MANAGEMENT	169	28	29	1	169	179	10	179	10	180	(1)
MEDICAL DIRECTORATE	165	27	25	(2)	165	153	(11)	153	(11)	153	0
HUMAN RESOURCES	23	4	2	(2)	23	14	(8)	14	(8)	15	(0)
STRATEGY & DEVELOPMENT	294	49	55	6	294	299	5	299	5	293	6
BUSINESS INFORMATICS	173	29	20	(9)	173	121	(52)	121	(52)	121	(0)
QUALITY ASSURANCE	190	32	24	(8)	190	149	(41)	149	(41)	148	1
ESTATES AND FACILITIES	120	20	19	(1)	120	115	(5)	115	(5)	115	(0)
FINANCE	269	45	31	(14)	269	173	(96)	173	(96)	170	3
GENERAL RESERVE - ADMIN	(53)	(2)	48	50	(53)	233	286	233	286	244	(11)
CORPORATE GOVERNANCE	192	32	17	(15)	192	110	(82)	110	(82)	110	(0)
Grand Total	**2,013**	**343**	**343**	**0**	**2,013**	**2,058**	**45**	**2,058**	**45**	**2,058**	**0**

Calderdale CCG Delegated Primary Medical Services Summary at 30th September 2020 **Appendix C**

PRIMARY CARE SERVICES:	6 Months	In month			Year To Date (£)			Forecast		Forecast M05	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	8,068	1,345	1,540	195	8,068	9,177	1,110	9,177	1,110	9,177	0
PMS	1,518	253	143	(110)	1,518	856	(662)	856	(662)	856	0
APMS	1,173	195	63	(132)	1,173	381	(792)	381	(792)	381	0
QOF	1,390	232	226	(6)	1,390	1,357	(33)	1,357	(33)	1,357	0
Enhanced Services	159	26	27	0	159	156	(2)	156	(2)	156	0
Premises - Reimbursed Costs	1,485	248	269	22	1,485	1,600	115	1,600	115	1,597	3
Premises - Other	239	40	51	12	239	131	(108)	131	(108)	95	36
Prof Fees Prescribing & Dispensing	84	14	9	(5)	84	26	(58)	26	(58)	27	(1)
Collaborative Payments	0	0	0	0	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	258	43	26	(17)	258	217	(41)	217	(41)	213	4
Other Non GP Services	333	56	56	1	333	338	4	338	4	338	0
Pensions	0	0	0	0	0	0	0	0	0	0	0
PCN	518	86	176	89	518	1,011	493	1,011	493	1,011	0
Reserves	556	104	(14)	(118)	556	668	112	80	(476)	80	1
Reserves - Other	80	13	0	(13)	80	0	(80)	588	508	630	(42)
Total Primary Care Medical	**15,860**	**2,654**	**2,573**	**(81)**	**15,860**	**15,919**	**59**	**15,919**	**59**	**15,919**	**0**

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 30th September 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	46	97.87%	£16,988,853.14	100.00%	690	97.32%	£121,461,097.99	99.93%
Non NHS	1008	96.92%	£8,117,650.93	73.80%	4,526	97.29%	£45,134,656.59	92.87%
Total	1,054	96.96%	£25,106,504.07	89.71%	5,216	97.30%	£166,595,754.58	97.92%

Appendix E

Calderdale CCG Resource Allocation Summary at 30th September 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)
Grand Total	**(153,257)**	**(15,860)**	**(2,013)**

Paper E

West Yorkshire and Harrogate Health and Care Partnership

System Oversight and Assurance Group

System Dashboard

17 August 2020

This dashboard is for internal management purposes only and is not for circulation into the public domain. It is to be utilised to inform SOAG discussions and is for the purpose of SOAG only.

West Yorkshire and Harrogate Health and Care Partnership

▲ Performance has improved compared with previous period
■ Performance has remained static
▼ Performance has deteriorated compared with previous period

Better Is...	
H (High)	Better performance the higher the value
L (Low)	Better performance the lower the value
	Not achieving constitutional standard

North Region Overview

Performance	Period	Better Is...	Standard	North East & Yorkshire	Trend	West Yorkshire & Harrogate	Trend	South Yorkshire & Bassetlaw	Trend	Humber, Coast & Vale	Trend	Cumbria & North East	Trend	North West	Trend	Cheshire & Merseyside	Trend	Greater Manchester	Trend	Lancashire & South Cumbria	Trend
A&E - Maximum 4-hour wait*	May-20	H	95%	93.1%	▼	92.3%	▼	91.1%	▼	92.2%	▼	95.3%	▼	91.2%	▼	92.6%	▼	89.5%	▼	91.7%	▼
RTT - Performance*	Apr-20	H	92%	52.8%	▼	51.7%	▼	61.3%	▼	46.4%	▼	53.1%	▼	52.1%	▼	52.4%	▼	51.4%	▼	53.3%	▼
RTT - 52ww*	Apr-20	L	0	6,623	▼	1085	▼	225	▼	3,058	▼	2,255	▼	7,011	▼	1328	▼	4,029	▼	1654	▼
RTT - Waiting list (actual)*	Apr-20	No standard	N/A	547,193	▼	129,602	▲	101,635	▼	118,833	▼	197,123	▲	576,868	▼	186,273	▼	282,590	▼	108,005	▼
RTT - Waiting List (Target)	Mar-18	L	Lower than 2018	561,077		154,580		94,055		102,827		209,615		499,712		164,900		214,298		120,514	
RTT - Waiting List Gap*		L		-13,884		-24,978		7,580		16,006		-12,492		77,156		21,373		68,292		-12,509	
Diagnostics - Performance*	Apr-20	L	1.0%	50.2%	▼	48.3%	▼	58.2%	▼	53.9%	▼	43.9%	▼	48.5%	▼	46.3%	▼	52.8%	▼	41.5%	▼
Cancer - 2-week wait**	Apr-20	H	93%	90.0%	▲	87.8%	▲	95.7%	▼	94.2%	▲	87.1%	▲	94.3%	▲	97.0%	▲	91.6%	▲	94.7%	▲
Cancer - 2-week wait (breast symptoms)**	Apr-20	H	93%	78.1%	▼	75.2%	▼	98.1%	▲	71.4%	▼	75.9%	▼	84.7%	▼	94.3%	▼	76.8%	▼	86.3%	▼
Cancer - 31-day from decision to treat to first treatment**	Apr-20	H	96%	93.9%	▼	93.9%	▼	96.5%	▼	94.9%	▼	92.4%	▼	92.9%	▼	93.4%	▼	92.6%	▼	92.8%	▼
Cancer - 62-day wait from referral to treatment**	Apr-20	H	85.0%	77.9%	▲	76.1%	▼	78.6%	▲	77.1%	▲	79.1%	▲	73.4%	▲	76.4%	▲	68.4%	▲	75.0%	▲
Mental Health - IAPT - Access (rolling quarter)**	May-20	H	5.50%	3.30%	▼	3.1%	▼	3.4%	▼	3.3%	▼	3.5%	▼	3.2%	▼	2.7%	▼	3.8%	▼	3.0%	▼
Mental Health - IAPT - Recovery (rolling quarter)**	May-20	H	50.0%	47.7%	▼	49.9%	▼	47.6%	▼	50.9%	▼	45.3%	▼	45.6%	▼	40.0%	▼	47.6%	▼	50.1%	▲
Mental Health - Early Intervention psychosis (EIP) - 2 week waits**	May-20	H	56.0%	65.3%	▼	49.1%	▼	78.9%	▲	73.1%	▼	73.1%	▼	69.4%	▼	72.7%	▼	75.5%	▼	43.8%	▼

* Please note uses provider level data mapped to HCP/STP/ICS
** Please note uses CCG level data mapped to HCP/STP/ICS

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate Overview

Better Is...	
H (High)	Better performance the higher the value
L (Low)	Better performance the lower the value
	Not achieving constitutional standard

Performance	Period	Better Is...	Standard	England		North East & Yorkshire		WY&H HCP		Bradford and Craven			Leeds		Calderdale		Kirklees				Wakefield		North Yorkshire	
				Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Bradford District & Craven	ANHSFT	BTHFT	Leeds CCG	LTHT	Calderdale CCG	CHFT	Greater Huddersfield CCG	North Kirklees CCG	CHFT	MYHT	Wakefield CCG	MYHT	North Yorkshire CCG	HDFT
A&E - Maximum 4-hour wait*	May-20	H	95.0%		91.7%		93.1%		92.8%		93.7%	95.2%		89.7%		93.7%			95.8%	CRS Testing		CRS Testing		95.1%
DTOC - Average daily DTOC beds	Feb-20	L	0		3,752		322		96		5	6		39		5			5	2		2		2
DTOC - NHS responsible for breaches	Feb-20	L	0.0%	Data unavailable at CCG/Local Authority Level	61.7%	Data unavailable at CCG/Local Authority Level	65.1%	Data unavailable at CCG/Local Authority Level	72.9%	Data unavailable at CCG/Local Authority Level	37.2%	45.1%	Data unavailable at CCG/Local Authority Level	96.9%	Data unavailable at CCG/Local Authority Level	56.5%	Data unavailable at CCG/Local Authority Level	Data unavailable at CCG/Local Authority Level	56.5%	74.4%	Data unavailable at CCG/Local Authority Level	74.4%	61.2%	43.2%
DTOC - Social Care responsible for breaches	Feb-20	L	0.0%		30.1%		31.0%		23.6%		62.8%	54.9%		3.1%		28.4%			28.4%	22.0%		22.0%	29.4%	56.8%
DTOC - Both responsible for breaches	Feb-20	L	0.0%		8.2%		4.0%		3.5%		0.0%	0.0%		0.0%		15.0%			15.0%	3.6%		3.6%	9.5%	0.0%
DTOC - Distance from Plan	Feb-20	L	No standard	Nil reporting during COVID																				
RTT - Performance	May-20	H	92%	52.0%		53.4%	52.8%	52.5%	51.7%	50.7%	52.9%	47.2%	52.2%	50.5%	CRS	CRS	CRS	49.2%	CRS	49.0%	51.9%	49.0%	49.8%	CRS
RTT - over 52 week waiters	May-20	L	0	50,536		6,023	6,623	915	1085	171	18	98	351	624	113	176	83	71	176	159	126	159	485	138
Diagnostics	May-20	L	1.0%	47.8%		50.2%	50.2%	48.7%	48.3%	61.0%	53.5%	67.5%	28.1%	20.7%	51.1%	53.0%	53.2%	43.3%	53.0%	46.5%	48.9%	46.5%	45.0%	34.3%
Cancer - 2-week wait	May-20	H	93.0%	92.5%		90.0%	90.0%	87.8%	87.3%	96.0%	91.4%	97.4%	74.2%	72.5%	98.9%	98.5%	98.3%	92.9%	98.5%	92.8%	92.7%	92.8%	92.1%	98.4%
Cancer - 2-week wait (breast symptoms)	May-20	H	93.0%	90.6%		78.1%	78.4%	75.2%	74.2%	98.3%	100.0%	100.0%	58.3%	56.1%	100.0%	97.7%	96.1%	51.7%	97.7%	59.8%	64.4%	59.8%	90.5%	87.9%
Cancer - 31 day from decision to treat to first treatment	May-20	H	96.0%	93.7%		93.9%	94.0%	93.9%	94.0%	95.7%	100.0%	91.9%	93.8%	92.7%	94.5%	98.1%	95.7%	94.9%	98.1%	93.7%	90.3%	93.7%	93.8%	92.2%
Cancer - 62-day wait from referral to treatment	May-20	H	85.0%	75.2%		77.9%	77.7%	76.1%	75.0%	74.3%	92.0%	73.7%	77.3%	66.2%	73.5%	85.5%	88.9%	67.9%	85.5%	76.9%	73.3%	76.9%	79.8%	82.4%
Mental Health - IAPT access (rolling quarter)	May-20	H	5.50%	3.5%		3.3%		3.10%		2.4%			3.60%		3.70%		2.60%	2.60%			3.10%		2.10%	
Mental Health - IAPT recovery	May-20	H	50.0%	48.2%		47.5%		49.9%		50.3%			49.6%		50.7%		50.6%	49.2%			49.5%		51.7%	
Mental Health - Early Intervention psychosis (EIP) - 2 week waits**	Feb-20	H	56.0%	70.0%		65.3%		49.1%		82.0%			64.0%		71.0%		34.0%	15.0%			63.0%		72.0%	

West Yorkshire and Harrogate Health and Care Partnership

Better Is...	
H (High)	Better performance the higher the value
L (Low)	Better performance the lower the value
	Not achieving constitutional standard

Urgent and Emergency Care

Measure	Period	Better Is...	Standard	WY&H HCP	Bradford and Craven			Leeds		Calderdale		Kirklees				Wakefield		North Yorkshire		NHS 111	YAS
					Bradford Districts & Craven CCG	ANHSFT	BTHFT	Leeds CCG	LTHT	Calderdale CCG	CHFT	Greater Huddersfield CCG	North Kirklees CCG	MYHT	CHFT	Wakefield CCG	MYHT	NY CCG	HDFT		
A&E - Maximum 4-hour wait* (Actual)	Jun-20	N/A	95%	92.8%		93.7%	95.2%		89.7%		93.7%			CRS Testing	93.7%		CRS Testing		91.3%		
A&E - Maximum 4-hour wait* (Plan)		N/A	No standard	Nil reporting during COVID-19																	
A&E - Monthly A&E Attendances	Jun-20	L	No standard	65,809		5,041	9,536		19,219		11,544			17,588	11,544		17,588		4,234		
A&E - Monthly A&E Admissions	Jun-20	L	No standard	13,675		1,164	2,433		4,057		2,609			3,412	2,609		3,412		907		
A&E - % Growth from previous year in Emergency Admissions	Jun-20	L	No standard	-29.9%		-35.6%	-31.0%		-29.8%		-27.4%			-29.5%	-27.4%		-29.5%		-26.5%		
A&E - Primary Care Streaming - Type 3 Attendances		N/A	No standard	Nil reporting due to COVID-19																	
A&E - Primary Care Streaming - Type 3 Patients Streamed		H	No standard																		
A&E - Super Stranded Patients		L	0																		
A&E - 12 Hour trolley Breaches*	Jun-20	L	0	1		0	0		0		0			1	0		1		0		
Cancelled Urgent Ops *		L	0	Nil reporting during COVID-19																	
NHS 111 - 111 Clinical triage - call to clinicans**	Jun-20	H	No standard																	45.2%	
NHS 111 - % calls answered in 60 seconds***	Jun-20	H	95.0%																	90.1%	
NHS 111 - % calls abandoned after waiting 30 seconds***	Jun-20	L	5.0%																	0.9%	
NHS 111 - dispositions as a % of calls triaged (ambulance dispatched)***	Jun-20	N/A	No standard																	12.0%	
NHS 111 - dispositions as a % of calls triaged (recommend A&E attendance)***	Jun-20	N/A	No standard																	15.2%	
DTOC - Average daily DTOC beds	Feb-20	L	0	96	Data unavailable at CCG/Local Authority Level	5	6	Data unavailable at CCG/Local Authority Level	39	Data unavailable at CCG/Local Authority Level	5	Data unavailable at CCG/Local Authority Level	Data unavailable at CCG/Local Authority Level	5	2	Data unavailable at CCG/Local Authority Level	2		2		
DTOC - NHS responsible for breaches	Feb-20	L	0	72.9%		37.2%	45.1%		96.9%		56.5%			56.5%	74.4%		74.4%	61.2%	43.2%		
DTOC - Social Care responsible for breaches	Feb-20	L	0	23.6%		62.8%	54.9%		3.1%		28.4%			28.4%	22.0%		22.0%	29.4%	56.8%		
DTOC - Both responsible for breaches	Feb-20	L	0	3.5%		0.0%	0.0%		0.0%		15.0%			15.0%	3.6%		3.6%	9.5%	0.0%		
YAS - Hear & Treat %	Jun-20	L	No standard																		10.00%
YAS - See & Treat %	Jun-20	L	No standard																		31.0%
YAS - Ambulance response Cat 1**	Jun-20	L	7 mins																		7 minutes 35 seconds
YAS - Ambulance response Cat 2**	Jun-20	L	18 mins																		18 minutes 17 seconds

* Please note uses provider level data mapped to CCG
** This indicator cannot be split by CCG so shows Yorkshire Ambulance Service figures
*** This indicator cannot be split by CCG so shows NHS 111 figures
**** This indictor cannot be split by CCG so shows H&WB footprint

West Yorkshire and Harrogate Health and Care Partnership

Elective Care and Diagnostics

Better Is...	
H (High)	Better performance the higher the value
L (Low)	Better performance the lower the value
	Not achieving constitutional standard

Measure	Period	Better Is...	Standard	WY&H HCP	Bradford and Craven			Leeds		Calderdale		Kirklees				Wakefield		North Yorkshire	
					Bradford District & Craven CCG	ANHSFT	BTHFT	Leeds CCG	LTHT	Calderdale CCG	CHFT	Greater Huddersfield CCG	North Kirklees CCG	CHFT	MYHT	Wakefield CCG	MYHT	North Yorkshire CCG	HDFT
RTT - Total incomplete waiting list (Actual)	Jun-20	L	Below Mar 18	116,891	26,400	6,715	18,809	34,095	45,517	12,670	23,435	14,352	9,140	23,435	26,377	20,234	26,377	23,048	11,583
RTT - Total incomplete waiting list (Plan)		L	Below Mar 18	Nil reporting during COVID-19															
RTT - Total incomplete waiting list (Variance)		L	Below Mar 18																
RTT - Total waiting list Vs March Baseline		L	Below Mar 18	-54,048	-16,195	-866	-14,975	-9354	-6,534	-4479	-7,536	-3392	-2812	-7,536	-4,682	-3645	-4,682	-2,216	-2,657
RTT - % patients seen within 18 weeks (Actual)	Jun-20	H	92.0%	52.5%	50.7%	52.9%	47.2%	52.2%	50.5%	CRS testing	CRS testing	CRS testing	49.2%	CRS testing	49.0%	51.9%	49.0%	49.8%	CRS testing
RTT - % patients seen within 18 weeks (Plan)		H	92.0%	Nil reporting during COVID-19						CRS testing	CRS testing	CRS testing	Nil reporting during COVID-19	CRS testing	Nil reporting during COVID-19				CRS testing
RTT - % patients seen within 18 weeks (Variance)		L	No standard							CRS testing	CRS testing	CRS testing		CRS testing					CRS testing
RTT - 52ww	Jun-20	L	0	915	171	18	98	351	624	113	176	83	71	176	159	126	159	485	138
Diagnostics - No. of patients waiting 6 weeks or more	Jun-20	L	-	17,088	6,549	1,855	4,996	2,129	1,551	2,092	4,771	2,920	995	4,771	2,938	2,403	2,938	2,451	820
Diagnostics - Total waiting list	Jun-20	L	-	35,103	10,954	3,467	7,399	7,568	7,500	4,093	8,997	5,485	2,299	8,997	6,318	4,917	6,318	5,450	2,390
Diagnostics - Performance (Actual)	Jun-20	L	<1.0%	48.7%	61.0%	53.5%	67.5%	28.1%	20.7%	51.1%	53.0%	53.2%	43.3%	53.0%	46.5%	48.9%	46.5%	45.0%	34.3%
Diagnostics - Performance (Plan)		L	<1.0%	Nil reporting during COVID-19															
Diagnostics Performance (Variance)		L	No Standard																

West Yorkshire and Harrogate Health and Care Partnership

Better Is...	
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L (Low)	Better performance the lower the value
	Not achieving constitutional standard

Cancer

Performance	Period	Better Is...	Standard	WY&H HCP	Bradford and Craven			Leeds		Calderdale		Kirklees				Wakefield		North Yorkshire	
					Bradford District & Craven CCG	ANHSFT	BTHFT	Leeds CCG	LTHT	Calderdale CCG	CHFT	Greater Huddersfield CCG	North Kirklees CCG	CHFT	MYHT	Wakefield CCG	MYHT	North Yorkshire CCG	HDFT
2-week wait	Jun-20	H	93%	87.8%	96.0%	91.4%	97.4%	74.2%	72.5%	98.9%	98.5%	98.3%	92.9%	98.5%	92.8%	92.7%	92.8%	92.1%	98.4%
2-week wait (breast symptoms)	Jun-20	H	93%	75.2%	98.3%	100.0%	100.0%	58.3%	56.1%	100.0%	97.7%	96.1%	51.7%	97.7%	59.8%	64.4%	59.8%	90.5%	87.9%
31-day from decision to treat to first treatment	Jun-20	H	96%	93.9%	95.7%	100.0%	91.9%	93.8%	92.7%	94.5%	98.1%	95.7%	94.9%	98.1%	93.7%	90.3%	93.7%	93.8%	92.2%
31-day for subsequent surgery	Jun-20	H	94%	86.0%	79.2%	100.0%	68.2%	84.4%	83.6%	68.4%	69.6%	80.8%	91.7%	69.6%	98.3%	96.6%	98.3%	92.3%	100.0%
31-day for subsequent anti-cancer drug regimen	Jun-20	H	98%	98.7%	97.7%	100.0%	95.8%	99.1%	99.4%	96.0%	97.6%	100.0%	100.0%	97.6%	98.6%	98.5%	98.6%	98.6%	100.0%
31-day sub-treatment - Radiotherapy	Jun-20	H	94%	96.5%	97.5%			96.2%	96.7%	97.4%		92.1%	100.0%			96.4%		96.2%	
62-day wait from referral to treatment (Actual)	Jun-20	H	85%	76.1%	74.3%	92.0%	73.7%	77.3%	66.2%	73.5%	85.5%	88.9%	67.9%	85.5%	76.9%	73.3%	76.9%	79.8%	82.4%
62-day wait from referral to treatment (Plan)		H	85%	Nil reporting during COVID-19															
62-day wait from referral to treatment (Variance)		L	No standard																
62-day wait for treatment following a referral from screening service	Jun-20	H	90%	7.7%	0.0%	100.0%	100.0%	0.0%	0.0%	25.0%	14.3%	0.0%	0.0%	14.3%	68.8%	0.0%	68.8%	100.0%	0.0%
No treated after 104 Day	Jun-20	L	0	44	7	1	5	20	28	6	8	3	3	8	7	5	7	6	2
OUTCOMES																			
Breast cancer screening uptake (50-70)	2018/19	H	72.4%					69.1%		72.5%		77.1%	72.5%			71.0%			
Cervical cancer screening coverage (25-64)	2018/19	H	72.6%					73.5%		76.7%		77.2%	72.6%			75.6%			
Bowel cancer screening uptake (60-74)	2018/19	H	60.5%					60.8%		62.7%		64.9%	60.2%			61.8%			
% patients presenting as an emergency	2019 Q1	L	19.3%					24.6%		19.6%		18.4%	23.0%			20.5%			
% patients diagnosed at stage 1 or 2	2018 Q4	H	75.0%	52.4%															
Patient experience average score (out of 10)	2018	H	8.8					8.9		8.7		8.8	8.8			8.7			

*Currently no standard therefore is benchmarked against %uptake for England

West Yorkshire and Harrogate Health and Care Partnership

Mental Health and Learning Disabilities

Better Is...	
H (High)	Better performance the higher the value
L (Low)	Better performance the lower the value
	Not achieving constitutional standard

Mental Health	Period	Better Is...	Standard	WY&H HCP	Bradford and Craven	Leeds	Calderdale	Kirklees		Wakefield	North Yorkshire
					Bradford District & Craven CCG	Leeds CCG	Calderdale CCG	Greater Huddersfield CCG	North Kirklees CCG	Wakefield CCG	North Yorkshire CCG
Dementia diagnosis rate	Jul-20	H	66.7%	67.1%	73.3%	74.3%	68.2%	65.1%	65.2%	62.2%	59.9%
IAPT - Access	May-20	H	5.50%	4.38%	2.40%	3.60%	3.70%	2.60%	2.60%	3.10%	2.10%
IAPT - Recovery	May-20	H	50.0%	50.4%	50.3%	49.6%	50.7%	50.6%	49.2%	49.6%	51.7%
IAPT - 6 week first treatment	May-20	H	75.0%	77.68%	95.5%	35.5%	94.1%	85.3%	84.6%	100.0%	91.8%
IAPT - 18 week First Treatment	May-20	H	95.0%	98.63%	100.0%	99.1%	100.0%	97.1%	96.2%	100.0%	100.0%
Early Intervention psychosis (EIP) - 2 week waits	Feb-20	H	56.0%	49.1%	82.0%	64.0%	71.0%	34.0%	15.0%	63.0%	72.0%
CPA within 7 days	19-20 Q3	H	95.0%	No updates available at this time							
Waiting times for urgent referrals to CYP Eating Disorder Services - within 1 week *Standard of 95% to be achieved by 2022. All systems working towards this	20-21 Q1	H	95.0%	81.8%	70.6%	100.0%	50.0%	100.0%	100.0%	75.0%	45.5%
Waiting times for routine referrals to CYP Eating Disorder Services - within 4 weeks *Standard of 95% to be achieved by 2022. All systems working towards this	20-21 Q1	H	95.0%	85.1%	92.5%	74.3%	95.2%	93.8%	81.3%	94.1%	45.7%
% of total OAP days - Total number of inappropriate out of area placement days over a 3 month rolling period	May-20	N/A	N/A	2,830	645	1,520	160	105	160	190	830
% of CY&P with a diagnosable MH condition receiving two or more contacts in the reporting period (YTD)	Feb-20	H	32.0%	No updates available at this time							

Learning Disabilities	Period	Better Is...	Standard	WY&H ICS	Bradford and Craven	Leeds	Calderdale	Kirklees		Wakefield	North Yorkshire
					Bradford Districts & Craven CCG	Leeds CCG	Calderdale CCG	Greater Huddersfield CCG	North Kirklees CCG	Wakefield CCG	North Yorkshire CCG
Transforming care - pre or post admissions CTRs within 28 days of admissions (Adults)*	Apr-20		75%**	No updates available at this time							
Transforming care - Annual Health Checks	19/20 Q3		N/A	No updates available at this time							
Transforming Care - Reducing hospitalisation* **NB** - This is an approximation of ICS-level performance target based on TCP data and are based on unify trajectories and not the recently revised trajectories	Jun-20		N/A	63	17	22	8	5	4	7	12

* For management purposes only. Not to be circulated beyond SOAG membership
** Expected performance by March 2019

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Quality and Safety Report and Quality Dashboard**	**Agenda Item No.**	10 b
Report Author	Sam Parkinson, Project Support Officer Penny Woodhead, Chief Quality and Nursing Officer	**Public / Private Item**	Public
GB / Clinical Lead	Dr Caroline Taylor, Vice Clinical Chair, GP Member	**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 September 2020, providing quality and safety information for our main providers and the following information: • Friends and Family Test guidance • Children Looked After – Annual report 2019 -20 • Learning Disability Mortality Review (LeDeR) Annual report 2019-20						
Previous consideration	**Name of meeting**	Quality Committee		**Meeting Date**	24/09/2020		
	Name of meeting			**Meeting Date**	Click here to enter a date.		
Recommendation (s)	It is recommended the Governing Body: ▪ **RECEIVES** this 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 (LeDeR) Annual report 2019-20						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

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	None					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	X

Strategic Objectives	Improving quality Achieving the agreed strategic direction for Calderdale	**Risk**	1635 - There is a risk to timely management of infection outbreaks in Calderdale due to the staffing, capacity and demand of the provision within the infection prevention and control team. 1565 - There is a risk that due to the impact of Covid-19 and CCG Quality team capacity existing quality surveillance and assurance mechanisms will not be possible. 1361 - There is a risk to patient safety, experience, the quality of care delivered by Local Care Direct (LCD) - the provider of Out of Hours GP Services via the West Yorkshire Urgent Care (WYUC) contract.
Legal / CCG Constitutional Implications	None identified	**Conflicts of Interest**	Any conflicts of interest arising from this report will be managed in line with the CCG's Management of Conflicts of Interest Policy.

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 (CQC) 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 Committees. 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. The outcome of this is then shared with Governing Body through the report and dashboard.

2.4 Further information on these can be found in the Quality Dashboard, Appendix 1.

3. Friends and Family Test guidance

3.1 Revised Friends and Family Test (FFT) guidance was originally published in September 2019, for implementation from 1st April 2020, replacing all FFT implementation guidance previously published. Due to the global pandemic, FFT data submission was suspended from March 2020.

3.2 NHS England has now advised that data submission will resume from December 2020 for acute and community providers (including independent sector providers) and should be in line with the new guidance. The first data to submit will be December's data, which will require to be submitted in early January 2021 and will then be published in February 2021.

3.3 An announcement regarding submissions for GP and dental practices is due in due course.

3.4 Further details can be found at the following link: https://www.england.nhs.uk/fft/fft-guidance/

4. Children Looked After – Annual report 2019 -20

4.1 The Quality, Finance and Performance Committee received the Children Looked After annual report at its meeting in September 2020. The report provided an overview of the work undertaken by the Children Looked After (CLA) Health Team in the last year, to demonstrate that they have discharged their statutory and legislative responsibilities for Children Looked After and Care Leavers. The report included achievements against various performance indicators, alongside progress on objectives and a reflection on the recent activity during the Covid – 19 period. Summary slides are presented at Appendix 2.

5. Learning Disability Mortality Review (LeDeR) Annual report 2019-20

5.1 The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities.

5.2 The Learning Disabilities Mortality Review (LeDeR) programme, commissioned by NHS England, was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

5.3 During the past 12 months, Calderdale CCG has worked in partnership with key stakeholders to deliver the LeDeR programme and deliver the reviews. Each of the LeDeR reviews describes a human story and we recognise the commitment and hard work of the Reviewers to not only complete the reviews, but to also tell those individual stories so that we can learn about those individuals' experiences and continue to drive any required improvement in the quality of health and care services. This work forms part of the wider Transforming Care agenda for people and an overview of the key activity to transform care for people with a Learning Disability have been provided in the report.

5.4 Delivering the LeDeR programme has not been without challenges. The annual report provides an overview of the current LeDeR program, progress in the CCG along with an overview of local work that has been undertaken to deliver the programme. The full report can be accessed at the following link https://www.calderdaleccg.nhs.uk/download/the-calderdale-ccg-greater-huddersfield-ccg-and-north-kirklees-ccg-learning-disabilities-mortality-review-programme-leder-annual-report-2019-2020/

6. Recommendations

6.1 It is recommended that the Governing Body:

- **RECEIVES** this update on Quality and Safety information to provide assurance regarding its main providers, plus the following updates:

    - Friends and Family Test guidance
    - Children Looked After – Annual report 2019 -20
    - Learning Disability Mortality Review (LeDeR) Annual report 2019-20

8. Appendices

8.1 Appendix 1 – Quality Dashboard
Appendix 2 – Children Looked After summary slides

Calderdale CCG Quality Dashboard
September 2020

CCCG Exception Report

Indicator	Target	Month/ Quarter	Month data from	YTD 2019-20
C-Diff	tbc	2	Aug 2020	28
MRSA	0	0	Aug 2020	0
MSSA	No target	2	Aug 2020	20
E-Coli	tbc	8	Aug 2020	68
Pseudomonas	No target	1	Aug 2020	3
Klebsiella	No target	4	Aug 2020	15

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.

Total antibiotic prescribing per 1000 STAR Pus

This is currently within the NHSE target of 1.161 and continues to work towards the stretch target set of 0.965 or below.

Broad Spectrum antibiotics

The prescribing of broad spectrum antibiotics as a % of all antibiotics prescribed over a 12 month period up to June 2020 has maintained at a value of 6.2%, which is within the NHSE target of 'at or below 10%' .

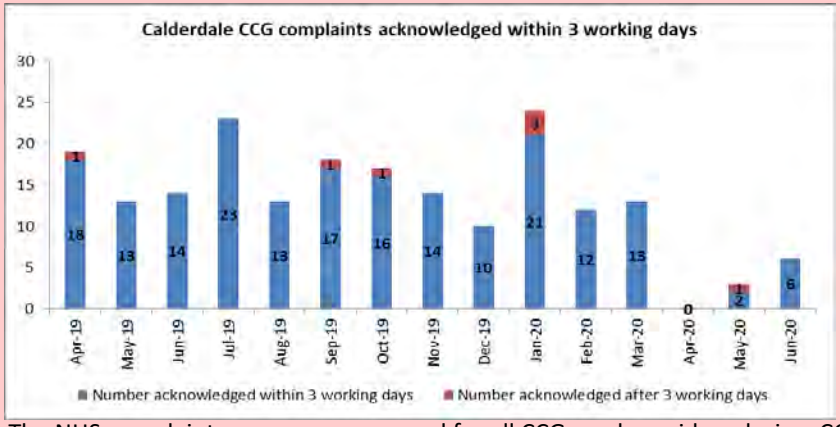
6.2 ⟷

Broad spectrum antibiotics as % total antibiotics prescribed June 2020 (added Sept 2020)

1.018 ↑

Total antibiotic prescribing items per 1000 STAR PUs June 2020 (added Sept 2020)

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.

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – September 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
Complaints	The % of complaints closed within target timeframe remains below target. The major challenge on performance remains within the medical division.	The complaints process has been temporarily paused throughout the Covid-19 pandemic. During this time the Trust has continued to monitor complaints through the Orange divisional risk panels. Divisional actions plans are in place inclusive of SMART - Specific, Measurable, Achievable, Realistic and Time Specific actions.	The CCG have been in attendance at the CHFT Internal Quality Committee. Attendance is expected to continue and additional assurances gained. Improvement work continues and the Trust are working on developing a number of patient stories to demonstrate the impact of a complaint on the patient and their families. Complaints performance has improved during April/May but continues to remain under target.
Harm Free Care Percentage of harm free care delivery is below the target of 95%.	Work is underway to identify the causes in relation to reducing pressure ulcers and UTIs. One potential cause is the validity of the data.	The Trust has altered their reporting systems. A hospital oversight framework inclusive of an overall performance score is provided within the monthly Board Report. Indicators are available in place for 6 individual domains. • Safe • Caring • Effective • Responsive • Workforce • Efficiency and Finance.	Further discussions continue to understand current position and associated actions between the Quality Manager and the Interim Associate Director of Quality and Safety and discussed via the internal CHFT Clinical Quality Board.
Never Events	The Trust have reported 2 Never Events since May 2020. These relate to a Wrong Site Surgery and a Retained Swab .	72h reports have been shared by the Trust and immediate learning identified. The investigations are ongoing and will be shared with commissioners upon completion.	One of the Never Event reports has been received and currently under review by the CCG. The 2nd report is ongoing and regular updates are provided by the trust to the Portfolio Lead of the Serious Incident Team and Quality Manager. Leaning and actions following these incidents will be reviewed at the joint CCG & Provider serious incident sub-group meeting.

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 July 2020.

Trust Reporting: The Trust have reviewed the integrated performance report. Indicators have been reviewed and refreshed and a number of additional indicators are now included. The indicators include enhanced details of complaints reporting and investigating, additional information on mortality rates, delayed diagnosis of cancers, surgical site infections and NEWS scores.

Never Events: The Trust have reported 2 Never Events relating to a retained swab and a wrong site surgery. 72h reports were received and early learning identified. One of the Never Event reports has been received and is under review by the CCG. The 2nd report is ongoing and is expected to be received by the CCG in November 2020. Updates on the investigations continue to be monitored at the Provider/CCG Serious Incident Sub-Groups which have continued throughout the pandemic. Assurances regarding the actions and learning from the incident investigations will be gathered by the Quality Manager and Serious Incident Team portfolio lead once the reports are finalised and shared.
The trust are active participants at the West Yorkshire Association of Acute Trusts (WYATT) and have developed close working links with neighbouring trusts to share learning following incidents.

CAS/NPSA Alerts: – An alert from the National Patient Safety Alerting Committee (NaPSAC) was issued informing of upcoming changes to the way patient safety alerts will be distributed. The trust have agreed a consistent format for future NPSA alerts. Work is ongoing to ensure that all future National Patient Safety Alerts set out clear and effective system-wide actions that providers must take on critical patient safety issues. Patient Safety Alerts are included within the trust Patient Safety Group report, this is shared with the Quality Team via the internal and commissioner led Quality Boards. Completion dates for the alerts are included within the report and a narrative update provided by the trust. Discussions are ongoing between the Quality Manager and CHFT Quality colleagues to discuss when this indicator is proposed to be back on track.

Complaints: The trust continue to find complaints response challenging although a marked improvement has been noted. The trust have increased the timeliness of responding to complaints and have adapted the response and support from the complaints team throughout the pandemic. The supportive approach by the Complaints Team has been welcomed by front line staff and new ways of working are showing improvements in both the timeliness and quality of complaint responses.
Additional indicators are now included within the trust board report to provide additional detail and assurance. These indicators are reopened complaints and complaints per 1000 bed days. Improvement work continues and the Trust are committed to developing a number of patient stories to facilitate and improve staff knowledge and understanding around the impact that a complaints have on their patients and families.

#NoF Patients With Admission to Procedure of < 36 Hours: Performance against this indicator remains challenging for the trust. The Quality Manager continues to discuss and gain assurances to understand if this decrease in performance is due to the Covid pandemic or other additional challenges.

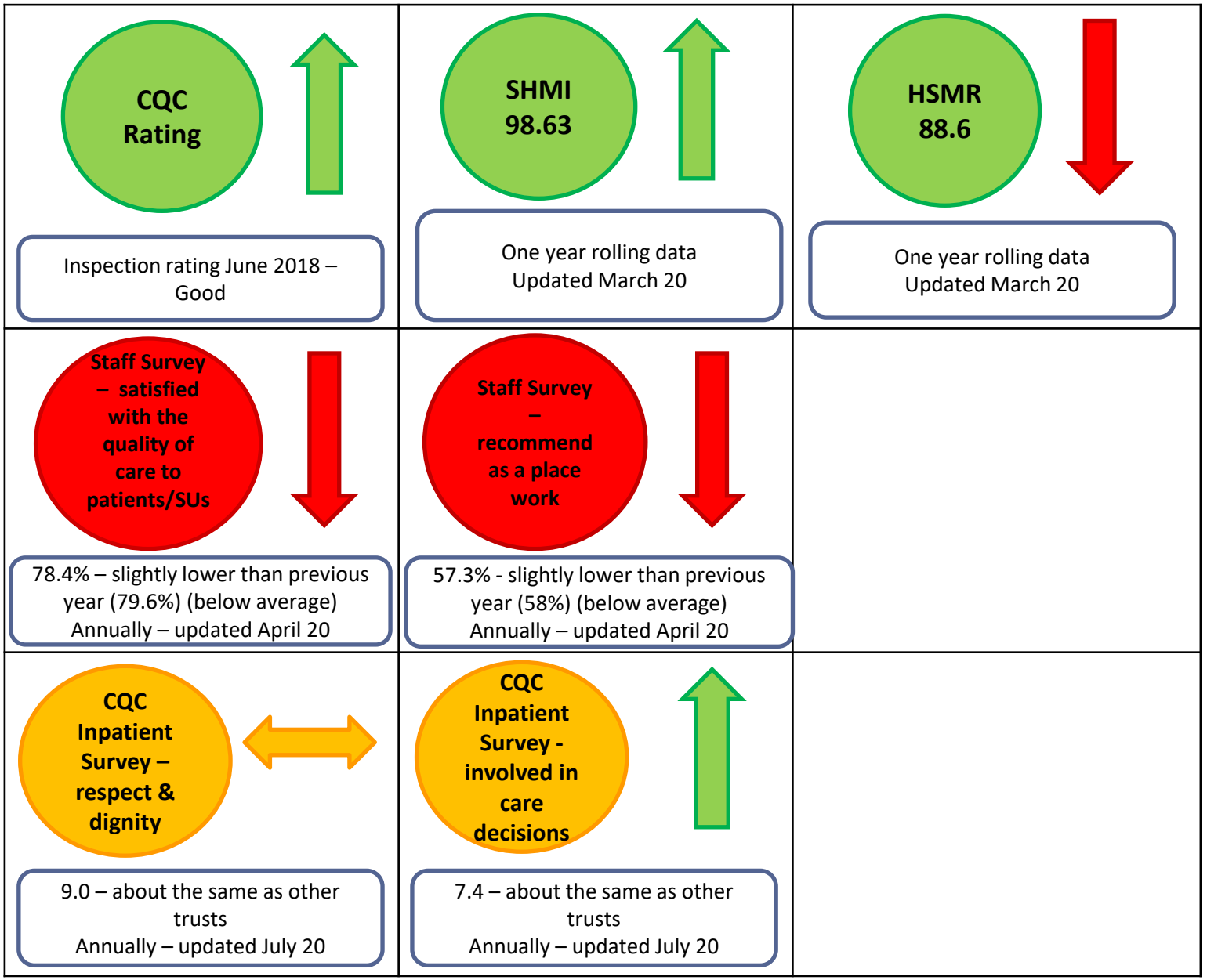
Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2020

			CHFT			Trend information																
						Direction of Travel			2019-20										2020-21				
Quality Domain	Indicator	Reporting Frequency	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
Safe	C Diff	Monthly	tbc	4	18	Aug-20	↑	↓	1	2	1	2	0	2	3	5	1	2	4	7	4
	E Coli	Monthly	n/a	0	12	Aug-20	↑	↑	4	4	1	0	1	3	1	4	2	5	4	1	0
	MRSA	Monthly	0	0	0	Aug-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	Monthly	n/a	0	5	Aug-20	↔	↑	2	1	1	2	2	4	1	0	0	2	3	0	0
	Never Events	Monthly	0	0	2	Aug-20	↔	↔	0	0	0	0	1	0	0	0	0	1	1	0	0
	Serious Incidents	Monthly	n/a	2	13	Aug-20	↔	↔	2	6	3	6	3	2	2	0	1	1	8	2	2
	Overall essential safety compliance	Monthly	>=95% Green >=90%<95% Amber <90% Red	95.85%	-	Jul-20	↑	↑	94.58%	95.22%	95.30%	95.32%	95.13%	94.79%	94.88%	94.81%	93.10%	94.11%	94.24%	95.85%	-
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	34.5%	-	rolling 6 months - Feb - July 20	↓	↓	72.2%	70.0%	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%	96.26%	95.97%	Jul-20	↑	↑	95.87%	95.72%	95.98%	96.60%	96.38%	95.97%	96.06%	95.46%	95.56%	96.05%	95.89%	96.26%	-
Caring	EMSA	Monthly	0	0	0	Jun-20	↔	↑	0	0	0	0	0	0	0	0	0	0	0	0	-
Responsive	% Complaints closed within target timeframe	Monthly	100%	70%	80%	Jul-20	↓	↑	22%	47%	40%	41%	50%	51%	47%	64%	94.0%	82.0%	80.0%	70.0%	-
	No of complaints re-opened	Monthly	n/a	1	8	Jul-20	↑	-									1	2	4	1	-
	% Last minute cancellations to elective surgery	Monthly	< 0.65%	0.13%	0.19%	Jul-20	↓	↑	0.67%	0.76%	1.31%	1.07%	0.92%	1.06%	0.79%	0.81%	0.32%	0.30%	0.00%	0.13%	-
	Percentage Non-elective #NoF Patients with admission to Procedure of <	Monthly	85%	42.86%	54.55%	Jul-20	↓	↓	80.85%	75.86%	77.55%	91.89%	72.41%	77.36%	67.57%	77.08%	56.10%	58.62%	66.67%	42.86%	-
	12 hour breaches in A&E (A&E trolley waits)	Monthly	0	0	0	Jul-20	↔	↔	0	0	0	9	0	0	0	0	0	0	0	0	-

Arrow key:

↑ movement towards target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – September 2020



Calderdale and Huddersfield NHS Foundation Trust
Exception Report – September 2020

Routine Monitoring

Proposed indicators to return to Routine Monitoring:

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – September 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 74 information governance breaches between 1st April and 31st July 2020. This is a further increase on the 49 information governance breaches reported in the previous 4 months between 01st December 2019-31st March 2020.	The Trust's IG lead has written to managers and is assisting them to address the issues with individual staff members. Focused communications campaign ongoing and information is being double checked before it is sent out. The Trust is also looking at utilising some videos to demonstrate the impact that an IG error has on people/ patients/ carers / staff and the wider Trust system. Planning session with senior leaders responsible for practice standards to be held in September (due to leave). 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.	Trust wide Information Governance staff training is back above the 95% target at 98.2%. 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.	5 formal complaints were closed in July 2020 with no reopened complaints. Of the 5, 5 (100%) were closed within 40 working days. Whilst small numbers this is excellent progress and it is envisaged this will be sustained; however, the coronavirus pandemic does pose a risk to this which has been highlighted and we will continue to monitor.

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 September 2020, dashboard data to July 2020.

The Trust's Integrated Performance Report (IPR) has been reviewed in line with interim reporting arrangements agreed by the Trust Board held in March 2020 . The interim arrangements commenced in April and currently remain in place in response to the Covid-19 pandemic. 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 July 2020.

Information governance breaches

July saw an increase in confidentiality breaches from 14 in June to 25. The number of breaches caused by information being disclosed in error increased significantly from 10 to 17 and breaches of this type were due to correspondence being sent to the wrong recipient or email/ postal address and information about other parties being attached to, or included with correspondence in error. Analysis of the incidents has been undertaken and a report was presented at the August Improving Clinical Information Group: the root causes identified were largely due to 'shortcuts', such as auto-filling email addresses or overtyping existing letters resulting in correspondence being sent to the wrong recipient.

Actions taken by the Trust in response to these breaches: The Trust's IG lead has written to the managers concerned and is assisting them to address the issues with individual staff members. There has been a communications campaign, including a piece in the brief, a banner on the intranet re IG and checking information before it is sent out. The Trust are also looking at utilising some videos to demonstrate the impact that an IG error has on people/ patients/ carers / staff and the wider Trust system. Additional focused actions may be identified as part of a planning session with senior leaders responsible for practice standards to be held in September (due to leave). 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 a date will be confirmed shortly. Trust wide Information Governance staff training is back above the 95% target at 98.2%.

Complaints closed within 40 days

5 formal complaints were closed in July 2020 with no reopened complaints. Of the 5, 5 (100%) were closed within 40 working days.
There were 25 new formal complaints, received in July; of these 2 have had timescales start, 4 have been closed as no consent/contact and 19 are awaiting consent/questions.
12% of formal complaints (n=3) had staff attitude as a primary subject.
34 **compliments** were received.

South West Yorkshire Partnership NHS Foundation Trust
Overview/triangulation

SWYPFT continued…

To note: The Trust's customer service team have logged a risk that there may be challenges in continuing to meet the Trust's 40 working days timeframe for responding to complaints. Some of these challenges are a direct consequence of the coronavirus pandemic as clinical services have struggled to allocate resource to investigating complaints.

CQC improvement plan
The Trust has stood back up a number of quality improvement initiatives that are linked to the CQC 'must' do and 'should' do actions.
CQC continue to provide guidance to providers on changes due to COVID 19 and will only undertake inspection visits to services where there are serious concerns. However, the CQC are continuing to undertake MHA visits remotely and the Trust continue to respond to any CQC enquiries and have engagement calls with their inspection team.

COVID 19 - Key priorities and progress made
- Review and revise governance systems in light of learning from Covid; learning from Covid has been pulled together and shared with each sub-committee of the Board
- Progress the identified clinical priority areas for restoration and reset
- Evaluate estate requirements and capacity in light of health & safety restrictions
- Work with partners in each place as well as both ICS systems to support restoration and recovery in each place
- Evaluate the new clinical models and digital approaches that have been used during the pandemic. Recovery planning toolkit developed, agreed and now being used
- Continue work to ensure the Trust is great place to work
- Deliver the requirements in the phase three planning guidance. Work has been undertaken to analyse and plan for the requirements in phase three
- Review the priority programmes for the next phase and develop scopes and key metrics. Priority programmes reviewed and proposals developed for the next phase. These have been shared with the EMT and will be discussed with the Trust Board in September .

Out of Area Beds – significant increase noted in July to the out of area bed days. It should be noted that the number (163) refers to the number of bed **days** spent out of area and that this relates to a small number of patients across the full geographical area. The rise in bed days is in line with national figures and post Covid peak we have been working with SWYPFT and the numbers are beginning to come down again for CKW. Additionally we are working across the ICS (Integrated Care System) to consider some 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.

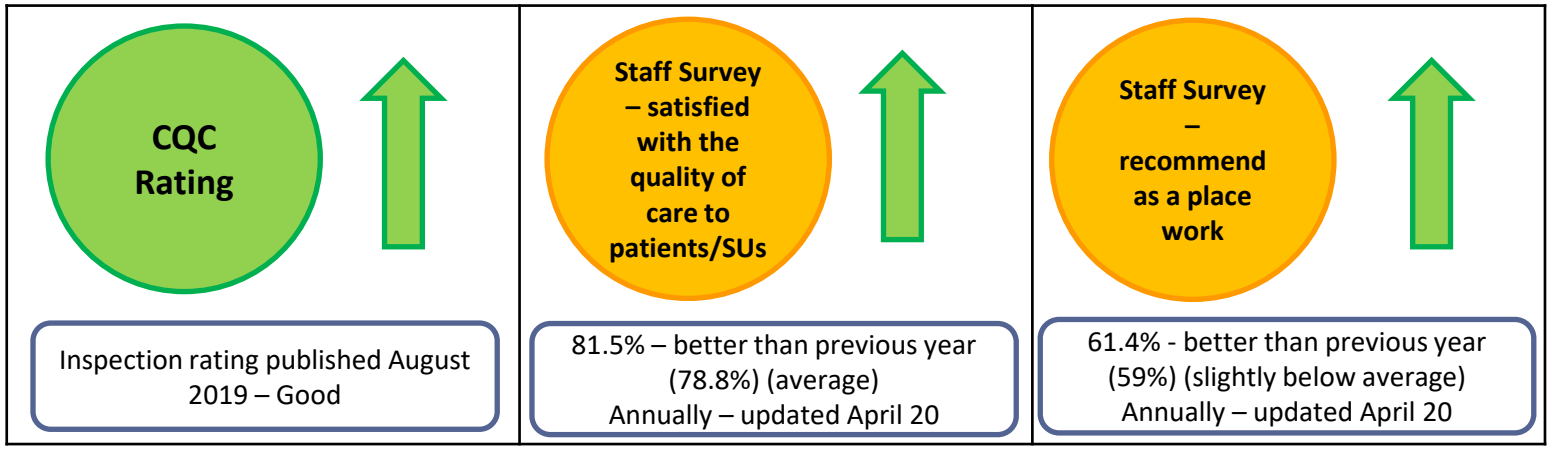
South West Yorkshire Partnership Foundation Trust
Quality Dashboard – September 2020

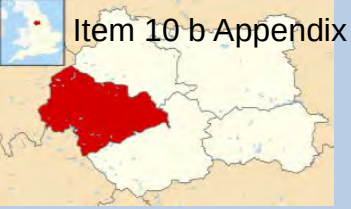
Quality Domain	Indicator	Reporting Frequency	SWYPFT				Trend information													
							Direction of Travel		2019-20								2020-21			
			Period Target	Month/ Period	YTD 2020-21	Month/ Period/Year data from	Previous Month/Period	Corresponding month 2019--20	A	S	O	N	D	J	F	M	A	M	J	J	A
Safe	Never Events	Monthly	0	0	0	Aug-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	6	14	Aug-20	↑	↑	2	5	2	1	3	8	2	2	0	3	3	2	6
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	100.0%		rolling 6 months - Feb - July 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%
Effective	No of inpatient admissions gate kept by Crisis Resolution Home Treatment (CRHT) teams	Quarterly	95%	99.7%		Q3 19-20	↑	-	98.2%		99.7%			Data collection paused			Data collection paused			Data collection paused	
Caring	EMSA	Monthly	n/a	0	0	Jul-20	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	-
Responsive	Complaints closed within 40 days	Monthly	80%	100%	-	Jul-20	↑	↑	53%	45%	55%	54%	80%	71%	80%	Paused	56%	90%	90%	100%	-
	No of complaints re-opened	Monthly	n/a	0	-	Jul-20	↑	-										0	2	0	-
	CAMHS - under 18's admitted to adult wards	Monthly	tbc	0	4	Jul-20	↑	↓	1	0	1	1	1	1	0	2	1	2	1	0	-
	Delayed Transfers of Care	Monthly	3.5%	1.0%	-	Jul-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%	-
	% Service users on CPA followed up within 7 days of dishcarge	Monthly	95%	100.0%	-	Jul-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%	-
	Out of Area Beds	Monthly	20/21 - Q1 247, Q2 165, Q3	163	-	Jul-20	↓	↓	146	21	4	55	49	139	175	137	23	8	72	163	-
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	-

Arrow key:

↑ movement towards target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – September 2020





Calderdale CLA Statistics 2019-2020

Children looked after 334 ↑ **Decrease of 1 from previous year**

The number of children starting to be looked after during the year was down from 112 to 104

The number of children ceasing to be looked after was up from 78 to 109

The number of unaccompanied asylum seeking children was up from 12 to 15

Children Looked After (CLA) : Key headlines: March 2020

Calderdale	CLA Team responsibilities
334 Children Looked After : Includes 15 unaccompanied asylum seeking children (UASC). (National Picture: The number of UASC increased by 11% to 5,070 and they represent around 6% of all children looked after in England)	During the reporting period • 92.35% Initial Health Assessments completed in timescale • 96% Review Health Assessments (RHA's) completed in timescale. • 61 RHA's completed by the team for CYP placed in Calderdale by other Local Authorities, due to distance to travel. • All age appropriate children registered with Dentist (national data not available • 83% of those registered had received a dental check in the last year at the time of their RHA. • An average of 94% of children under and over 5 are up to date with their immunisations at their RHA.
Approximately 204 care leavers age 18-25 (numbers are time and date specific)	This equates to 83% of our care leavers currently in the cohort 41 care leavers up to age 18 (37% of total number of care leavers) 258

The Team priorities for 2019-2020

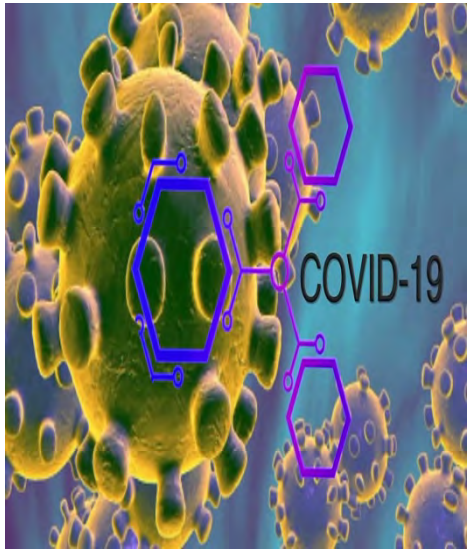
To continue to monitor and aim to meet KPIs set by the CCG	To develop process for collating health needs of all children entering care
To identify all young people who are misusing substances and don't want to engage with support services	To produce comprehensive outcomes data and themes for health needs for CLA
To develop close relationships with CASH services to ensure CLA receive the services they need & to identify those vulnerable to CSE & ensure appropriate interventions	Investigate working with CAMHS to inform the IHA & RHA process & work with the CTS service
Produce intercollegiate CLA slides for GPs & Dental Surgeries **Planning process in place**	Produce Calderdale version of Health Passport in collaboration with CLA

Covid Pandemic from March 2020 – what did the CLA team do to respond?

In response to NHS England Community Priorities Document:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-1-April-2020.pdf

3 members of team re-deployed to Children's Ward
Designated Doctor re-deployed for three days a week



RAG rated all RHAs to ensure high risk received a contact from the team

Wrote out to all CLA & Care Leavers with team contact details & offering advice & links to useful websites for support

Virtual IHAs and RHAs undertaken (completed all of Q1s within the timescales)

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**Amendments to Committee Terms of Reference**	**Agenda Item No.**	11 a-d
Report Author	Andrew O'Connor, Senior Corporate Governance Officer	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, Chair	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Officer

Executive Summary

Please include a brief summary of the purpose of the report

- Between January and March 2020, as part of the annual review of effectiveness, committees revisited their Terms of Reference (TOR) to ensure that they continued to reflect their remits and were fit for purpose.
- A small number of minor amendments were identified; these are presented to the Governing Body for approval as tracked changes **(Appendix a-d)**.
- The TOR of the CCG's statutory committees, Audit and Remuneration and Nomination, and mandatory committee, Commissioning Primary Medical Committee, are required parts of the CCG's Constitution. As such, any changes to these TOR have to ultimately be approved by NHS England (NHSE) as part of a constitutional variation.
- Subject to Governing Body approval of the proposed amendments, NHS England has agreed to accept these changes as part of the current application for constitutional variation which was submitted early in 2020. The outcome of this application was delayed by COVID-19, but is expected shortly.
- Following approval of the current application for variation, the CCG will consider any further changes that are required to made to TOR - including those to reflect recent appointments and changes in job titles and roles of senior managers as required - through the next cycle of committee meetings ahead of their being brought to Governing Body for approval and submitted NHSE at a suitable point.

Previous consideration

Name of meeting	CPMS Committee	**Meeting Date**	13/02/2020
Name of meeting	Quality, Finance and Performance Committees	**Meeting Date**	26/03/2020
Name of meeting	Audit Committee	**Meeting Date**	27/02/2020
Name of meeting	Remuneration and Nomination Committee	**Meeting Date**	27/02/2020

Recommendation (s)

It is recommended that the Governing Body **APPROVES** the proposed amendments to the following committee Terms of Reference:

1) Commissioning Primary Medical Services Committee (CPMSC)
2) Quality, Finance and Performance Committee
3) Audit Committee
4) Remuneration and Nomination Committee

Decision	☒	Assurance	☐	Discussion	☐	Other	

Implications			
Quality & Safety implications		None identified	
Public / Patient / Other Engagement		None identified	
Resources / Finance implications		None identified	
Strategic Objectives	▪ Improving governance	**Risk**	None.
Legal / CCG Constitutional Implications	CCG Constitution and Scheme of Reservation and Delegation	**Conflicts of Interest**	There are no identified conflicts of interest. Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.

Item 11 a

NHS
Calderdale
Clinical Commissioning Group

Commissioning Primary Medical Services Committee

Terms of Reference

Version:	**5.10 DRAFT ~~FINAL~~**
Approved by:	Governing Body
Date Approved:	~~11 April 2019~~
Responsible Senior Officer:	Chief Officer
Review date:	April 2021~~1~~ or earlier if required by organisational, statutory or regulatory change.

Contents

NHS Calderdale Clinical Commissioning Group

Commissioning Primary Medical Services Committee

1.0 Constitution and Purpose

1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Calderdale CCG.

1.2 The Commissioning Primary Medical Services Committee ("Committee") is established in accordance with Schedule 1A of the "NHS Act" and with NHS Calderdale Clinical Commissioning Group's (CCG) Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.3 The Governing Body has determined that the CPMS Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

Statutory Framework

1.4 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

1.5 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

1.6 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

1.7 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

a) Duty to have regard to impact on services in certain areas (section 13O);
b) Duty as respects variation in provision of health services (section 13P).

1.8 The Committee will be subject to any directions made by NHS England or by the Secretary of State.

2.0 Authority

2.1 The Committee has been established in accordance with the above statutory provisions and under delegated authority from the Governing Body to enable the members to make collective decisions on the review, planning and procurement of primary medical care services in Calderdale, under delegated authority from NHS England.

2.2 The Primary Medical Care Commissioning Committee has authority from the Governing Body to make decisions within the bounds of its remit. Specifically:

a) Financial Plans in respect of primary medical services
b) Procurement of primary medical services
c) Practice payments and reimbursement
d) Investment in practice development
e) Contractual compliance and sanctions

2.3 The decisions of the Committee shall be binding on NHS England and NHS Calderdale CCG.

2.4 The Commissioning Primary Medical Services Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of Calderdale CCG or member of the Governing Body and they are directed to co-operate with any reasonable request made by the Committee.

2.5 The Committee is authorised to delegate tasks to such individuals, sub-groups, working groups or individual members as are necessary to fulfil its responsibilities within its terms of reference. The committee may not delegate executive powers delegated to it within these terms of reference (unless expressly authorised by the Governing Body) and remains accountable for the work of any such group.

2.6 In order to ensure that any conflicts of interest are appropriately managed within CPMSC sub-groups, the minutes of those meetings will be submitted to the committee detailing any conflicts and how they have been managed.

2.7 The Committee is authorised by the Governing Body to commission reports or surveys it deems necessary to help fulfil its obligations. In doing so, the committee must operate within the requirements of the CCG's Standing Financial Instructions and Standing Orders.

2.8 In exceptional cases, the Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so the committee must follow any procedures put in place by the Governing Body for obtaining legal or professional advice. The Governing Body is to be informed of any issues relating to such action.

2.9 Any such arrangements shall reflect appropriate arrangements for the management of conflicts of interest.

3.0 Membership

3.1 The Committee shall be established as a committee of the Governing Body and consist of:

Members

- Lay Member to the Governing Body (Chair of the Committee)
- Lay Member (Patient and Public Involvement) (Vice Chair of the Committee)
- Chief Officer
- Chief Finance Officer/Deputy Chief Officer
- The Secondary Care Specialist or the Registered Nurse
- Two GP Members of the Governing Body

Attendees

- A representative of Calderdale Health and Wellbeing Board as nominated by that organisation
- A representative of Healthwatch as nominated by that organisation
- Representative of NHS England
- Head of Primary Care Quality and Improvement
- Head of Contracting and Procurement
- Head of Finance
- Chief Quality & Nursing Officer
- ~~Head of Corporate Affairs and Governance/Board Secretary~~
- Administrative support

3.2 Other officers may be invited to attend any or part of any meeting as and when appropriate.

4.0 Arrangements for the Conduct of Business

4.1 Meetings of the Committee shall:

a) Be held in public, subject to the application of 23(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.2 **Chairing the Committee**

The Chair of the Committee shall always be a lay member of the committee. In the event of the chair of the Committee being unable to attend for all or part of the meeting, the Vice Chair will chair the meeting/that part of the meeting.

4.3 The Vice Chair of the Committee shall always be a lay member of the Committee.

4.4 **Quoracy**

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

- A Lay Member
- Either the Chief Finance Officer or the Chief Officer
- Either the Secondary Care Specialist or the Registered Nurse

4.4.2 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.

4.5 **Voting**

Should a vote need to be taken, only the 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.

4.6 **Frequency of meetings**

4.6.1 The Committee shall meet as business dictates and at least once per year.

4.6.2 When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

4.7 **Declarations of interest**

4.7.1 Members of the Committee shall abide by the requirements of the CCG's Constitution, Standing Orders, Standing Financial Instructions and Management of Conflicts of Interest Policy.

4.7.2 Any conflicts of interest (real or potential) shall be managed in line with the CCG's Policy and Statutory Guidance on the Management of Conflicts of Interest.

4.7.3 All declarations of interest will be minuted and recorded in line with the CCG's policy on the Management of Conflicts of Interest

4.7.4 The interests of all the members of the committee including those required attendees shall be recorded on the CCG's register(s) of interests and publicised on the CCG's website.

4.8 **Administrative Support**

Administrative support for the Commissioning Primary Medical Services Committee will be provided by a member of the Primary Care Quality and Improvement Team.

- Agreement of the agenda with the Chair and Head of Primary Care Quality and Improvement
- Circulation of agendas and supporting papers to Committee members at least ten calendar days prior to the meeting.
- Drafting of minutes for approval by the Chair within seven working days of the meeting.
- Keeping an accurate record of attendance
- Keeping an accurate record of the management of conflicts of interest
- Matters arising and issues to be carried forward
- Maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- Maintaining the annual work-plan for the Committee
- Following each meeting, forward an executive summary report to the ~~Yorkshire and Humber Area Team of NHS England~~, NHS England and NHS Improvement – (NE and Yorkshire)
- together with the minutes of the meeting once approved and the minutes of any sub-groups to which responsibilities are delegated under paragraph 6.4 below.

5.0 Duties/responsibilities of the Committee

5.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary medical care services in Calderdale, under delegated authority from NHS England.

5.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Calderdale CCG, which will sit alongside the delegation and terms of reference.

5.3 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

5.4 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

5.5 This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

5.6 The CCG will also carry out the following activities:

a) Plan, including needs assessment, primary medical care services in Calderdale;

b) Undertake reviews of primary medical care services in Calderdale;

c) Co-ordinate a common approach to the commissioning of primary care services generally;

d) Have oversight and review the financial plans for primary medical care services in Calderdale;

e) Taking procurement decisions in respect of primary medical services. These shall be in line with statutory requirements and guidance, the CCG's Constitution and

Standing Orders and the Delegation Agreement between NHS England and the CCG.

5.7 The Committee has the authority to approve policies in respect of all areas of its responsibilities.

5.8 **Governing Body Assurance Framework and Risk Management**

5.8.1 The Committee shall oversee the continued development of the Governing Body Assurance Framework in respect of the principal risks relating to those functions, responsibilities and powers delegated to the CPMS Committee.

5.8.2 The CPMS Committee has responsibility for operational risks relating to those functions, responsibilities and powers delegated to the CPMS Committee. The Committee shall:

- Review and monitor the corporate risk register in respect of the risks identified above, requesting action by accountable individuals to manage risks, as required.
- Recommend to the Governing Body, the content of the corporate risk register which relates to those risks that fall within the responsibility of the CPMSC, and are rated at 15 or above, as a true reflection of the current risk position.
- Provide the Audit Committee with assurance that risks associated with Commissioning Primary Medical Services Committee are being managed in line with the Integrated Risk Management Framework.

6.0 Reporting

6.1 The Committee shall receive the minutes of any sub group or working group established under paragraph 2.5.

6.2 The Governing Body shall receive the minutes of the Committee's formal meetings.

6.3 Following each meeting, the Committee shall produce an executive summary report which will be submitted to the ~~Yorkshire and Humber Area Team of NHS England~~ NHS England and NHS Improvement – (NE and Yorkshire), together with its minutes once approved. The summary report and minutes will be for information. These will be submitted together with the minutes of any sub-groups to which responsibilities are delegated under paragraph 2.5.

7.0 Conduct of the Committee

7.1 All members shall have due regard to and operate within the Constitution of the CCG, standing orders, standing financial instructions and other financial procedures.

7.2 Members of the committee shall abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.3 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.4 The committee shall agree an Annual Work Plan with the Governing Body and in line with the Governing Body's Assurance Framework.

7.5 The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Commissioning Primary Services Committee to the Audit Committee

7.6 The review of the terms of reference should also take account of any Directions issued by the Department of Health or NHS England and any revised model terms of reference issued by NHS England.

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

ENDS ~~24 January 2019~~13 February 2020

Change History

V. no.	Changes applied	By	Date	Circulation
0.1	Amendment of NHS England model terms of reference to apply to Calderdale CCG	Corporate and Governance Manager	20.01.15	Chief Officer, Chair of Audit Committee, Chair, Chief Finance Officer Head of Primary Care Quality NHSE
0.2	Proposed amendment to add NHS England to 'in attendance' to allow NHSE to attend if necessary to 'advise on any technical matters'. To clarity para 8.3 '..after each meeting'.	Alison Knowles, NHSE	21.01.15	Chief Officer, Head of Primary Care Quality.
0.2	No additional changes		29.01.15	Lay Advisor
0.3	Proposed amendments, Lay Advisor to the Governing Body	Incorporated for review	04.02.15	Governing Body and SMT
1.0	**FINAL**	Governing Body	05.02.15	Governing Body, NHS England, website
1.1	Proposed amendments	John Mallalieu	25.03.16	
1.2	Proposed amendments	Judith Salter	12.04.16	
1.3	Proposed amendments	Judith Salter/John Mallalieu	13.0416	CPMS Committee (21st April 2016)
2.0	**FINAL**	Governing Body	09.06.16	Governing Body, website
2.1	Proposed amendment – to amend deadline for sending papers out, incorporate authority to approve policies, update responsibilities to incorporate GBAF and risk register, update requirements regarding sub-groups in line with the revised statutory guidance on management of conflicts of interest.	Judith Salter	20.01.17	CPMSC Committee
2.2	**Amend** 4.8 to read 10 'calendar days' **Remove** 6.3 – requirement to produce an 'executive summary' as the committee is meeting sufficiently regularly to have timely minutes.	CPMSC	02.2.2017	Submitted to Governing Body 6 April 2017

3.0	**FINAL**	Governing Body	06.04.17	Governing Body, website
3.1	Submitted to the CPMSC (development) for review	JS	01.02.18	CPMSC
3.2	Additional amendments from CPMSC and Audit Yorkshire	JS	07.03.18	CPMSC
4.0	**FINAL**	Governing Body	12.04.17	Governing Body, website
4.1	Proposed amendment following CPMSC review on 24.01.19	CPMSC	11.04.19	Submitted to Governing Body
5.0	**FINAL**	**Governing Body**	**11.04.19**	**Website**
5.1	**Reviewed and amended**	**CMPSC**	**13.02.20**	Submitted to Governing Body

Item 11 b

NHS
Calderdale
Clinical Commissioning Group

Quality, Finance & Performance Committee

Terms of Reference

Current Version/Status:	**1.~~0~~1 DRAFT ~~FINAL~~**
Approved by:	Governing Body
Date:	~~24 October 2019~~ tbc
Responsible Senior Officer:	Chief Officer / Chief Quality and Nursing Officer.
Review Date:	April 2021 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 Officer
- Chief Finance Officer (CFO)/ Deputy Chief Officer (DCO)
- 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 Officer or Chief Finance Officer (CFO)/Deputy Chief Officer
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

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

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

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
- CHFY and SWYPFT Partnership Transformation Boards
- ~~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~~ March 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	**Reviewed and Updated – submitted to QFP March 2020**	**AOC/ PW**	**18/03/20**

NHS
Calderdale
Clinical Commissioning Group

Audit Committee

Terms of Reference

Version:	**8.1~~0~~ FINAL**
Approved by:	Governing Body
Date Approved:	~~11 April 2019~~TBC
Responsible Senior Manager:	Chief Finance Officer/Deputy Chief Officer
Review date:	April 2021 or earlier if required by organisational, statutory or regulatory change.

Contents

NHS Calderdale Clinical Commissioning Group

Audit Committee

1.0 Constitution and Purpose

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

1.2 The Audit Committee is a Committee of the Governing Body of NHS Calderdale CCG.

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

1.4 In addition, the Governing Body has delegated scrutiny of the following functions to the Audit Committee;

- Audit
- Governance, risk management and internal control
- Emergency Preparedness and Business Continuity

2. Authority

2.1 The Audit Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires within its remit, from any employee of Calderdale CCG or member of the Governing Body and they are directed to co-operate with any reasonable request made by the Committee.

2.2 The Committee will request and review reports, evidence and assurances from managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the CCG.

2.3 The Committee is authorised by the Governing Body to commission reports or surveys it deems necessary to help fulfil its obligations.

2.4 In exceptional cases, the Committee is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so the Committee must follow any procedures put in place by the Governing Body for obtaining legal or professional advice. The Governing Body is to be informed of any issues relating to such action.

2.5 The Committee is authorised to approve and keep under review policies and procedures of the CCG relevant to the role of the Audit Committee.

3.0 Membership

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

Members:

- Lay Member with expertise/experience in financial management/audit matters (who will act as Chair)
- Lay Member (Finance and Performance)
- Lay Member (Lay Member – Public and Patient Involvement (PPI)
- Lay Advisor
- Registered Nurse or Secondary Care Specialist~~)~~
- One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.

Attendees:

The following will be required to attend each meeting:

- Chief Finance Officer/Deputy Chief Officer or the Head of Finance
- ~~Head of Corporate Affairs and Governance~~
- External and internal audit representatives shall normally attend meetings.

3.2 The Chair of the Governing Body shall not be a member of the Committee.

3.3 Other Officers of NHS Calderdale CCG may be required to attend.

3.4 At least once a year, the Committee shall meet privately with the external and internal auditors.

3.5 The Chief Officer shall be invited to attend and will discuss, at least annually, with the Audit Committee the process for assurance that supports the Annual Governance Statement. He will also be invited to attend when the Committee discusses the draft internal audit plan and internal accounts.

3.6 Any full member of the Governing Body is entitled and encouraged to attend this Committee with observer status.

4 Arrangements for the Conduct of Business

4.1 Chairing the Committee

The Lay Member with expertise/experience in financial management/audit matters will Chair the Committee. In the event of the chair of the Committee being unable to attend for all or part of the meeting, the remaining members present will elect one of their number to chair the meeting/that part of the meeting.

4.2 **Quoracy**

Meetings shall be considered quorate when two non GP members and one GP member of the Governing Body is present.

4.3 **Voting**

Should a vote need to be taken, only the core members of the Committee shall be allowed to vote**.** In the event of a tied vote, the Chair shall have a second and casting vote.

4.4 **Frequency of Meetings**

There will be a minimum of three meetings per year. The External Auditors or Head of Internal Audit may request a meeting if they consider one is necessary.

4.5 **Declaration of Interests**

Any conflicts of interest (real or potential) shall be managed in line with the CCG's Policy and guidance on the management of conflicts of interest**.**

All declarations of interest shall be minuted.

4.6 **Administrative Support**

Administrative support for the Audit Committee will be provided by a member of the Corporate Governance Team.

- Agreement of the agenda with the Chair.
- Circulation of agendas and supporting papers to Committee members at least five working days prior to the meeting.
- Drafting of minutes for approval by the Chair within ten working days of the meeting and then distributed to Committee members within 25 working days.
- Keeping an accurate record of attendance
- Keeping an accurate record of the management of conflicts of interest
- Matters arising and issues to be carried forward
- Maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions
- Arranging meetings between the Audit Committee members, external and internal audit.

5.0 Duties/Responsibility of the Committee

The Duties and Responsibilities of the Committee are as follows:

5.1 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards[1] and provides appropriate independent assurance to the Audit Committee, Chief Officer and the Governing Body. This shall be achieved by:

- Considering the major findings of internal audit work (and managers' responses) and ensuring co-ordination between internal and external auditors to optimise the use of audit resources.
- Agreeing any local Internal Audit Strategy and monitoring its implementation.
- Reviewing, approving and monitoring the implementation of the local internal Audit Plan, ensuring that this is consistent with the audit needs of the CCG as identified in the GBAF.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Undertaking an annual review of the effectiveness of internal audit.

5.2 External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and the organisation's responses to their work. This shall be achieved by:

- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.

- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.

- Discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee.

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Governing Body and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Ensuring that there is a clear policy in place for the engagement of external auditors to supply non-audit services.

[1] Public Sector Internal Audit Standards 2013

5.3 **Counter Fraud and Local Security Management**

The Committee shall satisfy itself that the CCG has adequate arrangements, policies and procedures in place for countering fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

5.4 **System of internal control and financial reporting**

5.4.1 The Committee shall approve the comprehensive system of internal control, including budgetary control that underpins the effective, efficient and economic operation of the CCG.

5.4.2 The Committee shall approve the arrangements for the CCG's statutory financial reporting duties.

5.4.3 The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.

5.4.4 The Committee shall ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

5.4.5 The Committee shall approve the Annual Report and Financial Statements on behalf of the Governing Body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Explanations for significant variances.

5.5 **Integrated governance, risk management and internal control**

5.5.1 The Committee shall maintain an overview of the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the CCG's activities that supports the CCG's objectives. In particular the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular, the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances prior to approving the Annual Report and Financial Statement. ~~endorsement by the CCG's Governing Body.~~

- The underlying assurance processes that indicate the degree of achievement of CCG's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements, including the

process for reviewing and approving the ~~review of the~~ Governing Body Assurance Framework ~~prior to submission to the Governing Body.~~.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

- The CCG's Integrated Risk Management Framework, highlighting issues to the Governing Body as appropriate.

- The Information Governance system across the whole of the CCG's activities. The Committee shall achieve this by reviewing the annual Senior Information Risk Owner (SIRO) Report, Information Governance (IG) toolkit and any other information governance reports as appropriate.

5.5.2 The Committee will have effective relationships with other Governing Body Committees in order to understand the processes and linkages.

5.6 **Emergency Preparedness and Business Continuity**

The Committee shall maintain an overview of the adequacy and effectiveness of emergency preparedness and business continuity arrangements in place across the organisation.

5.7 **Whistle Blowing**

To review the effectiveness of the arrangements in place for allowing staff/Governing Body to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

5.8 **Other assurance duties**

5.8.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the CCG if and when appropriate.

5.8.2 The Committee will undertake an annual review of the effectiveness of the other Governing Body Committees.

6.0 Reporting Arrangements

6.1 The Audit Committee shall submit the minutes of its meetings to the Governing Body. The Chair of the Committee shall draw the attention of the Governing Body to any issues that require disclosure to the full Governing Body or require executive action.

6.2 The Committee shall submit an annual report to the Governing Body. The annual report will also describe how the Committee has fulfilled its Terms of Reference and

provide details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

6.3 Reports on specific issues, together with any recommendations shall be prepared for consideration by the Governing Body as appropriate.

6.4 The Auditor Panel has been established as a sub-group of the Audit Committee. The Audit Committee will maintain close relationships with the Panel as set out in the Auditor Panel Terms of Reference.

7.0 Conduct of the Committee

7.1 All members shall have due regard to and operate within the Constitution of the CCG, Standing Orders, Standing Financial Instructions and other financial procedures.

7.2 Members of the Committee shall abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

7.3 The Committee shall produce an annual work plan in line with the Governing Body's Assurance Framework.

7.4 The Committee shall undertake an annual self-assessment of its performance against the annual plan, membership and terms of reference. Any resulting changes to the terms of reference shall be submitted for approval by the Governing Body.

ENDS ~~17.01.19~~ 27.02.20

History

Version No.	Changes Applied	By	Date
Final	**Approved by the Governing Body**	**JS**	**11.04.13**
1.1	Submitted for review to the Audit and Governance Committee	JS	12.11.13
1.2	Amended following Audit and Governance Committee review	JS	21.11.13
2.0 Final	**Approved by the Governing Body**	**JS**	**16.1.14**
2.1	Proposed amendments submitted to Audit Committee for consideration	JS	22.1.15
2.2	Proposed amendments following Audit Committee	JS	23.1.15
3.0 FINAL	**Approved by the Governing Body**	**JS**	**09.4.15**
3.1	Proposed amendments following the Audit Committee Development Session Feb 2016	JS	20.09.16
3.2	Recommended to the Governing Body following the Audit Committee on the 30.09.2016	JS	04.10.16
4.0 FINAL	**Approved by the Governing Body**	**JS**	**13.10.16**
4.1	Amendments to CFO title and para.4.5 to ensure consistency across Committee ToR	**JS**	**25.05.17**
5.0 FINAL	**Approved by the Governing Body**	**JS**	**08.06.17**
5.1	Submitted for review to the Audit Committee	JS	18.01.18
5.2	Incorporated clarification wording to better align with the SoRD following recommendation from Audit Yorkshire	JS/ David Longstaff	29.03.18
6.0 FINAL	**Approved by the Governing Body**	**JS**	**12.04.18**
6.1	Submitted to the Audit Committee for review	JS	17.01.19
6.1	Submitted to the Governing Body for approval	JS	11.04.19
7.0 FINAL	**Approved by the Governing Body**	**AOC**	**11.04.18**
8.0 FINAL	**Change to membership agreed by Chair and CFO/DCO under urgent powers (Lay Advisor joining and Lay Member PPI attendance required).** **(Ratified by Governing Body on 23 April 2020)**	**AOC**	**18.02.20**
8.1	**Submitted to Audit Committee for review**	**AOC**	**27.02.20**

Item 11 d

NHS
Calderdale
Clinical Commissioning Group

Remuneration and Nomination Committee

Terms of Reference

Version /Status	**7.10 ~~Final~~ Draft**
Approved by:	Governing Body
Date approved:	TBC
Responsible Senior Officer:	Chief Finance Officer/Deputy Chief Officer
Review Date:	April 2021 or earlier if required by organisational, statutory or regulatory change.

Contents

NHS Calderdale Clinical Commissioning Group

Remuneration and Nomination Committee

1. Introduction

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

1.2 The Remuneration and Nomination Committee is a Committee of the Governing Body of NHS Calderdale CCG.

1.3 The Remuneration Committee has three key functions:

a) The Remuneration and Nomination Committee shall advise the Governing Body on determinations about the appropriate remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it and on provisions for other benefits and allowances under any pension scheme established by the CCG. It shall also advise the Governing Body on any arrangements for termination of employment of the Chief Officer or the Chief Finance Officer/Deputy Chief Officer[1].

b) To review and approve Human Resources' Policies on behalf of the Governing Body in accordance with the CCG's scheme of reservation and delegation.

c) To ensure that the Governing Body and its committees have the appropriate balance of skills, experience, knowledge, perspectives and independence to enable them to discharge their respective duties and responsibilities effectively.

1.4 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

2.0 Authority

2.1 When required, obtain legal or other professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary. In doing so the Committee must follow any procedure put in place by the Governing Body for obtaining legal or professional advice. The Governing Body is to be informed of any issues relating to such action.

[1] Health and Social Care Act 2012 (c.7), Part 1 – health service in England, 14L (3) and 14M (3)

3.0 Membership

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

Members

- Lay Member of the Governing Body (Finance and Performance) (Chair of the Committee)
- Lay Member of the Governing Body (Patient and Public Involvement)(Deputy Chair of the Committee)
- One GP member of the Governing Body
- The Secondary Care Specialist

The nominated deputy for the Secondary Care Specialist is the Registered Nurse

3.2 The Governing Body Chair is a member of the committee for the Nomination elements of the Committee's business.

In attendance:

3.4 A Human Resources and OD specialist will be present at all meetings to act as the Human Resources and OD Advisor.

3.5 The ~~Head of Corporate Affairs and Governance~~ Senior Corporate Governance officer (or Goverance Lead in their absence) will be present at all meetings to provide governance advice to the committee.

3.6 Other officers, including the Chief Officer, Chief Finance Officer/Deputy Chief Officer or external advisors, may be invited to attend for all or part of any meetings as and when appropriate. They shall not be in attendance for discussions about their own remuneration, fees and allowances and terms of service.

3.7 In the circumstances where the remuneration, fees and allowances for Lay Members or the Registered Nurse are being discussed, the GP member of the Governing Body and Secondary Care Specialist with advice from the Chief Finance Officer (CFO)/Deputy Chief Officer and Human Resources and OD Specialist will consider and make recommendations as appropriate.

3.8 This arrangement will need to be reviewed if the terms of engagement of the Secondary Care Specialist or the Registered Nurse change, in order to manage any conflicts of interest.

3.9 In the circumstances where the remuneration, fees and allowances for the GP members of the Governing Body are being discussed, the Lay Members and Secondary Care Specialist or Registered Nurse, with advice from the CFO/Deputy Chief Officer and Human Resources Specialist will consider and make recommendations as appropriate.

4.0 Arrangements for the Conduct of Business

4.1 Chairing the committee

The Lay Member (Finance and Performance) shall chair the committee and the Lay Member (Patient and Public Involvement) shall be Deputy Chair. In the event of the Chair or Deputy Chair of the Remuneration and Nomination Committee being unable to attend for all or part of the meeting, due to the need to manage conflicts of interests, the remaining members present will elect one of their number to chair the meeting/that part of the meeting.

4.2 Quoracy

4.2.1 Meetings will be considered quorate when at least three members are present, including either the Chair or Deputy Chair of the Committee.

4.2.2 Where one or more members of the committee are unable to attend for all or part of the meeting due to the need to manage conflicts of interest, the meeting will be considered quorate if ~~the committee members~~ those identified as in attendance at paragraph 3.4 - 3.5 are present.

4.2.3 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.

4.4 Voting

4.4.1 Should a vote need to be taken, only the core members of the committee shall be allowed to vote.

4.4.2 In circumstances where there is a tied vote, the item will be referred to the Governing Body for decision.

4.5 Frequency of meetings

The Remuneration and Nomination Committee shall meet as business dictates but at least twice per year.

4.6 Declaration of Interests

4.6.1 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**.**

4.6.2 All declarations of interest shall be minuted.

4.6.3 Members of the committee shall not receive copies of papers and shall not be present for any discussion about their own remuneration, fees, allowances or terms of service.

4.7 The Chief Finance Officer/Deputy Chief Officer or any other manager acting in an advisory capacity shall not receive copies of papers and shall not be present for any discussion about their own remuneration, fees allowances or terms of service.

4.8 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the committee.

4.9 **Administrative Support**

4.9.1 Administrative support for the Committee will be provided by a member of the Corporate Governance Team. The ~~Head of Corporate Services and Governance~~ Chief Finance Officer/Deputy Chief Officer will provide appropriate support to the Chair and Committee members. Duties will include:

- Agreement of the agenda with the Chair.
- Circulation of agendas and supporting papers to committee members at least five working days prior to the meeting.
- Drafting of minutes for approval by the Chair within ten working days of the meeting.
- A summary of the minutes will be distributed to the committee within 20 working days and will be formally approved by the committee electronically.
- Keeping an accurate record of attendance.
- Keeping a record of matters arising and issues to be carried forward.
- Maintain an on-going list of actions, specifying members responsible, due dates and keeping track of these actions.
- Advising the committee on pertinent areas/issues.
- Enabling the development and training of members.

4.0 Duties/responsibilities of the Committee - Remuneration

4.1 The Remuneration and Nomination Committee shall advise the Governing Body on determinations about the appropriate remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it and on provisions for other benefits and allowances under any pension scheme established by the CCG.

4.2 Approve disciplinary arrangements for employees, including the Chief Officer (where he/she is an employee or member of the CCG) and for other persons working on behalf of the CCG.

4.3 Review the disciplinary arrangements where the Chief Officer is an employee or member of another CCG.

5.4 The Remuneration and Nomination Committee shall have oversight of the process for reviewing the performance of the Very Senior Managers (VSMs) and individual Governing Body members.

5.5 It shall also make recommendations to the Governing Body any arrangements for termination of employment of the Chief Officer or the Chief Finance Officer/Deputy Chief Officer.

5.6 In considering any recommendations to the Governing Body on severance payments of the Chief Officer or Chief Finance Officer/Deputy Chief Officer, the committee will seek HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money'.

5.7 In formulating these recommendations, the Committee shall:

- Apply best practice in the decision making processes, for example, when considering individual remuneration, the committee will:
  - Comply with current disclosure requirements for remuneration;
  - Ensure that the recommendations are based on clear and transparent criteria.
- Take into account the need to ensure that employees, members of the Governing Body and people who provide support to the CCG are fairly rewarded for their individual contribution whilst having proper regard to the CCG's circumstances and performance and to the requirements of fair and open procurement / recruitment policies and to the provisions of any national arrangements.
- Take into account reports that monitor and evaluate the performance of individuals.
- Take into account relevant employment and equality law.

5.8 Oversee and make recommendations on the proper calculation and scrutiny of termination payments for redundancy, assisted voluntary early retirement, or by mutual agreement, taking account of such national guidance as is appropriate.

5.9 Review and approve Human Resources' Policies on behalf of the Governing Body in accordance with the CCG's Scheme of Reservation and Delegation.

6.0 DUTIES/RESPONSIBILITIES OF THE COMMITTEE - Nomination

6.1 Governing Body and its committees – appropriate balance of skills and expertise

The 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.

The committee will fulfil this responsibility by:

a) Regularly reviewing the structure, size and composition (including the skills, knowledge, experience and diversity) of the Governing Body and making recommendations to the Governing Body on any changes;

b) Regularly reviewing the membership of the Governing Body committees, in consultation with the committee chair and lead officer and make recommendations to the Governing Body on any changes;

c) Overseeing the process of changeover of committee membership, in consultation with the committee chair and lead officer in order to ensure a planned changeover, induction process and effective operation of the committees;

d) Review those results of the Governing Body and Committee annual review of effectiveness that relate to the composition of the Governing Body and Committees.

e) Oversee the creation and delivery of Governing Body and committee action/development plans.

f) Review the time needed by Governing Body members (excl. VSMs and the Chief Quality and Nursing Officer) to fulfil their duties, as required.

6.2 Appointment and re-appointment process for Governing Body members

The Committee shall:

a) Maintain oversight of the terms of office of individual Governing Body members in respect of dates for renewal of tenure/re-election or retirement.

b) Maintain an oversight of the re-appointment of Governing Body members prior to the conclusion of their specified term of office, giving due regard to the outcome of their annual performance review and ability to continue to contribute to the Governing Body in the light of knowledge, skills and experience required. This is with the exception of the Very Senior Managers (VSMs) and the Chief Quality and Nursing Officer.

c) Oversee the production of job descriptions and the recruitment process for Governing Body members, including the election process for the GP members of the Governing Body.

d) Before any appointment is made to the Governing Body, evaluate the balance of skills, knowledge, experience and diversity on the Governing Body, and in the light of this evaluation, review the description of the role and capabilities required.

e) Lead the process for Governing Body appointments including VSMs and the Chief Quality and Nursing Officer; making recommendations to the Governing Body.

6.3 Succession planning

The Governing Body needs to give full consideration to succession planning for all its members including the Very Senior Managers and Chief Quality and Nursing Officer, taking into account the challenges and opportunities facing the CCG, and the skills and expertise needed on the Governing Body in the future.

The Remuneration and Nomination Committee will support this by:

a) Overseeing the development of succession plans for:

- Governing Body members, including GP members from member practices, Secondary Care Specialist and the Registered Nurse
- VSMs/Chief Quality and Nursing Officer
- Chair, Deputy Chair, Clinical Vice Chair

b) Keeping under review the leadership needs of the organisation, with a view to ensuring the continued ability of the CCG to attract high calibre Governing Body members.

6.4 Development or amendment of CCG Policies or CCG Constitution

The Remuneration and Nomination Committee shall make recommendations to the Governing Body on the development or proposed amendment of CCG policies or CCG Constitution, resulting from the deliberations of the committee.

7.0 Governing Body Assurance Framework and Risk Management

7.1 The Remuneration and Nomination Committee:

a) Shall oversee the development of the Governing Body Assurance Framework in respect of the principal risks relating to its remit.

b) Shall ensure that its annual work plan appropriately reflects the strategic objectives and principal risks in the Governing Body Assurance Framework.

c) Has responsibility for risks in line with its remit. The Committee shall:

- Review and monitor the corporate risk register in respect of the risks identified, requesting action by accountable individuals to manage risks, as required.
- Provide the Audit Committee with assurance that those risks are being managed in line with the Integrated Risk Management Framework.

8.0 Reporting Arrangements

8.1 The Remuneration and Nomination Committee reports to the Governing Body.

8.2 The committee's discussions will usually relate to individuals and will be confidential. The minutes will be private and will be submitted to the Governing Body in the private section of the meeting.

8.3 Individuals seeking access to elements of the minutes that refer to themselves, should submit a Subject Access Request, in line with the CCG's Records Management Policy.

8.4 The Chair of the Committee shall draw to the attention of the Governing Body any issues that require approval, disclosure or other executive action.

8.5 The Remuneration and Nomination Committee will ensure that ratification is sought on any decisions by NHS England as required.

9.0 Conduct of the committee

9.1 All members will have due regard to and operate within the Constitution of the CCG, Standing Orders, Standing Financial Instructions and other financial procedures.

9.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

9.3 The committee shall undertake an annual self-assessment of its performance, identifying opportunities to improve its effectiveness. The annual assessment will include a review of performance against the committee's annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from the Remuneration and Nomination Committee to be submitted to the Audit Committee.

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

ENDS ~~5 February 2019~~ 19 February 2020

Change History

Vn. No.	Changes Applied	By	Date
1.0 FINAL	**Approved by the Governing Body**	**JS**	**11.04.13**
1.1	Submitted to remuneration committee for recommendations regarding amendments	JS	07.11.13
1.2	Incorporating proposed amendments from the remuneration committee	JS	07.11.13
1.3	Submitted to Audit and Governance Committee for review. Amendments incorporated	JS	21.11.13
2.0 FINAL	**Approved by Governing Body**	**JS**	**16.1.14**
2.1	Submitted to Remuneration Committee for review:	JS	18.12.14
2.2	Submitted to Audit Committee for recommendation to Governing Body, subject to any amendment.	JS	22.1.15
2.3	Additional amendments relating to the oversight of VSM and Governing Body appraisal process. (Remuneration Committee 18 Dec 2014 and 26 Feb 2015)	JS	27.2.15
3.0 FINAL	**Approved by Governing Body**	**JS**	**9.4.15**
3.1	Reviewed by Remuneration Committee, no changes recommended	JS	
3.1	amendments to take account of transfer of HR function to new provider	JS with Remuneration Committee Chair	
4.0 FINAL	**Approved by Governing Body**	**JS**	**14.4.16**
4.1	Proposed amendments to enable the committee to approve remuneration, terms and conditions of Governing Body members. Amendments to align to the Scheme of delegation. Amendment to the arrangements for minute taking and for approving minutes if moving to 1-2 meetings per year.	JS (reviewed by Remuneration Committee 23rd February)	16.2.17
4.2	Changes to the Scheme of Delegation and Reservation regarding the remuneration committee reviewed by DAC Beachcroft LLP and approved by the CCG membership and NHSE.	To be submitted to Governing Body	08.06.17
5.0 FINAL	**Approved by Governing Body** with the further amendment that the Lay Advisor role is replaced by the Lay Member role (Finance and Performance), establishment of a deputy chair and requirement that quoracy includes either the committee chair or deputy chair.	**JS**	**08.07.17**
5.1	Submitted for review to the Remuneration Committee	Judith Salter	18.01.18

5.2	Submitted for approval by Governing Body	Judith Salter	12.04.2018
6.0 FINAL	**Approved by Governing Body**	**JS**	**12.04.18**
6.1	First draft for comment	JS	10.07.18
6.2	Reviewed by GB development planning group – minor amends	JS	17.10.18
6.3	Reviewed by SMT – minor amends	JS	29.11.18
6.4	Reviewed by Remuneration Committee	JS	24.01.19
6.5	Following advice from NHSE; incorporated changed requirements regarding making recommendations on the remuneration of employees and people who provide services to the CCG.	JS	05.02.19
7.0 FINAL	**Approved by Governing Body**	**AOC**	**11.04.19**

Name of Meeting	Governing Body	**Meeting Date**	22/10/2020
Title of Report	**High Level Risk Log and Report - Risk Cycle 3 2020-21 (17 Aug – 2 Sep 2020)**	**Agenda Item No.**	12
Report Author	Robert Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair, GP Member	**Responsible Officer**	Neil Smurthwaite, Interim Accountable 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 third risk review cycle of 2020-21. ▪ The Calderdale Clinical Commissioning Group Risk Register currently contains a total of 38 risks with 6 risks marked for closure. ▪ Of these open risks, there are: - 2 CRITICAL risks (scoring 20) - 5 SERIOUS risks (scoring 15-16).						
Previous consideration	**Name of meeting**	Combined Quality, Finance & Performance Committee	**Meeting Date**	24/09/20			
	Name of meeting	Senior Management Team	**Meeting Date**	08/09/20			
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 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.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications						
Quality & Safety implications	No quality & safety implications.					
Engagement & Equality implications (including whether an equality impact assessment has been completed)	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 (including Staffing/Workforce considerations)	No resource / finance implications.					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**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 & 62 (see Appendix 2).

2.0 Risk Review: Risk Cycle 3

2.1 Risk Cycle 3 commenced on 17 August 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 8 September 2020.

2.2 All risks were submitted to the combined Quality, Finance & Performance Committee for review at their meeting on 24 September 2020.

2.3 There were two critical risks rated 20 at the end of Risk Cycle 3 (see 2.7).

2.4 The CCG Risk Register for Risk Cycle 3 has now been archived and Risk Cycle 4 (2020-21) will commence on 9 November 2020.

Risk Register Summary: Risk Cycle 3

2.5 At the end of Risk Cycle 3, the CCG had 38 risks on the Corporate Risk Register. There are 6 risks marked for closure this risk cycle meaning there are 32 open risks (there were also 32 open risks at the last risk cycle).

2.6 31 of total CCG risks (81%) are categorised as quality, finance & performance risks and 7 (19%) are categorised as commissioning of primary medical services (CPMS) risks.

High Level Risks

2.7 There are two Critical risks (scoring 20) on the risk register at the end of Risk Cycle 3. There were also two at this position at the end of Risk Cycle 2.

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 2 risk cycles
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 patient care and patient experience being compromised.	20	Static for 3 risk cycles

See appendix 2 for both 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 8 as 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
1501	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as Delayed Transfers of Care (CTOC). This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	16	Static for 2 risk cycles
1366	There is a risk to patient safety, experience and quality of care for the delivery of the GP Out of Hours Service provided by Local Care Direct (LCD) via the West Yorkshire Urgent Care (WYUC) contract. Due to COVID 19 response and subsequent publication of national guidance, business as usual performance management in relation to NQRs is suspended until 31st July 2020. The focus of the current risk is responding COVID 19 pandemic and risk log is 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 5 risk cycles
187	Under-achievement of 18 week performance (Incomplete referral to treatment (RTT)) at specialty level due to pressures in certain specialties compounded by COVID-19 resulting in breaches of patients Constitutional right to access certain services within maximum waiting times.	16	Static for 1 risk cycle
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 1 risk cycle
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 1 risk cycle

2.9 There were eight risks in total which were rated as Serious during risk cycle 2. During risk cycle 3 three of the risks were no longer categorised as serious:

Risk ID	Risk Summary	Risk Score	Risk Movement
1557	The risk is we fail to manage running cost spend within the ring fenced allocation of £4.1m which means will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG.	12	Reduced from 16 to 12 in light of the fact there has been some retrospective allocation adjustments for the first quarter - however still risk as new financial regime due to start October with plans going in September
1556	The CCG will fail to deliver our 2020/21 planned in year breakeven and therefore fail to deliver a planned £5.5m cumulative surplus.	12	As 1557 above
1373	That the access rates for Improved Access to Psychological Therapy (IAPT) in Calderdale will fall significantly due to the withdrawal of the Insight Healthcare, which provides around 70% of the activity within that service. People will not be able to access help and support at the time they need it, waiting times will increase (with Calderdale failing to meet the waiting times targets and access rates mandated in the NHS Long Term Plan.	4	Reduced from 16 to 4. Vita have been commissioned to provide IAPT. To be closed during next risk cycle

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 3 of 2020-21. This is following a review of the risks at the combined Quality, Finance & Performance Committee meeting on 24 September 2020.

4.0 Appendices

Appendix 1: High level risk log for risk cycle 3 as at 25 September 2020.

Appendix 2: Critical risk reports for risks 1493 and 62

Item 12 Appendix Item 1

Risk register of high level risks for risk cycle 3 for GB - 221020

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)	Neil Smurthwaite1	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on acute post-C19 bed plans which require minimum delayed patients.	(a) A&EDB review performance as a standing item monthly (A&EDB stood down from March-June, but performance and assurance work being done weekly as part of C19 delivery and reset plans) (b) System call in place monthly to review risks and mitigating actions - continued through C19 period (c) Twice weekly calls between CCG, CHFT and CMBC to review all patients on the transfer of care list (weekly through C19) (d) Surge and Escalation processes documented and agreed by A&EDB	(a) Completion of work to measure the harm to patients resulting from delays (CCG and CHFT are developing an approach) (b) CHFT's bed plan is set at 10 delayed transfers at any one time. At the time of writing the number if nearly 60 across Calderdale and Greater Huddersfield (the majority are Calderdale)	(a) A&EDB highlight report considered by QF&P as a standing item (b) Performance updated to QF&P includes TOC performance (c) CCG agreement to recurrently fund hospital discharge staff and additional home care to support patient flow and reduce delays (d) Maintaining a strong TOC performance is included with the CCG's Reset Plan (e) Winter Reset plan agreed by A&EDB at their August 20 meeting, key action is TOC reductions	(a) Calderdale has a previous history of moving from being a national outlier for poor performance, to being a national outlier for positive performance (shows the ability of the system to respond)	(a) Assurance on impact of activities to stem the post C19 steady increase in TOC and reportable DTOC (b) Continued issues within the care home sector which can preclude swift discharge from hospital (c) Delivery of bed modelling assumptions for CHFT for elective and non-elective which assume a TOC list of no more than 10 across Calderdale and Greater Huddersfield. (c) Delivery of new national guidance, received w/c 23/8	Static - 2 Archive(s)
62	13/06/2013	Finance	20	(I4xL5)	8	(I4xL2)	Neil Smurthwaite1	That the system will return to the pre-C19 levels of demand and will not 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 patient care and patient experience being compromised.	(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) - stood down March - June, but performance being assessed weekly (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 on delivery of sustainable performance post C19 given rising demand on minor pathway (b) Outcome from proof of concept on new Urgent Care Hub on both sites (was paused, but work now progressing) (c) Urgent Treatment Centre offer being developed given new build timeline is 2023/24 (d) Data to be shared with system	(a) Performance reviewed at Q&P and GB (b) Engagement with patients on reason for attendance ; completed and presented to A&EDB (c) Quality Team have oversight of any learning from 12 hour breaches (d) Working Group established to try to improve the mental health pathway in A&E to avoid 12 hour breaches (e) Approach from 19/20 - 23/24 accepted by NHSE, ie no fully functional UTC established until at least 23/24 (f) Winter Reset action Plan agreed, with focus on reducing A&E attendances, including comms work	(a) CHFT performance is in upper quintile (best) in West Yorkshire and nationally (b) Extended access in general practice now in place (c) Quality Committee triangulate all known quality indications, including complaints, and there are no undue quality concerns at this time. This will be reviewed monthly (d) Walk-in centre contract extended until March 2021 (e) GPs and A&E clinicians met to strengthen working relationships.	(a) Learning from systems testing a different performance regime (b) Learning from Urgent Care Hub proof of concept (c) Ability of the system to not return to pre-C19 levels of demand	Static - 3 Archive(s)
1501	12/03/2020	Finance	16	(I4xL4)	4	(I2xL2)	Neil Smurthwaite1	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as DTOC. This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	The CCG is working as part of the local and regional systems to respond to the COVID-19 pandemic. The CCG is participating in local place based, regional and national calls and meetings. The CCG is working with providers to understand their plans in responding to the pandemic. The CCG is designing and implementing swab testing processes for drive in locations and home testing. The CCG has identified a site for drive through testing. A new coronavirus monitoring system across WY and Harrogate is being established for coordination of all coronavirus patients and reporting to NHS E. The CCG is identify if the CCG has internal clinical capacity to help in the running of the swab testing drive through service. The CCG has internal communications processes in place with Staff around COVID-19	The CCG is 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 - 2 Archive(s)
1366	25/06/2019	Finance	16	(I4xL4)	4	(I4xL1)	Debbie Graham	There is a risk to patient safety, experience and quality of care for the delivery of the GP Out of Hours Service provided by Local Care Direct (LCD) via the West Yorkshire Urgent Care (WYUC) contract. Due to COVID 19 response and subsequent publication of national guidance, business as usual performance management in relation to NQRs is suspended until 31st July 2020. The focus of the current risk is responding COVID 19 pandemic and risk log is established for the delivery of service during the pandemic, changing/different interpretation of national guidelines on Personal Protective Equipment (PPE) and refusal of clinicians to see face to face patients.	(a) West Yorkshire Commissioners have established a sub group under WYUECN arrangements to look into commissioning of the services and likely changes for 2020/21. This commissioning group will also look into the long term service developments for GPOOH on a West Yorkshire footprint and will continue to pick up operational risk (C19 and non-C19)	There are no gaps in controls, commissioners and provider continue to work to provide assurance on service delivery and risk during the C19 period, with risks escalated regionally and nationally as needed	(b) Monthly contract report to CMB (c) Risk discussed in various forums and relevant additional assurance requested/received; West Yorkshire Sub-Regional 111 clinical quality meeting, 111/999 Joint Quality Board and 111/WYUC Contract and Performance Meeting. (c) Quality Surveillance groups. (f) The winter funding and investment through WY&H provides opportunity to develop and adjust existing service delivery model to the key future challenges. A highlight report is provided through WY&H urgent care network demonstrating progress on the initiative along with their impact on the service (g) Quality risk articulated on the risk register.	(a) As a mitigating factor for continuous service provision and access along with patient safety, LCD have made communications on a collective as well as individual level with clinicians explaining the application of national guidance on PPE for non- hospital, non-ICU use. (b) As a mitigating action LCD reported to work up a clinical protocol of double triaging of the patients required home visits (where the impact of this risk is higher). (c) Positive assurance was provided that the service will provide home visits to the patients as per clinical needs. (d) Clinical audit of both levels of triages will also be conducted and shared with Commissioners.	The service is facing situation where due to local guidance on PPE (which are higher specs than national PPE guidance) clinicians are refusing to see patients in F2F setting like home visits etc. Therefore three main interconnected issues reported are: (a) Clarity on Guidance- Issue of local guidance from LMC (currently from Bradford CCG) on PPE in spite of National guidance (c) Lack of PPE (d) Clinician's refusal to Face to Face patients LCD has assured that the PPE they are offering matches with national standards of non-hospital, non- ICU.	Static - 5 Archive(s)

187	19/03/2012	Finance	16	(I4xL4)	6	(I3xL2)	Martin Pursey	There is a risk of under-achievement of 18 weeks performance (Incomplete referral to treatment (RTT)) at specialty level due to pressures caused by the pandemic resulting in breaches of patients' Constitutional right to access certain services within maximum waiting times.	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 22 weeks c) Joint work between CCGs, CHFT and Independent sector to ensure we maximise all 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) Formal agreement of approach to gathering thematic views of patient harm	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) 18 weeks performance is reported to QF&P d) Notes of Out Patient Transformation Board to be considered at QF&P	a) Joint meetings locally and with West Yorkshire to ensure an aligned approach to planning submissions b) New joint communications groups established to oversee messaging to patients and system. c) Joint approach to the roll-out of referral support systems to support minimum data sets for referrals, to support effective clinical assessment and triage	a) CCGs and GPs remain fully sighted on progress and issues given the pace of the work	Static - 1 Archive(s)
240	10/06/2013	Finance	15	(I3xL5)	2	(I2xL1)	Martin Pursey	There is an increased risk due to the COVID-19 pandemic that the lack of availability of Appointment Slots at Calderdale and Huddersfield Foundation Trust (CHFT) exceed the agreed 4% due to CHFT having fewer outpatient appointments available for patients to book into. This potientially results in patients being unable to access their provider of choice, poor patient experience and reputational damage to both provider and commissioner.	a) Discussed as part of the CHFT Contract Management Group b) Responsibility of the monthly Outpatient Transformation Group within CHFT Partnership Arrangements c) ASI's filled where possible each day in CHFT Appointment Centre d) Reported within CHFT to their Executive Board meetings within integrated performance report.	a) The 'switch off' of elective work in response to COVID-19 effectively removed all routine slots b) The phasing of routine electives will need to be understood and what impact it will have c) ASI related complaints reported through DATIX d) Managing lower capacity (reset/new normal)	Regular updates on performance against the ASI target included in the F,P and C report (target is maximum 5% of patients awaiting an appointment) and discussed at the following monthly meetings - a) CCCG, GHCCG and CHFT Quarterly Partnership Board b) CCCG, GHCCG Commissioned Services Meeting c) CCCG, GHCCG and CHFT Contract Management Group d) 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%. 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 - 1 Archive(s)
202	26/02/2013	Finance	15	(I3xL5)	3	(I3xL1)	Neil Smurthwaite1	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 - 1 Archive(s)

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 1493
Risk Type: Quality, Finance & Performance
Risk Category: F&P – Performance
Date first issued: 20th December 2016

Date last reviewed: 30.09.20

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
3	Risk description	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experience, harm to patients, and also pressure on acute post-C19 bed plans which require minimum delayed patients
4	Current position (include any relevant data as attachments)	During the covid period, the system saw a significant reduction in the number of delayed transfers of care (formally reported DTOC), and the number of patients on the transfer of care list overall: In terms of reportable days delayed for Calderdale: April 19 – 234 days delayed March 20 – 475 days delayed April 20 – 17 days delayed (unvalidated as no national submission) June 20 – 31 days delayed (unvalidated) July 20 – 39 days delayed (unvalidated) August 20 – 43 days delays (unvalidated) Since the start of the pandemic NHSE suspended reporting of formal DTOC reporting, and therefore no benchmarking data is available to understand the relative position of Calderdale nationally. However, the system has a live data flow of patients on a discharge journey out of hospital and this is monitored daily to mitigate any delays. Further detail is provided below.
-	Assessment of the issues	The huge reductions seen in the number of delayed transfers of care during the covid period were, in the main due to a national mandate to decant the majority of those who were, at that point not acutely ill, and could be treated in

		other settings, and, the implementation of a pathway to rapidly discharge people from hospital. This included additional post-acute capacity being provided by Spire and BMI to support patients in this cohort. At that time, this reduction could be seen on the live TOC list which showed an average of 5 Calderdale patients on the list at any one time. Through oversight of the live TOR list, we know that the system has not been able to maintain this very challenging number (5 or below for Calderdale) during the reset period. This is significant given this is the number included in bed modelling assumptions for winter by CHFT Delivery of this number remains very challenging, however both CHFT and CMBC have reported significant improvement in the number of delays and the ways of working, particularly between the hospital and social care. At the time of writing the number on the live TOC list is 21 patients. However, it should be borne in mind that this is live and subject to hourly change, and also that at the same period last year that number was over 70.
6	Actions	Optimising discharge has been identified at one of the 4 top priorities by the A&EDB and it is overseeing implementation of recently received national discharge guidance; particularly; • Confirming organisational and system executive leads • Developing a new System Co-ordinator role • Developing bids for submission to a regionally allocated discharge funds • A rapid appraisal of risk and mitigation as we move into winter – with the potential to utilise unallocated BCF funds to support the output of the appraisal. • Implementation of new Reason to Reside methodology which identifies new cohorts of potential patients who could be discharged if other community offers were in place or strengthened. • The Care Home Programme established jointly with CMBC continuing to focus on the safe discharge of patients from hospital into care homes. There is also the potential to stand back up additional community bed capacity in the event of a second peak or winter surge.
7	Identified gaps	• Benchmarking information to show the relative position of Calderdale (due to a national pause in data submission) • Output of using the Reason to Reside methodology in Calderdale to enable us to understand the true scale of patients who should be receiving post-acute care in a different setting. • Our ability to deliver at the levels included in bed modelling assumptions.

Relevant data: A&E performance data is available to commissioners and is available on request

Risk Owner: Debbie Graham, Head of Integrations and partnerships

Senior Manager: Neil Smurthwaite, Interim CO

Date review completed: 30.9.20

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 62
Risk Type: Quality, Finance & Performance
Risk Category: F&P – Performance
Date first issued: 20th December 2016

Date last reviewed: 30.09.20

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 3 = 15
3	Risk description	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 patient care and patient experience being compromised.
4	Current position (include any relevant data as attachments)	During the Covid period, demand for A&E services dropped significantly. For September 2020, A&E attendances are increasing and approaching 80%+ of pre-CV19 levels. Current performance is set out below Month CHFT National July 20 94% 92% August 20 91% 89% Sept 20* 89% N/A * up to 30th Sept – subject to change due to validation
5	Assessment of the issues	Delivery of the 4-hour target is an important element of the NHS Constitution and the local urgent and emergency care system. Whilst performance is challenging locally, Calderdale and Huddersfield NHS Foundation Trust's (CHFT) performance remains consistently in the upper (best) quartile nationally.
6	Actions	The A&EDB continues to have oversight of delivery of the 4 hour target, and the following actions are taking place: • Analysis of data to understand themes and learning • Reframing of communications strategy for winter – focus is on localities where there is high utilisation of A&E, to identify alternative offers. Generic communications across all other localities (Calderdale and

		Greater Huddersfield. • Agreed and exception-reporting, at A&E Delivery Board 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. • Implementation of a new 111 First model (December for our system), which promotes local offers as alternatives to ED attendance and ambulance call outs, by strengthening the local Directory of Services used by 111 and creating opportunities for 111 to book patients into ED if necessary.
7	Identified gaps	• Understanding of the full impact of social distancing on future models of care as demand increase • Understanding the impact of the winter communications and winter reset plan on A&E attendances • Dialogue with community provider alliance on system support to reduce attendances – planned for October. • Impact of 111First

Relevant data: A&E performance data is available to commissioners and is available on request

Risk Owner: Debbie Graham, Head of Integrations and Partnerships

Senior Manager: Neil Smurthwaite, Interim CO

Date review completed: 30.9.20

Item 3 a

NHS Calderdale Clinical Commissioning Group

Minutes of the Audit Committee Meeting
held on 18 June 2020, 2.00pm
Microsoft Team Meeting

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	Neil Smurthwaite	(NS)	Interim Accountable Officer
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Interim Chief Finance Officer
	Andrew O'Connor	(AOC)	Corporate Governance Officer (Minutes)
	Jonathan Hodgson	(JH)	Audit Manager, Audit Yorkshire
	Olivia Townsend	(OT)	Local Counter Fraud Specialist, Audit Yorkshire (from minute number 75/20 onwards)
	Helen Kemp-Taylor	(HKT)	Head of Internal Audit, Audit Yorkshire
	James Boyle	(JB)	Senior Manager, Public Sector Audit, KPMG
	Rob Gibson	(RG)	Corporate Systems Manager (for item 5, minute no. 67/20 and item 8, minute no. 70/20)
	Sam Byrnes	(SB)	Senior IG Officer (for item 5, minute no.70/20 and item 8, minute no. 68/20)

63/20	**APOLOGIES FOR ABSENCE**	
	Apologies were received from Tim Cutler (Partner, KPMG) and Danielle Hodson (Assistant Audit Manager, Audit Yorkshire). NS was in attendance as Interim Accountable Officer. LS was in attendance as the Interim Chief Finance Officer. The meeting was quorate.	
64/20	**DECLARATIONS OF INTEREST**	
	JB was declared to have **direct financial** interest in relation to item 9d, Auditor Panel Annual Report. He had received the meeting papers but it had been agreed that he would leave the meeting for the whole of this item. There were no further 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.	

65/20	**MATTERS ARISING FROM THE MEETING HELD ON THE 27 FEBRUARY 2020**	
	DECISION: The minutes of the Audit Committee meeting held on the 27 February 2020 were **RECEIVED** and **ADOPTED** as a correct record. **Actions** All actions arising from the meeting had been completed.	
66/20	**CONTRACTING REPORT**	
	MP explained that the report provided the committee with information concerning waivers, current, completed and proposed tenders and extracts from the CCG's Contracts Register (by exception). The following key points were highlighted: ▪ **Contracts Register** - The CCG was in a good position regarding outstanding signatures. ▪ **Procurements** – Some procurement activity had been paused due to changes in priorities and COVID 19. Updated information concerning effected procurements would be provided to future meetings. The Dermatology Services procurement exercise had been paused as part of the market was incapacitated. The exercise was expected to recommence toward the end of 2020. ▪ **Waivers –** The names of colleagues who had signed off the waivers had been included at Appendix 1. Regarding the information provided concerning upcoming waivers, "Todmorden Group Practice" was verbally corrected to "Calder Community Practice" (which is based in Todmorden). Future reports would include additional narrative concerning the reasons for a waiver being proposed. Additional information concerning matters reported on the Contracts Register extract would be supplied to help the committee understand the reasons for the delays. Comments and questions were invited. ▪ The Contracts Register was noted to be in a good position considering the difficulties impacting providers and other organisations. ▪ The intention to supply of additional information concerning the reasons why waivers were being proposed was welcomed, but caution was advised regarding the extent of the additional information provided. It was suggested that the identification of themes would meet the committee's requirement concerning contracts rated red while limiting the burden on staff. MP indicated that he intended to include an additional section in the body of the report in order to escalate any particular matters of concern. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** for assurance the contents of the report, appendices and progress to date.	

67/20	**GOVERNANCE ASSURANCE DASHBOARD**	
	SB presented the following information concerning the Data Security and Protection Toolkit (DPST): ▪ **Data Security and Protection Toolkit (DPST)** – NHS Digital had delayed the DPST annual submission date from the end of March to the end of September 2020 due to COVID 19. The CCG was planning to make its submission by mid-July. Work was taking place in regard meeting the 95% data security training target (Standard 3). As at Tuesday 16 June 2020, the CCG had achieved 90% for all staff and 70% for Governing body Members. With regard to Standard 9 (IT Protection), the final piece of work required involved the signing of and timescales for a data security action plan. Assurance was provided that this piece of work would be completed in the near future. Comments and questions were invited: ▪ JM confirmed that he would follow up with Governing Body members concerning the data security training requirement in his role as Deputy CCG Chair. The 10 July 2020 was agreed to be the latest deadline for completion. ▪ In response to a question, SB explained that the data security action plan had been generated following an external data security review of Health Information Service and CCG. She confirmed that only dates on the timeline required agreement for the piece of work to be completed. RG in presenting the next part of the dashboard highlighted the following: ▪ **Subject Access Requests (SAR) (Breaches in excess of 5 workings days) -** There had been a breach of more than 5 working days in relation to a SAR received in quarter 4. Due to COVID 19 and practical limitations arising from the need for social distancing, the CGG's Continuing Health Care (CHC) Team had not been able to provide the requested information by the statutory deadline. The applicant had been kept informed throughout and arrangements were now being put in place for CHC staff to safely work at Dean Clough in order to ready the information for disclosure. ▪ **Subject Access Requests (Complaint received by the CCG)** – the internal review process relating to a SAR responded to during quarter 3 of 2019/20 had been delayed due to COVID 19 and practical limitations arising from the need for social distancing. The applicant had been kept informed throughout and the CCG's Information Governance (IG) Manager and Senior Governance Officer had been given permission to return to Dean Clough to continue the review observing the relevant health and safety measures. ▪ **Freedom of Information (FOI) Requests (Breaches equal to or exceeding 10 working days) –** There had been a breach of more than 10 days in quarter 4 of 2019/20 and another in quarter 1 of 2020/21. The breaches were in relation to information held by the CCG's CHC Team whose ability to respond had been impacted by the deployment of their staff in response to COVID 19. Staff were now returning to their substantive roles and good progress was reported being made to return any outstanding information requests. Comments and question were invited: ▪ RG confirmed that applicants were in receipt of regular communications during the period of the delays.	

	▪ RG provided assurance that the CCG had sufficient arrangements in place to respond to requests for information. AOC advised that the CHC Team had already returned most of the outstanding FOI's for release. ▪ **Registers of Interest** – The review of the CCG Member's Register had been postponed to Quarter 2 due to COVID 19. The committee felt it was appropriate to do a "light touch" review of the register in Quarter 2. ▪ **Risk Management –** Committees had focused on key decisions due to COVID 19 and as such had not received the scheduled reports. The committee was assured that the routine assurance work had been carried out on both the Risk Register and Governing Body Assurance Framework (GBAF). SB provided the following update on policies overseen by the committee: ▪ The review of the CCG's Confidentiality and Data Protection Policy and Information Security Policy would form part of single IG Policy Booklet which would come for approval to the committee's next meeting in September. **DECISION:** The Audit Committee **RECEIVED** the report for assurance.	
68/20	**SENIOR INFORMATION RISK OWNER'S ANNUAL INFORMATION GOVERNANCE REPORT 2019/20**	
	NS presented Senior Information Risk Owner's (SIRO) Annual Report for 2019/20 inviting questions and comments. ▪ The committee was supportive of the SIRO Annual Report forming part of the governance dashboard during the next cycle. ▪ The report was noted to provide a good overview of work and activity across the year. **DECISION:** The Audit Committee **RECEIVED** the report for assurance.	**SB**
69/20	**FREEDOM OF INFORMATION ANNUAL REPORT 2019/20**	
	AOC presented the Freedom of Information (FOI) annual report for 2019/20. The report was explained to provide an overview of the CCG's performance against the requirement of the FOI Act. An increase in breaches during the year, particularly during quarters 1 and 2 were highlighted including the reasons for these and the changes or mitigations that had been made to avoid their reoccurrence in the future. The committee was assured than in instances where qualified exemptions had been applied; the necessary supporting evidence was in place in the event of challenge. There had been no complaints received during the year. Comments and questions were invited. ▪ As with the SIRO report, it was suggested the dashboard also be used to provide the FOI annual report at the end the 12 month cycle. NS asked that authors me mindful of meeting audit requirements when introducing this change. There was also a	**AOC**

	request to authors to ensure that enough information is provided in order to enable members to have full understanding of the issues. ▪ There was a discussion about the resilience of the CHC Team to provide FOI responses on a sustainable basis. NS confirmed that a great deal of work had taken place to help build greater strength and depth within the team but recognised that there was still more to be done including expanding the number of staff able to fulfil the Team's responsibilities in terms of FOI requests. There was also recognition of the need to do more training with staff to support them in returning the draft responses quickly and appropriately. ▪ JH reminded the committee that Audit Yorkshire was undertaking a controls improvement audit with the CCG's CHC Team including an advisory report and follow up during 2020/21. **DECISION:** The Audit Committee **RECEIVED** the report.	
70/20	**RISK MANAGEMENT ANNUAL REPORT 2019/20**	
	RG presented the Risk Management Annual Report 2019/20 drawing attention to the following: ▪ The CCG had received **"HIGH ASSURANCE"** for its Integrated Risk Management Framework. A change concerning references to the Head of Corporate Affairs and Governance role had been made during the report's drafting stage. ▪ Changes to governance assurance arrangements as set out at 2.3. ▪ The appendices had been circulated in error. Comments and questions were invited. ▪ JM thanked RG for the addition at 4.2 recognising the role of the Commissioning Primary Medical Services Committee in reviewing its own risks. He asked that the CCG Annual Report be checked to ensure that reference was made to this. **DECISION:** The Audit Committee **NOTED** the CCG's Annual Risk Management Report: a. As a supplement to the ongoing assurance on risk management received during the year; b. As evidence that the CCG is committed to continually reviewing and developing its risk management processes.	
71/20	**COMMITTEE ANNUAL REPORTS**	
	a.) Quality, Finance and Performance Committee FJ introduced the Quality, Finance and Performance Committee's Annual Report having been appointed as the committee chair from 1 April 2020. He drew attention to the committee having been formed through the merger of the Quality and the Finance and Performance Committees during the year, the decision to reduce the number of	

	committee meetings as part of the broader changes within the CCG's governance arrangements, and changes to the committee's membership. Comments and questions were invited. ▪ JM reflected that the report provided a comprehensive overview of the activity of the committee but was not sure that it clearly communicated that the activity described covered the work undertaken both prior to and following the merger of the committees. It was agreed that the minutes reflect the committee's recognition of this. It was also agreed that the activities described provided sufficient assurance concerning the appropriate and effective management of matters relating to quality, finance, performance and risk across the CCG by the committee during the year. **DECISION:** The Audit Committee **RECEIVED** the report. **b.) Commission Primary Medical Services Committee (CPMSC)** JM presented the CPMSC committee's Annual Report reminding members that that the committee holds it meeting in public and that it business often provides conflicts of interest that require careful and ongoing management. The committee was also recognised to have made a number of challenging determinations during the year. Comments and questions were invited. ▪ It was agreed that reference to the "Yorkshire and Humber Area Team of NHS England" at 5.3 in the Committee's Terms of Reference needed to change to align with the reference at 4.8.	**AOC**
	DECISION: The Audit Committee **RECEIVED** the report. **c.) Remuneration and Nomination Committee** JM presented the Remuneration and Nomination Committee Annual Report. He noted that during the year the responsibilities of the previous Remuneration Committee had been expanded to included matters concerning Nominations. Moreover, that planned development activity would be focused on developing and supporting members in order to ensure that the committee continued to successfully discharge its responsibilities. Attention was drawn to the key items of business undertaken and discharged by the committee during the year. Comments and questions were invited. **DECISION:** The Audit Committee **RECEIVED** the report. NS suggested that the process by which committee annual reports are submitted to the Audit Committee might be reviewed. There was support for this. PR and DCC	**PR/NS/ AOC/ HKT**

	volunteered to provide input. JM welcomed the standardisation of committee annual reports but asked that the focus on committee development be retained. HKT offered to feed in examples from practice elsewhere. **d.) Auditor Panel** JB left the meeting at this point as per the arrangements for the management of the conflict of interest declared earlier in the meeting. PR presented the Auditor Panel Annual report. The Panel had been convened in order to procure a new external audit service for the CCG. **DECISION:** The Audit Committee **RECEIVED** the report. JB re-joined the meeting.	
72/20	**AUDIT COMMITTEE DRAFT ANNUAL REPORT**	
	PR presented the draft Audit Committee Annual Report. Comments and questions were invited. **DECISION:** The Audit Committee **RECEIVED** the report.	
73/20	**INTERNAL AUDIT**	
	a.) DRAFT Internal Audit Annual Report 2019/20 including final Head of Internal Audit Opinion JH presented the Internal Audit Annual Report 2019/20 including the Head of Internal Audit Opinion. Attention was drawn to the following: ▪ The 2019/20 Audit Plan had been agreed by the Audit Committee at its meeting on 16 May 2020. 106 days had been allocated. 10 of the days had been deferred to 2020/21. ▪ All 96 days had been delivered for 2019/20 as set out at 3.1. The planned CHC Assurance Audit had been changed to to a Controls Improvement Audit during the year. ▪ 8 moderate recommendations had been raised as an outcome of the completed audits in 2019/20. There had also been two minor recommendations. All recommendations had been accepted by management and followed up. ▪ All Key Performance Indictors as set out at Appendix 1 had been achieved with the exception of the KPI relating to the percentage of management responses received within 15 days of the issuing of draft reports. ▪ A summary of all audit outcomes for the year was provided at Appendix 3. Since the last committee meeting the CCG had only received high assurance opinion reports or advisory reports relating to the Data Protection Toolkit and the first stage CHC Controls Improvement Audit. A summary of each of the reports was provided at Appendix 4.	

	Comments and questions were invited. ▪ The report was noted to provide an overview of the information previously reported to the committee. ▪ The efforts of management in delivering consistently high level of assurances were noted. ▪ The aspiration of achieving an overall rating of high assurance for the organisation was noted. ▪ Comparatively the CCG was noted to perform very well. ▪ The working relationship between Internal Audit and CCG Management was noted to be much improved. HKT presented the Head of Internal Audit Opinion confirming the CCG had received an overall Internal Audit opinion of **SIGNIFICANT** assurance. The opinion was noted to be the outcome of three streams of work looking at the Governing Body Assurance Framework, the Integrated Risk Management Framework and audits undertaken during the year. HKT signalled the ambition for Audit Yorkshire to work with the CCG during 2020/21 to achieve an improved overall level of assurance opinion. The Chair gave their thanks to Audit Yorkshire for their work with the CCG during the year. He also gave thanks to the efforts of management and CCG staff. Comments and questions were invited. ▪ In response to a question, HKT confirmed the CCG benchmarked among the highest performing CCGs. ▪ The committee confirmed that auditors had recognised the improved working relationship with CCG management during their private meeting. **DECISION:** The Audit Committee **NOTED** the contents of the DRAFT Annual Report featuring the final Head of Internal Audit Opinion and **TOOK ASSURANCE** from compliance with the Public Sector Internal Audit Standards and delivery of the statutory duty to produce the Head of Internal Audit Opinion.	
74/20	**EXTERNAL AUDIT ISA 260 REPORT**	
	JB presented the ISA 260 end of year report for 2019/20. ▪ All external work had been completed and subject to the completion of final checks JB confirmed KPMG would be in a position to sign the financial statements, opinion and Value for Monday (VFM) conclusion ahead of the submission deadline. ▪ KPMG intended to issue an **UNQUALIFIED** audit opinion on financial statements, an **UNQUALIFIED** regulatory opinion and an **UNQUALIFIED** conclusion on the CCG's VFM arrangements. This was noted to be a very positive outcome for the CCG. ▪ A single adjusted audit difference had been identified in relation to the prescribing accrual which was noted to be a national issue. JB confirmed that the view was management had been prudent and made use of the information they had at hand and that there was no evidence of management overriding the control or any fraud risk concerns to be raised. ▪ No adjusted audit differences had been identified other than presentational issues which had been raised with and resolved by the CCG's finance team. ▪ One prior year control recommendation in relation to the formalisation of the review of SVS control account reconciliations had been followed-up. This had been found to	

	have been fully implemented in-year. ▪ No recommendations had been made for 2019/20. ▪ As required, all variances above £300K emerging from the agreement of balances processes had been identified. The KMPG view was that no adjustments were required. ▪ No VFM issues had been identified during the audit. The impact of Covid 19 had been taken into account in this regard as had considerations from a "going concern" position. ▪ JM thanked the finance team for their work and support. The Chair thanked KPMG for their work. Comments and questions were invited. ▪ LS recognised that circumstances during the audit had been challenging and that it was positive that the process it had been concluded effectively with a positive outcome. ▪ In response to question, JB confirmed that all outstanding matters had now been resolved. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** the contents of the report for assurance.	
75/20	**ANTI-CRIME**	
	OT joined the meeting at this point. **a.) Counter Fraud Annual Report 2019/20 (including Self Review Tool)** OT presented the Counter Fraud Annual Report for 2019/20. Attention was drawn to the following: ▪ The report provided an overview of information and activity previously reported to the committee. ▪ The CCG's Self-Review Tool (SRT) Assessment had been completed and submitted to the NHS Counter Fraud Authority. Standard 3.1 was now rated as green and, as such, the CCG was reported as rating as GREEN overall. Comments and questions were invited. ▪ The copy of the SRT in pack at Appendix A was noted to be the uncorrected version. OT confirmed that the final version which had been submitted would come back to the committee's next meeting for information. **DECISION:** The Audit Committee **RECEIVED** and **NOTED** the contents of the report for assurance. **b.) Counter Fraud Workplan 2020/21** OT presented the Counter Fraud Annual Workplan 2020/21 for approval. 18 days were proposed to be allocated for completion of the plan. The intention would be to again achieve a GREEN rating overall. OT would be looking at how aspects of the plan could be delivered virtually in the changed circumstances. Any issues or gaps arising from the staff survey would be addressed through further activities which would be added to the plan.	

	Comments and questions were invited. ▪ A reference to NHS Wakefield on p1 of the plan was noted to require amendment. ▪ Assurance was sought on the types of activity that were being delivered to reduce the threat of fraud now that more people were now working from home. OT confirmed that specific COVID bulletins were going out on a monthly basis. Some work was taking place to anticipate and plan for potential fraud activity that may emerge in the coming months. ▪ LS reported NHSE had commissioned spot audits of Covid claims. It was anticipated that this would be rolled out to all commissioners and providers at a later date and would be significant areas of work and risk during the year. ▪ In response to a question, LS confirmed that, year-to-date, the CCG had incurred £1.9m of Covid costs. The greatest costs related to primary care and the hospital discharge programme. Detailed reports would be submitted to the Quality, Finance and Performance Committee and Governing Body. ▪ PR directed OT to work undertaken by the Centre of Procurement Excellence on identifying Covid related fraud and that of the National Audit Office. OT confirmed she was currently redeployed and was only working 1 day a week in her Counter Fraud role. This would increase to 2 days a week from 1 July. **DECISION:** The Audit Committee **APPROVED** the Counter Fraud Workplan 2020/21.	
76/20	**LETTER OF REPRESENTATION ON THE ACCOUNTS**	
	NS presented the draft letter that would be presented to the CCG's external auditors concerning the CCG's accounts. He confirmed that it was draft and may be amended subject to KPMG carrying out its final checks. **DECISION:** The Audit Committee **RECEIVED** the letter of representation on the accounts.	
77/20	**CCG ANNUAL REPORT AND ACCOUNTS 2019/20**	
	LS presented the CCG's Annual Report and Accounts 2019/20 for approval by the committee under delegated authority from the Governing Body. The final submission date for the annual report and accounts to NHSE was 25 June 2020 in accordance with amended national timetable. The annual report and accounts had been produced in line with all the relevant guidance. The committee was noted to have already heard the opinion of the auditors in relation to the accounts earlier in the meeting. The following points were highlighted: ▪ The table provided at 3.6 in the report summarising the CCG's performance against its statutory financial duties. All duties had been met. An increased surplus of £1m had also been delivered. ▪ In its deliberations concerning the annual report and accounts the committee was asked to consider the questions set out at 4.2 and 4.3 and confirms the statement of disclosure to the auditor at 4.4. Comments and questions were invited.	

	▪ In response to a question, LS confirmed the CCG had been set a target in 2020/21 to reduce its running costs in-year by 11.8%. A significant proportion of the savings had been achieved in the previous financial year in preparation of the reduction. In terms of the interim financial arrangements for 2020/21, the CCG's allocation was less than what had been anticipated; as such, the CCG was working with NHSE to understand the reasons for this and to establish whether adjustments would be made. The overall expectation for the CCG was that it would deliver its break even targets against running cost and programme allocations. ▪ JM recognised the Annual Report was straight forward, factual and compliant and told the story of Calderdale in a way that was not overly complicated. There was recognition of this being achieved during a very challenging period of time. ▪ The work of LS, Corrine MacDonald, AOC and RG and others across the organisation in producing the annual report and accounts in 2019/20 was recognised. It was felt to have produced a better end product. ▪ The report was also noted to reflect that the CCG's work tackling the underlying issues that contribute to people's health and well-being in Calderdale. Comments and questions specifically concerning the accounts were invited: ▪ In response to a question, LS confirm that in accordance with delegated authority from the Governing Body, the accounts were being presented to Audit Committee for approval while a summary of performance and detail concerning some of the expenditure in order to finalise the end of year position would be reported through to Quality, Finance and Performance Committee. ▪ In response to request, LS explained that - The Statement of Comprehensive Net Expenditure (p113) provided a summary of income and expenditure from operating activities, excluding the CCG's allocation from NHSE. - The Statement of Financial Position (p114) was explained to be the CCG's balance sheet. It was noted the page numbers referenced on p114 of accounts as circulated would require amendment. The committee confirmed that it had: 1. Reviewed the Annual Report and the self-certification statements contained within it including: ▪ Page 45 - Modern Slavery Act; ▪ Page 48 - the statement made by Dr Matt Walsh as Accountable Officer ▪ Page 66 - data quality 2. Reviewed the Governance Statement. 3. Reviewed the Head of Internal Audit Opinion. 4. Reviewed the accounts in detail. 7. Reviewed the External Audit consideration of the accounts including the opinion and letter of representation. 8. Considered any non-adjusted mis-statements, what were they and what is the view of the Committee on these.	**LS**

	The committee also confirmed that: ▪ So far as members were aware, there was no relevant audit information of which the CCG's Auditor was unaware that would be relevant for the purposes of their audit report. ▪ That member had taken all the steps that they had ought to have taken in order to make themselves aware of any relevant audit information and to establish that the CCG's auditor was aware of it. Comments and questions were invited. **DECISION:** The Audit Committee **APPROVED** the Annual Report and Accounts for signature by the Accountable Officer and, prior to the submission, of the full audited and signed Annual Report and Accounts and full copy of the Head of Internal Audit Opinion.	
78/20	**AUDIT COMMITTEE WORK PLAN 2020/21**	
	AOC presented the workplan 2020/21 which was presented for assurance. The committee noted that it may need to amend the workplan in response to the changed environment over the coming months. Comments and questions were invited. **DECISION:** The Audit Committee **RECEIVED** the workplan for assurance.	
79/20	**ITEMS FOR GOVERNING BODY AND/OR OTHER SUB-COMMITTEES**	
	DECISION: The Audit Committee **AGREED** that the following items be fed through to the Governing Body or its committees. ▪ Approval of Annual Report and Accounts and the Finding of Internal and External Audits (Governing Body)	**(PR)**
79/20	**REFLECTIONS ON THE MEETING**	
	At this point in meeting the PR and AOC's connection to the meeting was broken. Subsequently, committee members indicated that the meeting had gone well, noting that all required business had been discharged and had finished on time.	
80/20	**DATE AND TIME OF NEXT MEETING:**	

	DECISION: The remaining members of the committee **NOTED** that the next meetings would take place as follows: **Private Meeting with Internal/External Audit** **24 September 2020, 10.30am-11.00am** **Saville Meeting Room, Dean Clough** *[Venue subject to confirmation]* **Audit Committee Meeting** **24 September 2020, 11am-1.15pm** **Saville Meeting Room, Dean Clough** *[Venue subject to confirmation]*	

Item 13 b

NHS Calderdale Clinical Commissioning Group

Minutes of the Quality, Finance and Performance Meeting held on Thursday 25 June 2020, 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) **(Deputy Chair)**
	Alison MacDonald	(AM)	Lay Member (PPI)
	Rob McSherry	(RM)	Registered Nurse
In attendance:	Debbie Robinson	(DR)	Head of Primary Care Quality and Improvement
	Martin Pursey	(MP)	Head of Contracting and Procurement
Presenters:	Clare Robinson	(CR)	Head of Nursing and Safeguarding
	Janet Smart	(JS)	Complaints Manager
	Stella Johnson	(SJ)	West Yorkshire Research & Development
	Sarah Antemes	(SA)	Head of Continuing Healthcare, Mental Health and Learning Disability Services
	Rob Gibson	(RG)	Corporate Systems Manager
	Tim Shields	(TS)	Head of Performance
Observing:	Denise Cheng-Carter	(DCC)	Lay Advisor, Governing Body
	Rob Atkinson	(RA)	Secondary Care Specialist, Governing Body
Minute Taker:	Zoe Akesson	(ZA)	Senior Administrator, Corporate Services

022/20 APOLOGIES FOR ABSENCE **Action**

FJ was welcomed as new Chair for the Committee.
Apologies were received from Debbie Graham, Head of Service Improvement.

023/20 DECLARATIONS OF INTEREST

FJ invited Committee members to declare any interests relevant to items on the agenda.

FJ and CT declared a direct financial interest with regards to item 17 of the agenda, Prescribing Gain Share. The conflict had been acknowledged and discussed prior to the meeting. FJ and CT had received the paper. FJ advised the Committee that he would hand the Chair to JM for the item. CT and FJ would be invited to provide their comments and then would be asked to leave the meeting for the non-conflicted discussion and decision.

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.

024/20 MINUTES OF THE QUALITY FINANCE AND PERFORMANCE MEETING HELD ON 26TH MARCH 2020

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

025/20 MATTERS ARISING

The one outstanding action (No 030/19) around participation in the E.coli data collection would be revisited at September's meeting when the updated IPC report would be available.

026/20 JOINT SAFEGUARDING CHILDREN AND ADULTS QUARTERLY REPORT Q3 AND Q4

CR presented the report which provided an overview of the Safeguarding Children and Safeguarding Adults work and activities undertaken from November 2019 to April 2020 including information and changes that took place during the pandemic.

Appended to the report was the current safeguarding cases that the CCG was involved with. It was noted this report was closed to the public and was shared with the Committee for information.

The following key points were made;

- During the pandemic, the team continued to have oversight of the safeguarding issues seeking assurance that commissioned providers were delivering their responsibilities
- The team continued to provide advice and support to providers including GPs.
- The team received a high level of assurance from internal audit on the CCG's safeguarding responsibilities however it was noted that CCG and GB staff adherence to Safeguarding statutory training needs to be addressed. It was noted this was not the responsibility of the CCG Safeguarding Team to address.

CR concluded the presentation by sharing the team's concern that some children and adults have not been seen during the pandemic and nationally there is a worry that this may lead to a rise in serious safeguarding cases.

Comments and questions were invited.

- In response to question, CR assured the Committee that the team regularly meet with the provider safeguarding committees to ensure safeguarding training compliance with provider organisations is happening. It was acknowledged there was a drift in training recently but this was due to re-deployment and will be picked-up. CHFT was also making arrangements for virtual training sessions for staff.
- In response to question around capacity, CR explained that during COVID safeguarding teams were deployed but they have all now returned. The team has capacity to manage any potential issues. They were working on a prioritisation plan and currently interviewing. There was cross cover in place with Kirklees CCG for priority issues and they also work on a West Yorkshire footprint where all ICS designated safeguarding professionals cover each other if required.

- In response to question, CR was confident that the new proposed safeguarding structure would be fit for purpose. By employing a deputy designated person in each place but at slightly different hours in would promote a place-based cross-cover approach. It would help to build relationships and share workload.
- The Committee recognised the high level of assurance given by internal audit and how this reflects the hard work by the team.
- JM commented on the initial and review health assessments. Historically this area had been a challenge however this year the volume completed had increased. CR explained this was due to a member of staff taking on the dual role of both designated nurse safeguarding children and children looked after to enable a dedicated nurse to do this work. By taking on this role it freed up funds to provide a dedicated nurse for this work.
- PW added there was a step change in the children looked after work and now local nurses do review health assessments for children out of area. It helps to give the CCG a better understanding of the numbers and quality assurance issues across West Yorkshire.
- PW provided assurance that conversations are happening both in adults and children's services in Calderdale regarding unseen issues that are emerging following lockdown and what this means for our safeguarding partnerships.

DECISION:

The Committee **RECEVIED** and **NOTED** the contents of the report. The Committee was **ASSURED** the CCG was fulfilling its Safeguarding roles.

027/20 COMPLAINTS REPORT

The annual complaint report for 2019-20 was received by the Committee. The report provided an overview of the complaints received about the services commissioned by the CCG during 2019-20 broken down by provider, category, level and response timeframe. In presenting the report, JS highlighted the following key points;

- The CCG received more Level 1 complaints, concerns and enquiries than in previous years. This was due to a change in the process of how they are captured as they come into the organisation.
- There was an improvement of complaints being responded to within deadline due to a change in timescales and the sign-off process during the latter part of 2018.

Questions and comments were invited.

- PW highlighted the work from the Parliamentary and Health Service Ombudsman. The case generated a large amount of the work between contracting and complaints. SMT would continue to monitor the action plan.
- When COVID hit, the CCG was instructed by NHSE to instigate a 3 month pause around complaints. The pause ends on 30 June and JS has been contacting any outstanding complainants. JS also explained that she had been handling any new complaints received during the pause as necessary.
- AM described the complaints system as robust pointing out that Level 3 complaints have gone down.
- NS highlighted a number of complaints involving CHFT. In response to question, PW explained that CHFT complaint arrangements are discussed at the CHFT Quality Board. The CCG would not monitor provider complaints.
- FJ referred to the table showing complaint by provider and asked for the

providers Opcare (previous) and Rosscare (current) to be shown on separate lines. It was noted that Rosscare inherited a number of complaints from Opcare and therefore there was a continuation of a number of complaints from Opcare to Rosscare rather than new complaints. JS informed the Committee that during 2020/21 only Rosscare complaints would be reported.

- PW explained that the Annual Complaints report would be discussed by Governing Body in July, which would require some consideration ahead of the meeting.

DECISION:

The Committee **RECEIVED** and **NOTED** the Complaints Annual Report for 2019-20.

028/20 RESEARCH 2019-20 ANNUAL REPORT

SJ presented to the Committee the Research Annual Report 2019-20, which summarised the joint activity of the West Yorkshire Research and Development team in collaboration with the CCG.

The following key points were made;

- The CCG's participation in the patient and family involvement in serious incident investigations project will potentially contribute to national policy.
- The CCG and their member practices have actively promoted research in Calderdale, which has resulted in recruiting 26 participants into research.
- The CCG have regularly advertised research educational and knowledge transfer events in their weekly staff bulletins to member practices.
- The CCG used research evidence to inform quality improvement work. The Medicines Management team worked collaboratively with other CCG colleagues across West Yorkshire to look at the current prescribing activity for antibiotics. The Lowering Anti-Microbial Prescribing (LAMP) project which commenced in April 2019 provided all general practices across the ICS with A&F reports that directly contribute to the work required in the primary care strand of Tackling Antimicrobial Resistance 2019-2024, the UK's five year National action plan. LAMP has been recognised by Professor Cliodna McNulty, the Head of Infection Control at Public Health England as this is the largest CCG led programme of its kind currently running in the country. The project has been put forward to the 2020 Antibiotic Guardian Awards in the prescribing and stewardship category.
- During COVID, staff were using a digital platform where reports can be accessed from all practices.

The following comments and questions were raised:

- FJ commented that the report provided a comprehensive overview and it was good to see this level of research taking place in the local area.
- In response to question around recruitment of participants, SJ explained that historically it had been difficult to recruit in Calderdale but this was improving and the WY R&D team are working on a federation level solution to increase activity.
- In response to question around publicising the research more widely, PW explained that currently it is shared with Committee, headline messages and link to the full report are included in the Quality and Safety report to Governing Body and key messages are included in the CCG bulletin to practices. Some CCGs publish the full report on their websites and this would be something to

consider in the future.

DECISION:

The Committee **RECEVEID** and **NOTED** the report. The Committee was **ASSURED** with the summary of research activities for 2019-20.

029/20 TRANSFORMING CARE UPDATE

SA provided the Committee with a quarterly update on transforming care programme. SA highlighted the following key points;

- There were currently 5 inpatients, 4 of which were short term admissions and 1 person was waiting for a bespoke housing solution which had been delayed due COVID.
- Work was ongoing around stopping over medication of people with a learning disability (STOMP) and was being led by SWYPFT. The CCG continued to monitor to ensure hospital beds were available if required.
- One of the key models of care at an ICS level was around learning disability provision. There were 3 assessment and treatment units (ATU) across the ICS but work was underway to move to 2, which would focus on delivering a better quality service. Due to COVID, the ATU reconfiguration had been paused at the engagement stage. It was also recognised that there had been an increased provider collaboration to manage demand for inpatient beds and maximise capacity between them.

Questions and comments were invited.

- In relation to question around a restart date for ATU engagement, SA explained there was no indication but would put the challenge back as part of the ICS reset work.
- PW asked for oversight of the learning disability mortality reviews (LeDeR) in each future TCP update.
- A comment was made that the Committee needs to be kept sighted on the ATU reconfiguration and for it to remain on the agenda due to the significant financial implications and to understand how it falls within the CCG's mental health priorities and investment profiles.
- To think carefully about how we capture and report to Committee and Governing Body on all the West Yorkshire work, possibly through our operational plan work streams rather than specific items.

DECISION: The Committee NOTED the update.

030/20 CONTINUING HEALTHCARE (CHC) GOVERNANCE ASSURANCE UPDATE

In providing the update SA highlighted the following key points;

- The CHC team successfully met all its national targets and performance metrics for 2019-2020.
- BroadCare - internal audit undertook a control improvement audit (CIA) to review the efficiency, effectiveness and understanding of the BroadCare system. There was an assurance around the safety aspect of the function but the audit highlighted a need for development in areas around performance and monitoring. An action plan was put in place and a Senior Operational Manager was recruited at the end of September to support the team and take the action plan forward.

- There were a range of challenges the team faced during 2019, which included an increase in fast track funding and referrals, staffing, complex care and care home issues. It was brought to the Committee's attention that these were managed whilst the CCG was successfully defending an employment tribunal case which took up a lot of management time and effort.
- CHCs contribution to the COVID discharge process had a huge impact on the team. CHC's role was to support the rapid discharge of patients which meant that clinical staff in the team were deployed to the front line and a skeleton service remained to continue with the active case management and keep the service running.
- The impact of the COVID discharge guidance has resulted in a back log of assessments, which the team was working jointly on with the Local Authority. It was also noted that a prioritisation process would be put in place for the back log reviews.

Questions and comments were invited.

- The Committee acknowledged it had been a difficult period over the last 12 months and recognised the team's hard work to reach its current stability compared to 12 months ago.
- The Committee commended the CHC team for how well it responded to the situation. It was also acknowledged that apart from ensuring capacity to respond to the back log, there must be time for recovery as everybody challenged at extreme end when colleagues start returning to the team.
- With regards to question around a plan to manage the back log of assessments and reviews, SA explained that there had been no communication from NHSE on the numbers however the system was looking at the pressures and how to address them. SA would draft a proposal for the Senior Management Team for an initial discussion.
- There was a short discussion around assurance. JM cautioned the Committee to look at the response activities to the impact of discharge guidance as a whole, rather than individually and for SMT to give a global view of the various strands of actions that needs to take place. In response to JM's comment, NS explained the focus had been on the new performance metrics set by NHSE however it was recognised there was now a need to capture this through performance reporting which previously has only focussed on the constitutional standards. The agenda for CHC around taking the learning from COVID and its integration work with the LA is huge and mainly operational which SMT has oversight of however clarity was required on what was reported to Committee for assurance. As the CCG was being asked to report more on mental health in CHC, NS suggested a committee development session to look at the CCG's wider performance.

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

031/20 QUALITY AND SAFETY REPORT

PW informed the Committee that routine quality reporting had been suspended during the first 3 months of pandemic and that a dashboard would be reintroduced at September's meeting. In presenting the report PW brought the Committee's attention to the following key points;

Local Care Direct Care Quality Commission (CQC) inspection report was published on 11 May 2020. The service received an overall rating of 'good', which it has maintained since March 2015.

The date for Trusts to publish their **Provider Quality Accounts** 2019-20 has been revised due to COVID. Currently there is no fixed deadline however NHSE/NHSI recommended a deadline of 15 December 2020. To enable a scrutiny process, Trusts should provide a draft quality account for comment to stakeholders and a date of 15 October 2020 was suggested. The quality team will be discussing the revised arrangements with the CCG's main providers and update the Committee.

A **Rapid Change** process was put in place to allow decisions to be made quickly whilst operating at Level 4. The team worked on a Rapid Impact Assessment tool which enabled the CCG to have some quality and safety oversight of our decision making during COVID. The list of the rapid impact assessments that have been done in the last 3 months are seen by SMT on a weekly basis.

The **CQC's routine inspection process** was suspended at the start of COVID but in May 2020 the Emergencies Support Care Framework was introduced. This interim arrangement allows the CCQ to have conversations with providers and request regular updates. PW was seeking assurance from our providers that the conversations were happening.

Quality Monitoring – during COVID, the quality team received a variety of national guidance on what we would normally report on from a quality point of view. The team have kept a log to understand the timeframes, when revised guidance is expected and when things will come back on line such as complaints and friends and family test. This will continue to be monitored and any quality risks identified associated with COVID, will be included on the Risk Register.

Infection Prevention Control (IPC) – a huge effort was made by colleagues in the CCG to respond to the Chief Nursing Officer's letter on 1 May 2020, which asked CCGs to lead on delivering training packages on IPC, PPE and testing to 100% of care homes (including those for mental health and learning disabilities) by 29 May 2020. The CCG had to find people to train as super trainers, train staff in IPC and PPE and deliver training to every care home within its locality within 2 weeks, reporting nationally on daily progress. Debbie Winder led the work, supported by colleagues and providers. The team successfully met the target and delivered the training offer to all homes. PW emphasised this was over and above the normal level of NHS support to the care sector, as IPC is usually provided by the Local Authority. A working group has been set up, which has a long term prevention plan around IPC to ensure the work continues to support the homes. PW extended her thanks to Debbie Winder for the work she did to ensure the CCG met the target and for the work she continues to do around IPC.

Principles to Deliver an Enhanced Universal Support Offer to Care Homes – there was a specific ask in the community letter received on 1st May 2020 for primary care and community health services to build on the good practices already in place to help support care homes. As a system and organisation the CCG met the target however there would be more to do to ensure the actions that have been put in place were having the desired impact. There would be a further evaluation from the region and further submission of the assessment and evaluation of the impact this was having.

Questions and comments were invited.

- The Committee commended the report, which reflected the hard work and commitment of the team. It was recognised that there now needs to be a time to recover, to embed the important work and allow staff to focus on their wellbeing.

- The team was thinking about future ways of working and taking the learning to incorporate into the ongoing quality agenda.
- RMcS added that the learning around working collectively would be a useful discussion at a further Governing Body workshop.

PW concluded the item by acknowledging the risk for the Calderdale population that have not received their care during this period of time and the need to think about our prioritisation, impacts and outcomes for some individuals.

DECISION: The Committee **RECEIVED** and **NOTED** the report including;
- Local Care Direct Care Quality Commission inspection publication
- Provider Quality Accounts
- The work being undertaken by the Quality Team to ensure the quality and safety of our provider organisations continues to be reviewed and monitored during the Covid-19 Pandemic.

032/20 FINANCE, CONTRACTING AND PERFORMANCE

Finance

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

The CCG met all its financial targets and duties for 2019-20. The accounts were signed-off by Audit Committee and submitted on 23 July 2020.

This year due to COVID, there have been significant changes. A temporary financial arrangement was put in place from the first 4 months of the year, business rules the CCG was operating under have altered and the allocation that was planned has significantly changed. Payment by results was suspended and replaced with a system of block payments based on last year's payments adjusted for inflation. A good proportion of the provider's income comes from the block payments however providers are able to contact NHSE directly for additional costs they are incurring due to COVID. Independent hospitals activity has been procured nationally. Non contracted activity has ceased and dealt with through a new lead commissioner arrangement.

The CCGs original allocation was £348m. 4 months allocation would have equated to £116m however the CCG received £112m resulting in a £4.3m shortfall against its plan. In light of this, the finance team reviewed the plan and have forecast a worst case scenario of £4.5m overspend for the first 4 months of the year, which is more than the reduction in allocation that was expected. LS explained that under the guidance CCG can claim back additional costs incurred above the allocation received and that the CCG is working under a level of trust within the guidance received from NHSE. There was some risk in relation to this but it was not unusual and most CCGs within ICS reporting overspends. It was noted that CCGs can claim for additional COVID costs under the temporary financial regime and the CCG had reported additional costs to NHSE in May however it was still waiting for agreement.

The following issues and pressures were noted;
- Acute – forecasting was under due to non-contracted activity (NCA) and Independent hospitals
- Mental Health – forecasting overspend due to 2020/21 MHIS commitments.
- Prescribing – potential £2.2m pressure due to Increase in forecast costs, no cheaper stock option (NCSO), CatM and QIPP under delivery.

- Primary Care – COVID costs and allocation was less than plan.
- Other/Reserves – 2019/20 had non-recurrent savings so the true cost was not reflected in 2020/21.
- Running Costs – overspend due to allocation lower than planned.

LS asked the Committee to approve the budget that had been allocated acknowledging the uncertainty of risk.

Questions and comments were invited.

- The Committee recognised the achievement of the CCG's delivery of its financial duties from last year.
- The Committee discussed the budget being less than the forecast expenditure. The Committee acknowledged the uncertainty of the risk but felt assured the finance team would manage the risk in line with the guidance expected from NHSE. The Committee was reminded that the deficit was a result of the financial arrangements that have been put in place nationally.
- LS would keep the Committee updated.

DECISION: The Committee;

- **NOTED** the 2019/20 final financial position and positive audit assurances
- **NOTED** the new temporary financial regime for the period April 2020 - July 2020.
- **APPROVED** the interim budgets in line with the revised allocations and acknowledged the uncertainty of risk.
- **NOTED** the forecast overspend for the period April - July 2020.
- **NOTED** new planning guidance due for the period August 2020 - March 2021.

Contracting

Due to the current situation and position in year, MP provided the Committee with a summary of the activity for supplier relief, which was part of the Government's response to COVID to ensure providers remained resilient.

The following key points were highlighted;

- NHS providers moved to block contract payments, which were agreed nationally using the month 9 balances (uplifted by 2.8%). All sanctions associated with those contracts disappeared. There was an expectation from the centre that some volume of activity would be delivered within the year and therefore prepayment would be expected. The contract team will work through the gap in delivery with the providers but there is a risk this may be carried forward into the following year.
- The Independent Sector activity was blocked purchased by NHSE on a national basis, this arrangement was expected to continue for the time being.
- For Other Non-NHS providers where services were subject to financial guarantee, if services have been delivered the payment has been upheld.
- For Any Qualified Provider (AQP) contracts payment would be on the basis of the activity of the agreed price. MP highlighted that the CCG has not been impacted as much as other CCGs in this area due to most of its AQP contracts being low value and not material in terms of the provider.
- Most of the COVID related supplier relief expenditure had been with the Local Authority (LA), with regards to care homes and domiciliary care providers. The CCG mirrored the LA's approach to apply a one-off payment of the COVID relief 5% uplift for a 12 week period.
- In line with national guidance, the CCG reported on the status of its larger

providers and if there had been a need to provide local relief.

There were no further comments.

DECISION: The Committee **NOTED** the update in relation to Supplier Relief and the revised arrangements for NHS contracting and payment during the COVID-19 pandemic.

Performance

TS provided a summary of the key messages from NHS constitution. It was noted that the constitutional standards remained during COVID.

A&E Performance - Performance against the 4hr target improved during the pandemic, resulting in the delivery of the 4hour standard in May. Performance at CHFT remained to benchmark well against the whole region.

Volume of Attendances - there was a significant drop in the volume of attendances during lockdown however attendances were now on the increase. Analysis was taking place to understand if there was an unmet need during this time and what can be done going forwards instead of returning to normal.

Bed Admissions and Bed Occupancy - the number of admissions into hospital reduced and bed occupancy was around 40 - 50% during April and May, which were all in response to the Phase 1 and protecting the critical care capacity.

Referral to Treatment

- The clinical review of standards, which the CCG was involved with pre-COVID, has been postponed. The CCG was waiting for instruction from NHSE on when it would resume.
- **52 week waits** - previously there had been issues with patients waiting at Leeds for complex surgery however there was now a higher number waiting across a range of specialities at CHFT. A number of urgent actions have been put in place focussing on specific areas to understand the capacity available and to enable the elective pathways to flow again.
- **Elective** - COVID and the fact that hospitals were not accepting referrals had a dramatic effect on operational activity. Referrals into the system dropped significantly including out-patient, day case and overnight stays.
- **Diagnostics** - performance has dropped dramatically in this area. All categories were affected and the volume of tests has increased. This was now a focussed area of the reset work and discussions were taking place regionally on how this would be managed.
- **Cancer waiting times** – strong performance reported for the majority of indicators.

Questions and comments were invited.

- To capture performance of continuing healthcare and mental health in the reporting going forwards**.**
- In relation to the question about waiting time for scans, discussions with providers were taking place on how capacity could be increased to deliver diagnostics. The independent sector was being used for cancer diagnostics, endoscopies and other specialities and CHFT were prioritising all 2 week wait and cancer referrals. In relation to routine referrals, an evidence based system approach had been applied, with GPs and consultants jointly seeing those that have the most need.

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

033/20 CORPORATE RISK REGISTER

The Committee received the risk register position statement for risk cycle 2 2020-21. RG highlighted the key points from the report;

There were 2 critical risks on the register;
R1493 - regarding delays in transfers of care
R62 – the risk of not delivering the 4hr A&E target

There were 8 new risks, including 2 scoring 16;
R1557 - regarding the management of the running costs spend
R1556 - risk concerning delivery of the plan £5.5m per accumulative surplus.

RG explained that the risks on last year's register were closed at the end of the financial year and reintroduced this year. Both risks had increased their score. It was also noted that at least half the risks had been impacted by COVID for this risk cycle.

Questions and comments were invited.

- In response to question, R1493 (Delayed Transfer of Care) remained high even though CHFT have reported fewer patients with packages of care over this period, as there was still a high risk to the system if levels of demand return post-COVID. The wording had subtly changed to reflect this.
- With regards to R1421, NS assured the Committee that conversations around financial viability of care homes were taking place. The CCG was working jointly with LA around the sustainability management market and there is an assurance group looking at what the long term future should look like. It was noted that the LA is lead for both care homes and testing. The risk for the overall viability is within quality however the market information work needs to be completed before considering if it is a risk for the CCG.
- There was a short discussion around how the CCG documents the COVID specific risks, capture emerging risks and forthcoming challenges over the next period in a way that is manageable and usable. It was felt that;
  - it was not necessary to open up the risk process to operational risks
  - some of the COVID risks are captured within the finance risks
  - high level risks are captured on the risk register for each of the functions
  - level of assurance was within Committee papers.

  There was a general consensus from the Committee that developing a second COVID risk register would not be beneficial. SMT would propose the COVID risks they want to put on the risk register and the Committee would continue to receive assurance through the reports.

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.

34/20 WORK PLAN

High level items remain on the work plan. Due to COVID, some items were moved at agenda setting and rescheduled for later in the year.

035/20 MINUTES AND HIGHLIGHT REPORTS

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

- Minutes from the CHFT Clinical Quality Board held on 26th February 2020
- Minutes from the SWYPFT Quality Board held on 5th December 2019
- Minutes from the SWYPFT Partnership Board held on 13th December 2019

There were no further comments.

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

036/20 MATTERS FOR THE;

036/20-a **Governing Body**

- Complaints Report
- Research Report - key messages into the quality and safety report.

036/20-b **Senior Management Team -** NA

036/20-c **Partnership Transformation Board -** NA

037/20-d **Local Medical Committee -** NA

038/20-e **Calderdale Primary Medical Services Committee**

- CPMSC risks will be reviewed at July's meeting.

039/20 ANY OTHER BUSINESS

There were no further items to raise.

FJ handed over the Chair to JM

040/20 PRESCRIBING GAIN SHARE

GP members of the Committee were reported to have a direct financial interest in relation to item 17 (Prescribing Gain Share).

In order to manage the conflict:

- The chair was passed to JM who took the item.
- All the Committee members received the papers. It was noted that a discussion had taken place with management on how the conflict would be handled. The Committee was reminded that the conversation was about cessation of the scheme and therefore there was a high level of perception and conflict for both GPs.
- The Deputy Chair (Chairing this item) advised he would have preferred the conflicted GPs to have not received the papers and he would be actively managing any actual or potential conflict as GPs gave their thoughts at the beginning of the discussion. The GP members confirmed they understood this.
- DR presented the paper.
- The GPs were invited to give their comments and then asked to leave.
- A further discussion took place with the remaining members for a decision.

In introducing the item, DR explained that the report provided the outrun position

for the primary care prescribing budget for 2019-20 and described the impact this had on the prescribing gain share scheme for member practices. The report acknowledged the current pandemic providing context around the impact of cost pressures, which were anticipated to continue into the current financial year.

Prior to inviting the GPs to speak, JM pointed out this was launched as a 3 year scheme with long term effects. The second year of the scheme had been challenging due to pricing and the pandemic, which was not a reflection of individual failure. Those who did generate a saving in the first year found it difficult to articulate and demonstrate this as a consistent saving.

The following comments were received from the GPs;

- It is important how the CCG communicates and explains its actions and reasons behind the decision.
- It was acknowledged that some practices have put a lot of effort into the scheme but the objectives of the scheme have not come to fruition.
- Take learning and apply principles for future schemes and models.

CT and FJ left the meeting.

The remaining Committee members considered;

- Running a scheme with no gain
- Adding quality elements to future gain focussed schemes
- Removal of the scheme in relation to cost effective prescribing
- Communication to practices

The Committee noted that Management would consider any further incentive schemes on a more targeted nature, learning from this scheme and would bring back further proposals to the Committee in future if or when appropriate.

DECISION:

The Committee;

APPROVED supporting the recommendation to cease the scheme and not operate it for a third year.

APPROVED supporting the recommendation that North Halifax PCN and Upper Calder Valley PCN will not have recurrent savings beyond 2020/21.

041/20 DATE AND TIME OF THE NEXT MEETING

The Committee **NOTED** that the next meeting would take place as follows:
24 September 2020, 2.00 – 5.00pm, venue tbc

NHS
Calderdale
Clinical Commissioning Group

Minutes of the Commissioning Primary Medical Services Committee Meeting held on 23 July 2020, 11am, via video conference

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)
	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, Health Watch, 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
	Dr Majid Azeb	(MA)	Clinical Lead for Primary Care (Item 5 only)
	Zoe Akesson	(ZA)	Senior Administrator
			There was no public in attendance.

08/20 APOLOGIES FOR ABSENCE **ACTION**

Apologies were received from Dr James Gray, Governing Body - GP Member.

JM welcomed members of the committee and reminded them that the meeting was not accessible to the public. The Committee was politely asked to adhere to the virtual meeting etiquette.

09/20 DECLARATIONS OF INTEREST

Members were invited to declare any interests relevant to items on the agenda.

GP members were declared to have an interest in items 9, 10 and 11. It was noted that MA was only attending for item 5 'Head of Primary Care report'. JM described how the conflicts would be managed as below;

- Item 9 'Finance Report'; asked for a decision around the suspension of the discretionary budget and the acceptance of the first 4 months of the delegated budget. Both GPs had a direct financial interest and non-financial professional interest. They received the paper however it was agreed SC could stay for the discussion but would leave prior to the decision making.

- Item 10 'Branch Surgery Approval for Bankfield'; asked for a decision on the use of the Rosemount premises following the closure of the Meadowdale APMS

practice. As a partner of Bankfield surgery, JG had both a professional (reputation amongst partners) and financial interest in this item. SC had a financial interest. JG and SC did not receive the paper and would not take part in the discussion or decision.

- Item 11 'Establishment of an Estates Sub-Group'; the GPs had a direct financial interest in this item as decisions around GP estate could impact on their income It was also acknowledged the conflict would become greater when decisions are made against the principles the group establishes. The two conflicted individuals did not receive the paper and it was agreed they would not be involved 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.

10/20 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

11/20 MINUTES OF THE OF COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE MEETING HELD ON 9 JANUARY 2020

The minutes of the committee meeting held in public on 9 January 2020 had been were approved electronically between meeting and were received for information.

Actions and Matters Arising

There was one outstanding action (04/20) to keep the Committee informed of risks and progress made arising from ongoing APMS mitigations activity from the Committee's task & finish group. The action was recorded as closed, as this is included in the Lead Officer's report and would be going forwards.

12/20 DECISION NOTICE 1 MAY 2020 - SPRING HALL GROUP PRACTICE APPLICATION FOR NOVATION OF GMS CONTRACT

Due to April's committee meeting being stood down, a paper on the novation of contract for Spring Hall Group practice was circulated to those committee members that were not conflicted for a decision. The novation of the contract was approved and the decision notice was received for information.

13/20 HEAD OF PRIMARY CARE REPORT

Committee was provided with a paper on the Calderdale General Practice response to the COVID pandemic.

In presenting the report, DR highlighted that the pandemic had accelerated immense change in the way that General Practice was delivered in Calderdale. In order to respond to the pandemic, General practice had to rapidly adopt a different operating

model and the practices and PCNs should be commended for their positive response to managing the situation as it both emerged and progressed. The challenging yet positive partnership approach between the Local Medical Committee, the PCN Clinical Directors and the CCG should not be underestimated and was a significant factor in how the changes were adopted so quickly in Calderdale.

The paper summarised some of the key national guidance documents and expectations up to June 2020 and described some of the decisions, processes and actions that were implemented in Calderdale to respond to the pandemic and to meet NHSE expectations. Some of the additional COVID costs that have been claimed by PCNs were also included in the paper.

In the paper DR described the learning and "the new normal" for General Practice and what this could mean. It highlighted some of the work that had been funded by the CCG to support practice transition into the next phases, including the engagement of the National Association of Primary Care to help PCNs gain a better understanding of population health management approaches, which were fundamental to the development of the PCNs and their vital role in improving local health outcomes for the future.

The paper concluded with some identified risks and work to mitigate these and the Committee was asked to note the content.

Comments and questions were invited.

- The Committee recognised the huge efforts from the whole of the primary care system in responding to COVID. It was highlighted that amongst adapting to the rapid changes, an OPEL type system was set up. This highlighted a couple of practices that would have struggled but due to working as PCNs all surgeries in Calderdale remained open, for all the population.

- A comment was made that although this was an incredible achievement in responding in such a short period of time, public perception and communication around accessing services was questioned. The Healthwatch survey signalled that some patients were struggling to contact their practices as they were closed or patients perceived them to be closed. It was unclear if this was due to COVID or APMS dispersal. HH was asked to investigate.

  ACTION: HH to establish reason why patients were unable to contact their surgery during the pandemic and feedback to DR. **HH**

- TS added this was also reflective of the feedback received by CMBC. Again he recognised the huge amount of work and change that had taken place across the system but now his concerns were around staff being able to refresh before the onset of winter.

- A question was raised around the utilisation of video consultations during the pandemic and how it would be developed as part of the online offer. DR confirmed that every practice had the facility and the CCG was working on gaining access to utilisation information to see if it was being used effectively. When the information becomes available it would be included in the Lead Officer's report.

The conversation continued during which the following points were made around establishing a "new normal";

- PW reminded the Committee there would be more challenges ahead working and

living in the new COVID world. In relation to the quality and safety of patients, there needs to be clear communication on what is available, how this can be accessed, embedding quality assurances through our 'reset' plans and using the information gathered by Healthwatch to gain a better understanding of the utilisation of services through different lenses.

- There was a short discussion on the GP offer. The following points were raised;
  - Although there were different options available to access services, it was clear that some patients were still defaulting to telephoning the surgery rather than using the GP online service. A system approach from all partners was required to help communicate messages around access to the public.
  - HH reminded the Committee about the perception of messages being received by the public and to be mindful in that although there was a limitation as to what could be offered people's safety is paramount and an inclusive approach needs to be built into so people feel like they have access.
  - TS echoed the importance of system messaging but also added that there was a need to establish a way of measuring how these changes have improved people's lives.
  - In order to adapt and use new technology there was a need to understand how to utilise this to deliver something better.
  - In relation to access to care going forwards, there was a need to consider the balance. Being mindful that some patients may find video consultations difficult compared to telephone conversations and while we need not throw away some of the old system we need to keep in mind the BAME population /workforce and to ensure they too are protected.
  - Be aware of other service developments in the system such as '*Talk before you Walk'*, that could impact on Primary Care.

In conclusion, there was gratitude and an acknowledgement from the Committee to parties who have moved Primary Care forward. It was acknowledged there was a significant piece of work to do on understanding the access, utilisation and prioritisation of the GP offer going forwards.

DECISION

The Committee **RECEIVED** the paper and was **ASSURED** with the content, noting the significant activity undertaken in Primary Care.

MA left the meeting

14/20 CONTRACTING REPORT

In presenting the report, MP highlighted the GP online consultation software contract, informing the Committee of the uptake of the provision in the contract which was extended for a further year.

It was noted that all 21 practices had returned their sign-up documents in relation to their participation in the elements of the NHSE DES and confirmation had been received that all PCNs had signed-up to Network DES 2020-21. The report also included an update on incorporation decisions made by the Committee and both novation agreements had been signed and returned to relevant parties.

The second part of the paper was a request from the Committee to give an indication of the benefits and reasons why some practices wanted to seek incorporation. These were as follows;

- Risk of liability

- Ability to encourage people to join practices without having to join partnerships that might have significant financial liability.
- Task benefits for individuals
- Lessons learned would be for early engagement so that issues commissioners may face when considering incorporations can be discussed.
- It was also noted that the novations had been agreed subject to a number of caveats in the Calderdale, Greater Huddersfield and north Kirklees CCGs, this brought consistency in the legal advice that was sought and standardisation in the documentation with regards to the caveats and clauses.

Questions and comments were invited.

- MP was asked to share the lessons learned with practices considering incorporation, to enable future applications to progress quickly.

- MP was asked to include a benefits statement in future incorporation application papers which would provide context for decision making by the Committee**.**

There were no further comments.

DECISION

The Committee **RECEIVED** and **NOTED** the content of the report.

15/20 CPMS RISK REVIEW 2020-21 (18 May to 8 June 2020)

RG reported that there were 8 CPMSC risks for consideration. There were no risks above 12 but of the 5 open risks, 3 were new for risk cycle 2.

JM invited questions and comments from the Committee.

- DR stated that risks 1561 and 1564 would be moved to Quality, Finance and Performance Committee (QFPC) for review, as they were currently not in the delegated responsibilities of this Committee. Following a short discussion around the clarity around risks for delegated duties, it was agreed that the formal risk review of risks outside of delegated primary medical services but that had a bearing on those services would take place at the Quality, Finance and Performance Committee (QFPC) and that the Lead Officer would highlight in her report any risks that would impact on the business of this committee.

- In relation to risk 1561, JM asked if the CCG was monitoring the dissatisfaction following closure of APMS, as this would change over time. RG was asked to review the scoring.

ACTION: RG to reduce the risk score of R1561. **RG**

SC left the meeting

DECISION

The Committee **AFFIRMED** it would review risks in relation to its delegated responsibilities only and any wider Primary Care risks that impact on the Committee would be raised in the Lead Officer's report.

The Committee **REVIEWED** the register and the management of the CPMSC risks.

The Committee **APPROVED** the risk register for reporting to Governing Body.

16/20 MEETING TIME AND WORK PLAN

There were no changes to the work plan. The Committee was content with the format.

JM raised the timing of the meetings as they fall on the same day as the Governing Body meeting in public, putting demands on both Governing Body and most importantly staff in preparing for 2 large formal meetings. JM asked the Committee if they would be interested in pursuing a move to another Thursday.

Comments and questions were invited;

- All agreed it would be more helpful to move the meeting dates. Members asked to inform JM of any further limitations to this arrangement outside the meeting. A preference for afternoons was noted.

ACTIONS: To work on finding alternative Thursday (pm) for future meetings. **ZA/JM/DR**

17/20 FINANCE REPORT

In presenting the paper LS highlighted the key points from the report;

- For 2019-20, the CCG delivered a break even budget against its allocation of £33.3m. The main overspend areas were APMS and premises, which were managed through releasing contingency reserves. It was noted that provisions were put into premises around dilapidations on APMS properties, which did not feature in the last finance report.

- For 2020-21, the plans submitted to NHSE in January were not implemented and a new finance regime was put in place due to COVID. The CCG was issued a part year allocation for 4 months (April - July) of £10.4m. Overspends against this, could be claimed against additional COVID monies. The CCG had been asked by NHSE to approve the initial budget for the 4 month period. LS pointed out that this had been the same for all budgets, which have been approved through QFPC. The Committee was asked to approve the delegated budget on this basis.

- With regards to the financial arrangements from August onwards, LS advised the Committee to remain prudent and not to approve any discretionary spend or plans until the planning guidance had been received. It was noted that this proposal excluded the decision that was to be considered on agenda item 10. It was agreed that work around developing plans should progress so the CCG was ready to take them through a governance process as soon as clarity was received.

- Presented in a paper last year, the CCG was intending to introduce equitable funding from 01/10/20. The PMS premium spending would be on a consistent basis across Calderdale. The CCG did commit to recalculating each financial year and the report included the values of what the budget would be with an additional £87K coming into the budget this year.

- The paper provided a high level outline of additional investments under the GP contracts. Additional roles reimbursement had increased significantly. NHSE were holding the additional funding and this could only be accessed if PCNs had well developed plans to spend the allocated amount. In the initial guidance, there

was an expectation that plans should be developed by PCNs by end of June and shared with NHSE by the end of July, this deadline had now been moved The CCG developed a tool kit to understand these plans and was now starting to receive plans back from the PCNs. The profile will increase significantly again into the following year, so there was a need to make sure the PCNs make best use of this.

There were no further comments or questions from the Committee.

DECISION

The Committee **NOTED** the 2019-20 budget.

The Committee **APPROVED** the given budget and **ENDORSED** the non-investment of spend approach until the budget for the remainder of the year is known. Noting an exclusion to this being any decision under item 10 on the agenda.

18/20 APPROVAL OF BRANCH SURGERY FOR BANKFIELD SURGERY

It was noted that the conflicted individuals were not present for this item.

DR presented a paper that sought approval from the Committee for the establishment of a branch surgery for Bankfield surgery practice in Elland.

The Committee was reminded that due to the closure of 2 surgeries in Elland, Bankfield Surgery has had a higher than average increase in their list size over the last 2 years. Also as part of the APMS post consultation deliberations meeting in January 2020, the establishment of a branch surgery was part of the mitigating actions to secure access and capacity and it was noted that one of the next steps was to secure a current premises solution.

The paper requested approval for a 3-year funding arrangement to cover rent and rates, whilst the CCGs long term estate strategy was being confirmed.

The paper contained information in relation to the responsibilities placed upon the Committee under delegated commissioning arrangements with NHSE and the responsibilities the CCG had with regards to premises which are set out in the National Health Service (General Medical Service's premises costs) directions 2013. The paper referenced the fact that the practice had an initial conversation with its patient representative group who were supportive but due to the recent pandemic further meetings have not taken place. The paper also reference that the CCG had ongoing financial commitments to NHS Property Services until the current lease at Rosemount expired at the end of October 2020.

Comments and questions were invited.

- For clarification, DR confirmed to the Committee that the branch surgery would be available for the whole of the Bankfield registered patients list.
- In order to manage population expectations, it needs to be clear in communications that this is an interim solution and be about timeframes.
- In response to question on operating hours, branch would be the same as surgery with the exception that it would close at 6pm.
- The PCN may offer other services from this location, as it is existing general practice not additional estate.

DECISION

The Committee **NOTED** the content of the paper and formally **APPROVED** the establishment of an interim branch surgery at Rosemount House, Elland for 3 years.

There were no further requirements or conditions as part of the approval.

19/20 ESTABLISHMENT OF AN ESTATES SUB-GROUP

It was noted that the conflicted individuals were not present for this item.

The paper proposed the establishment of a time limited estates sub-group to consider the principles and criteria against which applications for premises investment can be assessed. The paper advises the committee that there had been a number of requests for premises investments submitted to the CCG for consideration. Included in the paper was high level information in respect of the number of practices and the number of sites from which services were provided. The committee was reminded that it had responsibility for making decisions on premises investment under the delegation arrangements with NHSE and the specific elements of the delegation agreement were detailed in the appendix to the paper.

The paper highlighted that the CCG had very limited skills and capabilities in estates development and that there was a need to develop the estate strategy and the associated processes and criteria to enable the CCG to establish clear priorities for investment.

Due to potential conflicts of interest the membership of the subgroup excluded GPs. It was proposed that the lay member for patient and public involvement and secondary care specialist were not part of the subgroup in order to provide a more objective focus on the impact on patients as a consequence of decisions that were made on any formal applications.

Comments and questions were invited.

- In relation to the exclusion of the Lay Member from the sub-group, PW would pick up the principles around the quality and safety of patients with DR.
- Denise Cheng-Carter, the CCG's Lay Advisor would be part of the group to provide challenge along with other committee members.
- NS emphasised the need to produce a high level strategy that recognised priorities, direction of travel and working at scale which would give a clear outline for our expectations around any bids..
- Output from the sub-group to be presented at October's CPMSC.

JM concluded that by creating a small sub-group it would help the CCG manage estate applications. The group would set principles and these would come back to this committee, excluding GPs from the discussions, for validation and approval.

DECISION

The Committee **AGREED** for the time-limited Estates sub-group to be created.

21/20 DATE AND TIME OF NEXT MEETINGS IN PUBLIC

The Committee **NOTED** that the next meeting would take place on:

NHS Calderdale Clinical Commissioning Group

Calderdale Primary Medical Service Committee
Decision Notice

Report circulated 3 September 2020

Due to the COVID 19 public health emergency this single item meeting did not take place in public.

A virtual committee meeting was help with a single paper circulated on 3 September 2020 for decision by the committee members via email.

DECISION NOTICE

Member Recipients			
	Neil Smurthwaite	NS	Interim Accountable Officer
	John Mallalieu	JM	Committee Chair, Lay Member, Finance and Performance
	Lesley Stokey	LS	Interim Chief Finance Officer
	Alison MacDonald	AM	Lay Member, Patient and Public Engagement
	Dr Rob Atkinson	RA	Secondary Care Specialist
	Prof Rob McSherry	RM	Registered Nurse
	Dr Steven Cleasby	SC	GP Member
	Dr James Gray	JG	GP Member
Other recipients	Debbie Robinson	DR	Head of Primary Care, Quality and Improvement
	Emma Bownas	EB	Senior Primary Care Manager
	Neil Coulter	NC	Senior Primary Care Manager– NHS England/Improvement
	Tim Swift	TS	Council Leader and Chair of the Calderdale Health and Well Being Board
	Rob Gibson	RG	Corporate Systems Manager
	Helen Hunter	HH	Chief Executive, Health Watch, Kirklees and Calderdale
	Martin Pursey	MP	Head of Contracting & Procurement
	Penny Woodhead	PW	Chief Quality & Nursing Officer

Action

1. CONFLICTS OF INTEREST

There were no conflicts of interest declared.

The 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.

2. PROCESS FOR URGENT DECISIONS

The paper circulated proposed the establishment of urgent decision making arrangements for matters relating to COVID-19 that could not wait until the next scheduled committee meeting for decision.

In their responses, committee members were supportive of the proposal to establish the urgent decision making process and underlying rationale for the process being put in place. They recognised the reporting plan to the full committee and public, the intention to utilise the full committee where timing allowed and the intention to review the arrangements in three months' time.

DECISION:

That the Committee **approve** the urgent decision making process.

3. DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

Thursday 15 October 2020, 3.00pm, Video Conference

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Minutes of the meeting held in public on Tuesday 7th July 2020

Held virtually by Microsoft Teams

Members	Initials	Role and organisation
Marie Burnham	**MB**	Independent Lay Chair
Richard Wilkinson	**RW**	Lay member
Stephen Hardy	**SH**	Lay member
Dr James Thomas	**JT**	Chair, NHS Bradford District and Craven CCG
Michelle Turner	**MT**	Strategic Director of Quality and Nursing, Bradford District and Craven CCG
Dr Steven Cleasby	**SC**	Chair, NHS Calderdale CCG
Neil Smurthwaite	**NS**	Deputy Chief Officer, NHS Calderdale CCG
Dr Steve Ollerton	**SO**	Chair, NHS Greater Huddersfield 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
Apologies		
Helen Hirst	**HH**	Chief Officer, NHS Bradford District and Craven CCG
Dr Khalid Naeem	**KN**	Chair, NHS North Kirklees CCG
Dr Charles Parker	**CP**	Chair, NHS North Yorkshire CCG
Amanda Bloor	**AB**	Chief Executive, NHS North Yorkshire CCG
In attendance		
Esther Ashman	**EA**	Programme Director, Commissioning Futures
Stephen Gregg	**SG**	Governance Lead, Joint Committee of CCGs (minutes)
Ian Holmes	**IH**	Director, WY&H HCP
Anthony Kealy	**AKe**	Locality Director WY&H, NHS England & NHS Improvement
Catherine Thompson	**CT**	Improving Planned Care
Jonathan Webb	**JWb**	Director of Finance Lead, WY&H Health and Care Partnership

Item No.		Action
76/20	**Welcome, introductions and apologies**	
	The Chair welcomed everyone to the meeting, and apologies were noted. As a result of the COVID-19 restrictions, this was the first in public since January 2020 and was being held via Microsoft Teams. Members of the public were able to watch the livestream of the meeting.	

Item No.		Action
77/20	**Chair's update**	
	The Chair noted that since the last meeting, partners had been dealing with the impact of the COVID-19 pandemic. Staff in all organisations had played a huge part in responding to the pandemic, and the Chair thanked them for their hard work and commitment. COVID-19 had also meant that we had refocused and reprioritised our work as a Partnership. In such challenging times, collaborative working was more important than ever. The Chair noted changes in the commissioning landscape. The Bradford and Craven CCGs had merged to form a single CCG. Harrogate CCG had merged to form North Yorkshire CCG, which was now an associate member of this Committee. The Chair proposed a vote of thanks to members who had left the Committee – Andy Withers, Gordon Sinclair, David Kelly and Sohail Abbas. She also thanked Richard Wilkinson who was attending his last meeting.	
78/20	**Questions and deputations**	
	The Chair advised that because the meeting was being held virtually, questions would be handled differently today. Members of the public had been invited to send questions to the Partnership Team so that a member of our team could read them out on their behalf. One question had been received: **Question:** What, in the view of the JCCC, have been the effects on WYH ICS's ability to respond to the Covid-19 Pandemic, of: a) decade-long cuts to NHS funding, hospital beds and clinical staff - including ICU beds and staff? b) the government's failure to promptly authorise and direct widespread testing and tracing, from the start of the pandemic? c) the government's failure to source and provide adequate PPE? These questions were followed by a number of more detailed questions. As the questions largely related to the wider Partnership rather than the Joint Committee specifically, it was agreed that a written response would be prepared, drawing on the comments of partners.	
79/20	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. There were none.	
80/20	**Minutes of the meeting in public – 14 January 2020**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 14 January 2020, subject to the correction of a minor typographical error.	
81/20	**Actions and matters arising – 14 January 2020**	
	The Joint Committee reviewed the action log.	
	The Joint Committee: Noted the action log.	
82/20	**Joint Committee governance**	
	SG presented an update on key governance issues.	

Item No.		Action
	COVID had significantly disrupted governance arrangements and some 'business as usual', including approval of the Committee's annual report, had been carried out 'virtually'. Programmes had been refocussed and the existing Joint Committee work plan had largely run its course, which had meant that there has been no requirement for the Joint Committee to take any formal commissioning decisions during the lockdown. In March, members had agreed that a revised MoU and work plan be presented to the individual CCGs for approval. The main changes were the delegation of new commissioning decisions and changes in Committee membership, with North Yorkshire CCG becoming an associate member, able to contribute to the discussion but not to vote. The new MoU and work plan would come into effect once it had been approved by all of the West Yorkshire CCGs. The risk framework would be refreshed to reflect the Committee's new work plan. CCG mergers had meant that the PPI Assurance Group now had a core membership of only 5. SH said that further work was being done on the membership and role of the PPI Assurance Group to enable it to continue its core role of providing assurance to the Joint Committee. JW noted the importance of the Group drawing on the wide range of engagement activity that was taking place across all Partnership programmes.	
	The Joint Committee: a) **Noted** the 2019/20 annual report. b) **Noted** the progress in agreeing the new MOU and work plan and that the MoU would be presented to the Accountable Officers once it had been agreed by all of the CCGs. c) **Requested** that an agenda planner, based on the revised work plan, be presented to the meeting in public in October, together with the refreshed risk framework. d) **Requested** that further work be done to explore the future membership and role of the PPI Assurance Group.	**SG**
83/20	**Our response on COVID-19: Implications for the Joint Committee**	
	IH report on the response of the health and care system to the initial surge in the COVID-19 pandemic. As we moved to a more stable situation our focus was turning towards how we continue to meet the needs of people with COVID and other conditions. The paper set out the approach and how we had refocused our programmes to support the response. In this uniquely fast moving environment, priorities and pressure points would change frequently and an agile response was essential. While the specific focus of our work had changed, our Five year plan continued to set the high level objectives. The report included revised summary plans for each of the work programmes where decisions had been delegated to the Joint Committee. Alongside stabilisation and reset, the main development which would influence the Joint Committee's future priorities and approach was the commissioning futures work. Moving forward, the Committee's work plan and role would evolve to reflect these new priorities. JT noted the need for the Committee to be involved in the further development of the commissioning futures work. JW confirmed that an update on the work would be brought to a future meeting.	**JW/EA**

Item No.		Action
	The Joint Committee: a) **Noted** the approach set out in response to the pandemic, and the programme priorities for the next phase of the response. b) **Noted** the next steps to develop a revised forward plan for the Joint Committee based on these new priorities.	
84/20	**Improving Planned Care: Programme Refresh**	
	CT presented a summary of the changes to the Improving Planned Care programme as a result of the response to COVID-19. The proposed new priorities supported the stabilisation and reset of health and care services and included: • A single programme of work bringing together the Elective Care programme and the WYAAT Elective Surgery programme, under new leadership and overseen by a new Alliance Board. • Supporting places with restarting planned care and limiting the growth of waiting lists. This included a bid for a proposed elective care 'hub'. • Optimising the use of diagnostic capacity. • Supporting a different approach to pathways, focusing on prevention, shared decision-making between primary and secondary care and personalisation. Elements of the pre-existing work programme had been re-started where they supported the re-start of planned care, for example time-critical eye services. SO highlighted the need to manage carefully the transfer of work between primary and secondary care. JW acknowledged that the impact of changing pathways would be felt across the system and that effective partnership would be needed. TR noted the need to be clear that the work at WY&H level and in particular the elective care 'hub' would support work at place level. He also noted the need to join up work with places and other Partnership programmes around prevention. CT noted the importance of putting the health of the population at the centre of the Programme's work. She added that the Programme was working closely with other programmes on shared care, personalisation and prevention. JT noted the need to embed personalised care within all Programmes. The Clinical Forum supported the need to focus on population health and to ensure that learning was shared effectively across the Partnership. IH welcomed the establishment of a system-wide Programme designed to support place. SC highlighted the critical importance of the Programme, which would involve fundamental transformation across the system. Strong relationships and clinical leadership would be needed to ensure that shared responsibility was embedded across the whole system. JW added that system transformation was needed to ensure that capacity was used effectively to improve outcomes and reduce inequalities. Winning 'hearts and minds' would be key.	
	The Joint Committee: a) **Noted** the integration of the two programmes to form the Improving Planned Care programme b) **Supported** the proposals to address access to diagnostic testing and elective surgery c) **Supported** the proposals to address referrals and support proactive approaches to managing planned care. d) **Recommended** that CCGs take the proposals back into their individual CCGs for further consideration.	

Item No.		Action
85/20	**Any other business**	
	RW thanked the Chair and members for their support and for their contribution to the work of the Joint Committee over the past 3 years.	

Next Joint Committee in public – Tuesday 6 October 2020, 11am – 1pm.

Name of Meeting	Governing Body	**Meeting Date**	16/10/20
Title of Report	**Patient Story - Update on the involvement of children and young people in our work on THRIVE and Autism Spectrum Disorder**	**Agenda Item No.**	16
Report Author	Rhona Radley, Deputy Head of Service Improvement	**Public / Private Item**	Public
GB / Clinical Lead	Dr Caroline Taylor, GP Governing Body member	**Responsible Officer**	Debbie Graham, Head of Integration and Partnerships

Executive Summary							
Please include a brief summary of the purpose of the report	The purpose of this paper is to: ▪ update Governing Body and celebrate the involvement of Calderdale's children and young people (CYP) in the delivery of THRIVE and the work by our system to better meet the needs of children and young people, including those with Autism Spectrum Disorder (ASD); ▪ illustrate the difference this makes to our work, and planned next steps; ▪ inform Governing Body about some key issues arising from the impact of COVID-19 and how these are being addressed. This paper also provides additional detail on THRIVE, a person-centred, whole system approach for meeting the emotional wellbeing and mental health needs of needs of children and young people in Calderdale. This relates to the personal story presented via video by two of the young people helping shape our work. We have also included in Appendix 2 the Young People's Personal Statements from the ASD '*Find Your Brave'* Summit held in February 2020, as well as providing some key links (footnotes 5-7) that showcase some of the work of Tough Times. Some of the young people involved in this work are attending today's meeting to have a conversation with Governing Body about their involvement.						
Previous consideration	**Name of meeting**	CCG Senior Management Team	**Meeting Date**	07/10/2020			
	Name of meeting		**Meeting Date**				
Recommendation (s)	It is recommended that the Governing Body **1. NOTES** the significant contribution made by all the children and young people who are involved in shaping how mental health and emotional wellbeing services are designed and delivered for them. This includes those who designed and led the '*Find Your Brave*' Summit in February 2020 and who helped create the video shown today. 2. **NOTES** the key issues arising from the impact of COVID-19 and **RECEIVES ASSURANCE** of how these are being managed as a system by the Open Minds Partnership.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications						
Quality & Safety implications		The THRIVE Model has a national evidence base which supports the clear identification and mitigation of risk for individual service users.				
Engagement & Equality implications		The Tough Times Reference Group continues to be fully engaged in the ongoing delivery of THRIVE in Calderdale. Involving children and young people with ASD, and parent carers is an integral part of how Open Minds, the Open Minds Partnership and the ASD Steering Group operate.				
Resources / Finance implications		Commitments on THRIVE and ASD services for children and young people are reported as part of the Mental Health Investment Standard (MHIS).				
Has a Data Protection Impact Assessment (DPIA) been completed?		**Yes**		**No**		**N/A** X
Strategic Objectives	Achieving the agreed • strategic direction for • Calderdale • Improving quality • Improving value	**Risk**			Risk 1338 – CYP access to timely mental health (MH) services in particular 'at risk' cases for ASD & ADHD (Attention Deficit Hyperactivity Disorder)	
Legal / CCG Constitutional Implications	None	**Conflicts of Interest**			Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.	

1. Introduction

1.1 The purpose of this paper is to:

- update Governing Body and celebrate the involvement of Calderdale's children and young people in the delivery of THRIVE, and the work by our system to better meet the needs of children and young people, including those with Autism Spectrum Disorder (ASD);
- illustrate the difference this makes to our work, and planned next steps;
- inform Governing Body about some key issues arising from the impact of COVID-19, and how these are being addressed

1.2 This paper also provides additional detail on THRIVE, a person-centred, whole system approach for meeting the emotional wellbeing and mental health needs of needs of children and young people in Calderdale. This relates to the personal story presented via video by two of the young people helping shape our work. We have also included in Appendix 2 the Young People's Personal Statements from the ASD '*Find Your Brave*' Summit held in February 2020 as well as providing some key links (footnotes 5-7) that showcase some of the work of Tough Times.

1.3 Some of the young people involved in this work are attending today's meeting to have a conversation with Governing Body about their involvement.

2. Detail

2.1 Background

> *"The voice of children and young people has driven our transformation…We aim for children, young people and parents to be actively involved in all aspects of our work including supporting them to effectively challenge providers if services offered do not meet expectations…"*
>
> (Source: Calderdale Local Transformation Plan[1])
>
> *Children, young people and their families have a central role in deciding what success would look like for them, knowing that there will be 'no decisions about me, without me'.*
>
> (Based on the the Anna Freud Centre *THRIVE Framework* principles)

2.2 One of the key themes of the Calderdale Vision 2024 is 'Kindness and Resilience'. This states that we need to do more of [taking a] "*Partnership approach to mental health in workplaces and schools*.[2]"

2.3 This is what the Open Minds Partnership (OMP) aims to achieve (and more), in delivering THRIVE in Calderdale. The OMP is a cooperative of local authority, NHS, education, voluntary and third sector organisations working together to ensure Calderdale's children and young people have access to the emotional wellbeing and mental health support and services they need. The name of this cooperative was conceived by young people from the Tough Times campaign, back in 2015.

The OMP vision is: *To move away from a system defined by services and organisations to one built around the needs of children, young people and their families, offering choice and control, intervening early and building long term resilience.*

2.4 The involvement and participation of our children and young people is integral to the successful delivery of THRIVE and Open Minds Partnership ways of working, including our work on ASD. The responsiveness of our system to what children and young people tell us about how their mental health and emotional wellbeing services should and are designed and delivered, is one of the things that helps make Calderdale distinctive.

2.5 Governing Body previously received a report (October 2019) describing progress made by the core mental health providers (particularly Northpoint and South West Yorkshire Partnership NHS foundation

[1] https://www.calderdale.gov.uk/v2/sites/default/files/Calderdale-local-transformation-plan.pdf
[2] https://www.calderdale.gov.uk/vision/#themes

Trust (SWYPFT)) in delivering THRIVE, and lessons learned by the OMP. However, the OMP felt it would be timely to share some more recent highlights related to THRIVE, how this is influencing our system approach, and give our young people the opportunity to describe their experiences and dreams for Calderdale, in their words.

3. THRIVE – a brief reminder

3.1 THRIVE, a model of care developed by the Anna Freud Centre and adopted in Calderdale[3], is based on the concept that around 80% of children and young people at any one time experience the normal ups and downs of life but do not need individualised advice or support around their mental health issues. They are considered to be 'Thriving' (the central yellow circle in Figure 1 below).

The remaining 20% receive support and access to resources at any time from the most appropriate service that meets their needs, in the form of 'Getting Advice' (green), 'Getting Help' (blue), 'Getting More Help' (purple) or 'Getting Risk Support' (orange).

Figure 1

3.2 THRIVE is a person-centred, whole system approach, where responsibility for meeting the emotional wellbeing and mental health needs of needs of children and young people **is everyone's business.**

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

In addition, their needs **shouldn't and aren't always solely provided by** statutory mental health providers, Northpoint and SWYPFT (which is the old Child and Adolescent Mental Health Services (CAMHS) model). All agencies, including the third sector, such as Noah's Ark, Kooth and Which Way Up who work closely together **in partnership** to offer a rich diversity of support and **evidence-based treatment** that can meet the different needs of our young population and their families.

3.4 This concept – so different to CAMHS – has proved to be a challenge for some to understand.

Jayden (They, Their), kindly agreed to describe their own THRIVE journey for a video, with the voiceover provided by Shannah. Both are members of the Tough Times Group. The video, which accompanies this paper, aims to illustrate to Governing Body how THRIVE works in practice.

4. How we involve children and young people in delivering THRIVE

4.1 One of the contributing factors making it possible to implement the THRIVE model effectively in Calderdale is the leadership and commitment shown by the Local Authority and partners in the Emotional Wellbeing Taskforce to deliver the Local Transformation Plan (LTP).

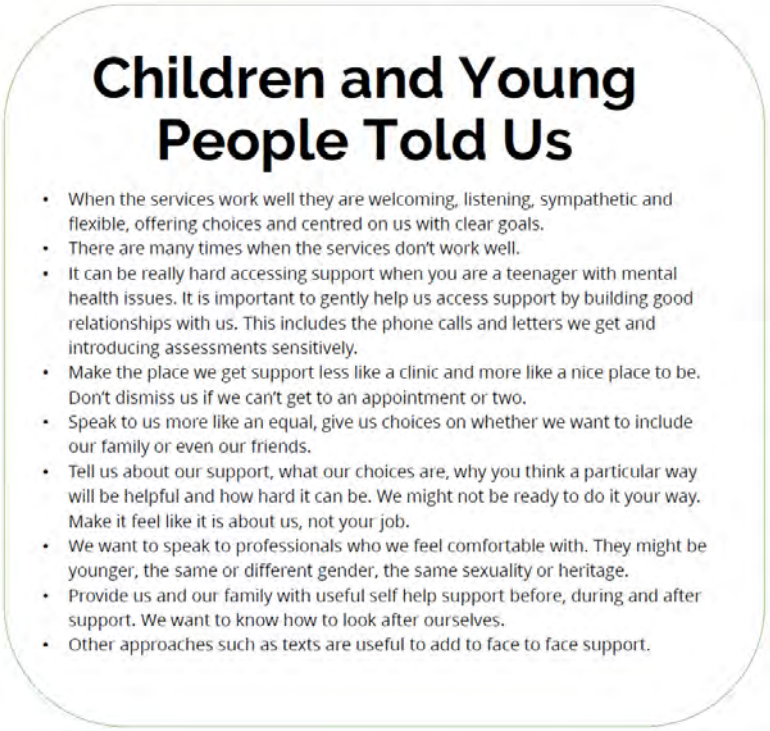
4.2 First developed in 2015, successive LTPs have prioritised offering children and young people access to a range and choice of early intervention and prevention services which support their resilience and self-care. This has provided a solid foundation from which to move forward with THRIVE. Each refresh of the

[3] The key principles of THRIVE are provided in Appendix 1.

LTP documents what has been achieved and how children and young people have shaped the way services are delivered in Calderdale.

4.3 Some key highlights about THRIVE to share with Governing Body include:

4.4 **Workforce Action Plan:** Our young people have been working with the core mental health providers to implement a workforce action plan focused on ensuring providers recruit, train and retain qualified staff who not only work together in partnership but also represent the communities they serve. This was developed following a workforce skills audit carried out within the Open Minds Partnership by an independent external consultant, informed by the views of children and young people:



4.5 **Young People's Survey:** Calderdale children and young people aged 5 – 19 (up to 25 for those with learning difficulties or disability) shared their experiences of mental health and emotional wellbeing in a survey designed by Calderdale Youth Council and the Tough Times Reference Group. The survey closed late February 2020.

4.6 **Anna Freud Centre Cascade Training:** The first of two Anna Freud Centre *Mental Health Services and Schools Cascade Training* workshops was delivered in February 2020. Funded by the Department for Education, this innovative programme has brought together over 50 professionals from schools and colleges, mental health providers and other key stakeholders across Calderdale. It aims to encourage closer working by all those providing mental health and wellbeing support to children and young people as part of THRIVE and the Open Minds Partnership. The second workshop will take place digitally on 11 November 2020.

4.7 **Wider Open Minds Partnership (OMP):** The Local Transformation Plan, managed by the Calderdale Emotional Health and Wellbeing (EHWB) taskforce, reached the final year of its five year timeframe this year (2020). At the same time, partnership working by the Open Minds Core Group (comprising the core mental health providers and commissioners), reached a level of maturity and readiness to broaden participation and further enhance system working.

The two groups joined together with young people in the Tough Times Group to form a wider OMP, digitally, in June 2020. A summary of Tough Times' recent key achievements, which they presented at the meeting, can be found in Appendix 3.

Meeting quarterly, the second meeting of the combined OMP group takes place in October 2020. The OMP will focus on establishing a work plan to focus on delivery of the NHS Long Term Plan CYP mental health commitments, the remaining areas for improvement from the Local Transformation Plan, and the Young People's Survey Action Plan. It will also discuss how the OMP can support children and young people who returned to full education following the COVID-19 lockdown, and the professionals working with them.

4.8 **Mental Health Support Teams (MHST):** In 2020, Calderdale was successful in securing NHS England funding for two Mental Health Support Teams (MHST). These teams will help young people directly in schools, by supporting teachers and staff to identify issues young people may have as early as possible, so they can get help and support when they need it. Their work is even more important in alleviating the impact of the COVID-19 Pandemic.

- Six secondary and seven primary schools were selected through an Expressions of Interest process to take part in Year 1 of the project.
- Calderdale College and three schools have been invited to take part in Year 2.
- One other school has been offered support and development to work with mental health providers in Year 1 outside of the MHST project, and will be invited to reapply for Year 2.

The recruitment process to create the MHSTs included young people on interview panels, and they also are members of the Calderdale MHST Steering Group who provide oversight for the project. An update on the MHST project can be found in Appendix 4.

5. Involvement of children and young people in system work focused on Autism Spectrum Disorder (ASD)

5.1 In January 2019, system leaders, community representatives and elected members attended Calderdale's first Children and Young People's Autism Spectrum Disorder (ASD) summit. Here they pledged to transform the experiences and outcomes of children and young people, and take positive Action on Autism.

5.2 A second Calderdale Children and Young People's ASD Summit ***"Find Your Brave"***: was held during National Children's Mental Health Week in February 2020. Calderdale young people with Autism Spectrum Disorder (ASD) designed and led a Marketplace event and stakeholder summit at North Bridge Leisure Centre. They provided artwork, told participants their personal stories and read their dreams for Calderdale. This provided such a powerful insight into the changes that still need to occur across the system for children and young people.

5.3 Some of the dreams they shared with us at the start of the evening can be found in **Appendix 2.**

5.4 System leaders gave an update on the 2019 pledges to transform the experiences and outcomes of children and young people, and take positive action on Autism. Partners celebrated the progress made since then and participants identified together how we all can continue the journey together in transforming the way we think, organise and operate in Calderdale. The Summit provided renewed focus, energy and commitment by partners to transforming ASD services for the Children and Young People of Calderdale.

6. Addressing the impact of COVID-19

6.1 Impact of COVID-19

6.1.1 In advance of the lockdown phase of the pandemic Open Minds Commissioners, providers and partners moved swiftly to plan their initial responses, and agree business continuity plans and governance mechanisms. Government guidelines on how statutory, third sector, primary care, secondary care and community services should be safely delivered during lockdown have been adhered to, to ensure risks to the public and members of staff are managed and mitigated.

6.1.2 New or revised management systems and processes were quickly established to support the workforce, and provide continuity of service for children and young people, including safe crisis care. The Open Minds First Point of Contact (FPoC) has continued to accept referrals throughout the Pandemic – over the telephone, email or via the web site. Case work and activities with children and young people which did not have to be delivered face-to-face continued where possible, either over the phone, via video-calls/web sites. Third sector services have either continued to accept new referrals, work with their existing clients or developed digital offers, depending on the staffing and capacity of each service.

6.1.3 Face to face appointments were arranged in line with UK Government guidance, for specific or exceptional circumstances, such as crisis and Eating Disorder.

6.2 Working with children, young people and partners during COVID-19

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

6.2.2 A digital anxiety programme introduced by the Open Minds First Point of Contact (FPoC) was developed with input from young people in Calderdale via the Tough Times Group. This provides online Cognitive Behavioural Therapy (CBT) informed support in addition to other digital tools available to young people in Calderdale.

6.2.3 Members of the Open Minds Partnership have continued to work with young people to develop, check and share a range of emotional health and wellbeing resources via the Calderdale Open Minds web site[4]. These include how to manage concerns and anxieties about coronavirus, and Worry Cards[5]. Developed by young people, the Worry Cards aim to help decrease stress levels about any worries or queries students might have, especially those who'd not accessed formal education since March 2020.

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

6.2.4 Tough Times created a poster[6] to promote the services available to support children and young people during COVID-19. This has been promoted widely by providers and partners throughout Calderdale.

6.2.5 Additional resources to support children and young people returning to education following lockdown include:

- bespoke return-to-school guides developed with, and for Calderdale's students, parents, and school staff. Partners, including Healthy Futures, School Nurses and the third sector, have supported students, families and staff throughout the Pandemic[7];

- a 'Wellbeing for Education Return' project being delivered in the Autumn 2020 term. Using new training resources provided by the Department for Education, Calderdale MBC, in collaboration with OMP partners, will use a small DfE grant to build on existing local initiatives to provide additional support to staff in state-funded schools and colleges. The aim is to help them better support students returning to education during the COVID-19 pandemic.

6.3 **Neurodevelopmental assessments, including for Autism (ASD)**

6.3.1 The priority of Open Minds throughout each phase of the Pandemic is keeping children, young people, families and staff safe. Open Minds has, with wider partners, kept their delivery approach under regular review. The service has continued to accept and triage referrals and complete background case work since the start of the Pandemic. There continues to be regular communications and updates between partners, and for a range of other stakeholders including: children, young people and parent carers, health and social care partners and education settings.

6.3.2 The timing, number and location of face-to-face appointments, which are a key part of the ASD assessment process, have been directly affected as a result of national and local guidance. Face-to-face appointments had to cease for children and young people newly referred to the First Point of Contact.

6.2.3 In addition, a number of children and young people who began their ASD assessments before COVID-19 experienced a pause because of the Pandemic. Open Minds continued to work with these children's assessments, where possible, via telephone appointments, gathering information from other services, or by providing socially distanced face-to-face appointments.

6.3.4 Our system restarted providing a reduced number of COVID-secure face-to-face neurodevelopmental appointments (ASD and ADHD) from July 2020, starting with conversation-based appointments with older children/young people (as opposed to play-based appointments with younger children). The reduced number is a result of the extra time needed between appointments to clean rooms, and arrange safe staffing in line with social distancing guidelines. It is worth noting that within the West Yorkshire and Harrogate Health Care Partnership, Calderdale was one of the first areas to restart these sessions.

6.3.5 ASD services across West Yorkshire have reported an increase in referrals since COVID-19. It is proving difficult to benchmark waiting times/numbers due to the variance between the commissioned and provided models, for example:

a) **Integrated Pathways**: there has been a national steer for services to move towards more joined up and integrated pathways for children and young people with complex needs. Services have been moving towards neurodevelopmental pathways (combining ASD/ADHD referrals). The integrated pathway works best for everyone, such as:

- children and young people: due to practitioners and services becoming more joined up, they tell their story once and are assessed once;
- families: as they know their needs are being recognised and met in the most effective way and;
- services: as a joined up approach also reduces duplication and ensures most effective use of resources.

N.B. *neurodevelopmental* assessments take longer and therefore fewer assessments are undertaken on a monthly basis, impacting on waiting times and lists.

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

b) Service Provision: some areas commission a pathway from one provider, whereas others have split pathways consisting of two providers - one for pre-school (Acute Paediatrics) and another for school-age (Mental Health Trusts). In Calderdale the current pathway is split between Calderdale and Huddersfield NHS Foundation Trust (CHFT) for pre-school and SWYPFT for school-age children and young people. Our intention pre-COVID was to move towards an integrated neurodevelopmental pathway.

c) Recording Activity: across the patch there are different approaches to recording waiting times activity. Most providers across West Yorkshire 'stop the clock' at the first appointment. However, Bradford 'stop the clock' at diagnosis outcome, hence a huge variance in the number of children and young people classed as 'waiting'.

CCG	Pre-COVID waiting times	Current waiting times	No. children & young people waiting
Bradford	24 months	36 months	1,433
Calderdale	12 months (school-age)	18 months (pre-school) 24 months (school-age)	Pre-school: 109 School-age: 187 ASD 247 Neuro (ASD/ADHD commenced Sept 2020)
Kirklees	6 months	12 months	700
Leeds	*Not provided*	5 ½ months	510
Wakefield	26 weeks (for assessment)	12 months	*Not provided*

6.3.6 The pre-COVID commitment was for Calderdale to reach a 12 month waiting time for school-age children and young people referred for ASD by 31 March 2020. As a result of the number of new referrals and having to cease face-to-face appointments during the earlier stages of the Pandemic, the waiting time has now reached 24 months.

6.3.7 Calderdale CCG service improvement, finance and contracting teams are working closely with providers to review demand and capacity, risks and mitigating options to reduce the waiting time. This work forms part of the wider Mental Health, Learning Disability and Autism (MHLDA) Reset plans currently underway. Oversight of this work is provided by the Open Minds Core Group, Senior Operational Group, Senior Management Team and Quality, Finance and Performance Committee, and further updates will be provided on the outcome of this initial reset work.

Following the '*Find your Brave*' Summit in February 2020 the Neurodevelopment (ASD/ADHD) Sub Group (a range of Calderdale partners and parent/carer representatives) are focusing on ensuring children and young people and their families/carers have timely access to support from the system regardless of a diagnosis. This requires a commitment from all partners across the system to review and change the way services are delivered.

7. Next steps for involving children and young people

7.1 **Workforce Action Plan:** many of the actions in the plan have either been completed or are in the process of being embedded as part of business-as-usual by the core mental health providers (after a slight delay due to COVID-19).

7.2 **Young People's Survey:** young people have created an action plan, to be shared at the October 2020 wider Open Minds Partnership meeting. This will be used to inform the Partnership's new work plan.

7.3 **Outputs from the '*Finding Your Brave'* Summit:** Inspired by the experiences of our young people shared at the '*Find Your Brave'* Summit, partners applied a renewed focus, energy and commitment to identify how we can all continue the journey together in transforming the way we think, organise and operate ASD services for the Children and Young People of Calderdale.

During Spring and Summer 2020 The ASD Steering Group held a series of 'deep dive' workshops to identify areas for further action.

THRIVE tells us that,

- systems and partners should work together in partnership as a whole system;
- we should help children, young people and their communities to bolster their resilience;
- the child or young person should receive support at any time from the most appropriate services and resource that meet their needs, not be driven by a specific diagnosis;
- their needs shouldn't be solely provided by statutory mental health providers, Northpoint and SWYPFT, other partners can meet their needs too.

A new action plan has been developed which is aligned to the THRIVE principles. It focuses on providing and promoting **early** intervention services and support for children, young people and their families, regardless of whether they have diagnosis of ASD or ADHD. This includes for example, attachment or behavioural issues, anxiety, managing transitions, meeting a child/young person's sensory needs.

The challenge is to ensure ALL organisations recognise the need to work together to improve access for children and young people with ASD/ADHD. The system needs to change together in offering choice and timely access to our children.

7.4 **Open Minds Partnership:** Children and Young People will continue to be involved in shaping and delivering the group's work plan.

7.5 **MHST:** The views, experiences and feedback from children and young people involved in the project will provide valuable insights that will be used to ensure the project achieves its objectives, and positive outcomes for children and young people.

8. Implications

8.1 Quality & Safety Implications

8.1.1 The THRIVE Model has a national evidence base which supports the clear identification and mitigation of risk for individual service users. The experiences of children and young people, and their families in the delivery of THRIVE are gathered and used to improve how services are delivered in Calderdale.

8.2 Engagement & Equality Implications

8.2.1 Involving children and young people with ASD, and parent carers is an integral part of how Open Minds, the Open Minds Partnership and the ASD Steering Group operate. The Tough Times Reference Group is an important group which continues to be fully engaged in the ongoing delivery of THRIVE in Calderdale.

8.3 Resources / Finance Implications

8.3.1 Commitments on THRIVE and ASD services for children and young people are reported as part of the Mental Health Investment Standard (MHIS).

8.4 Risk

8.4.1 Risk 1338 is included in the CCG's Corporate Risk Register relating to children and young people's access to timely mental health (MH) services in particular 'at risk' cases for ASD & ADHD. This is monitored and managed via the Open Minds Data and Contracting Sub Group, Open Minds Core Group, and will also be reported to the Senior Operational Group and Senior Management Team.

9. Summary

9.1 Implementation of the 'Thrive' model has been enabled because of the progress achieved in delivering the since 2015. Applying the THRIVE approach means the people of Calderdale are more likely to live healthy and independent lives, secure in the knowledge that, if they need them, services will be there to keep them safe, supported and cared for.

10. Recommendations

It is recommended that the Governing Body:

1. **NOTES** the significant contribution made by all the children and young people who are involved in shaping how mental health and emotional wellbeing services are designed and delivered for them. This includes those who designed and led the '*Find Your Brave*' Summit in February 2020 and who helped create the video shown today.
2. **NOTES** the key issues arising from the impact of COVID-19 and **RECEIVES ASSURANCE** of how these are being managed as a system by the Open Minds Partnership.

11. Appendices

Appendix 1: Principles of the THRIVE framework

Appendix 2: Dreams of the young people who designed the Calderdale Children and Young People's ASD Summit 2020: "*Find Your Brave*"

Appendix 3: Tough Times Reference Group achievements (June 2020)

Appendix 4: Calderdale MHST Project update

Appendix 1: Principles of the THRIVE framework

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

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

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

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

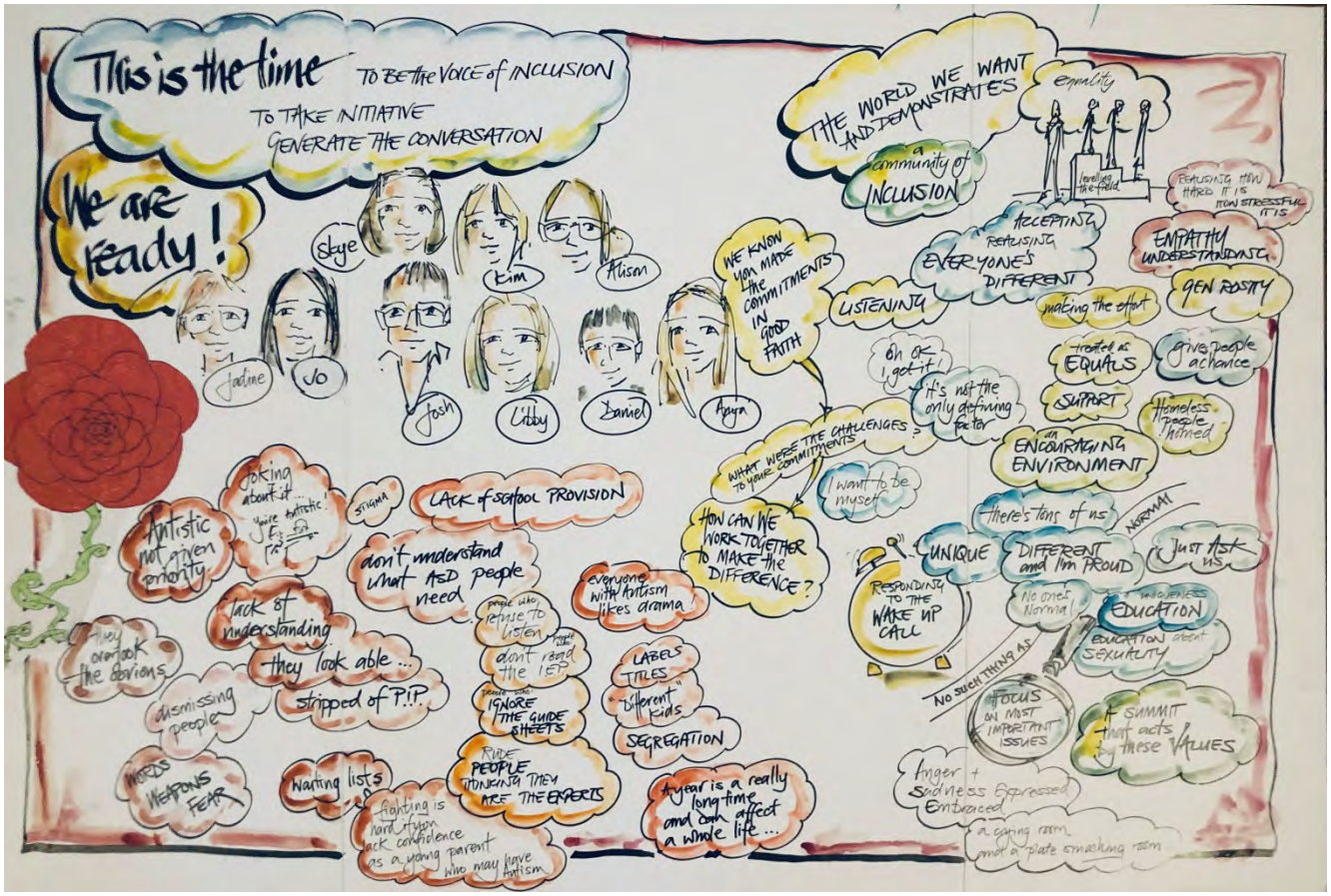
   In addition, their needs shouldn’t and aren’t always solely provided by statutory mental health providers, Northpoint and SWYPFT (which is the old CAMHS model). Other agencies, including the third sector, offer a rich diversity of support that can meet the different needs of our young population and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

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

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

Appendix 2: Dreams of the young people who designed the Calderdale Children and Young People's ASD Summit 2020:

"Find Your Brave"



Autism Summit Speech
Introduction by Anya:

Hi and thank you all for coming

Some people may remember me from the last autism summit, where I told my personal story about my journey, so I am pleased to have been invited back along with a group of young people each with experiences of autism, and as a group we have been leading the planning for this event.

We'd like today to be informative as well as a celebration of what has been achieved over the past year, and a collaboration between the different services in Calderdale and it's service users.
We hope you find it useful, educational, and hopefully you can extend what you learn or discuss today throughout your workplaces. So that in the future, those with autism will be supported throughout Calderdale and throughout life.

Hi, my name is Anya, I'm 20 and I attend Leeds Arts University. I decided to use my personal statement to share my dream for Calderdale.

Why I wouldn't cure my autism.
My autism means that I'm not very good at talking.
That I don't like a lot of noise.
Or I consider pressing the train's emergency lever when someone is eating salt and vinegar crisps.
It means that I see small flaws and obsess over them.
That sometimes I take things too literally.
And it means that I have to try really hard, maybe harder than others, to achieve what I want to.

But my autism also gives me the dedication I need so that I will achieve my goals.
My goals of going to university, of moving out, of meeting new people and of getting a creative job where I can be the best version of myself and work to the best of my abilities.
A job where I can let my autistic self be free.
My autism makes me the artist that I am and the artist that I want to be.
It gives me the ability to see and think differently to others.
The ability to think of unique ideas.

It gives me a unique perspective that not everyone is lucky enough to have.
The ability to see, understand and experience the world differently.
My autism means that I want to create things, good things, bad things.
I want to make and grow.
I want to draw.
I want to illustrate.

Because I'm autistic, I'm constantly reflecting on who I am and what I do.
I'm constantly looking for opportunities where I can grow and improve, I want to challenge myself, as an artist and as a person.
I want to become better at painting; I want to become more confident at taking photographs, I want to travel to new places and have new experiences.
And I have chosen this course because I believe it would provide me with opportunities to Improve my skills and to grow as a person.
Because of my autism, things go wrong, but that means that I'm always learning about myself and how I can grow.
To a point that I feel I know myself better than anyone.

I want other autistic people to have this ability.
So I volunteer for the Calderdale National Autistic Society.
I find it rewarding to know that I'm seen as a role model, that I'm looked up to, and I want to show others that they can achieve the things they really want to do.

So when people ask if I would cure my autism,
I say no,
Because who would I be without it?

This sums up my dream for Calderdale. That with the right support people with Autism can achieve, grow as people, feel proud and live their lives.

Anonymous

The next dream was written by a young adult who wishes to remain anonymous.

I've been to several schools all of which have struggled to meet my needs. I've had to live away from my family to go to autism specific schools. Even these schools struggled with my mental health.

Many many schools (across the whole country) have turned me away because of my mental health. Many mental health services and workers have refused to work with me due to autism and blam it all on autism - even though autistic schools have said it's not all due to autism.

Then I've been rejected or discharged for not engaging - even though I can engage in the right environment with the right adjustments. It's made me feel even worse.

Struggling to engage is not always my fault, clinicians need to use a different set of criteria for autistic people to check engagement. I've also been to mental health hospitals which I'm afraid of going back to.

That makes it hard for me to talk to any NHS staff - as I've been threatened with being sectioned and have been sectioned by 2 psychiatrists for not engaging when I was 14. I was very afraid and now I'm scared to say the wrong thing which means it takes me longer to trust.

I've had to fight really hard to get any support and to even stay alive has been a struggle for over ten years. When I've had suicide attempts that is the only time anyone actually listens and even then they don't LISTEN.

Clinicians are trained to treat and look for signs in Neurotypicals , but don't seem to know enough about autistic people. Each service says it is up to a different service and no one wants to actually help. I've had to almost die to get any support from adult mental health services and the crisis team.

So many people have let me down and said they'll stick around and have not done . All down to my difficulties and then blamed them on me like I've chosen them instead of helping me with them . This includes - mental health services , schools , 1-1 support in schools , respite workers , ASD team , so many different people.

This is what I need

Specific and well trained mental health workers who actually listen and don't judge based on typical patients.
If I say I'm feeling down / suicidal , even if I don't look it , I will definitely be feeling that way.

- *Clinicians and services - to recognise behaviour in communication. So if I'm being challenging I'm having a challenging time and can't communicate or you've not listened to me.*
- *Services - need to let parents be involved and not to tell me that they can't be. We need other ways to communicate like email and text. We also need training on other types of autism like PDA which can mean people have even higher anxiety and also don't always appear on first sight as autistic. There needs to be groups where it's not a sensory overload to attend then I can talk more*
- *Education -I needed an education and a school which could deal with autism and mental health needs. It's clear I can't cope in a mainstream environment, but there's nothing for someone like me and it's meant I've spent most my life at home.*
- *Everyone - I need help with living life and for people to understand why I struggle even if I seem capable sometimes - my struggles are often invisible and I often feel that way.*

Josh:

Hi my name is Josh Hunt, I'm 20 years old, I study an HNC in Animal Management at Kirklees College. I also work as a Calderdale Council park ranger.

I have 47 Chromosome Disorder XYY, which has similar traits to autism.

My dream for Calderdale is to include all students with special needs and autism to be in all main stream classes with other students and not to be excluded. And support to be put in place to allow that.

I hope you have enjoyed listening to my dreams for Calderdale, I am now going to pass you on to Beth.

Beth:

Hi, my name is Beth. I am 19. I work as a swimming teacher and I have Autism and Tourette Syndrome.

My dream for Calderdale is a supportive, inclusive exam system. I struggled to get emotional support for my exams. I have dropped out of education twice: once due to trauma combined with exam stress and one due to exam stress alone. The 1st time I dropped out was the February of my GCSE year. I still got good results but they weren't my best. Everyone deserves to be supported so they can do their best. The 2nd time I dropped out was in the November of my A level year – I did not get any A levels. Instead I decided to become a swimming teacher.

I believe if I had got my A levels I would probably still be a swimming teacher but I would be a swimming teacher with more options which would be nice because options are always nice to have – till you can't decide that is. Emotional support for exams could be as simple as making sure the student isn't under too much pressure and ensuring those who struggle can access support. The support can be as simple as a friendly person who will listen or counselling.

I also found it very difficult to get exam support – it actually took until year 11 for people to notice I wasn't finishing my tests/mocks. I needed extra time, rest breaks, a laptop, purple paper and my own room. I got most of that for my GCSEs apart from my own room but only due to the amazing SENCO I had. I was lucky to have such an amazing and supportive SENCO which many people did not have. I believe this is a standard that should be raised.

The fact I did not get a room by myself did not only hinder my results but others. My Tourettes can be quite loud and disruptive. By the time it got to A level time the supportive SENCO had left and the new SENCO tried to take away my rest breaks as well. The solution to this problem is seemingly simple – stop treating people with autism and other conditions like a statistic. They all need differing levels of support in exams and not giving that to them may effect funding in a positive way but it will also affect their exam results in a negative way.

I believe if I had the option I would have not gone down the exam route. If I was given the opportunity I would have probably only done practical exams/coursework based qualifications. There should be the realisation that not everyone flourishes in standardised tests and the implementation of an alternative. There is already the alternative of BTECs but it is not yet quite big enough. The alternative as I have already mentioned could be a practical exam or course work. This dream is bigger than Calderdale but has to start somewhere and I think Calderdale is the ideal place.

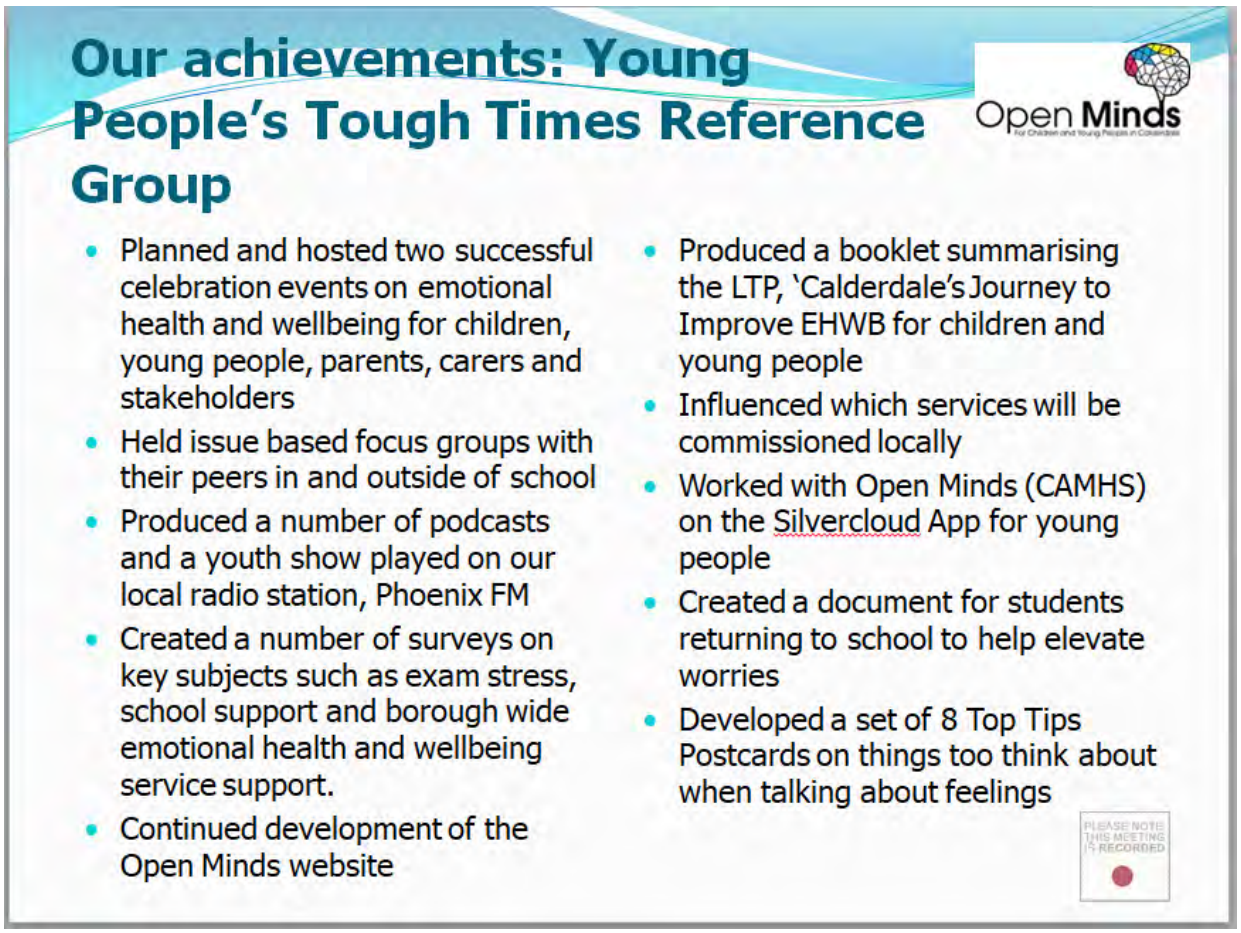
My equally important dream is for inclusion. This includes socially, in mental health and in educational settings.

I believe the main thing that will turn exclusion into inclusion is education on Autism and action against discriminatory behaviours. In schools, where possible, people with ASD and associated conditions should be included in the general school population. This would be done through education early on in school life of Autism and co-occurring conditions in RPSE. For this the staff would also need properly educating on Autism as at the moment it seems only the SENCO is properly educated. This has resulted in some staff telling me off due to my Autistic and Tourettic behaviour. I regularly got sent out of class to get water during a level for hiccups, when actually it was a tic that would not be helped by water.

There also needs to be further education on Autism for mental health services. I had a mental health nurse in CAMHS which stopped as I did not engage due to me not liking the person. They believed it was due to my Autism and stopped. I think it would have been possible for me to engage with someone different but they did not try again. This led to me going to a charity called Turning Point who I engaged with. This charity should not have had to pick up the slack because CAMHS did not let me try again. Even if it was my autism that meant I did

not engage they should have tried again with a different person or different therapy even. CAMHS need to let people with autism have a good chance at getting therapy by not giving up on their first attempt. It may take several different people or several different therapies but people with autism can engage with therapies.

Appendix 3: Tough Times Reference Group achievements (June 2020)



Appendix 4: Calderdale MHST Project update

Calderdale Mental Health Support Team Partner Update September 2020

We are pleased to inform you that:

We have recruited (starting at different points over September and October)

- ⇒ Team Leader: Ian Wood
- ⇒ Senior Clinicians: Nicola Kulyn and Lauren Smith
- ⇒ Clinicians: Caroline Baker, Sally Charles, Tanika Elliot

We have chosen the following schools for Year 1 (training and setup year):

Secondary	Primary
The Brooksbank School	Holy Trinity
Trinity Academy	Todmorden CE (A) J I & N School
Todmorden High	All Saints' CE J&I School
Brighouse High School	Bolton Brow Primary Academy
Ryburn Valley High School	New Road Primary
Lightcliffe Academy	Copley Primary School
	Colden J&I School

With these additional schools and College from November 2021:

Calderdale College, Park Lane Academy, Old Earth School (TBC) and The Greetland Academy

We are working hard to set up processes to provide support to schools as soon as possible. In the meantime we are encouraging schools and families to utilise the resources available on the Open Minds website, and to refer into the First Point of Contact in the usual way if needed

Other news

- Education Mental Health Practitioner (EMHP) trainee recruitment is from September 22nd
- The steering group will meet monthly from September 29th with representatives from schools and services.
- EMHPs will begin training in November once recruited

MHST Project Lead: Joe Krasinski joe@krasin.ski
MHST Service Manager: Ian Wood ian.wood@calderdalemhst.org.uk

NORTH POINT

Open Minds For Children and Young People in Calderdale

NHS Calderdale Clinical Commissioning Group