Item 3

Public Section of the Governing Body Meeting
held on Thursday 23 April 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)
	Penny Woodhead	PW	Chief Quality and Nursing Officer
	Alison MacDonald	AM	Lay Member (Patient and Public Engagement)
	Prof Rob McSherry	RM	Registered Nurse
	Prof Peter Roberts	PR	Lay Member (Audit)
In attendance	Denise Cheng-Carter	DCC	Lay Advisor
	Deborah Harkins	DH	Advisor to the Governing Body, Director of Public Health, Calderdale Metropolitan Borough Council
	Andrew O'Connor	AOC	Senior Corporate Governance Officer (Minutes)
	Sarah Antemes	SA	Head of Commissioning Continuing HealthCare, Mental Health and Learning Disabilities (for item 6, Minute No 26/20)
Observing	Zoe Akesson	ZA	Senior Administrator
	Steven Reed	SR	Communications Officer

21/20 APOLOGIES FOR ABSENCE **Action**

The meeting recognised that Dr Caroline Taylor (GP Member), Dr Farrukh Javid (GP Member), Dr James Gray (GP Member) and Dr Rob Atkinson (Secondary Care Specialist) were not in attendance. Item 3 on the agenda proposed to stand down all clinically active Governing Body members from CCG activity, with the exception of the CCG Chair, in order to prioritise the frontline response to COVID 19; as such, their attendance at the meeting was not required.

The meeting noted that it was not quorate but that this would be addressed by proposals at item 3 (Minute no 23/20).

Apologies were received for Iain Baines (Director of Adults and Wellbeing, Calderdale Metropolitan Borough Council).

Deborah Harkins (Advisor to the Governing Body, Director of Public Health, Calderdale Metropolitan Borough Council) had been delayed in joining the meeting.

During Item 4 (Minute Number 24/20), Deborah Harkins (Director of Public Health, Calderdale Metropolitan Brough Council was welcome to the Governing Body as its new Local Authority Advisor.

22/20 DECLARATIONS OF INTEREST

1. JM was declared to have a **direct financial** interest in item 10 (Reappointments to the Governing Body). It was agreed that JM would not be in attendance for this item.

2. It was declared that Governing Body members referenced in the report at item 11 (CCG Committee Membership 2020/21) had a **direct professional** interest. As the proposals had been through the CCG's internal governance and the item was largely confirmatory in nature, it was agreed that all Governing Body members in attendance would take part in the item, but that the Chair would continue to monitor the conflicts taking further action as required.

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.

23/20 PROPOSED GOVERNING BODY DECISION MAKING ARRANGEMENTS DURING RESPONSE TO COVID 19

SC in presenting the report explained that guidance from NHS England (NHSE) concerning actions to be taken to create system capacity i in response to COVID 19 had included a directive that GP members be focused on the delivery of Primary Care. Consequently, the paper proposed that clinically active Governing Body members, with the exception of SC as Clinical Chair, be stood down from Governing Body activity. To allow this to happen, the Governing Body was required to suspend standing order 9.7 (quoracy) and to agree temporary quoracy arrangements in order that decisions could continue to be made until clinically active members were recalled.

Comments and questions were invited:

- The proposal to stand down clinically active members was supported as the right things to do.
- The temporary quoracy arrangements proposed were recognised to be a stronger alternative to the existing alternative quoracy options set out in the Standing Orders and put the Governing Body on a stronger footing.
- That there were further options and flexibility in regard to achieving quoracy if required. In its guidance, NHSE had specified there would be no punishments for technical quoracy breaches at this time.

DECISION:

The Governing Body **APPROVED**:

1. the suspension of standing 9.7 (Quoracy);
2. the temporary quoracy arrangements set out at Table 1 in the report;
3. the standing down of clinically active Governing Body members from CCG activity in order to prioritise the frontline response to COIVD 19.

The meeting was now quorate and operating under its agreed temporary quoracy arrangements.

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24/20 COVID 19 UPDATE

[DH joined the meeting]

NS presented an update on work undertaken in response to COVID 19 pandemic.

Finance

NS explained that the centre had issued instructions concerning payments between commissioners and providers, much of which aimed to ensure the continuation of cash flow within the system. The measures implemented were related as set out in the report.

The CCG had determined that it did not need to amend its Standing Financial Instructions (SFIs) in order to increase delegated limits; however, as the CCG did not currently have a Chief Officer, it was proposed to maintain the existing combined limits of Chief Officer and Chief Finance Officer/Deputy Chief Officer (£500K total) by temporarily increasing the Head of Finance's limit to £250,000. This would ensure that decisions could be made at the appropriate level without requiring Governing Body approval. There had not been any instances where the CCG had needed to make a payment to this amount in response to the pandemic to date.

The 2019/20 annual accounts and reports were under production. The CCG had achieved all if its financial targets. Financial and performance planning had been suspended by NHSE. The CCG had submitted it budget plans but there was recognition that these would need to be revised to recognise the changed financial environment. Normal performance monitoring had also been suspended; although, data was still being collected.

Quality

A rapid change process had been introduced around Equality Impact Assessments (EIA) and Quality Impact Assessments (QIA). New services or service variations agreed would be brought back to committee meetings at later date when the CCG would revert to full impact assessments. The CCG was clear of the need for a consistent and thorough audit trail in regard to the decisions made throought the period of pandemic response.

A catalogue of all nationally mandated quality requirements has been collated, based on guidance from NHSE, listing any quality requirements where notification had been received to slow down, revise or cease reporting. This would enable to CCG to recommence reporting during the recovery phase. It was noted this would present a capacity challenge for both commissioners and providers at that point.

Quality monitoring was continuing but taking place in different ways. PW was having bi-weekly update meeting with Directors of Nursing and discussions with peers at provider organisations were taking place on an almost daily basis.

General Practice

Primary Care had mobilised the Clinical Directors in Primary Care Networks (PCNs) and the Local Medical Committee (LMC) had been fantastically engaged in new models of working across the system. Attention was drawn to the snapshot of work provided at 4.1. The CCG'S Senior Management Team (SMT) had agreed that it wanted to look closely at how Primary Care had responded to the pandemic and take

that learning forward during recovery e.g. seeing patients virtually.

National guidance had directed measures to guarantee income for general practice during the pandemic.

Workforce

The range of measures put in place to safeguard staff well-being was reported at 5.0. These included a range of national resources and those made available due to local decision and investment. SMT were promoting a message concerning the importance of communication and mutual support to all staff on an ongoing basis.

Additional Beds

Calderdale and Huddersfield NHS Foundation Trust (CHFT) had confirmed an approach to ensuring there were sufficient hospital beds to support the needs of patients in Calderdale and Greater Huddersfield during the peak of the COVID 19 period. Plans included a request for the system to establish additional beds which could flex in accordance with need and demand; ranging from support for people who needed nursing care and residential care to those who need bed based social care. Plans to support the bringing on of additional beds from existing sources were highlighted as set out at 6.2. The additional beds contracted by Calderdale Metropolitan Borough Council (CMBC) referenced in the report were for individuals where there had been a break down in existing care as opposed to their being unwell. The number of incidents of COVID 19 in care homes was noted to be significant and that community care presented the highest degree of risk at the date of the meeting. Additional beds for post hospital discharge were being provided at Calderdale Retreat staffed which was being staffed by existing care home staff, nursing staff from the CCG and GP's with a workforce model being planned to provide greater capacity.

Testing

A staff-testing drive-through service has been established at King Cross Fire Station providing a self-swabbing service for key workers across health and care system. Work was taking place with the Local Authority (LA) to enhance and increase the mobilisation of the drive-through. This included local communications to key workers. Performance to date had been impacted by national as opposed to local factors.

Personal Protective Equipment (PPE)

The CCG was working very closely with CMBC as the local lead on PPE to ensure GPs and community services had sufficient and appropriate PPE.

Comments and questions were invited:

- NS was thanked for the breadth and detail provided by the report.
- The amount of work that had been undertaken by staff was singled out by all members of Governing Body for recognition and praise. All members of staff and partners across the system were thanked for their commitment and significant efforts.
- CCG nurses who had volunteered to work on the frontline were singled out for praise as was the Continuing Health Care (CHC) team's implementation of changed discharge guidance and others changes in practice. Work to secure additional beds was also singled out.
- PW advised the Governing Body that the focus going forward needed to switch

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from acute into community. She had been involved in a number of conversations nationally with nursing leaders sharing the work being undertaken by CCG nurses to support this sector sharing examples of the things being done in Calderdale as well as gathering learning from elsewhere. The return to practice scheme had not had a huge impact Calderdale.

- In response to a question, NS confirmed that the CCG was meeting its financial reporting deadlines. The CCG was waiting to learn when audits would be completed in order to organise approval by the CCG's Audit Committee.
- The proposed change to the Scheme of Delegation was supported. It was recognised to be an appropriate temporary measure.
- In response to a comment concerning communications to people on the Governments Shielded Patients List (SPL), NS explained that the CCG had been required to follow national guidance and instruction in terms of communication with those on the list. Work had taken place to correlate the names on the list with local acute, LA and Primary Care data producing a list of just under 4000 local people. The LA was making contact with each of the individuals named through its community hubs. The hubs had contacted 1600 patients by the end of the previous week. LA and community services had worked to prioritise those they knew were at greater risk (i.e.) those without support. Practices were also contacting their more vulnerable patients. There was recognition that, when first published, there had been issues when people who had expected to be on the list had found they did not meet the criteria. In accordance with national guidance, those individuals had been directed to their local GPs. AM replied that support for those on the SPL list had been fantastic. DH reported that a booklet about COVID 19 and the community support hubs was being delivered to every household. NS added that anyone indicating they required support would receive it as per the agreed approach in Calderdale.
- In response to a question concerning the testing of patients before they re-enter the community, NS confirmed that there had been revised guidance on discharge received earlier in the week specifying that people must now be tested before they leave hospital.
- In response to a question concerning how the system would prepare for the indirect consequences of COVID 19, NS advised that the CCG's SMT were now beginning to focus on these next steps. Primary Care was receiving guidance regarding the need to communicate to patients that the NHS was still open for business and that referrals should still be made. Discussions were also taking place with CHFT to understand the backlog. At a West Yorkshire level, proposals around cancer treatment had been agreed to deal with the backlog in cancer surgery including using the independent sector to ensure patients were undergoing procedures locally. PW added there was a need to start a conversation with local GP's concerning the key messages that needed to be communicated to the population concerning the ongoing availability of service, for example around cancer diagnosis, immunisation etc.
- In response to a question, NS confirmed that the CCG would be looking to capture the positives in terms of practice and operational response for the organisation to take advantage of going forward. A set of recovery principles were being developed regionally in order that this was carried out consistently across the footprint.
- In response to a question, assurance was provided that the SPL had been through the acute trusts in order to ensure plans were in place for at risk individuals.

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DECISION:

The Governing Body**:**

- **RECEIVED** and **NOTED** the content of the report.
- **APPROVED** the proposed change to the Scheme of Delegation to temporarily increase the Head of Finance limit to £250,000.

25/20 MINUTES

DECISION:

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

26/20 CALDERDALE MENTAL HEALTH REHABILITATION SERVICE BUSINESS CASE

DECISION:

SA in presenting the report explained that the business case was in part an outcome of work that had taken place since 2017 between the CCG, CBMC, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and partners looking at the pathways for people with complex mental health needs who also require rehabilitation services. It was also explained to respond to national drivers as well as building upon existing work carried out in Calderdale including a 12 month CCG funded pilot.

SA explained that, in order to remove the need for people to go out-of-area to receive care, Calderdale needed the right housing options and service provision. The service proposed by the Business Case would sit between local community mental health teams and acute services and provide the intensive support that some higher risk individuals required in order to live in the community. The service would also reduce the need for and/or length of any acute admissions with individuals eventually transitioning to be supported by mainstream community mental health services and other available support networks.

The CCG pilot had been focussed on patients at Lyndhurst Hospital. By trying to keep a number of beds at the facility open, the additional capacity was used to support a number of its patients back into the community. The Business Case proposed to enhance staffing capacity to support this model. The intention was to only have 2 thirds of the beds occupied at Lyndhurst whilst supporting up to 14 people in the community who would be stepping down from Lyndhurst, an acute care setting, locked rehabilitation or secure service.

The service proposal was intended to maximise the use of existing resources at no additional costs to the CCG.

Comments and questions were invited.

- There was a request that baseline indicators be included in the business case. This was agreed. **SA**
- In response to a question, SA confirmed that Lyndhurst was a block funded service and, as such, there was no cost pressure to the provider from keeping the beds open. The key risk to the CCG was it not having enough beds in-area. It was explained that the new service mitigated this risk by providing options that would allow SWYFPT to manage demand from an acute setting, through Lyndhurst, into

the community, on the understanding that there would be fewer out-of-area beds which could be agreed by exception only. JM indicated that this would need to be closely monitored due to the potential financial risk.

- In response to a comment concerning the phrase that people would need to demonstrate "motivation and willingness" to be eligible, SA clarified that this was intended to convey the idea that someone had "rehabilitation potential" whilst recognising that, in a conventional sense, individuals might not outwardly display these attitudes.
- NS clarified that the cost of an out-of-area placement on average was around £3,500 per week and that the CCG needed to closely monitor its performance indicators to manage the identified financial risk.
- SA added that an additional mitigating factor to take into account would be the work and investment at Integrated Health and Care System (ICS) level which had been about to move into proposal and implementation phase when the pandemic halted progress.
- In response to a question, SA provided assurance that the service model had been developed and would be supported by services across the whole system.
- In response to a question, SA explained that patients who did not require admission to Lyndhurst might be stepped down into other specialised housing options and that work with the market was taking place in this area at an ICS level. She also accepted an offer of relevant contacts from PR.

The Governing Body**:**

1. **APPROVED** the business case to develop a complex mental health community rehabilitation service;

2. **AGREED** the recurrent financial investment by Calderdale CCG for a complex mental health community rehabilitation service provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

27/20 ACCESS TO INFERTILITY TREATMENT 2020-2023

PW in presenting the report explained that the revised policy was being presented for Governing Body approval in accordance with the CCG's Scheme of Reservation and Delegation. It was noted to be a Yorkshire and Humber (Y&H) wide policy which was originally agreed by Primary Care Trusts (PCTs). The policy only concerned eligibility to access to treatment, not the number of cycles. The issues raised by committees during the process of revision had now been resolved. There was no need for consultation on the changes as it enhanced the previous policy offer.

Comments and questions were invited:

- It was recognised that the issues raised at a committee level had been resolved.
- There was support concerning there being no need to consult on the changes.
- The communications leaflet was noted to be clear and concise.

DECISION:

The Governing Body **APPROVED** the revised policy including the updates and revisions.

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28/20 WEST YORKSHIRE AND HARROGATE MEMORANDUM OF UNDERSTANDING

NS in presenting the report explained that it asked the Governing Body endorsed the revised Memorandum of Understanding (MOU) for Collaborative Commissioning between CCGs and workplan to the CCG's Membership for approval. The key changes were reported as follows:

- NHS Harrogate CCG was to become an associate member of the Joint Committee following it merger with North Yorkshire CCG.
- Votes per organisation on the Joint Committee would return to one vote per CCG area.
- The three tests against which proposals would be assessed against before being considered for inclusion on the workplan had been set out in the MOU.
- Several changes to the workplan, including that relating to decisions concerning urgent and emergency care.

Comments and questions were invited:

- There was support for the changes including that concerning urgent and emergency care.
- There was recognition of the relevance of there being one vote per area in the context of the item concerning the CCG's Accountable Officers later on the agenda.
- PW recognised that the CCG needed to influence the development work that would take place around the new matters added to the workplan including maternity services.
- In response to a comment concerning the potential contradiction between standard commissioning policies and evidence based interventions listed as examples against the second test due to the variation at a place level across the Integrated Care System, it was recognised that there were and would be challenges in this regard.

DECISION:

The Governing Body:

1. **ENDORSED** the revised Memorandum of Understanding (MOU) and Joint Committee workplan to the CCG Membership for approval.
2. Subject to the support of the CCG Membership, **AUTHORISED** the Chief Finance Officer/Deputy Chief Officer to sign the MoU.

29/20 APPOINTMENT OF VICE CLINICAL CHAIR

SC in presenting the proposal that CT be appointed to the role of Vice Clinical Chair spoke to her experience, strengths and contribution the CCG, the local system and at a regional level.

The proposed appointment had been considered by the Remuneration and Nominations committee at its meeting on the 27 February 2020. The committee recommended the appointment to the Governing Body.

DECISION:

The Governing Body **APPOINTED** Dr Caroline Taylor (GP Member) as Clinical Vice

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Chair of the Governing Body.

30/20 REAPPOINTMENTS TO THE GOVERNING BODY

AOC in presenting the report explained that RA and JM's first three year terms of office were coming to an end on the 31 May 2020. As set out the in the report, the historic practice at the CCG for Lay Members, Secondary Care Specialist and Registered Nurse reaching this point would be that they would be reappointed for a further three year term subject to satisfactory appraisals. In January 2020, this convention had been endorsed by the Governing Body for inclusion in the CCG's revised constitution and subsequently approved by the CCG membership. The Remuneration and Nomination Committee had considered both appointments at its meeting on 27 February 2020 and was recommended both JM and RA be reappointed for a second three year term.

a. Reappointment of Rob Atkinson (Secondary Care Specialist)

DECISION:

The Governing Body **APPROVED** the reappointment of Rob Atkinson (Secondary Care Specialist) to the Governing Body for a second three year term of office.

[JM left the meeting at this point.]

b. Reappointment of John Mallalieu (Lay Member, Finance and Performance)

DECISION:

The Governing Body **APPROVED** the reappointment of John Mallalieu (Lay Member, Finance and Performance) to the Governing Body for a second three year term of office.

[JM re-joined the meeting at this point.]

31/20 CCG COMMITTEE MEMBERSHIP 2020/21

SC in presenting the report explained that, in accordance with the CCG's Constitution, the Governing Body was being asked to approve a number of appointments to its committees following recent changes in Governing Body membership. The paper also asked that the Governing Body ratify changes to the Audit Committee Terms of Reference which had been agreed by the Chair and Chief Finance Officer/Deputy Chief Officer between meetings.

JM confirmed that the proposals were in line with committee terms of reference, statutory requirements and had gone through the CCG's internal governance process including consideration by the Remuneration and Nomination Committee. The committee had considered the proposals at its meeting on the 27 February 2020 and recommended them to the Governing Body for approval.

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DECISION:

1. **NOTED** those appointments which were statutory requirements and **APPROVED** all other appointments.

2. **RATIFIED** changes to the Audit Committee's Terms of Reference.

32/20 COMMITTEE MINUTES

DECISION:

The Governing Body **RECEIVED** the Minutes of Meetings of the:

a) Quality, Finance and Performance Committee held on 19 December 2019
b) Commissioning Primary Medical Services Committee 9 January 2020

33/20 KEY MESSAGES FOR PRACTICES

DECISION:

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

- Standing down of clinically active Governing Body members
- Calderdale mental health rehabilitation service business case
- Access to infertility treatment 2020-2023
- The Appointment of Vice Clinical Chair

34/20 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 23 July 2020,
2.00pm Elsie Whitely Innovation Centre
(venue subject to confirmation)

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Governing Body Meeting – 23 April 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
CALDERDALE MENTAL HEALTH REHABILITATION SERVICE BUSINESS CASE	26/20	▪ Baseline figures to be included in the Business Case	SA	COMPLETE	Confirmed BC had been added 15.05.2020
KEY MESSAGES FOR PRACTICES	33/20	The Governing Body **AGREED** the following key messages: - Standing down of clinically active Governing Body members - Calderdale mental health rehabilitation service business case - Access to infertility treatment 2020-2023 - Appointment of vice clinical chair	Comms	COMPLETE	Published on Member Connect 27.04.2020

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Name of Meeting	Governing Body	**Meeting Date**	23/07/2020
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**	Not applicable	**Meeting Date**			
	Name of meeting	Not applicable	**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body **RECEIVES** and **NOTES** the content of the report.					
Decision	☐ **Assurance**	☒ **Discussion**	☐ **Other**			

Implications			
Quality & Safety implications	None identified.		
Public / Patient / Other Engagement	The CCG is committed to working with public, staff, patients, partners and other stakeholders to improve health care services.		
Resources / Finance implications	None identified.		
Strategic Objectives)	▪ 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 now enter a new phase of the pandemic we face another set of challenges. Within the report there are updates on key developments and also business as usual. Whilst our Finance paper will update the Governing Body on our current position we are in a very challenging environment as a result of the COVID pandemic. There is a level of uncertainty around planning guidance, increasing health inequalities, safe resumption of services and expecting capacity to somehow increase against the back drop of the unknown financial regime, bed capacity, infection prevention & control (social distancing), backlogs and staff availability. This is the most difficult planning phase we have seen and will rumble on for some time. The full impact will probably not be seen until well into the next financial year and we will keep the Governing Body fully updated.

1.2 As the lock down has eased we are seeing the movement of the population more and more in the headlines. Through the national testing process, specifically pillar 2 (the repeat testing of key workers) new cases are being found. We have encountered cases in General Practice and care homes but our working with partners has ensured minimal impact on services. This has been done by the continued support by our staff, particularly our primary care and quality teams supporting organisations with risks assessments and infection prevention control.

1.3 With the impact and benefits of the new test and trace process starting to be seen I have made the decision that to ensure we minimise the potential spread of COVID19 that the CCG staff will not be returning to the office at Dean Clough until 2021. This follows similar decision made by the Council. We need to ensure staff are safe and work has been ongoing to ensure people that need (not want) to work at the office can do in a safe environment. This means the default is to work at home. Risk assessments are being undertaken for all staff to ensure everything is in place to help our staff with support available to review work stations and ensure they are comfortable in this new way of working. In the office we have undertaken a full review of guidance and are communicating to staff how it will operate should they need to work from the office. This wasn't an easy decision and it is a balance of the risks; however, we need to play our part as an NHS organisation in minimising its transmission. The main learning from reduce lockdown is that it is still out there and considerable numbers show no signs of having it. We will review this in December.

1.4 Across the West Yorkshire & Harrogate (WY&H) Integrated Care System (ICS) the CCGs Accountable Officers are undertaking a review of what commissioning will look light in a changing infrastructure. As this develops I will bring further information to the Governing Body

for consideration. The current proposals are looking at a Commissioning Framework delivered in partnership of:

- Commissioning which happens in **each place**, tailored to local population need and focussed on improving population health, developed and delivered in that place, enacting the entire commissioning cycle.

- Commissioning which is **developed once across the WY&H footprint and delivered separately in each place** to a common specification/set of outcomes and standards defined at the ICS level. This will require some of the commissioning cycle to be enacted at an ICS level, with the remaining elements to happen at a local level.

- Commissioning which is **developed and delivered once across the WY&H footprint**, with the entire commissioning cycle enacted at an ICS level.

2.0 COVID Updates

As recognised above the following updates provide key information on COVID relates matters.

2.1 Care Home COVID-19 Resilience Plan

COVID has caused immense pressure for the care and nursing home sector. In light of this the Health and Social Care Scrutiny Board asked for an update on the local response for their July meeting. A paper was prepared jointly with the Local Authority on our response to protect and support the residents and the sector through the crisis and beyond. It gave an initial insight into the future intentions of the local Health and Social Care system, which with the help of partner agencies would not only make the sector become more resilient but it would reshape the provision to reflect and meet the future needs of the community. Attached at **Appendix 1** is a copy of the report being jointly presented to scrutiny and sets the framework of the integrated work we are undertaking with the Council.

2.2 Stabilisation and Reset

2.2.1 The WY&H Health & Care Partnership (C&CP) held a World Café Event on 28th May 2020 to launch its approach to Stabilisation and Reset (phase 2 of its COVID response plan). Each

‘place’ provided an overview of the high level priorities and principles in their own Stabilisation and Reset plans, and there was an opportunity to interface with each of the 17 H&CP programme areas. Each of the 17 programmes are being reframed to support the reset and ensure they are supporting place-based work. This also provides an opportunity for Calderdale to ensure that we are effectively represented in the work. A short summary of the principles and priorities developed for Calderdale and shared at the event are attached as **Appendix 2**

2.2.2 The CCG has created a Stabilisation and Reset plan for delivery of its response to Phase 2 of COVID planning. The plan has been agreed through SMT and is currently being discussed with staff to enable delivery. Progress will be monitored through governance and a separate report has been produced for the Local Medical Committee (LMC) as an agenda item.

2.2.3 In addition to this the ICS in conjunction with the military held a stress test on our current plans. This involved each place presenting their plans mapped against different scenarios for the pandemic and the plans being subject to scrutiny and challenge. Calderdale was led by Debbie Graham and supported by myself and Robin Tuddenham. Initial feedback suggested our plans are robust and we show good partnership working, which reinforces previous feedback as to how we have all worked in an integrated manner during this time. Once formal outcomes are received, we will share with the Governing Body for assurance.

2.2.4 Throughout the COVID period the CCG continues to chair weekly calls for the wider Calderdale and Greater Huddersfield system. This includes; Local Authority’s (LA’s), Public Health, Calderdale and Huddersfield NHS Foundation Trust (CHFT), Locala, LMC, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), third sector, CCGs, WY Community Pharmacy, GP representatives, LCD, Hospices, Emergency Planning Leads, BMI, Spire and NHSE (and more recently Yorkshire Ambulance Service (YAS) and Healthwatch).

2.2.5 The calls have provided a valuable opportunity for each organisation to identify its current state, risks and areas for mutual aid, as well as discussing issues of concern to all organisations; testing and shielding for example. These meetings will move to fortnightly during June, July and August, and step back up in September, or earlier in the event of a second spike and planning for winter. The A&E Delivery Board in July focused on planning for winter as part of our overall reset plans and the impact of COVID and potential scenarios. Previously not all partners would have been involved in such calls so again this shows the significant improvement in partnership working in Calderdale.

2.3 Clinical Dialogue

Through COVID, two new forums have emerged which provide opportunities for strengthening clinical dialogue:

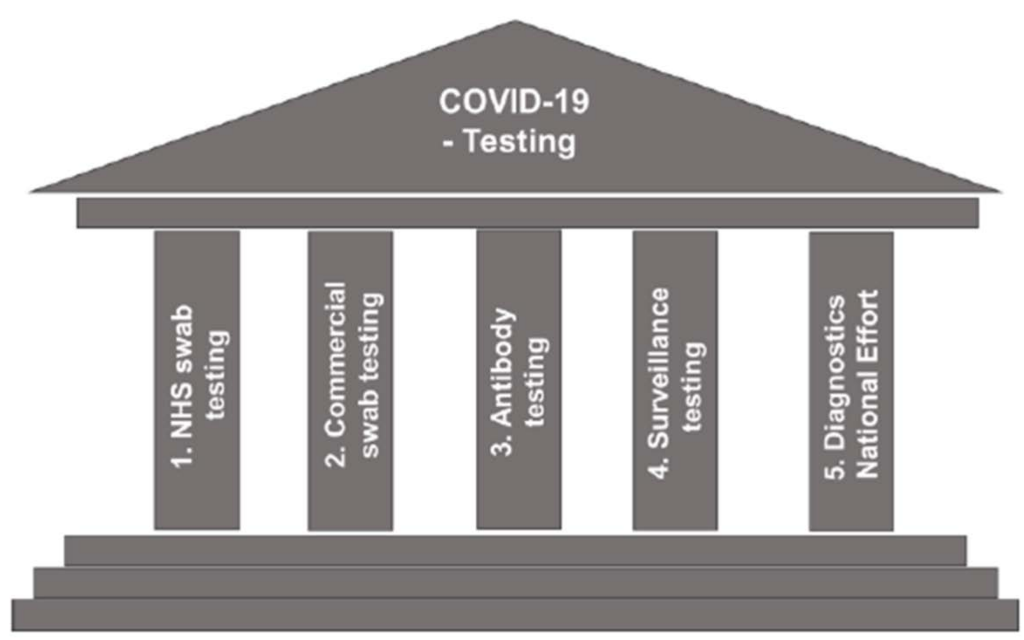
(a) Referral Planning – led by Helen Barker, Dr Steven Ollerton and Dr Steven Cleasby. The work focuses on the safe restart of elective activity; particularly developing an approach to the 6 high volume specialties, and diagnostics which require a review of the waiting lists jointly by clinicians from primary and secondary care. This provides learning for the 'new normal' for out-patients. Work done by the group is communicated to all clinicians in secondary and primary care. We have agreed to ensure that the LMC receive any communications directly as they are sent out to general practice.

The CCG and CHFT are also in dialogue with Spire and BMI to continue to ensure that they are able to continue to support the recovery of activity. Currently they are providing support for cancer pathways (endoscopy, urology and plastics). The dialogue is currently focused on support for surgery, diagnostics and out-patient activity.

(b) COVID Acute Clinical Interface Group – led for Dr Farrukh Javid. The focus of the work is to provide a vehicle for dialogue on acute pathways that emerge or change as a result of COVID, considering the implications for clinicians in both primary and secondary care. The LMC are represented.

2.4 Outbreak Governance, Test and Trace

2.4.1 As part of the ongoing recovery from the pandemic there is a national requirement for localities to have clear outbreak plans in place, which is supported by the Test & Trace process. This is led by our Public Health colleagues and has been embedded into the Council's existing recovery programme. I represent the CCG on the main outbreak board which is supported by the tactical Calderdale Health Protection Assurance Group. A copy of the local plan is included at **Appendix 3.** This is a key part of the pillars of testing, as shown below.



2.4.2 Calderdale CCG continues to lead the COVID-19 drive through testing for symptomatic and asymptomatic essential workers. In Calderdale whole care/nursing home testing is being co-ordinated, in order to provide a proactive approach for our most vulnerable services. For care homes this provides a level of security and comfort for staff, residents and their families. This has included extending to offer a 'drop and collect' service to care homes to test all staff and residents, GP staff and social workers (working within care home settings). This service is offered fortnightly and is organised on a locality rota. This is where we are seeing increased positive tests as referred to previously.

2.4.3 The WY&H H&CP, through its Population Health work stream have commissioned a piece of work into the impacts of COVID for our Black, Asian and Minority Ethnic (BAME) communities and staff **(Appendix 4).** The review, led by Dame Donna Kinnair, will provide us with a better understanding of the impact, help reduce inequalities and support recovery. The review aims to build on the existing work of our BAME network chairs and the Improving Health Population Programme and the learning will be embedded in the reset and recovery work. A steering group is being established so that the West Yorkshire system can work collectively to understand and confront the long standing health inequalities facing people.

2.5 Calderdale MBC Recovery

2.5.1 Calderdale Metropolitan Borough Council (CMBC) has established a structure to guide its recovery: and is currently setting up task and finish groups based on 6 themes. These schemes will report in the Council's Recovery Group, of which the CCG is represented, as it also doubles as the Localities Outbreak Management Board;

- Safe Transport
- Safe Workplace
- Safe Communities
- Safe Care
- Safe Transport
- Safe Space

2.5.2 Each of the 6 elements are interconnected to enable a safe future for Calderdale. The CCG is proactively involved in the Safe Care Task and Finish Group, which is morphing from the weekly Calderdale System call Safe. It is also involved in the Safe Communities work-stream which includes;

- Food Provision - (delivering more than 1,000 food parcels every week)
- Volunteers - (830 volunteers across the 5 Primary Care Network (PCN) hubs – supporting 1,200 individuals – many on a weekly basis)
- Social care hub - (7,797 individuals (aggregate) on the shielded lists for Calderdale. To date as 6,223 have been contacted). It is worth noting that community organisations have identified the confusion surrounding the changes being made by letter and text to patients who are shielded. We have confirmed that regardless of their status, we will continue to support people through the social care and volunteering hubs.
- Community Sector Support – linked to the work of the Voluntary Sector Infrastructure Alliance
- Community Cohesion/Tensions

3.0 Commissioning Developments

3.1 Children and Young People

3.1.1 Calderdale has been successful with its application to be part of the 2020-21 Mental Health Support Teams waves. Young people in Calderdale schools and colleges will soon be supported by two new dedicated Mental Health Support Teams. These teams will help young people 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.

3.1.2 This will see an increase in the number of mental health professionals working in Calderdale as part of the Open Minds Partnership: the cooperative of local authority, NHS and voluntary organisations that provide child and adolescent mental health services in our area.

3.1.3 Representatives from the Calderdale Open Minds Partnership attended the CMBC Children and Adults Scrutiny Board on 2nd June 2020. The Board was provided with a paper which described the Open Minds Partnership, 'Thrive' model of care and achievements to date.

3.1.4 The first meeting of the Open Minds Steering Group (the providers and commissioners of statutory children & young people's mental health services in Calderdale), together with the Emotional Health and Wellbeing Taskforce (led by CMBC) took place on 24 June. This brought together all the key stakeholders whose business is supporting the emotional wellbeing and mental health of children and young people of Calderdale, plus young people from the Tough Times Reference Group. Attendees discussed achievements of both groups who, to date, have been working in parallel. They agreed they now need to work together as a wider partnership, in a systematic way, to continue delivering the 'Thrive' model of care and NHS Long Term Plan. The outputs from the meeting are currently being reviewed and will be progressed with attendees.

3.2 Posture and Mobility (Wheelchairs) Service

3.2.1 This service has continued to operate during the COVID period, prioritising urgent referrals and repairs only (for children, young people and adults). Ross Care/Blatchford completed risk assessments to determine clinical priority and actions to be taken for urgent cases.

3.2.2 They also developed risk assessments for engineers who continue to work in the community. Ross Care implemented 'My Clinic' video software to support video calls with service users for urgent appointments. They plan to continue utilising this as part of their service offer.

3.2.3 They have also introduced an "Are you OK?" question when speaking to service users on the phone which has identified clients who are struggling with isolation/food; these have been signposted to local support services. They have introduced a facility where service users can send either photos or videos of broken equipment to Ross Care to facilitate swifter/more effective repairs element of their service

3.2.4 Since the contract start date (1st October 2019), they have continued to focus on reducing the number of open episodes of care. These have reduced from 1,162 on 1st October to 316 in April 2020.

3.3 **Improving Access to Psychological Therapies** (**IAPT**)

From 1st May 2020, following a transition period, VitaMind began providing IAPT services in Calderdale. Both VitaMind and SWYPFT IAPT are our providers under the Any Qualified Provider (AQP) contract process. Both organisations defaulted to the digital first method for delivery of sessions.

3.4 **Cancer**

The number of patients on a COVID affected pathway at CHFT for both treatment and diagnostics continues to reduce. CHFT are performing exceptionally well and by the end of June will have cleared all patients whose diagnostic tests were on hold. At the same time the number of cancer surgeries each week continues to increase. CHFT have established a Super Green Elective Surgery Unit in what was the Day Surgery Unit where major cancer surgeries will take place. This has been achieved through working with our independent sector providers to help with additional capacity. We are hoping through the reset planning phase to continue such relationships with the IS providers and not revert to an open market approach.

4.0 Right Care, Right Time, Right Place (RCRTRP) Update

4.1 Following the formal process of review and approval of the Strategic Outline Case (SOC) and associated letters of support, funding of £189m has been allocated to support the progression

of the reconfiguration. The SOC includes investment at both Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) (£177m transformation investment in CRH; and £20m backlog estate maintenance and transformation investment in HRI). In recognition of the need to expedite the investment at HRI to respond to the significant estate risks, the Trust is developing a Full Business Case for the HRI investment in parallel with the development of the Outline Business Case for CRH.

4.2 The public and colleague involvement work to develop a 'Design Brief' was concluded prior to the Covid-19 pandemic. The “Design Brief” describes the principles that will inform the detailed architectural design and construction schemes at both HRI and CRH and is published on CHFT's website. Further work has been undertaken to engage and listen to people’s reflections on the service changes implemented and experiences during the pandemic and to ask about their aspirations for future service delivery (‘Business Better than Usual’). The learning from this will inform the detailed design stage for the reconfiguration Programme and may identify opportunities for improvement and accelerated transformation in some areas.

5.0 Auditor Panel Update

5.1 The Auditor Panel was convened in February 2020 to oversee a procurement exercise for an external audit service for the CCG as the current contract of service was due to expire. The Panel agreed that the NHS Shared Business Services Framework would be used for this purpose. The Panel reconvened on 14th May 2020 to consider the outcomes of the procurement exercise and, having assured itself that a robust process had taken place in line with the organisation’s normal procurement rules, determined an award of contract under delegated authority from the CCG’s Governing Body. The contract was awarded to Grant Thornton UK LLP.

6.0 Annual Report and Accounts for 2019/20

6.1 The CCG’s Annual Report and Accounts 2019/20 were signed off by the Audit Committee, under delegated authority from the Governing Body, at its meeting on 18th June 2020. Subsequently, they were submitted to NHS England on the 25th June 2020 and published to the CCG’s website on the 8th July 2020, meeting the required deadlines. This is always a challenging process, particularly so this year, and I would like to give enormous

thanks to colleagues in finance, governance and all the other individuals and teams across the CCG who contributed and really rose to the challenge. Notwithstanding all of that, I am pleased to say that our accounts have been given an unqualified opinion from our auditors.

7.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

7.1 I have appended a summary of the discussions and decisions reached at the Joint Committee of CCGs which took place on 14th January 2020 **(Appendix 5)** and 7th July 2020 **(Appendix 6).**

8.0 Recommendations

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

9.0 Appendices

- Appendix 1 Care Home COVID 19 Resilience Plan - report to Health and Social Care and Scrutiny Board 16th July 2020
- Appendix 2 WY& H HCP Stabilisation and Reset Principles and Priorities
- Appendix 3 Local Outbreak Plan
- Appendix 4 WY&H HCP BAME Letter 30th June 2020
- Appendix 5 WY&H Joint Committee Key Decisions 14th January 2020
- Appendix 6 WY&H Joint Committee Key Decisions 7th July 2020

7

Report to Scrutiny Board

Name of Scrutiny Board	**Health and Social Care**
Meeting Date	16 July 2020
Subject	Care Home Covid 19 Resilience Plan
Wards Affected	All
Report of	Director of Adult Services and Wellbeing

Why is it coming here?

Covid-19 has placed considerable pressure on Social Care and in particular a strong focus has been placed upon the Care and Nursing Home sector at local, regional, national levels. An update has therefore been requested from the Health and Social Care Scrutiny Board to consider our local response.

What are the key points?

The report considers how as a system we have responded to protect and support the Care and Nursing Home residents and support the sector through the crisis.

As the Covid-19 Reset and Stabilisation phase gathers momentum we want to provide an initial insight into the future intentions of the local Health and Social Care system with partner agencies to assist the Care and Nursing Home Sector to become more resilient, and in so doing, reshape provision to reflect and meet the future needs of the community.

To support Scrutiny in your understand of the challenges faced by the sector, we have invited representatives from two local Care/Nursing Homes to present first-hand experiences of managing staff and caring for residents during the pandemic.

Possible courses of action (Recommendations)

For the Health and Social Care Scrutiny Board to receive the report and assess the level of assurance Members have on the robustness of our local approach to supporting the sector during the pandemic.
Consider how the Board would like to influence our future intentions.

Contact Officer

Sean Cook, Assistant Director, Operations, Adult Social Care and Well Being, Calderdale Council
Jill Holbert, Assistant Director, Commissioning and Partnerships, Calderdale Council
Sarah Antemes, Head of Continuing Healthcare, Specialist Mental Health and Learning Disabilities Services,Calderdale CCG
Jen Mulcahy, Programme Manager, Calderdale CCG

Should this report be exempt?

No

Report to Scrutiny Board

1. Background

Following the national outbreak of Covid-19 in March 2020, the Government implemented a National Action Plan. The plan was underpinned by a nationwide restriction of social mobility to contain further possible spread, supported by specific Action Plans to expand Acute Care and general capacity in the NHS in the event of significant demand placed on the country's infrastructure.

As the pandemic developed, it was identified that a disproportionate level of infections and deaths, compared to the wider population, were occurring in Care and Nursing Home settings. The Government subsequently published a National Action Plan for Social Care, with allocated resources, to specifically focus on this area. Each local area was required to develop a comprehensive Multi-Agency response co-ordinated by Local Authorities. This report outlines the detail of Calderdale's response to the Action Plan and subsequent outcomes.

First hand experience of those who have managed the crisis in Care and Nursing Homes in Calderdale during the pandemic will be provided.

Based on learning from Covid-19, an insight will also be given into the future support that Health, Social Care and Third Sector partners can provide the sector to develop greater resilience and potentially reshape provision to meet the needs of the most vulnerable members of our community in different ways.

Main Issues for Scrutiny

The residential care home and nursing home market in Calderdale comprises of 33 homes for older people with a total 1,474 beds.

It terms of profile, there are a large number of small and medium size providers (around 50% of providers), often run by family businesses, which do not have access to the regional and national infrastructure, support and advice available to homes run by larger companies.

Prior to the Minister of Care's letter in May 2020 to local areas, entitled *Support for Care Homes,* that requested a whole system response to the Covid-19 related concerns in residential and nursing homes, Calderdale as a place had already identified at an early stage of the pandemic, that significant assistance and support was required for this part of the Health and Social Care sector.

Place based support to residential and nursing homes during COVID-19 had been developed from early March of this year through the local emergency planning process and a multi-agency Care Home Task Group chaired by the DASS as Senior Responsible Officer, and established a local Care Home Support Plan.

The COVID-19: National Action Plan for Adult Social Care

The plan aims to protect and reduce risk in care homes and was developed alongside the Care Home Resilience and Outbreak Management Plans. Both plans are a central plank of Calderdale's Reset and Rebuild Framework *Living with Covid* -19 and the local model of the NHS Reset and Stabilisation Plan.

This Framework and the relevant plans, have been set within the context of the Council's ongoing work across the borough with Health and Third Sector partners through *Calderdale Cares*, overseen by the Health and Wellbeing Board and partner Executive Boards. During the pandemic, it has become increasingly apparent, that the Covid-19 specific plans, have served to give greater clarity, insight and impetus toward the ongoing realignment of Community Health Services, Primary Care, Public Health and Social Care Services to ultimately reduce inequalities, improve health and reduce need for bed-based care.

This has ensured that Calderdale Council, NHS partners, the Third Sector and Care Home providers have been equal and proactive partners in coordinating and providing targeted support to care and nursing homes in relation to prevention and infection control, provision of personal protective equipment (PPE), workforce support, testing and clinical support.

The *Care Home Support Plan* has been crucial in ensuring sustainability and safe care within the homes across the borough since the initial outbreak of COVID-19.

The flexible response developed locally has allowed Social Care to deploy Council Care staff management support and the direct provision of PPE to ensure that all homes were able offer safe levels of care to residents. The provision of additional accommodation referred to in more detail below, has also been crucial as a number of homes are based within Victorian buildings where the isolation, safe care and management of infection prevention and control can present particular challenges.

Daily arrangements to monitor and support the local market.

Calderdale Council, Calderdale CCG and the Calderdale and Huddersfield NHS Trust (CHFT) have jointly developed an Enhanced Residential Care/Nursing Homes Support Team (ECHST) and a daily Situation Reporting (SitRep). The SitRep continues to collect and collate a range of data from each care home in the borough to inform a dashboard covering key areas of intelligence, primarily to prevent the spread of Covid and identify quality, sustainability concerns:

- Bed vacancies
- Current and cumulative number of Covid 19 confirmed and symptomatic residents – both current and cumulative - and number of resident deaths
- Current and cumulative, staffing levels, staff absent from work and staff numbers of COVID-19 confirmed and symptomatic.
- Number of COVID-19 tests carried out and the results
- Additional support being provided by QUEST (Quest for Quality in Care Homes), community nursing and the council
- PPE supplies
- Quality of care and financial issues for the home

Daily contact continues to be made with all of Calderdale's residential and nursing services to quickly identify any difficulties they are experiencing with workforce and maintaining good levels of staffing to support the increasing dependency of people who are isolating or shielding. This supports the principles described in NHSE guidance on the Enhanced universal offer to care homes.

This data and intelligence informs the targeted support to care homes provided by council's Infection Prevention and Control Team, Public Health, Adult Social Care and NHS Community Nursing and QUEST.

The Multi-Agency Care Home Task Group has also developed a local *ECHST Care Home Support Plan*. This is specifically for those homes presenting with significant, imminent risk or with an increasing risk profile. The key component of this plan, is the deployment of a multi-agency COVID Response Team, staffed by CHFT, Public Health, ASC and the CCG to directly support the home(s), underpinned by a protocol between the 3 partners

The protocol covers all Residential and Nursing Home provision in Calderdale and is divided into two stages.

Stage one relates to work undertaken as part of the implementation of Calderdale's Care Home COVID-19 Prevention Plan, led by the Public Health Team. This directs testing and support, co-ordinated by the CCG to Residential Care and Nursing Homes without confirmed cases with residents and staff.

Stage two is initiated as soon as two (likely) cases of COVID-19 are identified in a setting. This will be initiated by the intelligence gathered by the Public Health Team, Business Relationship Managers from the Council's Contracts & Commissioning Team, CCG and CHFT to inform the daily SitRep. The intelligence will be considered by a daily meeting of the Tactical Command Group, representing the above agencies, to ensure immediate actions are taken to deploy the ECHST or elements of the team to designated homes.

A *Care Home Covid Prevention Plan* comprising of a Prevention Plan Brief, Prevention Implementation Plan and an Employee Wellbeing Plan has also been developed. The plan co-ordinates support to Covid-free care homes in Calderdale to prevent the transmission of Covid, to protect the most vulnerable and the resilience of the wider care home sector. The key strands of the action plan include:

- Develop and review hospital discharge to care home protocols, focused on keeping as many Care Homes as possible Covid free, including testing prior to discharge, discharging positive and unknown people to alternative provision and delaying discharge where necessary.
- Ensure that staff and residents in Care/Nursing Homes without confirmed cases are tested regularly so that cases can be identified as early as possible, and protective action taken.
- Undertake surveillance of Care/Nursing Homes without Covid cases, including the number and frequency of staff and resident tests, assessment of infection prevention skills, receipt of infection prevention training.
- Deliver a programme of co-ordinated support to, and engagement with, Care/Nursing Homes without Covid cases, to include infection prevention training and support,

identification of barriers to effective infection prevention in practice, advice on PPE and cleaning
- Regularly review the impact of the support provided and adherence to infection prevention in care homes without cases
- Co-ordinate and simplify communication with care homes on Covid prevention, the support available and how to provide feedback and raise concerns

To support the Calderdale prevention plan, NHS partners have deployed enhanced Infection, Prevention and Control, PPE and COVID-19 testing training, in line with the NHS offer of mutual aid described. Locally the target has been exceeded for the deployment of both super trainers and trainers and infection related training in all homes in line with the mandated training offer as of 29th May. For those homes that initially declined, follow up training and resources have been shared.

Assurance that actions are being implemented and plans are in place.

Whilst in the early weeks of the pandemic there had been a steady increase in both the number of Care/Nursing Home residents and staff that have tested positive for COVID-19 and an increase in staff and residents that are symptomatic, the number of deaths in care homes and positive cases has reduced significantly from the beginning of May to the current date compared to the previous month. Over two thirds of the care homes for older people in Calderdale have had no residents confirmed as COVID-19 positive and a number of care homes that previously had positive cases are now COVID-19 free. Currently there are only two homes supporting positive residents.

In Calderdale, whole Care/Nursing Home testing is being co-ordinated by Calderdale CCG. Testing for homes that are priorities for the national care home testing programme are booked through the national portal by the CCG on behalf of the Director of Public Health. All staff and residents in will be in receipt of fortnightly testing from the end of July.

In relation to PPE, the council has procured PPE from a range of sources including more local providers and has established a local collection and distribution process. A range of providers continue to be identified and to date over 1,000,000 pieces of equipment have been distributed locally. This has ensured that at every stage, Residential and Nursing Home providers have had sufficient supplies of PPE. Feedback from providers has been very positive, a view the Care Quality Commission have endorsed, highlighting Calderdale as an example of good practice.

Approach to short-term financial pressures experienced by care providers.

Both the Council and CCG have agreed a package of financial support for care homes for 12 weeks initially. Residential and Nursing Homes are receiving a payment that is 10% of the weekly fee (at 2020/21 prices) for the highest number of local authority funded placements the home had for during period 27th January to 7th May 2020.

Care homes have received 12 weeks of payment to the end of June. Local Authority staff have also been deployed to support residential and Nursing Homes as part of the overall support provided to assist providers incurring further additional costs for agency replacement staff and potentially spreading Covid-19 inadvertently across the sector.

Approach to providing alternative accommodation and local co-ordination for placing returning clinical staff or volunteers into care homes.

In Calderdale, a range of local accommodation has been commissioned to support hospital discharges and community step up where required. Additional bed capacity to support people to be discharged from hospital (*step down care)* and people in the community where formal or informal care breaks down (*step up* care) including hotel accommodation, has been commissioned by the council and CCG supported by an agreed discharge pathway.

This includes an innovative development which has attracted national media interest, in partnership with a local Hotel Cedar Court, commissioned to offer support to younger and older adults, people being discharged from hospital and those who require enhanced community support. This provides for 10 beds currently but has the capacity to increase to up to 70 beds if required. The hotel staff have worked alongside local authority day service staff to provide a person centred service that can also offer a break for carers where access to usual services and activities has reduced.

The short term accommodation commissioned in partnership with the CCG, includes up to 18 nursing care beds in a self-contained section of a local nursing home. This home can support Covid positive discharges and direct clinical support has been put in place within the home from CCG nurses. This service went live from 06/06/20 and formed a crucial part of the revised discharge protocol ensuring that people who were Covid positive were not discharged back to their care home until completion of their isolation period. This has helped to reduce the risk of spread of infection and risk of outbreaks in care homes.

Two new residential services have also been established within vacant properties to support people who are Covid positive and negative but need additional care before they can return to their normal place of residence including residential care homes. The first of these two facilities provides 6 beds and the second 10 beds, with the second having the capacity to increase by a further 13 beds to 23 if required. Both facilities have been staffed by redeployed local authority staff and also staff from a local care agency.

Enhanced support has also been provided to Residential and Nursing Homes to enable residents to be safely supported to isolate or shield. The Council has directly redeployed local authority staff to provide care and domestic support over the last three months to a number of care homes. This is reviewed daily to ensure that resources are targeted to the homes which require the most support.

In addition, the local accommodation to support hospital discharges and community step up referred to earlier, has been led and supported by both Council and NHS staff including returning clinical staff and volunteers from the council's volunteer hub.

Calderdale continues to commission rapid and urgent homecare to ensure that people can return home from hospital with the correct support and where appropriate to prevent hospital admissions.

Some of the above services particularly the building based provision, have not been fully utilised and are either in the process of being scaled down or de-commissioned. As a key preventative cornerstone of the local place based approach, this aspect of the plan has been recognised as

a positive factor in terms of ensuring sufficient capacity was built across the system in the event of services being required, while effectively addressing any potential spread in the Care/Nursing setting and wider community.

Collaborative Commissioning – Care Closer to Home

The Calderdale Health & Wellbeing Strategy is the agreed strategic direction for Calderdale adopted by the HWB. In developing the new collaborative community model we recognise the approach it describes:

- Health is not just in the gift of our health and social care services.
- A healthy society is not one that waits for people to become ill, but one which sees that health is shaped by social, cultural, political, economic, commercial and environmental factors - and then takes action on these for current and future generations.
- We know that key social determinants of health include: our education and employment opportunities; our housing; our income; our social networks; and where we live and the extent it facilitates physical activity, good food and social connection. These factors shape the conditions in which people are born, grow, live, work and age.
- Our community model recognises that these determinants are crucial in reducing health inequality and improving health – and the impact of the pandemic in deepening those inequalities

Over the past 8 weeks system partners have been reviewing the collaborative community approach building on the excellent work during covid-19, develop further the system for transformation utilising learning to make it sustainable.

The aim of the system was to 'Think big and Rapidly'. As part of this work a set of principles have been developed to wrap around the collaborative community model developed and proposal.

Infection Control Funding

The Government Department for Health and Social Care has allocated Calderdale Council £1,8921,731 from the Infection Control Funding. In line with the requirements all care homes in Calderdale have now received their first instalment of the funding, paid on a per bed basis of £963.06 per bed, using the information on the SitReP for the purposes of calculation. There are a number of conditions attached to the funding in relation to infection control measures and the second instalment is payable once the Council is able to demonstrate that these have been met.

Care Home Provider Resilience

The care homes across Calderdale have been impacted significantly by COVID, due to the number of Covid related deaths and vacancies which have arisen as a result of these. The average percentage rate of under occupancy was around 13 to 15% but this is now nearer to 20%. The number of new admissions slowed down dramatically during COVID, due to the need to manage and contain the spread of the virus Two nursing homes who historically have operated waiting lists, are now operating on 17% vacancy levels, and another care home for residential EMI has a vacancy rate of 30%. We anticipate that providers will take many months to recover as a result of this and others may not survive what was an already fragile market.

The Care Homes Enhanced Support Team (CMBC, CCG, CHFT) continues to support and keep oversight of the local position with care homes in Calderdale using the SITREP.

Future Re-Imagining of the Care/Nursing Home Sector

As a place system, Calderdale Council together with the CCG and CHFT partners have quickly recognised that the adversity of Covid-19 has inadvertently created a new and successful model of collaborative leadership and practice across the Residential and Nursing Home sector. An example has been the collective learning taken from the Enhanced Care Home approach, in which the above agencies rapidly deployed and aligned resources to immediately reduce and prevent the further spread of Covid-19 across the sector.

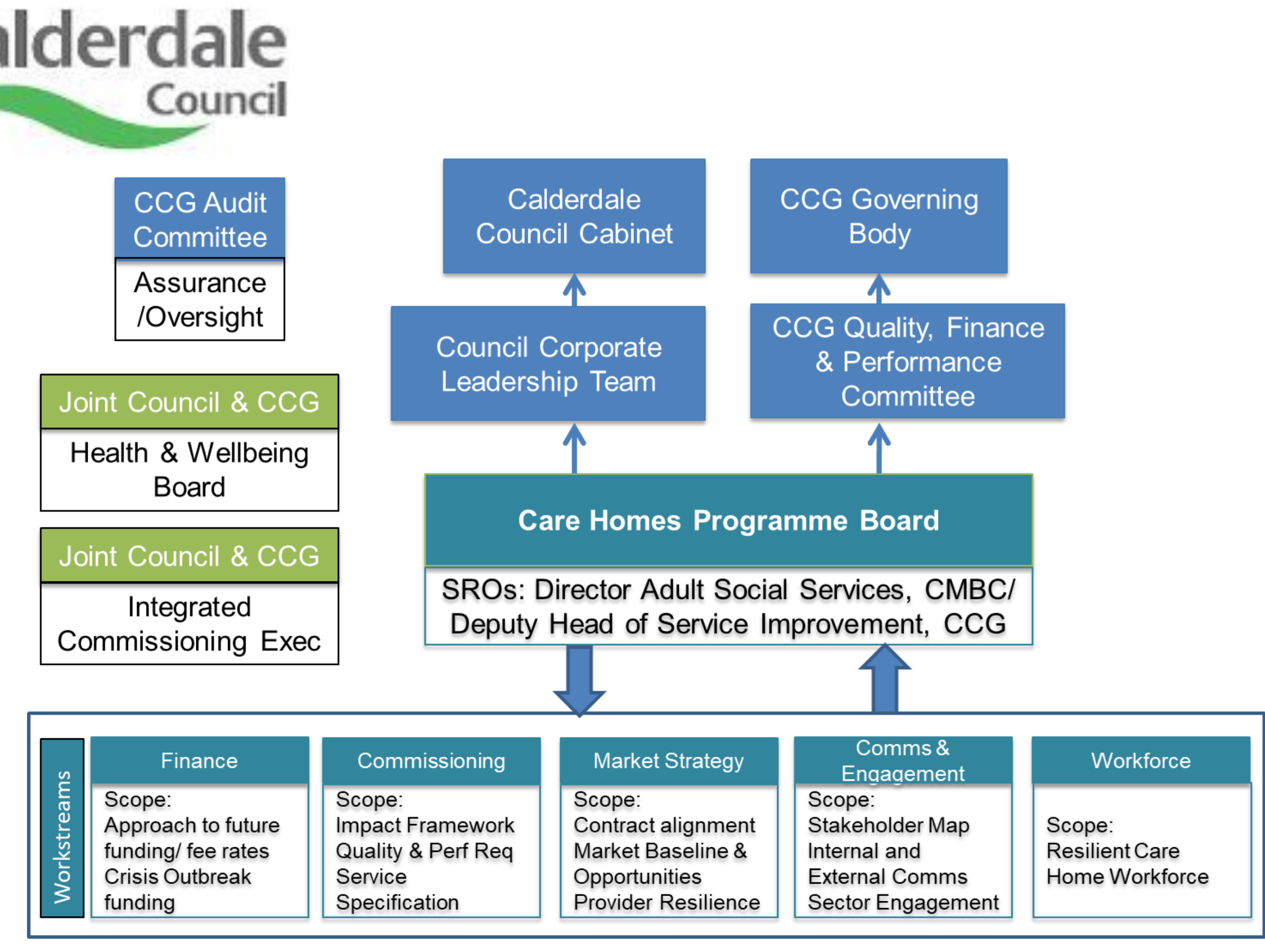
The consensus at a strategic and operational level across agencies is that this should be the catalyst to quickly capitalise on such a significant and proven achievement, while also beginning to address some of the endemic workforce and quality concerns that commonly feature in this area. By bringing clinical and social care expertise together with third sector thinking, the potential to change how care and support is delivered across Care and Nursing Homes in Calderdale in line with a refreshed Care Closer to Home and Integrated Living Model, could be the basis upon which this part of the sector is transformed.

The intention is to build the work of the Care Homes Commissioning Board and the learning from Covid-19 into a revised Programme structure that would: develop jointly (CCG/CMBC) owned Service Change proposals for the provision of adult social care in residential care homes and nursing homes across Calderdale which: incorporate learning from Covid-19; acknowledge delivery of the Enhanced Health in Care Homes by Primary Care Networks; and integrate into the overall Health and Social Care model to sustain delivery of the enhanced universal support offer.

The Programme Board will oversee the work to:

1. Undertake further engagement with Care Home service users to shape the proposals.
2. Complete a baseline understanding of the current market, what is commissioned/what we buy (Demand) and what is provided.
3. Identify opportunities regarding increased/changed demand as a result of service user feedback, demographic growth and Suppliers identification of what could be provided.
4. Produce a Commissioning Strategy and Service specification
5. Develop a Market management and Provider resilience strategy based on an evaluation of the market place strengths and weaknesses which clearly identifies responsibilities for providers in relation to Quality and Finance.
6. Co-ordinate and sequence implementation of proposals.
7. Communicate with Internal and External Stakeholders.

It is anticipated that the governance structure to support this could be as outlined in the diagram below:



The next step for the work is for the Programme Board to meet in development to set out the Roadmap to implementation, the critical path to delivery and the capacity and capability required, followed by a formal meeting of the Programme Board.

At this stage there are no plans that require consultation. However the further engagement with Care Home Service Users and the evaluation of potential opportunities regarding increased/changed demand as a result of service user feedback, demographic growth and Suppliers identification of what could be provided may identify a requirement and the committee will be informed should that be the case.

2. Further Action/Timescales

This briefing is an update to the Health and Social Care Scrutiny Board on the progress to date of the actions taken across the system to prevent and minimise the spread of Covid-19 across the Residential and Nursing Home sector in Calderdale. As such there are no actions or timescale to consider, apart from further updates as required, including report on the future shape of Residential and Nursing Home Sector.

3. Options Appraisal

Currently there no options to consider.

4. Climate Change

Future plans that will require a reconfiguration of physical assets, such as workforce and estates will take into full consideration the environmental impact as a such appropriate assessments will be undertaken and reported.

It is envisaged that any reconfiguration of resource will be locality based and therefore has less impact on the environment.

5. Conclusion

During the Covid-19 pandemic, the mobilisation and collaboration of Health, Social Care and Public Health resources with Third Sector support has proven to be a powerful model in reducing and preventing further spread of the virus over the last three months. It can be presumed therefore that this approach has significantly contributed to the lower number of positive cases, consequent outbreaks and deaths that have taken place in Residential and Nursing Homes across Calderdale, compared to similar areas. This has been demonstrated by the direct experience of Residential and Nursing Homes at the forefront of the crisis and the new collaborative practice that has arisen across all agencies. As such an opportunity has been created to potentially commission a new, different and sustainable model of care at greater pace than previously imagined prior to Covid-19.

Key Messages; Calderdale

- We are a strong system - integrated set of principles and priorities to guide reset are being developed (see draft principles - slide 9)
- Recognition of key issues:
  - Widening of health inequalities – including those who have been unable to access services during C19 period (physical and mental health)
  - Huge economic impact on Calderdale population
  - Impact of social distancing on delivery of all types of care, support and business as usual in the long-term
  - Integration of community offers and support to care homes are critical success factors (inc mental health)
  - Long-term impact on well-being of staff who have been through traumatic change
  - Our planning for reset – needs to be about winter 20/21 (is likely to be on a scale that we have not yet seen in terms of demand and out ability to meet it).
  - Insights from Impact Assessments and public views are important in shaping our reset and ensuring population ownership

Step 1. What are the priority population health outcomes?

System partners: CMBC, CCG, PCNs, LMC, CHFT, SWYPFT, Hospices, VCS, LCD, Locala, YAS, WYCP, NHSE (System Calls at both a CHFT and Calderdale footprint)

1. Priority Groups in the Population; those whose health and wellbeing is at greater risk due to C19: in particular those:

- Who have not received urgent care during C19 and for whom health inequalities are likely to have widened (for example Cancer and cardiovascular services)
- Of all ages who need mental health support
- Who remain shielded and vulnerable
- Who live in care homes
- Who may suffer from the long-term effects of C19 as we move into winter
- In BAME groups who have been disproportionately affected by C19
- At risk of violent crime and domestic abuse
- In other groups; Street homeless, unpaid carers

2. Safely opening up Calderdale; transport, workplaces, care and communities

Step 2. What does this mean in terms of service priorities?

Community;
- Community offers integrated around PCN footprints and new normal for GP
- New wrap around care home support from the system
- Integral role of VCS,
- Integrated end of life care pathways, ACP
- Protecting vulnerable and shielded patients, Screening

CMBC :
- Care home and home care market (strategic future and here and now)
- Roll out; Test, trace, isolate, Safely re-opening schools, Shielding and vulnerable patients

Acute
- Backlogs of patients who have not been in receipt of urgent care
- A&E, critical and emergency care resilience
- Safely re-opening elective care and role of IS
- Cancer pathways and role of IS
- Stroke & Cardiovascular pathways
- Respiratory pathways and the future care of post-C19 patients

Mental Health:
- Integrated all aged offer, support, suicide prevention, shielded patients, IAPT

CCG: Commissioning and procurement futures

Step 3.What are the requirements on other services?

- **System:** coalesce on development and delivery of new normal – principles and priorities (see last slide)
- **Community:** fully integrated model, MDT working, PHM, support for care homes, integrated end of life care pathways
- **CMBC:** recovery of population well-being, Track, Test & Isolate, retain shielding capability, support for the market
- **Third sector:** infrastructure support, lead new volunteering models to support vulnerable/shielded population. VCS offers a key part of system pathways
- **Acute:** new ways of working – elective, diagnostic and non-elective pathways which manage social distancing requirements
- **Mental Health**; support for the psychological impact of C19, shielded patients
- **General Practice:** build on PHM architecture and learning from C19, agree new normal, support re-opening of elective care
- **Transport**; commissioned to support new normal

Step 4. What are the constraints?

Personal Protective Equipment:
- Strong supply chain (in line with mapping of requirements)

Testing:
- Confusion of offers, logistics and supply issues
- Size of Track, Test and Isolate agenda, and rolling out of antibody testing
- Impact on 14 days isolation period on patients and staff absence

Workforce:
- High levels of absence, particularly in social care commissioned services
- Ability of testing to support staff to return to work

Physical estate:
- New acute clinical offers to support safety of staff and patients (out-patients, beds, 70% occupancy, diagnostics, super green/cancer care)
- Red and green site approach for primary care for phase 2
- Future estate requirements given shift to home working

Medicines:
- Availability of drugs (particularly end of life)
- Business continuity issues community pharmacy (MDS)

Winter:
- We need to plan for winter as we plan our reset

Step 5. What innovations should we retain / adopt from elsewhere?

Pathways:
- Care home support; wrap-around system support models
- New community bed offers (post acute, social care, D2A)
- Services moved out of hospital which will stay as part of our new model (eg Frailty)
- End of Life; support, integrated working and focus on ACP
- Third sector part of infrastructure
- Stroke rehabilitation out of hospital
- Mental health support and advice
- OPAT at home
- Social care and volunteering hubs (at a system level)

Digital
- Maximise impact of high adoption of digital solutions locally (direct care and BAU)
- Integration of EPR, GP systems and CMBC client system to drive forward PHM
- Digital by default for out-patients, third sector, mental health etc

Intelligence:
- Engagement and co-production with population and staff
- Embedding of PHM innovations started pre-C19
- Embedding learning from 4,800 stratified vulnerable and shielded people

New ways of working
- Clinical Dialogue has increased at a strategic level and will be maintained
- New opportunities for clinical dialogue at a patient level

General Practice Development:
- PCN architecture; hot and cold sites, home visiting service – looking at models for the future.

Step 6. What does this mean in terms of addressing need. What are the gaps?

Health Inequality/Economic Analysis;
- Output of C19 impact analysis commissioned by CMBC (economic/wellbeing)
- Impact of reduced urgent care during C19 period

Mental Health;
- Being ready for potential impact of lock down – emerging

Social Care:
- System agreement on supporting shielded and vulnerable patients
- Support for the social care market

General Practice:
- Joint primary and secondary care CAS approach for 6 high volume specialties and diagnostics
- Understanding the impact of C19 on primary care - SITREP in place to support system with high level indication of pressure areas.

Beds
- Full bed plans to enable 70% occupancy and social distancing underway
- Reframing of reconfiguration assumptions underway
- New community bed model – building on C19 learning underway

Third Sector:
- Support individual organisations underway

Principles (draft)

- **Strong leadership** take every opportunity to strengthen relationships and dialogue; clinically, professionally, organisationally and with our communities
- **Safety**; keep our population and our workforce safe - be clear about the implications of social distancing and infection prevention and control in our planning
- **Positive experience**; be clear with our population about what they can expect in we move into a post-C19world, co-produce solutions and seek their views to support the reset.
- **Winter** – in planning for our reset we are also planning for winter
- **Economy and inequalities** – recognise the financial and economic downturn that will emerge - approaches to recovery must drive reduction in inequality not exacerbate it (use ICS EQIA/QIA processes)
- **Third sector** – ensure we take the opportunities to ensure they have a stronger and more integrated role and voice in our future world
- **Communicate;** – be clear and joined up in our messaging
- **Innovate:** maximise the potential to learn from C19 and accelerate transformation - establishing the 'new normal'
- **Understand the Context** – understand the system perspective rather than simply those of our own organisations, increasing our appetite for trust and risk.
- **Implication & impact**; be clear about how plans impact on others in terms of; workforce, logistics, organisations
- **Use Data and evidence**; ensure we are data driven – understand what has changed, what we want to keep, what we want to stop.
- **Work on a WY&H Footprint** – Influence the work at WY&H and work on 'at scale' solutions where they support local patient care, and apply the Ethical Principles agreed by the ICS

Timelines

Timescales	Planning Stages
1. Jan-April 2020	• Level 4 incident • Focus on critical care and building capacity to respond to C19
2. April-June	• 2020 Immediate recovery actions post-C19 surge • Focus on urgent activities
3. July 2020 – March 2021	• More comprehensive planning review • Focus on building elective and potential C19 spike • during the winter phase
4. April 2021	• onwards Focus on recovering and developing the NHS towards the • 'new normal'

Item 5 Appendix 3

CALDERDALE COVID-19 OUTBREAK PREVENTION & CONTROL PLAN

June 2020

V1.6

Version Control

Version Number	Author	Purpose/Change	Date
1.1	Ben Leaman	Initial draft	17/06/20
1.2	Ben Leaman	Second draft, with comments from Debs Harkins and Caron Walker	23/06/20
1.3	Ben Leaman	Third draft, comments from Ian Hughes	24/06/20
1.4	Ben Leaman	Fourth draft, following videoconference with Cllr Tim Swift, Robin Tuddenham, Ian Hughes and Debs Harkins	24/06/20
1.5	Ben Leaman	Fifth draft, additional comments from Debs Harkins, Nigel Broadbent and CCG	25/06/20
1.6	Ben Leaman	Sixth draft, additional comments from Debs Harkins, Caron Walker, CCG and following peer review	26/06/20

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1 Introduction

1.1 Calderdale Council, alongside multiple organisations and partnerships across the Borough, has been working to support a range of settings (e.g. schools, care homes, workplaces) and communities, both proactively and reactively as part of the overall COVID-19 response. This activity will continue in the Test and Trace phase of epidemic management, working closely with Public Health England (PHE). However, the focus of both the proactive and reactive work will need to change, as workplaces, schools and the Borough more generally open more widely, and as the national Test and Trace programmes becomes embedded.

1.2 Local Authorities have been asked to develop Outbreak Prevention and Control Plans by the end of June 2020, focusing on seven themes:

a) Care homes and schools – Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response).

b) Identification of high-risk places, locations and communities, e.g. homeless shelters, migrant worker dormitories/accommodation for vulnerable migrants, high-risk workplaces (e.g. meat packing plants, slaughter-houses among others), places of worship, ports and airports. Defining preventative measures and outbreak management strategies.

c) Local Testing Capacity – to prioritise and manage deployment of testing capacity quickly to the places that need it for outbreak management (e.g. NHS, pop-up, mobile testing units etc).

d) Local Contact Tracing – Led by PHE, but for LAs to consider mutual aid and support structures - identifying specific local complex communities of interest and settings. There is a need to develop assumptions to estimate demand, developing options to scale capacity if needed.

e) Data and integration – national and local data integration and ability to measure R number locally; links with Joint biosecurity centre work (to include data management planning, data security and data linkages).

f) Vulnerable people – supporting vulnerable people to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities.

g) Local Boards - Establishing governance structures led by existing Covid-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the general public.

1.3 This document is Calderdale's COVID-19 Outbreak Prevention and Control Plan (OPCP) and is intended to operate for the next 18 months, with a formal review in June 2021.

1.4 The document should be regarded as a living document, which will be updated as required and, in particular, should supporting documents that are developed on a wider basis than just Calderdale change. No material changes to our approach, and by extension this document, will take place without formal review through the member-led governance process.

1.5 The national Test and Trace programme is part of the broader national strategy to control the transmission of COVID-19 from person to person. This Outbreak Prevention and Control Plan for COVID-19 sets out how health protection expertise and capabilities are combined with a wider multi-agency response to prevent and control COVID-19 to reduce its spread and subsequent morbidity and mortality. Specialist health protection skills and capabilities sit within an already functioning system which includes local authority public health and environmental health functions alongside PHE. Co-ordination capabilities sit with the Strategic Co-ordinating Groups of our Local Resilience Forum.

2 Background and context

2.1 On 31 December 2019 a new coronavirus disease was identified in Wuhan, China. This is now called COVID-19 and is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Subsequently the infection spread around the world and was labelled a Public Health Emergency of International Concern by the World Health Organisation (WHO) on 30 January 2020. It was then decreed to be a pandemic on 11 March, the fifth pandemic since the Spanish Flu a century ago.

2.2 As of 21 June 2020, almost 9 million cases of COVID-19 have been reported in more than 188 countries and territories, resulting in close to 500,000 deaths. Both figures are likely to be significantly lower than actual numbers. There are different ways of measuring the death rate, and it is hard to compare between countries. However in the UK between 7th March (when we saw the first death from COVID-19) and the 5th June there have been over 50,000 deaths to date where COVID-19 is mentioned on the death certificate, and almost 65,000 excess deaths compared to what we would expect to usually see.

2.3 Multi-national research to understand the epidemiology of COVID-19 is underway and information about its symptoms and impact are emerging as we learn more about it. Common symptoms include fever, a new continuous cough and loss of or change in sense of smell or taste. Complications may include pneumonia and acute respiratory distress syndrome. The time from exposure to onset of symptoms is typically around five days but may range from two to fourteen days. There is no known vaccine or specific antiviral treatment, although some medical interventions have been shown to be effective in those who are in acute respiratory distress and new potential interventions continue to be proposed following intense medical studies. All effective medical interventions identified to date help those people who have more severe consequences of the infection rather than being treatment for COVID-19 infection per se.

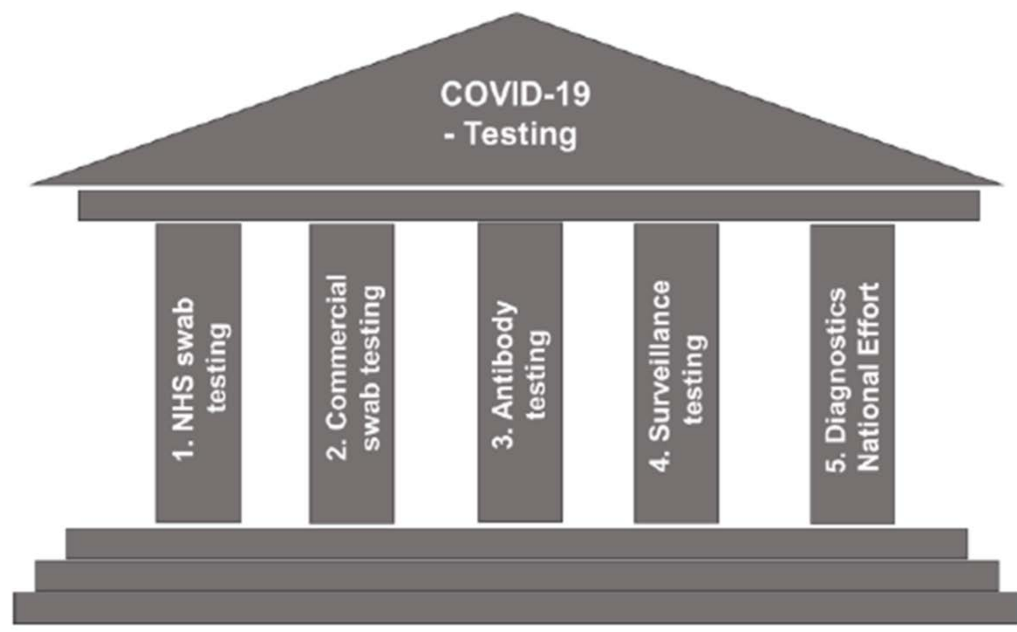
2.4 Controlling a communicable disease depends on interrupting its spread from person to person. The national strategy initially focussed on case-finding and isolation by testing suspected cases and identifying contacts of confirmed cases and was managed by PHE. With limited capacity for testing nationally, as cases increased during March 2020 capacity for testing was deemed

overwhelmed and testing was redirected towards seriously ill hospitalised cases.

2.5 This change in strategy was prompted by a rising number of cases and severe strain on hospital acute care beds. At this point the national strategy changed, moving away from a ‘find, test, isolate, contain’ approach to one focused on delaying the spread of infection to ensure the NHS could manage demand. This was commonly referred to as ‘flattening the curve’ and was a tacit admission that infection rates were out of control.

2.6 The preventative approach focussed initially on hand and respiratory hygiene, before the rising number of cases prompted the introduction of ‘lockdown’ of the economy at the end of March and subsequent strategies based on ‘stay at home’, ‘social distancing’, household self-isolation where symptoms are present and protecting the clinically vulnerable.

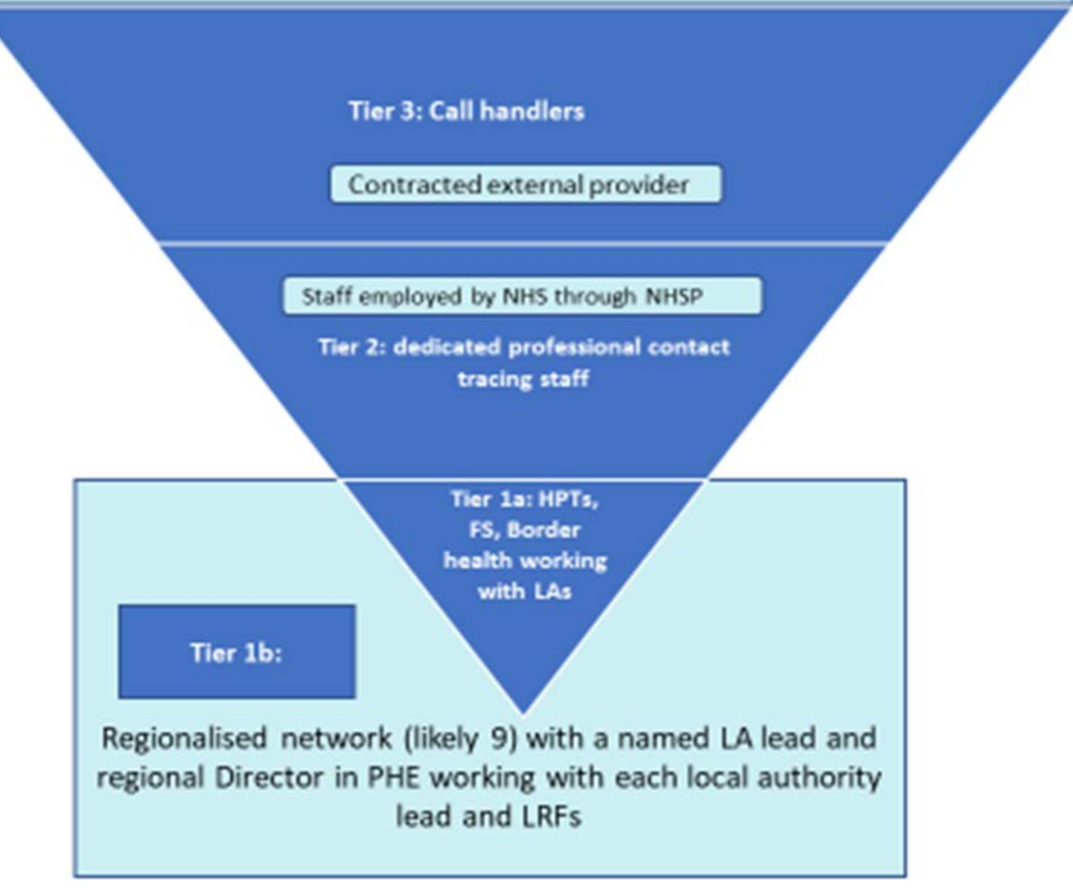
2.7 Efforts to increase testing capacity restarted from the beginning of April 2020, with a national five pillar plan announced on 2nd April. On 18th May everyone in the UK became eligible for testing if they have symptoms. The testing pillars are illustrated below:



2.8 Anyone with symptoms can request testing through a national portal (Pillar 2 testing). Tests are generally delivered either through national test sites (Leeds and Bradford are our local ones) or by post. Additional testing capacity is in

place locally for key workers, but with a limited number of tests per session. We offer local testing for priority settings such as care homes through the local satellite service – and can respond to high risk settings and individuals through this route too in a small outbreak scenario. Additionally, the army deploy mobile testing units to pre-designated sites which are available by appointment, and this has included a site used frequently in Todmorden. As of June 2020, local Directors of Public Health can influence the deployment of mobile testing units to respond to local outbreaks and local COVID-19 surveillance.

2.9 The NHS Test and Trace Service went live on 28th May. Locally we do not have direct control over the national NHS Test and Trace programme, which is led by the Department of Health and Social Care. A bank of contact tracers was commissioned from the private sector to follow up people who test positive and provide advice on household isolation as well as identify close contacts, who are in turn contacted and asked to self-isolate. The national programme has three tiers within it, with Local Authority Public Health forming tier 1b, as detailed below:



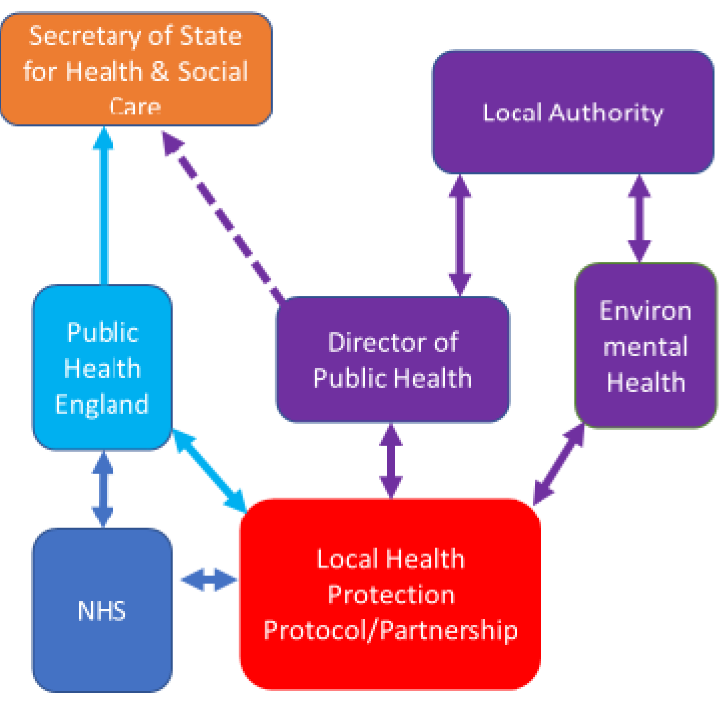
2.10 The establishment of the national programme has happened from the top down, separately to established local systems. The speed at which this has happened is challenging and the disconnect between national and local programmes of work has been complicated to unify. In May a national team was set up to ensure these systems are more closely linked with expertise from PHE and embedded into local authority public health teams in order to shape the test and trace programme to meet local need. The programme seconded Tom Riordan (Chief Executive of Leeds City Council) and Sarah-Jane Marsh (Director of Testing, NHS Test and trace, seconded from substantive post as Chief Executive of Birmingham Women's and Children's NHS Foundation Trust) to build links with local authorities. This has provided an opportunity for us to influence the national programme and develop our local response to make Test and Trace work more effectively.

2.11 Recognition of the important role that Local Authorities have, and their innate understanding of their local areas, comes with a critical role in the delivery of the national 'Test and Trace' programme. Whilst this opportunity is welcome, it should be recognised that Local Authority Public Health teams have little control over the national programme infrastructure and delivery mechanisms. We do, however, have more local involvement in the management of outbreaks, under the coordination of PHE, and increasingly will have more scope for local surveillance to identify areas of raised community or cohort transmission and the ability to respond appropriately.

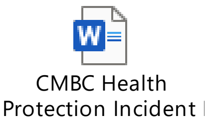
2.12 The COVID-19 outbreak has impacted most severely on groups and communities that already experience poor heath, exacerbating existing health inequalities. National policy and programmes to control the pandemic including testing, contact tracing, self-isolation messages and social distancing measures have proved difficult to access and adhere to for some communities. Local Authorities know our local communities and are best placed to ensure that local outbreak prevention and control activities reach and are effective for all communities in our local areas.

2.13 Health protection and communicable disease control is a key strand of public health practice and part of the day to day work of local public health teams, in partnership with Public Health England (PHE) along with colleagues in Environmental Health and the local NHS. The current operational model can be illustrated by the following simplified model:

Local Health Protection System simplified diagram



2.14 Calderdale has strong outbreak management arrangements in place, with robust governance under the leadership of the DPH. These well-established outbreak management arrangements are underpinned by the Calderdale outbreak management plan developed and approved by the Calderdale Health Protection Assurance Group (CHPAG). These arrangements are robust, effective, timely, and responsive, outlining clear roles and responsibilities of health and care services to manage outbreaks within a wide range of settings and population groups. The Calderdale Covid-19 Outbreak Prevention and Control Plan builds on the existing outbreak plan, scaling up and enhancing existing arrangements and services to meet the needs of local communities.



3 Purpose of the Outbreak Prevention and Control Plan (OPCP)

3.1 The Calderdale OPCP will help us achieve our objectives, which are to:

- Keep cases of COVID-19 low in Calderdale
- Spot trends early and identify clusters of cases quickly
- Respond quickly and appropriately if outbreaks occur

3.2 By meeting the above objectives, we will help the Borough and the nation return to a degree of normality by keeping transmission of COVID-19 as low as possible.

3.3 There are a number of ways we will do this:

3.3.1 Prevent outbreaks and cases before they occur via rigorous messaging around staying at home, social distancing, hand and respiratory hygiene, good infection prevention and control, self-isolating when symptomatic or household members are symptomatic, getting tested if symptoms present, reducing the risk for those deemed who are clinically vulnerable and providing support for those that are struggling to comply with self-isolation or shielding due to their personal circumstances. We will take a universal approach to this with all our citizens and a targeted approach where required with our more vulnerable citizens.

3.3.2 Communicate with our citizens through clear messages on what we are doing to reduce the risk of transmission and what they can do to protect themselves and those they live and work with. We will also promote and legitimise Test and Trace so residents with symptoms become more likely to understand the benefits of testing and self-isolation.

3.3.3 Engage with high risk cohorts, settings and communities. We will co-produce strategies with our local communities, settings, cohorts and communities of interest to reduce the risk of infection for those who are at higher risk of the consequences of infection.

3.3.4 Support those citizens who become vulnerable as a result of self-isolating by ensuring effective links are made between Test and Trace and the local community support available. This will build on our existing Volunteer Hub initially but will move to VCS-led support over time to ensure sustainability over the coming 18 months.

3.3.5 Test the right people at the right time, through promotion of the national testing portal. We will mobilise Mobile Testing Units to support an outbreak scenario that requires rapid testing in a setting or community. We already have in place a system to regularly test symptomatic and asymptomatic staff and residents in high-risk settings such as care homes and healthcare settings. We will explore the opportunities to provide walk-to testing sites in our more densely populated urban areas where we know there are communities more likely to be adversely impacted by the consequences of contracting COVID-19.

3.3.6 Surveillance of data that tells us what is happening in our communities. This will involve an integration of intelligence we receive from the Joint Biosecurity Centre and locally sourced intelligence, to help us intensify action where needed (specific geographies, settings, cohorts or communities of interest). We will develop local surveillance mechanisms and early warning indicators, working with our neighbours through the West Yorkshire and Harrogate Integrated Care System.

3.3.7 Respond to outbreaks as they occur via routine outbreak management processes and Standard Operating Procedures (SOPs). We will be clear when a 'simple' outbreak becomes a 'complex' incident and escalate accordingly to allow us to respond appropriately.

3.4 Outbreak control management via Test and Trace has a small impact on overall transmission reduction – estimated to be as low as 15%. At least half of transmission reduction to date has come from people staying at home, and 30% from 2 metre social distancing[1]. Prevention measures will continue to be the mainstay of our approach in Calderdale to keeping cases of COVID-19 low in our population.

3.5 Studies also suggest that nationally, only approximately half of people with symptoms suggestive of COVID-19 are reporting them to the national NHS Test

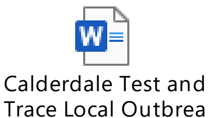
[1] BMJ 2020;369:m2151

and Trace system. We need this to be much higher in Calderdale, therefore there is a very significant communication and engagement programme needed for at least 12 to 18 months.

4 Strategic oversight

4.1 Local authorities are required to establish a member-led Local Outbreak Control Board to oversee the local element of the national Test and Trace programme.

4.2 In Calderdale this function will be undertaken by the Calderdale Recovery Coordination Group (CRCG), chaired by the Leader of the Council.



4.3 The CRCG will ensure that there is effective communication and public oversight of the implementation of Test and Trace in Calderdale.

4.4 The CRCG will oversee the implementation of a Outbreak Prevention and Control Plan for Calderdale with a particular focus on communication across sectors and with communities to maximise understanding and commitment of any required behaviours needed by individuals and organisations.

4.5 Decisions of the CRCG will be given effect through the governance arrangements of the sovereign bodies represented.

4.6 The CRCG will meet on a three weekly basis initially, although the chair has the authority to make recommendations to change the frequency.

4.7 The key role of the board is to support the effective communication of the NHS Test and Trace programme and the implementation of the Outbreak Prevention and Control Plan in Calderdale, ensuring that they are delivered in ways that are appropriate, accessible and effective for all local communities. It will:

4.7.1 oversee the development and delivery of communication and engagement as part of Calderdale's inclusive approach to recovery, helping to make sure that all communities and sectors are communicated with and effectively engaged.

4.7.2 help ensure that all key stakeholders have been identified and that the best routes to communicate and engage with them are utilised.

4.7.3 review the effectiveness of outbreak management approaches used, assessing whether the required behaviours by individuals and organisations are adopted across the Borough.

4.7.4 receive regular updates from the Director of Public Health about the incidence of Covid-19 in Calderdale, local patterns in its transmission and local outbreaks.

4.7.5 provide public oversight of progress on the implementation of the Test and Trace programme in Calderdale, and its reach into communities and groups that are most vulnerable

4.7.6 ensure that the implementation of the Outbreak Prevention and Control Plan builds on existing good practice and that lessons learned from other geographies are taken into account.

4.7.7 identify any barriers to progress and delivery and help resolve them, making the most of any opportunities that may arise.

4.7.8 provide reports to the Health and Wellbeing Board and make recommendations to partners about measures to be taken to prevent and control outbreaks.

4.8 The quorum is for all meetings and must include the Chair or the Deputy Chair. Agenda items can be reviewed and recommendations from the board requested by email, at the chair’s discretion.

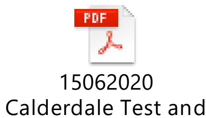
4.9 The membership of the CRCG includes the appropriate representation from key stakeholders in Calderdale, as follows:

Board membership			
Name	**Title**	**Organisation**	**Role**
Cllr Tim Swift	Council Leader	Calderdale Council	Chair
Cllr Jane Scullion	Deputy Leader	Calderdale Council	Deputy Chair
Robin Tuddenham	Chief Executive	Calderdale Council	Chair of Gold
Deborah Harkins	Director of Public Health	Calderdale Council	Chair of Health Protection Board
Marc Cole	Interim Director, Regeneration & Strategy	Calderdale Council	Lead Officer for Recovery
Neil Smurthwaite	Accountable Officer	Calderdale Clinical Commissioning group	NHS
Adrian Waugh	Superintendent	West Yorkshire Police	Police
Martin Hathaway	Managing Director	Mid Yorkshire Chamber of Commerce	Business community
Dipika Kaushal	Chief Executive	Voluntary Action Calderdale	Voluntary, Community & Faith Sector
John Rees	Principal	Calderdale College	Education sector
Janette Pearce		Together Housing	Housing Sector
Lucy Bradwell	Communications Service Manager	Calderdale Council	Lead Officer for Communications

4.10 We have detailed how the local governance will work, and how the local system fits with the national system in the embedded diagram below. To summarise, the CRCG will receive reports from and task actions to CHPAG and will be responsible for updating the following local and regional structures as required:

- West Yorkshire Local Resilience Forum
- CMBC Cabinet
- Calderdale Health and Care Leaders Board

- Calderdale Health and Wellbeing Board
- CMBC Gold and Silver



4.11 In practice, this means the CRCG can expect to receive the following:

- A weekly report from the Director of Public Health, detailing any outbreaks that are currently active in Calderdale and current statistics on Test and Trace at Calderdale level.

- A more detailed update on the current position of any declared COVID-19 incidents in Calderdale.

- Any request upward for support from CHPAG.

4.12 The CRCG can task the Director of Public Health with taking actions back to CHPAG for resolution.

5 Tactical coordination

5.1 The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits with:

- PHE under the Health and Social Care Act 2012
- Directors of Public Health under the Health and Social Care Act 2012
- Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
- NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and PHE to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
- Other responders specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004
- In the context of COVID-19, there is also the Coronavirus Act 2020.

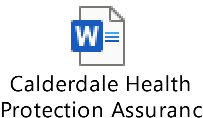
5.2 This underpinning context gives local authorities (Public Health and Environmental Health) and PHE the primary responsibility for the delivery and management of public health actions to be taken in relation to outbreaks of communicable disease through local Health Protection Partnerships. In Calderdale this is overseen by the Calderdale Health Protection Assurance Group (CHPAG). These arrangements are clarified in the 2013 guidance: Health Protection in Local Government. The legal context for Health Protection is designed to underpin the leadership of the local Director of Public Health, working closely with other professionals and sectors.

5.3 PHE is mandated to fulfil the Secretary of State's duty to protect the public's health from infectious diseases, working with the NHS, local government and other partners. This includes providing surveillance; specialist services, such as diagnostic and reference microbiology; investigation and management of outbreaks of infectious diseases; ensuring effective emergency preparedness, resilience and response for health emergencies. At a local level PHE's health protection teams and field services work in partnership with the Director of Public Health. PHE fulfils strategic and operational leadership roles both in the development and implementation of outbreak control plans and in the identification and management of outbreaks.

5.4 The Local Authority Director of Public Health has primary responsibility for the health of local communities. This includes being assured that the arrangements

to protect the health of the communities that they serve are robust and are implemented. The local Director of Public Health is therefore responsible for developing and deploying Outbreak Prevention and Control Plans by bringing together, and co-ordinating expertise from across local partners.

5.5 Tactical coordination will therefore be undertaken by the Calderdale Health Protection Assurance Group (CHPAG), an existing and well-established partnership arrangement under the leadership of the Director of Public Health.



5.6 The aim of the Calderdale Health Protection Assurance Group is to provide assurance to the Director of Public Health in Calderdale about the adequacy of prevention, surveillance, planning, quality, safety and response with regard to health protection issues. Membership of the group has been reviewed and revised to ensure the right people are involved in tactical coordination. Membership will include the following (or an agreed deputy):

CHPAG membership		
Name	**Title**	**Organisation**
Deborah Harkins	Director of Public Health	CMBC
Ben Leaman	Consultant in Public Health	CMBC
Caron Walker	Consultant in Public Health	CMBC
TBC	Infection Prevention and Control Nurse	CMBC
John Beacroft-Mitchell	Emergency Planning Manager	CMBC
Amy McGarry	Senior Environmental Health Officer	CMBC
Debbie Graham	Head of Integration and Partnerships	CCG
Lucy Bradwell	Communications Service Manager	CMBC
Jayne Leech		VAC
Paula Holden	Public Health Intelligence Manager	CMBC
Sarah Richardson	Assistant Director, Customer Services	CMBC

5.7 In addition, the following members may be co-opted depending on the agenda items and ongoing outbreaks:

CHPAG attendees (dependent on agenda)		
Name	**Title**	**Organisation**
Penny Woodhead	Chief Quality and Nursing Officer	CCG
Jean Robinson	Senior Infection Prevention and Control Nurse	CHFT
TBC	Infection Prevention and Control	SWYPFT
Kate Horne	Senior Programme Manager, Sexual Health	CMBC
Mercy Vergis	Consultant in Communicable Disease Control	PHE
Nichola Winter	Screening and Immunisation Lead	NHSEI
Mark Randall	Assistant Director, Education and Inclusion	CMBC
Rob Murray	Assistant Director, Early Intervention and Safeguarding	CMBC
Rhona Radley	Deputy Head of Service Improvement	CCG
Debbie Robinson	Head of Primary Care Quality and Improvement	CCG
Sean Cook	Assistant Director Adult Social Care Operations	CMBC
Any others as required, at the discretion of the Director of Public Health		

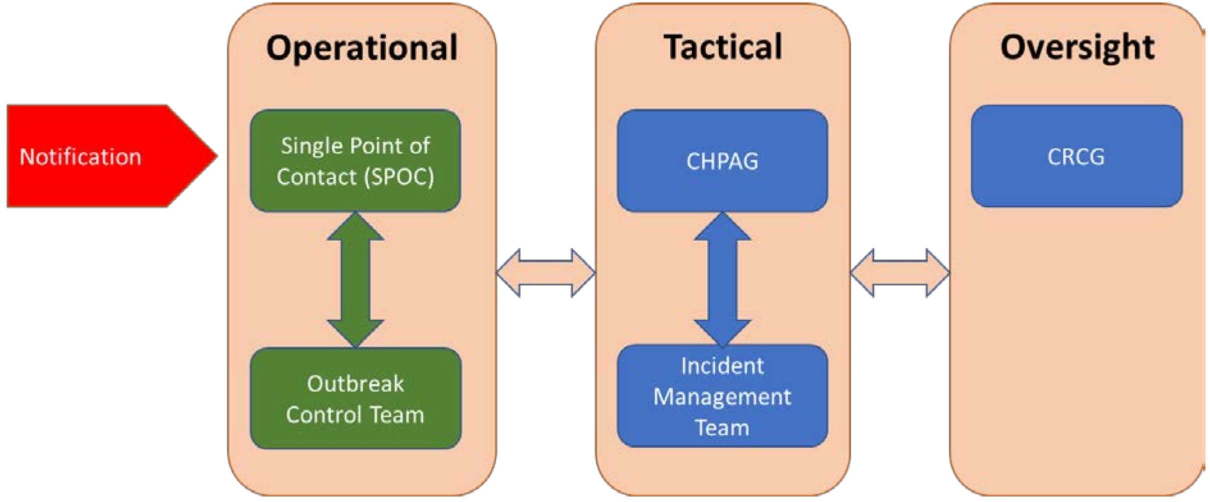
5.8 CHPAG will continue to undertake its core purpose across a range of health protection issues but will be focussed primarily on tactical coordination of the Calderdale response to COVID-19 for the foreseeable future.

5.9 CHPAG, and by definition the Director of Public Health, will receive updates from Outbreak Control Teams via the Outbreak Control Single Point of Contact (SPOC) detailing progress on any current outbreaks. CHPAG will consider progress and can escalate any outbreak to an incident. The Director of Public Health also has the right to do this independently of CHPAG.

5.10 Escalation of an outbreak to incident status means a broader range of partners will be involved in investigation and will always be led by a Public Health

Specialist (Consultant in Public Health or Director of Public Health) at a local level, in partnership with emergency planning and communications.

5.11 The diagram below indicates the flows into and out of CHPAG:



6 Operational delivery

6.1 Our approach to outbreak prevention and control is based on the following outbreak management principles:

- Population level prevention
- Targeted prevention
- Outbreak preparedness
- Outbreak response
- Outbreak learning

6.2 This is based on the premise that our goal is preventing outbreaks first and foremost, and particularly in settings or cohorts that are likely to be at greater risk. Where outbreaks do occur, we are prepared and understand the process we will follow to ensure a rapid and effective response – with a clear escalation process if it warrants moving from 'simple' outbreak investigation to 'complex' incident management. Finally, we will learn from outbreaks (and incidents) that occur both within our borough – through outbreak reports to the Local Outbreak Control Board - and more broadly from other outbreaks regionally and nationally.

6.3 Population level prevention describes the measures we are currently taking and includes promoting national guidance and a comprehensive communication and engagement programme with local communities and settings to support them stay COVID-19 free.

6.4 A range of Standard Operating Procedures (SOPs) have been developed jointly by Directors of Public Health and PHE regionally, which we will adopt locally (see section 7).

6.5 The purpose of the SOPs is to outline initial joint working arrangements between PHE Yorkshire & The Humber and local systems responding to confirmed cases of COVID-19, to reduce transmission, protect the most vulnerable and prevent an increased demand on healthcare resource.

6.6 The arrangements outline common principles and plan for flexibility in implementation at place. There will be a rapid transition period while resources and capacity are developed locally to support this.

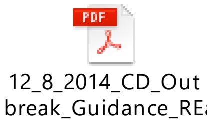
6.7 Notifications of outbreaks will be made to the Local Authority through a Single Point of Contact (SPOC), which will be managed by the Public Health Consultants. Any notification of an outbreak will be subject to a risk assessment completed by PHE, and as such any notification the SPOC receives from PHE can be considered an outbreak that requires further investigation. Where we are notified of potential outbreaks, either through local surveillance or via direct notification from a setting, the SPOC will escalate this to PHE for consideration. Outbreaks will only be declared by PHE, not locally.

6.8 The definition of an outbreak in a COVID-19 scenario is where two or more people with confirmatory COVID-19 (positive test) are linked by a common setting. This could be a health or care setting, a workplace, a school or a business. Single cases may be investigated in high-risk settings such as healthcare settings but won't necessarily be declared as an outbreak.

6.9 Upon notification, the SPOC will liaise with PHE to:

- Where required, mobilise an outbreak control team (OCT) to investigate the notification within one working day
- notify the Director of Public Health, who will:
  - notify the Chief Executive of the Council
  - notify the Leader of the Council, respective portfolio holder(s) and ward members
  - notify the communications team
  - notify the local MP

6.10 The OCT will operate in the context of the PHE Communicable Disease Outbreak Management Operational Guidance. This sets out clear processes for managing outbreaks at local level.



12_8_2014_CD_Outbreak_Guidance_RE

6.11 The purpose of the OCT is to agree and coordinate the activities involved in the management, investigation and control of the outbreak. The OCT will:

- assess the risk to the public's health
- ensure that that the cause, vehicle and source of the outbreak are investigated, and control measures implemented as soon as possible

- agree a communications plan
- seek legal advice where required

6.12 Membership of the OCT will vary according to the nature or circumstances of the outbreak and the incident level. A PHE HPT staff member is expected to be involved in all outbreaks. Usually an Environmental Health Officer and a Local Authority public health professional will also be required. Additional members will be expected to be involved dependent on the nature of the outbreak. For example, in an outbreak associated with a school the Headteacher will be encouraged to join the team, in a workplace outbreak, a representative of the employer will be encouraged to join.

6.13 The Public Health professional will be responsible for leading the coordination of the data collection and ensuring all reporting is completed at a local level. They will also be responsible for completing outbreak updates and drafting 'lessons learnt' reports to pass up to CHPAG. They will act under the supervision of a Public Health Specialist.

6.14 The existing Environmental Health data management system will be utilised for recording all data associated with outbreaks, with access granted to Public Health professionals.

6.15 The protection of the public's health takes priority over all other considerations.

6.16 The primary objective in outbreak management is to protect the public's health by identifying the source and implementing control measures to prevent further spread or recurrence of the infection.

6.17 The outbreak control team (OCT) must always give due consideration to their responsibilities in supporting investigations which may result in legal proceedings for example under the:

- Corporate Manslaughter and Corporate Homicide Act 2007 (as guided by the Work Related Death Protocol)
- Food Safety Act 1990 and associated regulations
- Health and Safety at Work etc. Act 1974 and associated regulations

6.18 These responsibilities include obtaining and ensuring the continuity, or chain, of evidence for presentation in concurrent or subsequent legal proceedings as well as civil proceedings or a Coroner's Inquest. Evidence may include

information relating to patients and contacts obtained in the course of the investigation of an outbreak. The OCT should if required seek guidance regarding the chain of evidence for a potential prosecution.

6.19 Secondary objectives include refining outbreak management, training, adding to the evidence base about sources and transmission of infectious agents and lessons learnt for improving communicable disease control.

6.20 Responsibility for managing outbreaks is shared by all organisations who are members of the OCT. This responsibility includes the provision of sufficient financial and other resources necessary to bring the outbreak to a successful conclusion. NHS commissioned organisations should have a requirement in their contract to provide what is needed to rapidly respond to outbreaks.

6.21 Outbreaks confined to NHS Trust premises, whether acute, community or mental health, will usually be led by the relevant trust in accordance with their operational plans and with the advice and input of a local Consultant in Communicable Disease Control (CCDC). The local CCG and DPH should also be informed. This includes by extension any outbreaks in primary care settings.

6.22 If any party is concerned with another organisation's response to an outbreak the CCDC should initially discuss the issue with the responsible commissioner. If the issue cannot be resolved by discussion between parties, they should seek advice from the PHE Centre director and local DPH.

6.23 If the outbreak crosses HPT or LA boundaries there will need to be close liaison with neighbouring HPTs and LAs and a decision made as to who will lead the investigation. The PHE Centre Director or HPT Directors together with the respective DsPH should make this decision as soon as possible. The lead area will most likely be where the outbreak is first identified or the majority of cases reside. Where the outbreak crosses LA boundaries the relevant DsPH will need to establish and maintain good communication with the neighbouring authority.

6.24 It is essential that effective communication is established between all members of the OCT, partners, the public and the media and maintained throughout the outbreak.

6.25 A communications lead should be part of the management of an outbreak from the outset and a strategy developed for informing the public and key

stakeholders should be discussed and agreed at the OCT. Communications teams of organisations involved should be in contact with each other to ensure that messages are consistent.

6.26 The Chair should ensure that minutes are taken at all OCT meetings and circulated to participating agencies as soon as possible afterwards. All key decisions should be recorded, the minute-taker is accountable to the Chair for this. It is recommended that administrative support be provided to the OCT as standard.

6.27 Use of communication through the media may be a valuable part of the control strategy of an outbreak and the OCT should consider the risks and benefits of proactive versus reactive media engagement in any outbreak.

6.28 The OCT will decide when the outbreak is over and will make a statement to this effect. The decision to declare the outbreak over should be informed by on-going risk assessment and when:

- There is no longer a risk to the public health that requires further investigation or management of control measures by an OCT.
- The number of cases has declined.
- The probable source has been identified and withdrawn.

6.29 At the conclusion of the outbreak the OCT will prepare a written report. Final outbreak reports are primarily for dissemination to a distribution list agreed by OCT members and should be completed within 4 weeks of the formal closure of the outbreak.

6.30 Lessons identified and recommendations from the outbreak report and constructive debrief process should be disseminated as widely as possible to partner agencies and key stakeholders. These should be reviewed by the Local Outbreak Control Board within 3 months of the formal closure of the outbreak. Learning should be reviewed against local plans and plans updated in light of this where required.

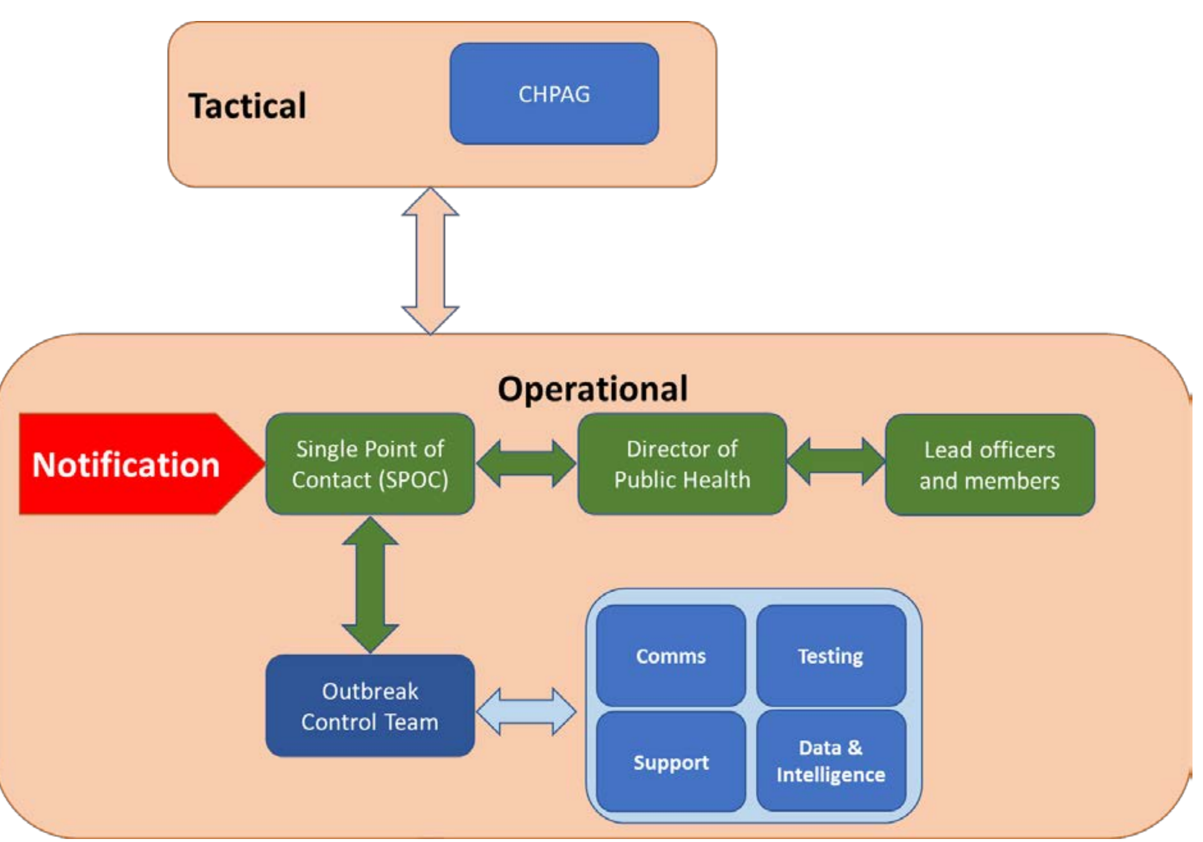
6.31 Where the OCT feels it is warranted, an outbreak will be upgraded locally to an incident. This will be a decision that is taken by the OCT, and will be escalated to CHPAG. The DPH will take a lead role on any incident. This could be due to the following circumstances:

- Need for additional internal resources
- Increased severity of the incident
- Increased demands from partner agencies or other government departments
- Heightened public or media interest
- Increase in geographic area or population affected
- Requirement for mutual aid

6.32 To summarise, the key tasks of the OCT are as follows:

- to review the epidemiological, microbiological and environmental evidence and verify an outbreak is occurring
- to regularly conduct a full risk assessment whilst the outbreak is on-going
- to develop a strategy to deal with the outbreak and allocate responsibilities based on the risk assessment
- to determine the level of the outbreak according to the PHE National Incident Response Plan and Concept of Operations documents (NIRP and CONOPs)
- to ensure that appropriate control measures are implemented to prevent further primary and secondary cases
- to agree appropriate further epidemiological, microbiological and environmental investigations
- to communicate with other professionals, the media and the public as required providing accurate and timely information
- to determine when the outbreak can be considered over based on on-going risk assessment and taking account of risk management actions
- to make recommendations regarding the development of systems and procedures to prevent a future occurrence of similar incidents and where feasible enact these
- to produce reports at least one of which will be the final report containing lessons learnt and recommendations

6.33 The below flowchart summarises the operational model as described in this section of the document:


Tactical
CHPAG
Operational
Notification
Single Point of Contact (SPOC)
Director of Public Health
Lead officers and members
Outbreak Control Team
Comms
Testing
Support
Data & Intelligence

7 Standard Operating Procedures

A set of standard operating procedures have been developed jointly by Public Health England and Directors of Public Health across the Yorkshire and Humber region. These will be reviewed regularly, are subject to change and may be added to. This list in this plan will be updated as that occurs.

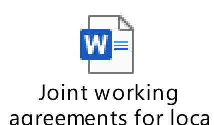
7.1 Education settings

7.2 Vulnerable people within residential settings

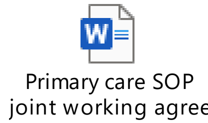
7.3 Care homes

7.4 Workplace

7.5 Underserved groups

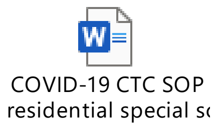


7.6 Primary care



7.7 Domiciliary care

7.8 Residential special schools



8 How we meet the 7 key themes

Key theme	What we have done	What we will do	RAG rating
Care homes and schools – Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response).	We have a standard operating procedure in place for both care homes and schools	We will work with settings to ensure they understand the process, from prevention through to notification of confirmed cases and their role in outbreak control if required	GREEN
Identification of high-risk places, locations and communities, e.g. homeless shelters, migrant worker dormitories/accommodation for vulnerable migrants, high-risk workplaces (e.g. meat packing plants, slaughter-houses among others), places of worship, ports and airports. Defining preventative measures and outbreak management strategies.	We have identified most areas listed to date, including high-risk workplaces and homeless shelters and have defined outbreak management strategies and preventative measures.	We will finalise identification of areas listed, and commence work with those areas to prevent infection and ensure they are aware of their role in outbreak control if required	AMBER
Local Testing Capacity – to prioritise and manage deployment of testing capacity quickly to the places that need it for outbreak management (e.g. NHS, pop-up, mobile testing units etc).	We have the ability to deploy mobile testing units to respond to outbreaks currently.	We will receive more local control over testing in the coming weeks, allowing is to respond locally to outbreak in a more streamlined way	GREEN
Local Contact Tracing – Led by PHE, but for LAs to consider mutual aid and support structures - identifying specific local complex communities of interest and settings. There is a need to develop assumptions to estimate demand, developing options	We will mobilise public health and environmental health officers should mutual aid and support be required, to cover complex communities of interest. Modelling	We will refine our modelling as further tools are developed regionally and nationally.	GREEN

to scale capacity if needed.	has been undertaken using a PHE tool, but is imprecise at this point in time		
Data and integration – national and local data integration and ability to measure R number locally; links with Joint biosecurity centre work (to include data management planning, data security and data linkages).	We have established how we will monitor pseudonymised data once we start receiving it and are assured this should happen shortly	Local surveillance is considered really important, using our local knowledge with available data to identify potential patterns of infection. We will do this once we receive the data to support the function	AMBER
Vulnerable people – supporting vulnerable people to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities.	We have a well-established community support hub, that provides support to vulnerable people across the Borough	We will develop the Council-led support hub transfers to VCS leadership and management to ensure a sustainable model is in place to provide support for those that may become vulnerable as a result of self-isolating	GREEN
Local Boards - Establishing governance structures led by existing Covid-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the general public.	We have established governance structures, and clear lines of responsibility in place – including communicating with the general public	We will review our governance processes at regular intervals to ensure they remain fit for purpose	GREEN

9 Resourcing

9.1 Calderdale has been allocated £1,233,390 to develop and implement an Outbreak Prevention and Control Plan, working with a range of stakeholders across Calderdale.

9.2 This welcome funding allows us to ensure we have enough capacity within Calderdale to respond appropriately to outbreaks when they occur, as well as prevent them from occurring wherever possible.

9.3 The funding is predicated on bringing additionality to the system, not filling financial holes.

9.4 The funding is in addition to funding received to support adult social care, which in particular supports work within care homes and domiciliary care.

9.5 The table below details the proposed allocation of the funding, along with any stipulations regarding the allocation. The funding is based on activity for the next 18 months, recognising it is impossible at this stage to know where we will be at that point.

Amount	Agency	Role
£200,000	Environmental Health, CMBC	➢ Second a senior environmental health officer into the outbreak control team on a whole role basis ➢ Back-fill the above post with 2 WTE EHOs for 18 months (agency acceptable) ➢ Expand license for data management system by 15 ➢ Train 15 members of the Public Health team to use the EH data management system
£200,000	Public Health, CMBC	➢ To include recruitment of up to 2 additional WTE IPC nurses (agency acceptable) to support outbreak management
£50,000	Comms, CMBC	➢ Develop a comms plan to ensure we communicate to all citizens in Calderdale effectively ➢ Perform a key role in OCTs, working with partners ➢ Collaborate on engagement

		strategies with partners to ensure we co-produce messages with communities and settings
£60,000	Public Health, CMBC	➢ Dedicated project support
£75,000	VCS	➢ Recruit a VCS project lead to work with CMBC to oversee the transfer and subsequent operation of the Volunteer Support Hub from CMBC to a sustainable community model
£200,000	VCS	➢ Seed funding to support the operationalisation of the VCS-led Volunteer Support Hub
£100,000	Public Health Nursing, Locala	➢ Recruit up to 2 WTE public health nurses to support outbreak prevention and response in school and early years settings
£100,000	TBC	➢ To enable local delivery of testing
£248,390	Unallocated	➢ Contingency

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Tuesday, 30 June 2020

To: West Yorkshire and Harrogate Health Care System Leadership Executive Group

Dear colleague

West Yorkshire Commission into impacts for Black, Asian and minority ethnic communities and staff: Understanding impact, reducing inequalities, supporting recovery.

Our Partnership has big ambitions to tackle health inequalities and support Black Asian and Minority Ethnic communities and staff. The COVID-19 pandemic has brought these issues into even sharper focus, and never has this been more important to move forward the implementation of actions at pace. Following the conversation at the Partnership Board on the 2 June 2020, and as requested by Cllr Swift, Chair of the Board, a new piece of rapid review work (July to September 2020) has been commissioned.

We are delighted to announce that this review will be led by Dame Donna Kinnair.

Donna is a British nurse and has been Chief Executive and General Secretary of the Royal College of Nursing since August 2018. She has specialised in child protection, providing leadership in major hospital trusts in London, teaching, and advising on legal and governmental committees. Donna has also been recognised for her influence, having been listed in the 2020 Powerlist which lists the 100 most influential Britons of African/African Caribbean descent.

The intention is to build on the report findings published by Public Health England on Tuesday 2 June regarding the disparities in the risk and outcomes of COVID-19. This provides further evidence, should we need it, that the impact of COVID-19 has replicated existing health inequalities we know exist across West Yorkshire and Harrogate communities and workplaces.

The review will look to understand the impact of COVID-19 on our Black, Asian and Ethnic Minority communities and staff, review and accelerate our existing work on health inequalities, and embed in our work on reset and recovery an enhanced focus on this in all that we do as a health and care system.

We do have work to build on, we already have a fantastic group of BAME network chairs who are directly influencing the work of the Partnership in this area, and work is well underway in the Improving Population Health Programme leading practical and focused interventions across our six local places (Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield).

Through this work we will strengthen our commitment to employing a diverse workforce and providing progression opportunities for BAME staff, whilst demonstrating our commitment that we 'stand' with' those from ethnic minority backgrounds who have experienced racial prejudice – as so powerfully articulated by the 'Black Lives Matter' social movement.

The work will be accountable to the System Leadership Executive Group and the Partnership Board, with regular update reports and key actions for implementation. It will complete in the autumn with an independent report setting out the next steps. It is not intended to replace local placed based work – it will complement and support system wide working.

The Partnership's BAME network will continue to have a significant role and voice in the work, as will our partners working in the voluntary and community sector.

We are all in agreement that action is needed to both understand and tackle deep-seated and longstanding health inequalities facing people, and although tackling wider inequalities cannot fall to us alone, we are in an ideal position to both listen and lead as part of the solution, whilst making the most of the excellent relationships we have with other key players, such as the West Yorkshire Combined Authority leading on recovery, and our universities.

We need everyone to support this system-wide change and we know from our conversations locally and across the system there is strong support to work together.

We are now taking this commission forward, establishing a steering group with clear terms of reference, and will keep you updated throughout.

In the meantime please don't hesitate to get in touch with any questions or suggestions you may have.

Yours sincerely

Councillor Tim Swift, MBE, Leader of Calderdale Council and Chair of West Yorkshire and Harrogate Health and Care Partnership Board

West Yorkshire and Harrogate Health and Care Partnership CEO Lead

Robin Tuddenham, CEO for Calderdale Council and West Yorkshire and Harrogate Health and Care Partnership, Co-Chair of the Improving Population Health Programme

Cc: WY&H HCP Programme Leads
WY&H HCP Clinical Forum
WY&H Local Place Based Planners

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

Summary of key decisions - Meeting in public, Tuesday 14 January 2020

Urgent and emergency care update
The Committee considered an update on the Urgent and Emergency Care Programme. The update covered progress on work streams including workforce, population health management, integrated services and access to local urgent care services. The update also highlighted the arrangements for responding to winter pressures through a Winter Delivery Agreement. This included the establishment of a virtual 'Winter room' to enable closer partnership working between Accident and Emergency Boards, Acute Trusts, Yorkshire Ambulance Service and NHS England, including information sharing, trend analysis, escalation and support.
The Committee: Noted the update.
Hip policies
As part of the Elective Care/Standardisation of Commissioning Policies Programme, the Committee considered a WY&H-wide policy for hip replacement surgery and key-hole surgery. Having single policies would help to address any unnecessary variations in care. Evidence-based clinical thresholds would also mean that surgical procedures would only be carried out when they were clinically effective, and where alternative non-surgical options had been ineffective. The emphasis on shared decision-making and supported self-management would require staff development to make sure that all clinical staff within MSK and elective orthopaedic services had the right skills.
The Committee: Agreed to adopt the hip policies across WY&H.
Cataract surgery pathway and policy
The Committee considered a WY&H-wide pathway and policy for cataract surgery, which is the most common planned surgical procedure in the UK. Across WY&H there are around 25,000 procedures every year, which is expected to increase as people live longer and the population increases. The Committee supported proposals to make better use of community optometrists, including high street opticians. Referral for cataract surgery would come directly from a community optometrist rather than a GP. Community optometrists would evaluate an individual's suitability for surgery, discussing options with them before a shared decision was made. Patients who have had uncomplicated routine cataract surgery will have their follow-up checks carried out by a community optometrist too. Making better use of our community optometrists would release specialist capacity in hospitals to see higher risk patients with potentially sight-threatening conditions. The Committee noted the financial and capacity challenges involved in implementing the policy. The Programme team were working with partner organisations across eye care services to consider the options for delivering services.
The Committee: Agreed to adopt the cataract pathway and policy and asked the Task and Finish Group to report back on how risks to implementation will be mitigated.
Joint Committee governance
The Committee considered a range of proposals to further strengthen collaborative working, including the Committee taking on responsibility for developing commissioning arrangements at WY&H level. The Committee also considered proposals for adding new service matters to the Committee's work plan, including maternity services and Assessment and Treatment Units providing specialist hospital support for adults with moderate to severe learning disabilities.
The Joint Committee: Agreed that the proposals be presented to the CCGs for consideration.

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

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

Summary of key decisions - Meeting in public, Tuesday 7th July 2020

Chair's update

The Chair noted that since the last meeting in January, health and care partners had been dealing with the impact of the COVID-19 pandemic. The Chair thanked staff for their hard work and commitment. The Chair also noted changes in the commissioning landscape. Bradford and Craven CCGs had merged to form a single CCG and Harrogate CCG had merged to form North Yorkshire CCG, which was now an associate member of the Committee.

Joint Committee governance

The Committee considered a governance update, noting that a revised Memorandum of Understanding and work plan had been circulated to the CCGs for formal approval. The work plan included the delegation of new commissioning decisions to the CCG. CCG mergers meant that the PPI Assurance Group now had a core membership of only 5 and there was a need to consider its role and membership, including how it might link into other patient and public assurance mechanisms.

The Committee:

a) **Noted** the 2019/20 annual report and the progress in agreeing the new MOU and work plan.
b) **Requested** a report on the future membership and role of the PPI Assurance Group

Our response on COVID-19: Implications for the Joint Committee

The Committee considered a report on the response of the health and care system to COVID-19 and how programmes had been refocused to support the response. While the specific focus of our work had changed, the Partnership's Five year plan continued to set the high level objectives. The Committee reviewed the summary plans for each of the work programmes where decisions had been delegated to the Joint Committee. The Committee noted that its work plan and role would need to evolve to reflect new priorities arising from the response to COVID-19. It would also need to reflect the development of strategic commissioning across WY&H ('Commissioning futures')

The Committee:

a) **Noted** the response to the pandemic and the priorities for the next phase of the response.
b) **Noted** that a revised forward plan for the Joint Committee would be developed based on these new priorities.

Improving Planned Care: Programme Refresh

The Committee considered changes to the Improving Planned Care programme. These included integrating the programme with the West Yorkshire Association of Acute Trusts' Elective Surgery programme. Supporting the restart of planned care was a key priority. This included optimising access to diagnostics and proposals for an elective hub which would help local places to manage planned care. Other priorities included a different approach to pathways, featuring shared decision making between primary and secondary care. The Committee noted the critical importance of this programme for improving both access to care and health and wellbeing outcomes.

The 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 referral and support proactive approaches to managing planned care.
d) Agreed to take the proposals back into their individual CCGs for further consideration.

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

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Complaints Annual Report: 2019/20**	Agenda Item No.	6
Report Author	Janet Smart – Complaints Manager	Public / Private Item	Public
GB / Clinical Lead	Dr Farrukh Javid (GP Member, Chair of Quality, Finance and Performance Committee)	Responsible Officer	Penny Woodhead – Chief Quality and Nursing Officer

Executive Summary							
Please include a brief summary of the purpose of the report	NHS Calderdale CCG aims to commission high quality services, but occasionally things can go wrong. When they do, it seeks to put them right and learn from the experience to improve services. Complaints are one way of receiving individual perspectives of the service provided and through the outcome of the investigation, areas for improvement identified. This report sets out the position for 2019/20 and details the complaints received broken down by provider, category, level and response timeframe.						
Previous consideration	**Name of meeting**	Quality, Finance and Performance Committee		**Meeting Date**	25/06/2020		
Recommendation (s)	It is recommended that the Governing Body **NOTES**: 1. Complaints received about services commissioned by Calderdale CCG during 2019/20 2. Categorisation by provider, category, level and response timeframe.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications			
Quality & Safety implications		None identified.	
Public / Patient / Other Engagement		No implications from this report, however consideration of the annual report and key themes emerging from complaints are an important part of patients' experience.	
Resources / Finance implications		None identified.	
Strategic Objectives	▪ Improving quality ▪ Improving value	**Risk**	None identified.
Legal / Constitutional Implications	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the Regulations) require all Clinical Commissioning	**Conflicts of Interest**	Any conflicts of interest arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest

	Groups (CCGs) to provide an annual report regarding complaint activity information. This should include the number and nature of complaints and identify the lessons learned		Policy.

ANNUAL COMPLAINTS REPORT:

1 April 2019 – 31 March 2020

1.0 Purpose of Report

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

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

1.3 This report outlines the complaints received by Calderdale CCG between 1 April 2019 and 31 March 2020. This data outlining the total number of complaints received has been compared in the first table for the previous four years.

1.4 In accordance with Audit Yorkshire recommendations made in 2018, the complaints, concerns and enquiries received in 2019/20 have been compared against those received in 2017/18 and 2018/19.

COMPLAINTS

Total number of complaints received by Calderdale CCG

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

Complaints – Calderdale CCG

	2017/18	2018/19	2019/20
Complaints received	152	138	208
Complaints investigated by Calderdale CCG:	52 (34%)	47 (34%)	39 (19%)
CCG related	26 (17%)	39 (83%)	31 (79%)
Related to other providers	26 (17%)	8 (17%)	8 (21%)
Calderdale CCG responses within deadline: Yes No Still Open/On Hold	22 (42%) 24(46%) 6 (6%)	34 (72%) 11 (23%) 2 (5%)	23 (59%) 7 (18%) 9 (33%)
Level (section 4 provides a definition of the levels).	78 (52%) - Level 1 50 (33%) - Level 2 22 (14%) - Level 3 2 (1%) - Level 4	90 (65%) - Level 1 37 (27%) - Level 2 10 (7%) - Level 3 1(1%) - Level 4	169 (81%) - Level 1 33 (16%) - Level 2 4 (2%) – Level 3 2 (1%) – Level 4

2.0 Number of complaints investigated

2.1 Of the 208 complaints received by Calderdale CCG in 2019/20, not all were investigated by the CCG. This is for a number of reasons – most commonly because they did not fall within the remit of the Calderdale CCG and were passed to another organisation to investigate.

Initial Response	2017/18	2018/19	2019/20
Investigated by Calderdale CCG	52	47	39
Passed to another organisation for investigation and to respond directly to the complainant:			
- Bradford Districts CCG	2	-	-
- Calderdale & Huddersfield NHS Foundation Trust	32	27	50
- Calderdale Council	1	2	2
- Greater Huddersfield CCG	7	-	2
- Locala Dental Service	-	-	6
- Insight Healthcare	-	1	-
- North Kirklees CCG	1	1	1
- NHS 111	4	2	2
- Opcare (*now Rosscare with effect from 1 October 2019*)	-	2	10
- Primary Care/NHS England	26	33	38

- South West Yorkshire Partnership Foundation Trust	8	5	7
- Yorkshire Ambulance Service	-	5	2
- Other	19	2	9
Enquiry handled by complaints team	-	-	15
Acting as third party to review	-	5	8
For information only	-	3	-
Referred to Healthwatch	-	-	4
Closed due to lack of consent	-	2	5
On hold	-	1	8
TOTAL	**152**	**138**	**208**

3.0 Number of complaints by provider

3.1 Of the 39 complaints received and investigated by the Calderdale CCG during 2019/20 as Level 2, Level 3 and Level 4 complaints, 31 (shown in the table below) related directly to the Calderdale CCG. This means 8 of the complaints investigated by Calderdale CCG involved other providers.

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

3.3 Calderdale CCG is always sensitive to a complainant's needs and endeavours to avoid complainants being passed unnecessarily through numerous organisations. In cases where complaints are complex and involve a number of different organisations, the CCG is well placed to co-ordinate a response to a complainant. However, in many instances, a complainant's concerns can be best addressed directly by the provider organisation without the Calderdale CCG acting as an intermediary.

Provider	2017/18	2018/19	2019/20
Calderdale CCG	26	39	31
Calderdale & Huddersfield NHS Foundation Trust	7	1	-
Insight Healthcare	1	-	-
NHS 111	1	-	
Leeds Teaching Hospitals NHS Trust	1	1	-
Opcare (now Rosscare with effect from 1 October 2019)	7	2	4
South West Yorkshire Partnership Foundation Trust	5	1	-
Weight Management Service	1	-	-
Multi Providers: BMI and GP Surgery	-	-	1
Calderdale CCG and Calderdale Council	1	-	1
Calderdale CCG and Opcare	1	-	-
Calderdale CCG and Calderdale &	-	1	2

Huddersfield NHS Foundation Trust			
Insight Healthcare and South West Yorkshire Partnership Foundation Trust	1	-	-
Yorkshire Ambulance Service, Calderdale & Huddersfield NHS Foundation Trust and South West Yorkshire Partnership Foundation Trust	-	1	-
Calderdale CCG, GP Surgery and Calderdale Council	-	1	-
TOTAL	**52**	**47**	**39**

4.0 Complaints by category

4.1 The 39 complaints received and investigated by Calderdale CCG during 2019/20 can be categorised as shown in the table below:

Category of complaint	2017/18	2018/19	2019/20
Aids, appliances, equipment, eg wheelchairs	7	3	5
Appointments	6	1	3
Attitude of staff	2	1	1
Care and treatment	7	4	4
CAMHS	-	-	1
Choice of provider	-	-	1
Commissioning decisions made by Calderdale CCG: Individual Funding Request (IFR) Access to Infertility Treatment	 1 -	 2 6	 2 5
Communication	-	1	-
Confidentiality	1	2	-
Continuing Healthcare process	15	9	6
Delays in diagnosis	-	1	-
Failure to follow agreed guidelines/ processes	-	-	1
Ear wax removal/irrigation service	-	-	2
Medication related issues			3
Mental Health services	-	-	1
Patient records	-	1	-
Practice management	-	-	1
Prescribing changes	10	9	-
Referrals	1	1	1
Reimbursement of costs	1	1	-
Subject Access Request/Complaint	-	-	1
Transport	-	-	1
Travel expenses	-	1	-
Treatment charges	-	2	-
Waiting times	-	1	-
Weight management	1	1	-
TOTAL	**52**	**47**	**39**

4.2 Of the 39 complaints, 16 fell within the following 3 categories and are broken down below:

Continuing Healthcare Process – 6 complaints

All the 6 complaints related to issues connected with the Calderdale CCG's Continuing Healthcare processes.

Aids, Appliances and Equipment – 5 complaints

4 of the complaints related to the wheelchair service provided formerly by Opcare and by Rosscare since 1 October 2019.

One of the complaints related to the provision of Hearing Aids.

Access to Infertility Treatment – 5 complaints

All the 5 complaints related to issues relating to the Access to Infertility Treatment Policy.

5.0 Complaints by level

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

<u>Level 1- Simple complaints</u>

- How to make a complaint
- The correct NHS Trust and services to deal with the complaint
- Appointments

<u>Level 2 – Low/simple, non-complex issues</u>

- Delayed or cancelled appointments
- Event resulting in minor harm e.g. cut or strain
- Loss of property
- Lack of cleanliness
- Transport problems
- Single failure to meet care needs e.g. missed call back
- Medical records missing

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

- Event resulting in moderate harm (e.g. fracture)
- Failure to meet care needs
- Miscommunication or misinformation
- Medical errors
- Incorrect treatment
- Staff attitude or communication

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

- Event resulting in moderate harm (e.g. fracture)
- Event resulting in serious harm (e.g. neglect)
- Failure to meet care needs
- Miscommunication or misinformation
- Medical errors
- Incorrect treatment
- Staff attitude or communication

5.2 The table below shows the classification of complaints received.

Level of complaint	2017/18	2018/19	2019/20
Level 1	78	90	169
Level 2	50	37	33
Level 3	22	10	4
Level 4	2	1	2
Total	**152**	**138**	**208**

5.3 The data indicates the number of Level 1 concerns and enquiries increased significantly during 2019/20. This was partly due to a new concerns and enquiry system implemented by the Complaints Manager with Calderdale CCG's Corporate Team during the year. This is still in its infancy and will be further improved upon during 2020/21.

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

There was a slight increase in Level 4 complaints.

6.0 Complaints by deadline

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

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

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

Final Response sent within agreed timeframe	2017/18	2018/19	2019/20
Yes	22	34	23
No	24	11	7
Still Open/On Hold	6	2	9
Total	**52**	**47**	**39**

Final Response sent within agreed timeframe by Provider during 2019/20	Yes	No	Still Open/On Hold
Calderdale CCG	17	5	9
Opcare/Rosscare	3	1	-
Multi agency: Calderdale CCG & Calderdale & Huddersfield NHS Foundation Trust	2	-	-
Multi agency: Calderdale CCG and Calderdale Council	1	-	-
Multi agency: BMI & GP Surgery	-	1	-
Total	**23**	**7**	**9**

6.4 In 2019/20 Calderdale CCG saw an improvement in complaints being responded to within deadline. This was partly due to changes made to the complaint handling timescales and sign off process in the latter part of 2018.

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

- Two of the delays were due to the cases being more complex than initially thought.
- One was due to the workload of the investigator
- One was due to staff absence
- One was due to the involvement of a solicitor
- One was due to the time NHS England took to provide the CCG's investigator with information.

6.6 The one multi-provider complaint response was not sent within the agreed timeframe due to the time a provider had taken to provide Calderdale CCG with their investigation comments.

6.7 In all the 7 cases, the complainant was contacted prior to the agreed response date to advise that the complaint was still underway. They were also provided with an explanation why this was the case.

7.0 Pause of the NHS Complaints Process

7.1 On Friday, 27 March 2020 Calderdale CCG received information from NHS England and NHS Improvement that they were supporting a system wide pause of the NHS complaints process so that health care providers in all sectors (including

Calderdale CCG) could concentrate on providing front-line duties and responsiveness to COVID-19.

7.2 The Complaints Manager contacted all the relevant stakeholders, such as local MPs and Healthwatch to inform them about the pause. Information was also placed on our website and email systems.

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

7.4 All new complaints were acknowledged and appropriately logged.

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

8.0 Parliamentary and Health Service Ombudsman

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

8.2 During the early part of Quarter 1 of 2019/20, Calderdale CCG was notified that the PHSO intended to investigate a complaint handled by Calderdale CCG during 2017/18.

8.3 Calderdale CCG fully complied with providing the PHSO with the information they requested and implemented the recommended actions.

8.4 During Quarter 3 of 2019/20, the PHSO caseworker contacted Calderdale CCG and confirmed that the detail provided in the action plan directly addressed the actions recommended by the PHSO. The action plan is being overseen by the Senior Management Team (SMT).

9.0 Learning from complaints

9.1 Calderdale CCG is committed to learning from complaints and wherever possible complaint responses include a section which highlights the learning from the complaint and how this will be shared or used in the future. This has been demonstrated by, for example, the CHC team who have continued to make changes to their processes as a result of complaints received about their service.

10.0 Provider and GP Practice Assurance on Complaints Handling

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

10.2 Assurance on GP practice complaints handling remains a function of NHS England, however, practices are required to complete an annual return providing NHS England with numbers and subject matter of complaints. Calderdale CCG receives feedback on submissions. However, at the end of Quarter 2 of 2019/20, due to a system change in NHS England, it was not possible for them to provide Calderdale CCG with details of the number of practices who completed the submission in this report. At the end of Quarter 4 Calderdale CCG was informed that the annual data collection from GP Practices had been suspended due to the COVID-19 pandemic. An update will be provided to the Quality Finance and Performance Committee in the 2020/21.

Name of Meeting	Governing Bodies	**Meeting Date**	23/07/2020
Title of Report	**Joint Safeguarding Children and Adults Annual Report 2019/20**	**Agenda Item No.**	7
Report Author	Gill Poyser, Young Designated Nurse Safeguarding Children Luke Turnbull, Designated Nurse Safeguarding Adults	**Public / Private Item**	Public
GB / Clinical Lead	Dr Stephen Cleasby, CCG Chair	**Responsible Officer**	Penny Woodhead – Chief Quality and Nursing Officer

Executive Summary							
Please include a brief summary of the purpose of the report	This annual report provides a review, in the form of a presentation, of the Safeguarding Adults and Safeguarding Children's work undertaken within and on behalf of Calderdale CCG from April 2019 to March 2020. An overview of the pertinent legislation is provided along with assurance being demonstrated that the CCG has discharged its statutory and legislative responsibilities for Safeguarding Children and Adults at Risk of abuse or neglect. The report details the some of the impact and achievements of the team for the reporting period and the work priorities for 2020/ 21. Overall the report provides assurance that the CCGs are engaged and supporting work to Safeguard Adults at risk of abuse and neglect and Safeguarding Children that forms part of its responsibilities.						
Previous consideration	**Name of meeting**	None		**Meeting Date**			
	Name of meeting	None		**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: 1. **RECEIVE** the report; 2. **NOTE** its contents; 3. **CONFIRM** that it is assured that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity.						
Decision	☐	**Assurance**	☒	**Discussion**	☐	**Other**	

Implications						
Quality & Safety implications	Included within the report					
Engagement & Equality implications	The report provides assurance of the engagement with local partners for safeguarding work and activity An Equality Impact assessment has not been completed					
Resources / Finance implications	None					
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)	**Yes**		**No**		**N/A**	√

Strategic Objectives	▪ Achieving the agreed strategic direction for Calderdale ▪ Improving quality ▪ Improving value ▪ Improving governance	**Risk**	None
Legal / CCG Constitutional Implications	No current legal or constitutional implications	**Conflicts of Interest**	Any conflicts of interest arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest Policy.

1. Introduction

1.1 This report provides a presentation that summarises the safeguarding work and activity undertaken by the Shared CCG Safeguarding Service on behalf of NHS Calderdale Clinical Commissioning Group from 1st April 2019 to the 31st March 2020.

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

2. Detail

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

3. Implications

3.1 Quality & Safety Implications

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

3.2 Engagement & Equality Implications

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

3.3 Resources / Finance Implications

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

3.4 Data Protection Impact Assessment

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

3.5 Risk

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

3.6 Legal / CCG Constitutional Implications

There are no legal or CCG Constitutional implications

3.7 Conflicts of Interest

Any conflicts of interest arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest Policy.

4. Recommendations

It is recommended that the Governing Body:

1. **RECEIVE** the report;
2. **NOTE** its contents;
3. **CONFIRM** that it is assured that the CCG is fulfilling its responsibilities as a statutory partner in safeguarding work and activity.

Item 7a

Safeguarding Adults & Children Annual Report

April 2019 – March 2020

Report authors:

Clare Robinson: Head of Nursing & Safeguarding

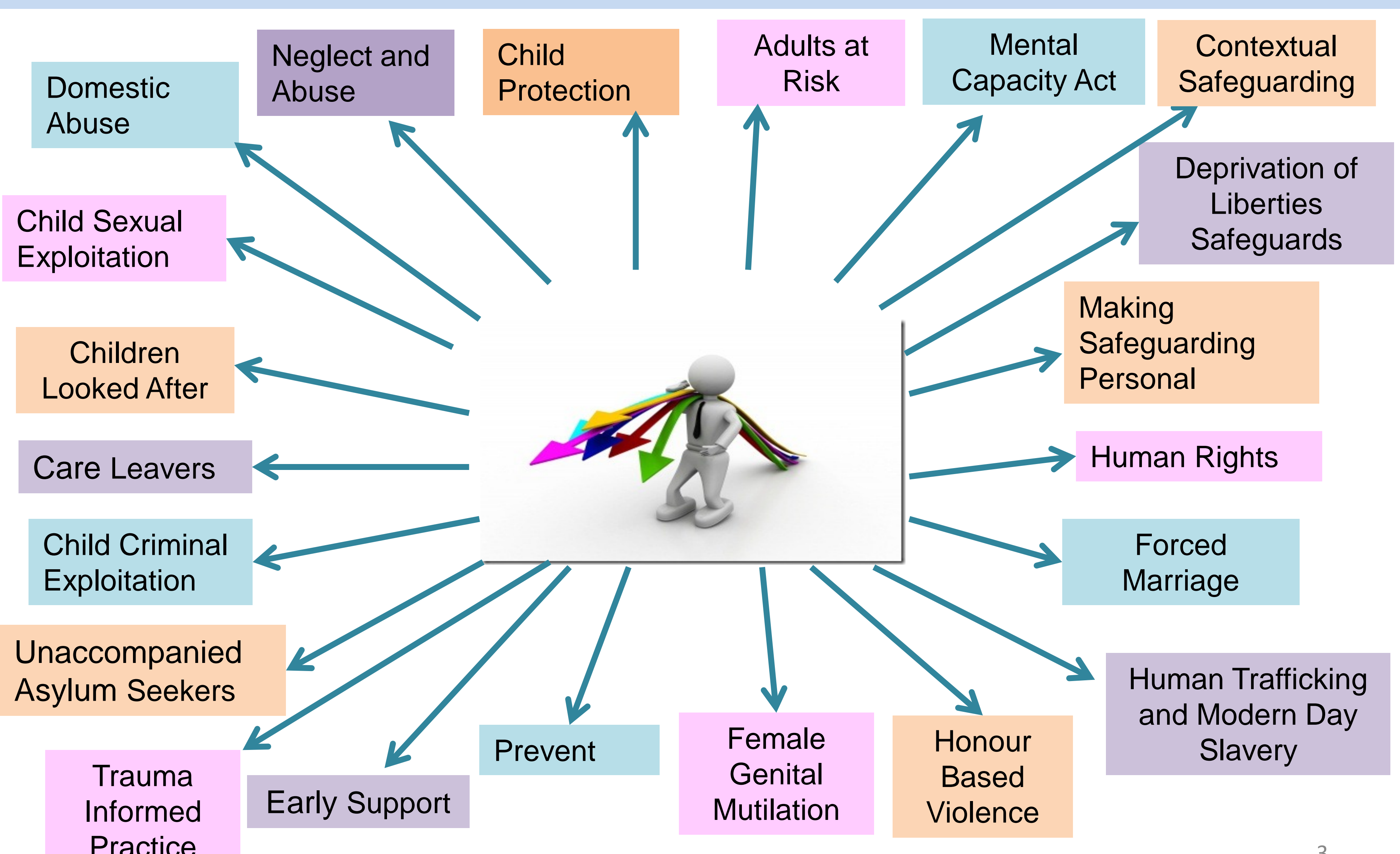
Gill Poyser-Young: Designated Nurse Safeguarding Children

Luke Turnbull: Designated Nurse Safeguarding Adults

This annual report:

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

Scope of Safeguarding



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

Shared CCG's Safeguarding Service (MOU in place)

Executive Safeguarding Lead
Chief Quality and Nursing Officer

Head of Nursing and Safeguarding
(also holds role of Designated Nurse Safeguarding Adults Kirklees)

GHCCG & NKCCG

Designated Nurse Safeguarding Children

Designated Nurse Safeguarding Adults

Named GP Adult and Children
Left post in April 2020 – recruitment in process

Calderdale CCG

Designated Nurse Safeguarding Children, Children Looked After and Care Leavers

Designated Nurse Safeguarding Adults

Named GP Children
Named GP Adults

Deputy Designated Nurse Safeguarding Children *left post in April 2020 – recruitment in process
Deputy Designated Nurse Safeguarding Adults *left post in Nov 2019 – recruitment in process

Safeguarding Support Officer

NHS England Safeguarding Accountability and Assurance Framework 2019:

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

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

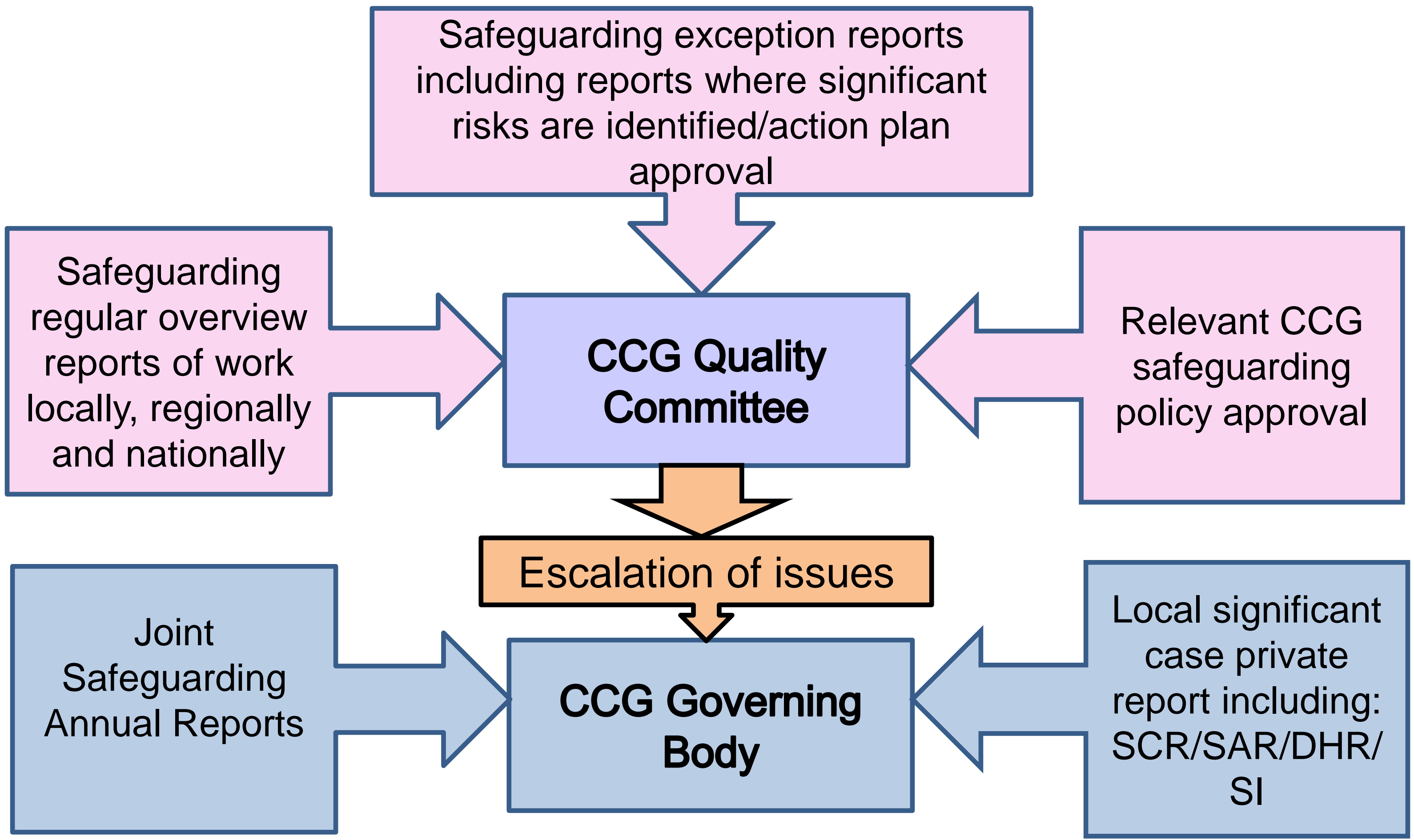
Designated Doctor - Safeguarding Children
Calderdale : Commissioned from CHFT

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

Designated Nurse – Children Looked After
Calderdale CCG

Designated Doctor – Children Looked After
Calderdale: Commissioned from CHFT

CCG Governance arrangements for reporting Safeguarding:



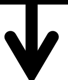
Safeguarding Adults and Children requirements articulated on the Governing Body Assurance Framework (GBAF)

Children Looked After (CLA) in Calderdale:

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

Designated Nurse Children Looked After CCCG

Designated Doctor Children Looked After (commissioned from CHFT)



Children Looked After Clinical Team
(Commissioned from CHFT)

Governance and CCG Oversight:

Joint performance monitoring with CCG Designated Nurse & LA

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

Regular 1:1 meetings with CCG Designated Nurse

Regular reporting of data to CCG Quality Committee

Annual Looked After Children report shared in CCG Quality Committee

Regular reporting to Local Authority Corporate Parenting Board

CCG responsibilities:

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

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

Approved by Quality Committee :

CCG Safeguarding Policy (approved March 2019)

CCG Domestic Abuse Policy (approved August 2019)

CCG PREVENT Policy (approved August 2018)

CCG MCA policy (reviewed August 2019) to be re-reviewed 2020 in light of Liberty Protection Safeguards

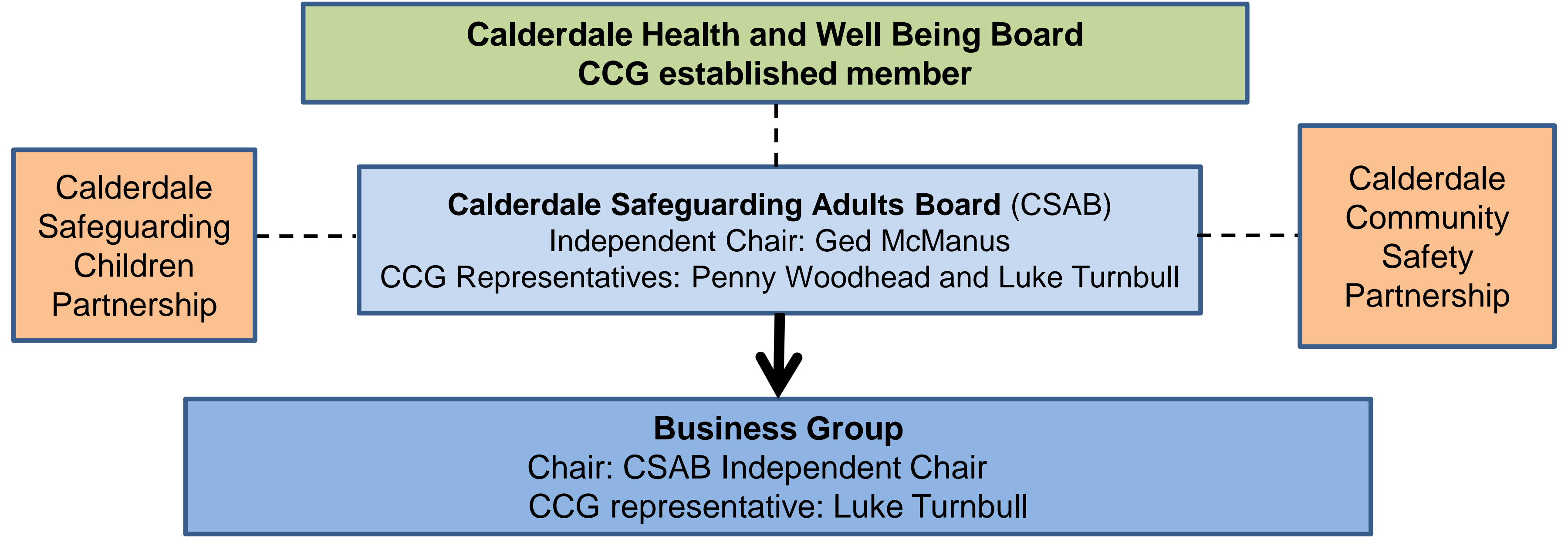
Up to date required Recruitment and other Policies are also in place:

CCG Recruitment and Selection Policy (April 2018)

CCG Whistleblowing (Freedom to Speak Up) Policy (November 2018)

CCG Disciplinary Policy (February 2021)

Calderdale Safeguarding Adults Board



The CCG have contributed to/ led on:

CSAB Strategic Plan

CSAB Annual report

CSAB Constitution: CSAB Roles and Responsibilities

CSAB Engagement Strategy

CSAB Board minutes

Safeguarding week activities

Development of the Performance Indicator Report

Increased service user involvement with CSAB

Development of safeguarding champions model

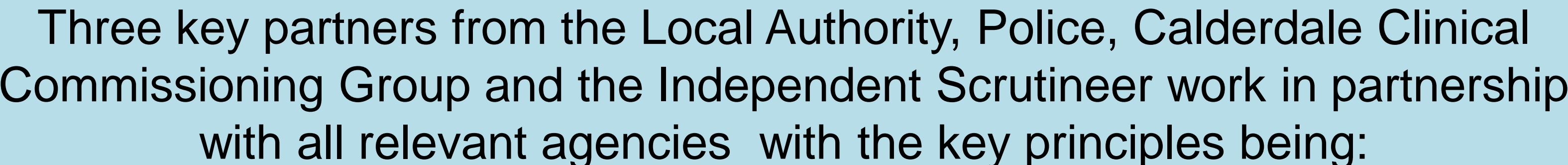
Multi-agency safeguarding audits including: the use of the MCA when administering flu vaccinations in care homes, practitioner recognition of CSAB policies, procedures and guidance

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

Multi-Agency Safeguarding Children Arrangements

Following Sir Alan Wood National Review and the revised Working Together to Safeguard Children (WTSC 2018) Calderdale became an early adopter site for the new arrangements for Safeguarding Children

Calderdale Safeguarding Children's Partnership replaced the Safeguarding Children's Board from 1st April 2019



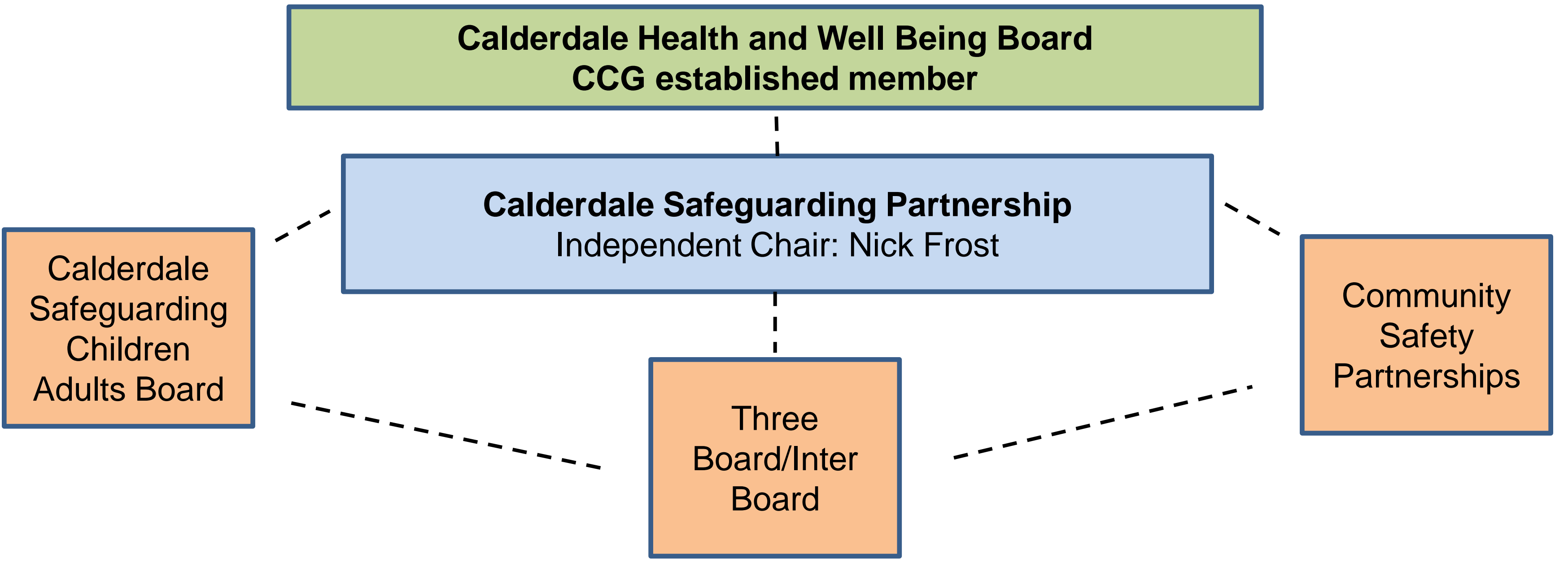
- High quality of safeguarding
- Independent Scrutiny

- Seek the voice of young people
- Engage the community

- All agencies engage in SCPR process
- Develop regional activity

Calderdale Multi-Agency Safeguarding Arrangements (published April 2019)
https://safeguarding.calderdale.gov.uk/wp-content/uploads/2019/01/Calderdale-Multi-Agency-Safeguarding-Arrangements.pdf

Calderdale Safeguarding Children Partnership



During the reporting period the CCG and health providers have contributed to development of new guidance and audit processes including:

- **Transition** – Best Practice to Facilitate Transitions from Children's to Adult Services – recommendation form an adult SCR
- **Harmful Sexual Behaviours** – Practitioners identified concerns but practitioners uncertain about appropriate referral route
- **SMART Planning** – Recommendation form an SCR to ensure work previously undertaken could demonstrate continued improvement in child protection plans. Proposed changes to early help process came out of this audit.
- **Perinatal Mental Health** – To promote the safety of children & young people who live with a parent with mental ill health following a recommendation from an SCR about the importance of undertaking a full assessing the risks of parental mental ill health & medication on parenting

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

Subgroups of Calderdale Safeguarding Children Partnership:

Child Death Overview Panel

Combined Calderdale, Kirklees and Wakefield

https://safeguarding.calderdale.gov.uk/professionals/safeguarding-children/child-deaths/

Performance Monitoring & Quality Assurance:

Detailed multi-agency performance scrutiny across and within the health system will take place in the HAIG

CCG Safeguarding Team supporting

Child Safeguarding Practice Review

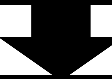
https://safeguarding.calderdale.gov.uk/professionals/safeguarding-children/training-and-development/child-practice-review/

Child Sexual Exploitation & Contextual Safeguarding

https://safeguarding.calderdale.gov.uk/professionals/safeguarding-children/child-sexual-exploitation/

Health Assurance & Improvement Group (HAIG) Reporting into CSCP

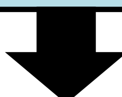
2019: Completed review of Calderdale Health Advisory Group chaired by Designated Nurse



Health Assurance and Improvement Group (HAIG)

To provide strategic oversight and commitment to key work to lead assurance, improvement and the scrutiny of safeguarding children arrangements across the local health sector.

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



1st meeting September 2019 new format:

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

Other Safeguarding Children's Partnership work

CCG team provided support and expertise in local area approaches and strategies

Performance Monitoring Children's Looked After Team
Designated Nurse joint meeting with LA & Public Health to scrutinise the performance

Corporate Parenting Panel
CCG represented by Designated Nurse& Designated Doctor for CLA. Named Nurse for CLA also attends

Independent Scrutiny & Assurance Section 11 (Children Act 2004)
Safeguarding Team complete CCG report & undertake assurance regarding GPs

Task & Finish Groups such as Neglect Strategy, FGM, Mental ill-health, Contextual Safeguarding
Designated Nurse attends

Joint Targeted Inspection (JTAI)
Preparation meetings for all JTAIs & scrutiny against national findings

Children Looked After (CLA) : Key headlines as of 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 • 104 children became looked after • 109 children ceased to be looked after • 3 unaccompanied asylum seeking children received in to care • 41 care leavers up to age 18 (37% of total number of care leavers) • 84 Initial Health Assessments completed • 426 Review Health Assessments (RHA's) completed. • 96% RHA's completed for under and over 5 year olds, (2 each per year) • 21 RHA's completed by other Local Authorities on our behalf, due to distance to travel. • 61 RHA's completed for other Local Authorities by the team, due to distance to travel.
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

Other work:

- 33 health passports were issued.
- Close collaborative relationships with Calderdale Therapeutic Service, Pathways, sexual health and substance misuse services

Statutory work on behalf of the CCG

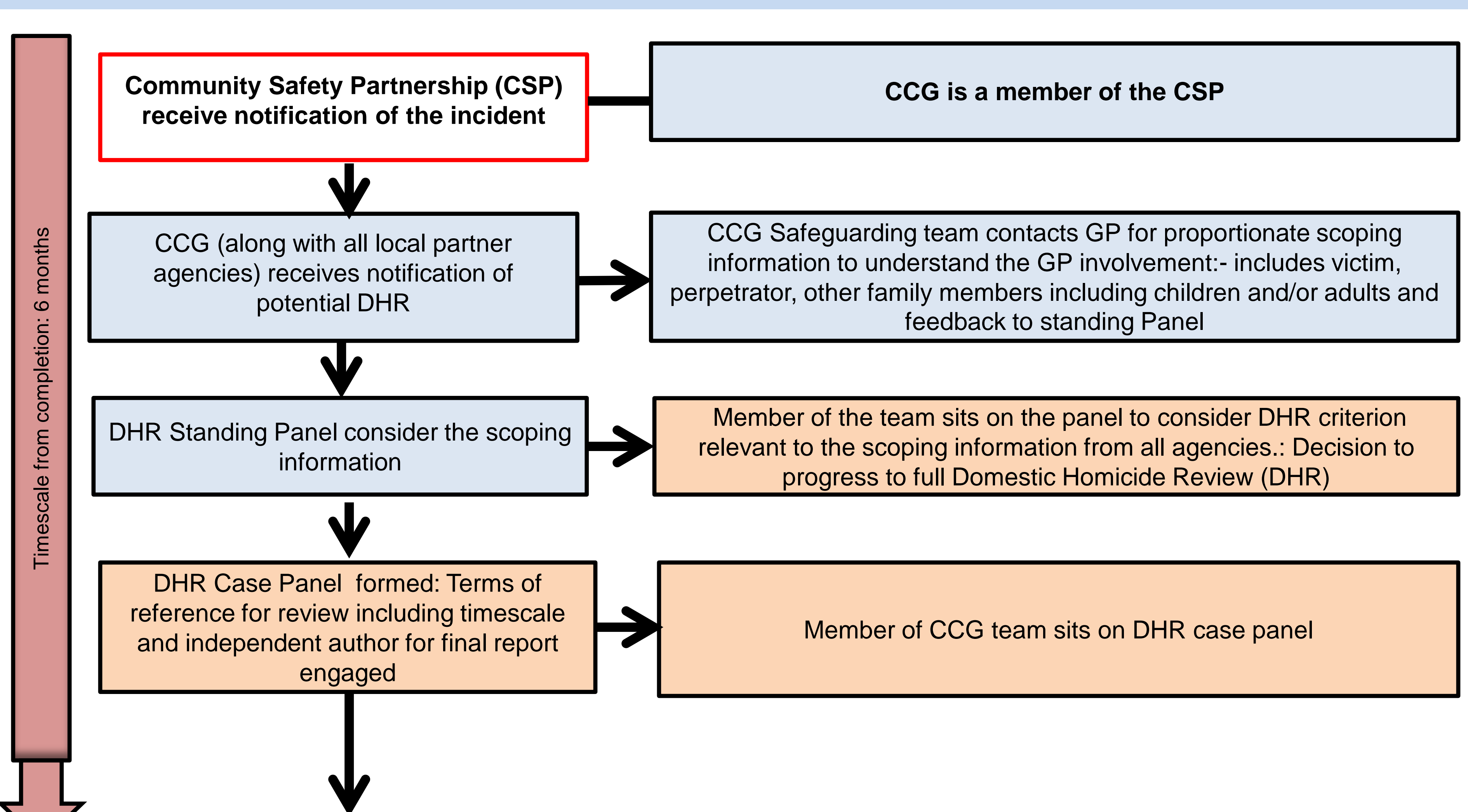
Safeguarding Children Practice Reviews (SPRs) http://www.legislation.gov.uk/uksi/2018/789/contents/made	These reviews are for Serious Child Safeguarding Cases e.g. - Abuse or neglect is known or suspected; and - The child/young person has died or been seriously harmed. Serious harm includes (but is not limited to) serious and/or long-term impairment of mental health or emotional, intellectual, emotional, social or behavioural development. This should also cover impairment of physical health.	The Designated Nurse Safeguarding Children is the Chair of the CSCP SPR Sub Group and attends all individual case reviews to provide health expertise and oversight. A member of the CCG Safeguarding Team also complete any required GP Chronologies or Individual Management Reports – IMR's - (report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice by the General Practitioner/Practice who had been involved in the case. The Designated Nurse/Deputy Designated Nurse then disseminate key relevant learning across local health footprint.
Safeguarding Adults Review (SAR) (Section 44 of the Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect)	Held when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern about the way agencies worked together to support the individual. The purpose is to learn the lessons about how professionals and organisations work together.	A member of the CCG Safeguarding Team will complete any required General Practice Individual Management Reports – IMR's - (report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice by the General Practitioner/Practice involved). The Designated Nurse Safeguarding Adults is the panel member on all SARs to provide health expertise and coordination. The panel's role is to support and challenge the analysis of the findings and ensure appropriate recommendations are made and implemented . Key relevant learning is disseminated by the CCG safeguarding team across local health footprint.

Independent Investigations https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/	**NHS England responsible for commissioning** investigations into homicides that are committed by patients being treated for mental illness	Head of Nursing and Safeguarding or Designated Nurses represent CCG's at panel meetings for local cases
Domestic Homicide Review (DHR) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf	Established on a statutory basis under the Domestic Violence, Crime and Victims Act (2004), and led by the Safer and Stronger Community Partnership, on behalf of the Home Office. A DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:- A person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship Or A member of the same household as himself/herself. Held with a view to identifying the lessons to be learnt from the death.	Designated Nurses attend the Case Panels to provide health expertise and oversight. A member of the CCG Safeguarding Team completes any required General Practice Individual Management Reports for cases and disseminates key relevant learning across local health footprint
Child Death Overview Panel (CDOP) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pd	Responsible for reviewing information on all unexpected child deaths. They record preventable child deaths and make recommendations to ensure that similar deaths are prevented in the future	Designated or Deputy Designated Nurse Safeguarding Children attend all local CDOP meetings to provide expertise

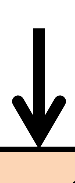
CCG engagement - serious cases that require statutory response

The team have provided safeguarding expert support in **1 DHR, 2 SARs and 2 SCRs and 1 LLR** this year.

Calderdale DHR case that demonstrates team involvement – mirrored process in all statutory cases:



Timescale from completion: 6 months



DHR Panel request partner agencies to complete chronology of their involvement and then an Individual Management Review (IMR - full report with analysis)

Another member of CCG team liaises with GP Practice involved, secures a copy of the medical records and completes a chronology on behalf of the Practice and then progresses to complete IMR of the GP involvement for each identified subject of the proposed DHR Overview Report.

4- 6 DHR Case Panel meetings: to review Chronologies and IMRS to analyse report in order to identify is any learning

Consistent overview and input from the member of the safeguarding team who is a health 'expert in safeguarding' panel member: giving context and clarity to health information presented from IMR's and chronologies

DHR Independent author drafts the Overview Report

DHR Case Panel members offer support, guidance, offers challenge to presented information: CCG member provides health input for the final version of the Overview Report.

DHR Panel submit the Overview Report and identify Learning from the case

Member of team who completed GP Practice IMR to seek they agreement for the learning and assurance from the Practice that they are taking action to address issues.

CCG Safeguarding Team takes learning from the case and disseminates across health partners where relevant and appropriate, gains assurance and ensures lessons are embedded in to provider practice.

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

CCG Mental Capacity Act Lead: Designated Nurse Safeguarding Adults

Liberty Protection Safeguards

Provider assurance

Policy and guidance development

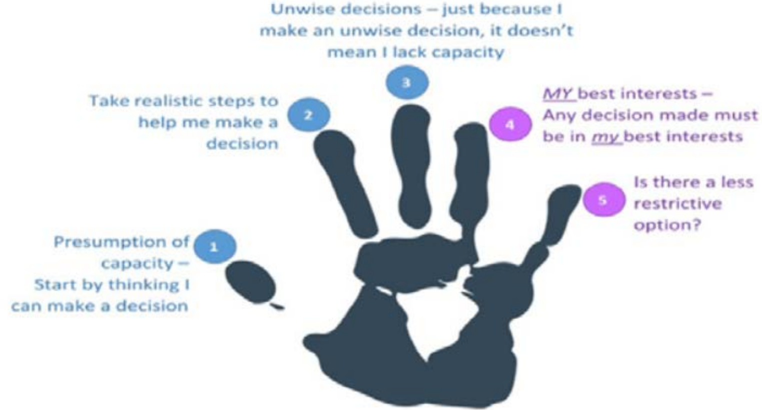
Local interpretation of case law

Regional and national fora

CHC DoLS assessments

Supervision

Advice to GPs, CHC, providers, commissioners



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

CCG engaged in other work at local and regional level

Calderdale Domestic Abuse Strategic Board
Designated Nurse Safeguarding Children represents the CCG. The CCG has agreed and signed up to the local 6 step commitments and agreed funding to commission a health service representative to sit on the DA daily hub on behalf of all health providers.

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

Calderdale District Silver Programme Precision Meeting
A member of the Safeguarding Team represent health partners at the multi-agency meeting. Programme Precision is the new name for work involving West Yorkshire Police, local partners and the public to work together to tackle serious and organised crime in the county. Serious and organised crime covers a range of crimes including drugs, firearms, child exploitation, cybercrime, modern slavery, gangs and county lines.

Delivering Assurance

CCG Assurance

- Internal audit of Safeguarding Team – **High Assurance delivered that CCG is fulfilling its responsibilities**
- Monitor CCG compliance with safeguarding training
- Audit/Challenge of Safeguarding Boards (e.g. Section 11 and Peer Challenge events)
- GP safeguarding standards audit and subsequent action plan
- Audit of CCG Safeguarding responsibilities by NHSE

Provider Assurance

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

Delivering assurance – Team impact

The *Prevent* Agenda:

The team have monitored the health providers and challenged each to deliver on their required responsibilities: All our main health providers are now compliant with national training Prevent training requirements

CCG Safeguarding training requirements:

The team monitor safeguarding training compliance requirements of staff, report and escalate any issues these via internal governance arrangements

Safeguarding Standards

As part of the CCG's Safeguarding Adults and Children Policy there is a prescribed set of required safeguarding standards for main health providers and for General Practice:

The standards are available and used by our commissioning teams when commissioning services, development of service specifications etc. Safeguarding prompts are now embedded in Quality Impact Assessments.

CCG Audit and Challenge:

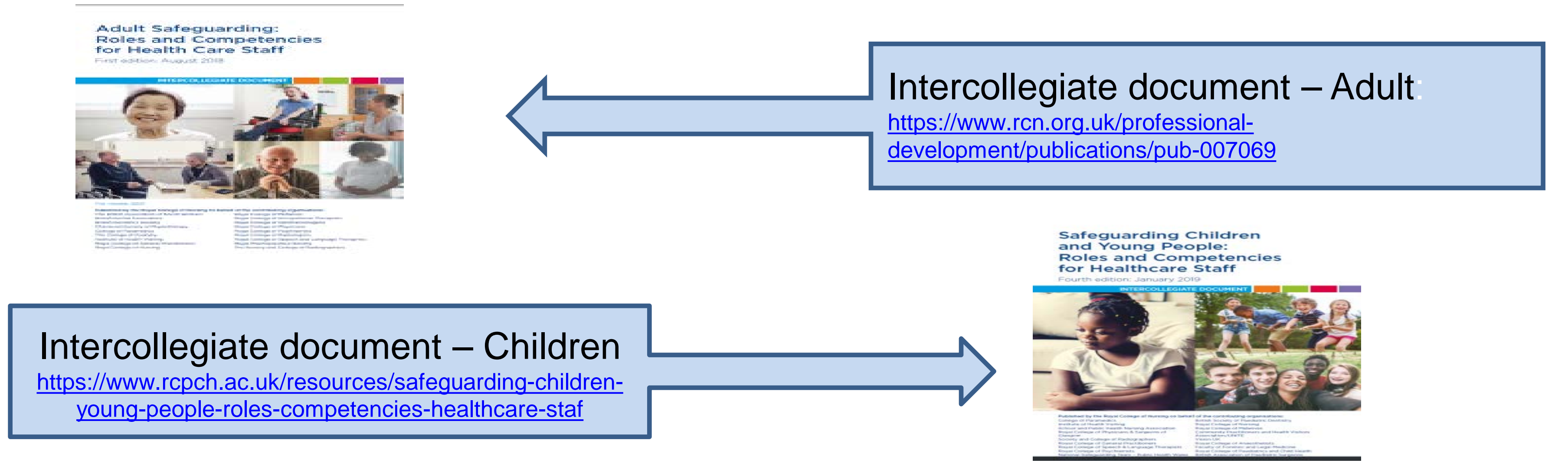
As chair of the Performance and Quality subgroup of the CSAB, the Designated Nurse Safeguarding Adults leads the CSAB's approach to data, intelligence and audit.

CCG responsibilities:

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

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

The guidance is based on:



Other training available:

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

Safeguarding in the ICS

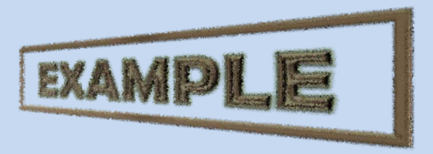
- New group of Designated Nurses / Professionals from each CCG in WY&H ICS called the IDPN (ICS Designated Professionals Network)
- IDPN chaired by CCG Head of Nursing and Safeguarding
- Aim to "do once and share"
- Agreed shared approach for safeguarding support for work-streams and programme leads
- All members have agreed work stream e.g. MH/ LD and links with ICS lead
- Consider safeguarding response to new pathways across ICS
- Agreed safeguarding aspects of QIAs
- Planning for agreed safeguarding standards
- NHSE engaged

Other work and activities of the Safeguarding Team

- **Supporting GP's including training** – The team offer training, advice, support and information to all GP Practices across Calderdale. Quarterly GP safeguarding leads meetings led by the Named GPs

- **Safeguarding Adults Health Alliance** – The team facilitate a forum for the leads in both commissioning and provider organisations to meet at regular intervals. To facilitate working together across boundaries, sharing information, experience and good practice in a mutually supportive and progressive approach that builds a strong health voice.

- **Safeguarding Supervision** – all members of the team provide safeguarding supervision for other specialist safeguarding professionals in other CCGs, health providers in Calderdale and across the WY&H ICS.



Examples of the team supportive work this year

Provision of Safeguarding training support:

- Learning Event facilitated for GP’s to support Practice staff to be able to meet the required safeguarding training standard.
- Re-engineering of GP Safeguarding Leads meetings (facilitated by the Named GPs on a quarterly annual basis) to include bespoke training sessions for Safeguarding Leads to provide up to date information, provide group supervision and support them in their safeguarding roles in practices
- Delivered bespoke safeguarding training to Governing Body

Provision of expert safeguarding advice and support:

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

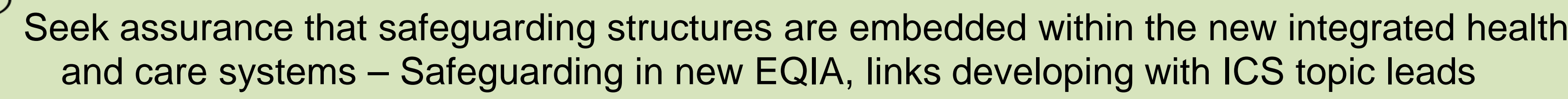
Supervision:
Members of the Safeguarding Team continue to provide safeguarding supervision to Named Nurses working with Provider Services

The Team priorities for 2019-2020

Working with the CSCP to embed the new safeguarding partnership arrangements in practice

Development of the Safeguarding Children's Health Assurance and Improvement Group and outcomes focused data set

Working with the CSAB to embed the Making Safeguarding Personal strategy into practice – work is ongoing and the Designated Nurse is supporting the work



Seek assurance that safeguarding structures are embedded within the new integrated health and care systems – Safeguarding in new EQIA, links developing with ICS topic leads

Preparing for the implementation of the new Liberty Protection Safeguards (delayed implementation date from Oct 2020).Local multi-agency implementation group established & chaired by Designated Nurse Safeguarding Adults

Strategic Objectives for 2020 – 2021

Review and update the CCG Mental Capacity Act policy

Prepare for the implementation of the new Liberty Protections Safeguards

Continue to actively support the Adult & Children's Safeguarding Partnership arrangements in Calderdale

Post Covid 19 Recovery including review and assessment of team effectiveness during the pandemic and potential post-Covid surge

Engage and drive the process for delivering Safeguarding requirements at ICS level and within Integrated care models

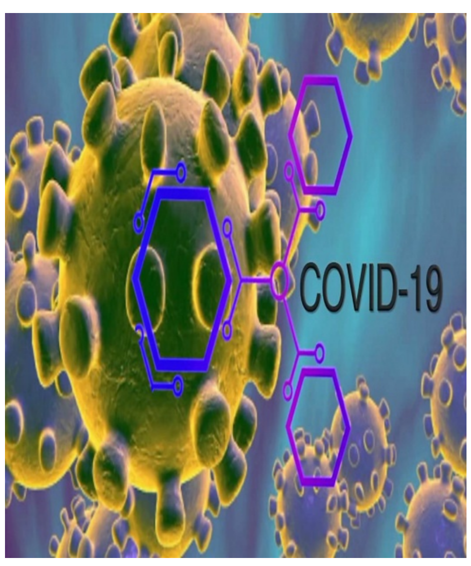
Covid Pandemic from March 2020 – what did the team do to respond?

Safeguarding Business continuity Plan – identified priorities

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

Monitoring & supporting providers to provide assurance via virtual routes

Delivered supportive safeguarding guidance documents for Primary Care teams



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

Supported the response to NHS England Community Priorities Document

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

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

Worked flexibly, utilising nursing skills to support CCG priorities

Key legislation that underpins Safeguarding work

Children:

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

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

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

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

Working Together to Safeguard Children (2018)

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

The Intercollegiate Document 2019

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

Key legislation that underpins Safeguarding work

Adults:

The Care Act 2014

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

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

The Mental Capacity Act

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

NHS England Safeguarding and accountability and Assurance Framework

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

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Public Sector Equality Report 2020**	Agenda Item No.	8
Report Author	Sarah Mackenzie-Cooper, Equality and Diversity Manager	Public / Private Item	Public
GB / Clinical Lead	Alison MacDonald, Lay Member (Patient and Public Involvement)	Responsible Officer	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary								
Please include a brief summary of the purpose of the report	This presentation provides an annual update of activity undertaken to embed equality within the organisation and its activities. As an organisation the equality agenda is critical to our success and is reinforced by our visions and values. We work to understand the communities we serve and make better decisions ensuring the services we plan and buy meet the needs of the population of Calderdale. This report provides evidence of our compliance with the Public Sector Equality Duty (PSED) and demonstrates our commitment to equality and inclusion.							
Previous consideration	Name of meeting	Quality, Finance and Performance Committee			Meeting Date		20/03/2020	
	Name of meeting				Meeting Date			
Recommendation (s)	It is recommended that the Governing Body **RECEIVES** the report for assurance following its approval by the Quality Committee at its meeting on 20 March 2020.							
Decision	☐	Assurance	☒	Discussion	☐	Other		

Implications						
Quality & Safety implications	Examples of activity are described within the report.					
Engagement & Equality implications	The report describes the CCGs approach to equality and details work to assure equality obligations. It also describes the interdependencies between engagement and equality					
Resources / Finance implications	The report makes reference to the Workforce Race Equality Standard and the employee profile.					
Has a Data Protection Impact Assessment (DPIA) been completed?	Yes		No		N/A	x

Strategic Objectives (which of the CCG objectives does this relate to?	Improving quality Improving governance	**Risk**	None
Legal / CCG Constitutional Implications	No legal or constitutional implications	**Conflicts of Interest**	No conflicts of interest have been identified. Any conflicts of interest arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest Policy.

1.0 Introduction

1.1 The purpose of the Public Sector Equality Duty Report is to demonstrate the CCG's compliance with the public sector equality duty included within the Equality Act 2010.

2.0 Detail

2.1 The public sector equality duty, as part of the Equality Act 2010, is made up of a general equality duty which is supported by specific duties. The 'specific duties' are intended to drive performance on the general equality duty.

2.2 The general equality duty requires the CCG, in the exercise of our functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

2.3 Protected characteristics are defined as:

- Age
- Sex
- Disability
- Gender Reassignment (Transgender)
- Race
- Religion or Belief
- Sexual Orientation
- Pregnancy and maternity
- Marriage and civil partnership.

We additionally pay due regard to the needs of carers when making commissioning decisions.

2.4 The CCG has a statutory duty to publish a report, annually by 31st March to demonstrate compliance with the equality duty.

2.5 The information published must include:

- Information relating to employees who share protected characteristics (for public bodies with 150 or more employees); and
- Information relating to people who are affected by the public body's policies and practices who share protected characteristics (for example, service users).

2.6 This Public Sector Equality Duty report has been published, the statutory publishing deadline was the 31/3/2020 and is shared for discussion and assurance.

2.7 There is no prescribed format for the report, but various examples from other areas were considered and best practice developed. This year a presentation has been developed, this will be published alongside a plain PDF version for improved access.

2.8 The report demonstrates how the CCG has met its equality duties by consciously thinking about the three aims of the Equality Duty as part of the process of decision-making, using EIAs to deliver assurance. It details our approach to equality, legal responsibilities, progress over the last year, local population and workforce data. As the content is mostly already available on our website or on our partners web links have been used.

2.9 The Equality Act 2010 outlines that the report should be made accessible to the public, free of charge. In addition to publishing the report electronically on the website, the report will be made available in other formats on request.

3.0 Next Steps

3.1 To develop the Workforce Race Equality Standard report, a shadow Disability Equality standard report, the Equality Delivery System (internal facing goals) and staff survey outputs. Use these to develop a Workforce Equality action plan.

4.0 Recommendations

4.1 It is recommended that the Governing Body **RECEIVES** the report for assurance following its approval by the Quality Committee at its meeting on 20 March 2020.

5.0 Appendices

5.1 Appendix 1 - Public Sector Equality Duty Report 2020

Public Sector Equality Duty 2020

www.calderdaleccg.nhs.uk

Annual Report

This report provides an overview of the equality work undertaken by the CCG in the last year to demonstrate and provide assurance to the Governing Body and others that the CCG has discharged their statutory and legislative responsibilities for Equality.

Equality Act 2010 and the Public Sector Equality Duty

Publishing equality information and setting equality objectives demonstrate the Clinical Commissioning Groups (CCG) compliance with the Equality Act 2010 and meet the Public Sector Equality Duty. The duties are described; Equality Act and Public Sector Equality Duty

Equality – how we deliver

Equality and Diversity Strategy	Our strategy outlines our commitment and intentions to promote equality, tackle health inequalities and improve health outcomes for our local people and communities
Equality Delivery System	The Equality Delivery System (EDS2) is an NHS equality assurance framework designed to help NHS organisations improve the services we provide for our local communities, consider health inequalities in our local area and provide better working environments free of discrimination. It is delivered in partnership with other NHS organisation and with public engagement.
Equality objectives	Our equality objectives have been developed following involvement with the local voluntary, community and social enterprise sector, staff and public sector partners, including through the implementation of the EDS2. The objectives set out the three equality priorities that will be worked on over the next four years.

Improving Health, Improving Lives

Equality – how we deliver

WRES	The WRES requires NHS organisations to demonstrate progress against nine indicators of workforce equality for BME staff. It was developed in recognition of the poorer experiences of BME staff in the NHS.
Equality Health Panel	Our Equality Health Panel provides a regular opportunity for protected groups and their representatives to share their views, information and feedback with the CCG and providers in Calderdale.
Accessible Information Standard	The 'Accessible Information Standard' establishes a framework so patients and service users (carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss, receive accessible information and communication support when accessing NHS or adult social services.
Accessibility	We work to make sure all the work we do is accessible and considers the needs of our communities and staff.

Equality objectives

Two of our objectives focused on improvements for LGBT+ people and young people: accessing GP practices and services and improving and increasing our engagement with both groups.

Views were sought from LGBT+ and other young people and a report published and 2 videos produced by LGBTQ young people

https://www.youtube.com/watch?v=r0O75kXK0O4&feature=youtu.be

The video shows positive and negative examples of experiences at their GP

Workforce

The workforce data referred to in this report has been taken from the electronic staff record (ESR). All records are available but staff do not have to provide information. The ESR system does not capture information on transgender staff.

The small number of staff employed in the CCGs means there has to be caution when reporting on staff equality profiles to avoid publishing person identifiable information; identifying staff against their protected characteristics.

The workforce is summarised at the end of December 2019

Workforce headlines

	Staff
Disabled staff	8.2%
Sex	
Women	80%
Men	20%
Religion	
Christian	52.9%
Ethnicity	
White	88.2%
Asian/Asian British	<5%
Age	
20-35	9.4%
36-55	68.2%
56+	22.4%

IMPROVING HEALTH, IMPROVING LIVES

Patient involvement and experience

NHS Calderdale Clinical Commissioning Group

The NHS belongs to us all. Listening to you our communities helps us understand what patients need and want. We make sure we hear voices from our diverse patients and public, we equality monitor our activities and target communities who may not have their voices heard.

These views shape our decisions; the feedback we receive helps us improve local healthcare services. We publish what we learn and explain why decisions have been made.

Annual Statement of involvement 18/19

Engagement and Patient Experience Action Plan 2018/19

You told us, we listened

Patient involvement and experience

We asked you about your experience of using wheelchair services. **You told us** the service needed to be improved. **We worked with** services users, carers, voluntary sector and stakeholders to develop a new service. We set up a service user group to help us during the procurement to appoint a new provider.

https://youtu.be/cqourbFooRg

got to know what was going on and the
fact that they had a chance to speak and

Governing Body Patient Stories

Patient stories are shared at Governing Body meetings. Hearing about their experience means we don't lose sight of what we are doing and understand that our decisions affect real people. This year the Governing Body heard about the experience of being sectioned, recovery, hopeful families and fitness, older people's experience of health and care services and mental health in the workplace.

Providers

The CCG work with our providers to make sure the equality agenda is delivered where its most needed; in interactions with patients and carers.

Each provider is directly supported by a member of the equality team. We support them and monitor equality progress through our meetings.

Our providers have similar equality obligations and their progress is detailed below.

Calderdale and Huddersfield Foundation Trust

PSED

EDS2 - pg 89

Equality Objectives pg 83

WRES

WDES

Gender pay gap

Gender pay & bonus gap

Difference between Men and Women	Mean (Average)	Median (Middle)
Gender Pay Gap	26.3%	8.4%
Gender Bonus Pay	60.4%	97.5%

Proportion of staff receiving a bonus

	Received a bonus	No bonus received
Female	1.5%	99.4%
Male	6.3%	93.9%

Bonus pay relates to payments made in the period 1st April 17 - 31st March 18

South West Yorkshire Partnership Foundation Trust

PSED – workforce report

EDS2 – report and internal goals

WRES – report and action plan

WDES – report and action plan

Equality Objectives – listed in Annual Report pg 33

Gender pay gap includes other equality characteristics (ethnicity and disability)

Strategy

With all of us in mind

Yorkshire Ambulance Service

PSED – workforce report

WRES

WDES – action plan

Equality Objectives – embedded in strategy pg 20

Strategy

Gender pay gap

Population Profile, Demographic Data and Health Inequalities

NHS Calderdale Clinical Commissioning Group

Calderdale Public Health Report 2017/8

Joint Strategic Needs Assessment (JSNA)

Calderdale Health Profile

Calderdale Demographics

Calderdale Overview

CCG Strategies and Plans

Calderdale Operational Plan

Calderdale Wellbeing Strategy 2019-24

Calderdale Operational Plan

Next steps

The CCGs will continue to deliver on the equality agenda and support providers. We will;

- Implement the EDS2, WRES and in 2021 the Workforce Disability Equality Standard
- Continue to work with patients and the public to ensure their views are central to our work – through the Equality Health Panel and in our engagement and consultation activities
- We will ensure that the equality agenda is included in all relevant areas of the CCGs work
- Work with colleagues to ensure equality becomes intrinsic and embedded in our work

Name of Meeting	Governing Body Meeting	Meeting Date	23/07/2020
Title of Report	**Patient and Public Engagement Annual Statement of Involvement 2019/2020**	Agenda Item No.	9
Report Author	Jill Dufton, Senior Engagement Manager	Public / Private Item	Public
GB / Clinical Lead	Alison MacDonald, Lay Member - Patient and Public Involvement	Responsible Officer	Penny Woodhead, Chief Quality and Nursing Officer

Executive Summary								
Please include a brief summary of the purpose of the report	The purpose of the report is to provide an annual account of NHS Calderdale CCG (& our partner's) engagement activity. The report sets out all engagement activity delivered during the period April 2019 to March 2020. The report also describes the engagement activity planned for the forthcoming year April 2020 to March 2021 and details of progress made on previous submissions of engagement and consultation that took place between 2016/18.							
Previous consideration	Name of meeting		Meeting Date					
	Name of meeting		Meeting Date					
Recommendation (s)	It is recommended that the Governing Body: ▪ **APPROVE** the annual statement of involvement as an accurate account of engagement activity during this period so the report can be published.							
Decision	☒	Assurance	☐	Discussion	☐	Other	Click here to enter text.	

Implications							
Quality & Safety implications	Generates information required to complete project EQIAs.						
Engagement & Equality implications	The report explains the approach to engaging and involving the public, patients, carers/families and staff. And also equality.						
Resources / Finance implications	There are no financial implications						
Has a Data Protection Impact Assessment (DPIA) been completed?	Yes		No		N/A	x	
Strategic Objectives	• Improving quality • Improving value	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

1.0 Introduction

1.1 The purpose of this report is to provide an annual account of our engagement activity for the previous financial year April 2019 - March 2020

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

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

1.4 The report also describes the engagement activity planned for the forthcoming year April 2020 to March 2021 and details of progress made on previous submissions of engagement and consultation that took place between 2016/18.

2.0 Detail

2.1 NHS Calderdale CCG has a 'Patient and Public Engagement and Experience Strategy' which sets out our approach and process for engaging people and underpins our 'whole system approach' to supporting this work.

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

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

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

- Key emerging themes for activities in 2019 - 2020
- Using insight to support commissioning decisions
- Equality
- Involvement activity April 2019 – March 2020

NHS Calderdale Clinical Commissioning Group (CCG)

- Children and Young People's Experience of their local GP practice
- Right Care, Right Time, Right Place (RCRTRP)
- Alternative Provider Medical Services (APMS) pre consultation engagement
- Alternative Provider Medical Services (APMS) consultation
- Calderdale Health Forum (CHF)
- Children and Young People (C&YP) Autism Spectrum Disorder Summit 'Find your Brave
- Equality Delivery System 2 (EDS2)
- Improving Access to Psychological Therapies (IAPT)
- Out of Hospital Care
- Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Adults Experience of their local GP practice

Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- Transforming hospital services in Halifax and Huddersfield design principles engagement phase
- Cancer

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
- Trust staff networks to encourage a diverse workforce
- Developing a ‘Carer’s Charter’
- ‘The Dales’ improving adult inpatient wards
- Single Point of Access (SPA)
- Suicide Bereavement Support Service (SBSS)

Voluntary Action Calderdale (VAC)
- Engagement Champions
- Healthy Hearts
- Alternative Provider Medical Services consultation

Calderdale Council
- Dementia friendly apartments at Railway Bridge View
- Children and young people on domestic abuse support in Calderdale
- Cancer / bowel cancer screening

Healthwatch
- Single Point of Access (SPA) for adult mental health services in Kirklees and Calderdale
- NHS Long Term Plan
- Enter and view visits
- Children and Adolescent Mental Health Services (CAMHS)
- Telephone and video outpatient’s clinics at Calderdale and Huddersfield NHS Foundation Trust (CHFT)

Disability Partnership Calderdale
- Engagement with disabled people regarding their experience of NHS services

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
- NHS Long Term Plan – Healthwatch engagement
- NHS Long Term Plan – Unpaid carers engagement event
- NHS Long Term Plan – Voluntary and community sector showcase event
- Young carers engagement event – ‘couldn’t care less’
- Healthy Hearts cholesterol engagement
- Health and care learning disability champions

- Projects planned for 2020 – 2021

2.5 The report also describes how we have used the insight we have gathered from all engagement and consultation activity to support commission decisions, and how we plan to continue using this intelligence in 2020/21.

2.6 We recognise that it can take several months or even years before any outcomes or changes can be reported on from any engagement and/or consultation activity that takes place. So we took the opportunity to look back over a number of years and reflect on changes made following engagement and consultation. The report describes the progress made on previous submissions of activity that took place between 2016/18.

2.7 An additional section on equality has also been included following an assessment of the engagement functions by the Equality Deliver System (EDS) in 2017/18. This item has been included as the delivery plan for our equality objectives is from April 2018 – March 2022. The CCG want to describe progress in this area to ensure we involve the diverse population of Calderdale and those groups protected by 'The Equality Act 2010'.

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

3.0 Next Steps

3.1 The next steps will be:

- To publish the this report on our website
- To continue to deliver engagement on the projects identified in 2020/21
- To identify the specific target audience we want to engage further and continue to develop our approach to engaging specific target audiences
- To generate the intelligence required to support equality impact assessments
- To continue to catalogue all our engagement and consultation activity

4.0 Implications

4.1 Quality & Safety Implications

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

4.2 Engagement & Equality Implications

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

5.0 Recommendations

5.1 It is recommended that the Governing Body:

- **APPROVE** the annual statement of involvement as an accurate account of engagement activity during this period so the report can be published.

6.0 Appendices

- Patient and Public Engagement Annual Statement of Involvement report from April 2019 - March 2020

Item 9 a

Patient and Public Engagement
Annual Statement of Involvement 19/20

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Acknowledgements

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

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

We’ve also the take the opportunity to look back over a number of years and reflect on changes that have been made following engagement and consultation.

Summary of Calderdale CCG engagement 2019/20

Calderdale CCG have a published Public and Patient Involvement and Experience Strategy which sets out the CCGs approach to involving local people and the legislation the CCG must work to. The duty to involve local people is set out in sections 242 and 244 of the Health and Social Care Act 2012, The NHS Constitution and the Equality Act 2010.

The CCG has involved over 2000 local people over the year in 2019/20 on the following areas:

- Alternative Primary Medical Services (APMS) engagement on the future of two practices
- Equality Delivery System (EDS) and improving access to GP Practices for young people and people who are who are Lesbian, Gay, Bisexual, Transsexual or Questioning (LGBTQ)
- Alternative Primary Medical Services (APMS) consultation on the future of two practices
- Improving Access to Talking Therapies for adults (IAPT) engagement

Reports of all the findings from these pieces of work can be found on our website https://www.calderdaleccg.nhs.uk/get_involved/engagementandconsultation/

We asked, you told us, we listened:

We asked young people to tell us about their experiences of using GP services in Calderdale and around support for those who identified as LGBTQ.

Young people told us that practices could make people feel more supported by using more child friendly language and inform of all choices. Young people also said to have more gender awareness of current issues and support and increased support for mental health and autism. We were also told that waiting rooms need to be more inclusive and to have more access to appointments

We worked with our GP practices, who are now taking up training with 'The Pride in Practice' to empower staff to give excellent care to LGBTQ patients and practices are reviewing the recommendations from the survey for service improvements.

The work we did in Calderdale has also been recognised as best practice and shared with the National Programme Broad for Pride in Practice.

Calderdale 'Involving People' strategy

A key priority during 19/20 for the CCG and partners such as the local authority, voluntary community sector and providers has been the development of a new system wide strategy to 'involving people' in Calderdale.

The strategy will create opportunities to build on existing approaches and maximise the resources and assets that are available in our communities (people who live there, the organisations and services that have a home within those communities).

We will continue to strengthen the approach to communication and engagement with our population, maximising opportunities for meaningful conversation and co-production.

Organisations across Calderdale 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).

Calderdale's 'involving people' strategy will be uploaded to the CCG website later this year.

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

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

1. Introduction

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

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

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

This report provides an overview of the engagement and consultation activities that have taken place over the past year from 1st April 2019 until 31st March 2020 and includes a summary of what people told us, what the outcome was and where you can find further information. It also includes details of any engagement or consultation activities that are currently planned for 2020/21.

2. About Us

NHS Calderdale Clinical Commissioning Group (CCG) is the CCG covering 22 General Practices and a registered population of more than 222,000 patients. CCGs are groups of GPs that are responsible for planning and designing local health services in England. We do this by 'commissioning' or buying health and care services including:

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

Clinical Commissioning Groups work with patients and health and social care partners (e.g. local hospitals, local authorities, local community groups etc.) to ensure services meet local needs. CCG boards are made up of GPs from the local area and at least one registered nurse and one secondary care specialist doctor.

The CCG is made up of local clinicians who are working together to secure the best possible healthcare for local communities. Our aim is to improve the health and lives of local people by increasing life expectancy, making sure we commission and provide good quality services and to reduce health inequalities across the district.

Our vision and values

The CCG's vision is:

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

Our values are;

- Preserve and uphold the values set out in the NHS constitution
- Treat each other with dignity and respect
- Encourage innovation to inspire people to do great things
- Be ambassadors for the people of Calderdale
- Work with our partners for the benefit of local people
- Value individuality and diversity and promote equity of access based on need
- Commission high quality services that are evidence based and make the most of available resources
- Encourage and enable the development of care closer to home

Download a copy of the CCG Constitution here.

Our priorities

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

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

- Ensuring a safe environment and protecting people from harm
- Reducing inequalities in Calderdale

Our finances

NHS Calderdale CCG is responsible for devolved healthcare budgets of approximately £337 million on behalf of our patients and people living across Calderdale.

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

3. Our approach

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

We have a 'Patient and Public Engagement and Experience Strategy' which sets out our plans and to ensure that we adopt a whole system approach to supporting this work.

Our strategy enables us 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,
- The recommendations of the Francis Report.

The strategy shows that we are committed to ensuring that we actively engage with patients, the public and other key stakeholders to ensure that the commissioning, design, development, delivery and monitoring of healthcare in Calderdale meets the needs of our population. By listening to patients, and learning from their experience of health care we can understand what really matters to people.

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

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

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

Patient and Public Engagement and Experience (PPE&E) Steering Group
The purpose of the Patient Experience and Patient and Public Engagement Steering Group is to shape, steer and advise on any engagement and consultation activity.

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

- Networking – developing and sustaining positive relationships across the group membership.
- Collaborating - working together with providers to identify areas of good practice, areas of concern and actions for improvement.

- Learning – sharing good practice across local providers as well as being mindful of the ongoing work of the West Yorkshire and Harrogate STP as new plans are developed across the region.
- Shaping – Setting, monitoring and driving the delivery of the patient experience priorities.

Calderdale Health Forum
Calderdale Health Forum has been set up by the CCG as a forum to gather together representatives from each of the member practices' patient reference groups (PRGs). Throughout the year we discuss engagement topics at the Health Forum meetings, this gives the group an opportunity to discuss in detail some of the main pieces of work and understand the priorities of the CCG and provide feedback on these. The Network meets on a bi-monthly basis, but members are also informed of engagement opportunities on an on-going basis. We engage with the network as part of our decision making process.

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

Engagement Champions are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf. By working with volunteers in this way the response to our conversations has strengthened and increased, particularly amongst seldom heard groups by helping to give communities a voice.

Patient Stories
Patient stories help bring experiences to life and will encourage the CCGs to focus on the patient as a whole person rather than just a clinical condition or as an outcome. They have the potential to inspire us to make successful changes, educate the workforce, to support learning about what works well and to promote excellence. We now have a system in place to collect stories as part of the CCGs approach to involving people.

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

Patient Advice and Liaison Service (PALS)
PALS helps the NHS to improve services by listening to what matters to patients and their families and making changes when appropriate. PALS provide the following functions to the population of Calderdale:

- Providing the public with information about the NHS including complaints procedures, and helping with any other health-related enquiry

- Helping resolve concerns or problems and providing information for those using the NHS, outside support groups and improving the NHS by listening to concerns, suggestions and experiences

- Providing an early warning system for NHS trusts and monitoring bodies by identifying problems or gaps in services and reporting them

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

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

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

Service redesign activities
Throughout the year we actively promote any activities for people to become involved.

Engagement as part of the development of our commissioning intentions will feed into the overall themes arising locally and support our decision making in respect of future actions.

We will continuously cross reference the themes which arise from patient and public engagement to update and reflect on the intelligence we have to date.

4. Engagement and consultation activity

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

The report includes all engagement and consultations that has been undertaken and completed during 2019/20, including any that started before 1 April 2019, or that started during the period of this report, but are not yet completed. It also includes details of engagement and consultations planned for 2020/21 and details of progress made on previous submissions of engagement and consultation that took place between 2016/18.

From all the work we have completed this year and in 5 previous years these are our **key emerging themes**:

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

5. Using insight to support commissioning decisions

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

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

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

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

From our vast data source we have been able to provide a number of composite reports which have underpinned our understanding of our local population. This approach has also resulted in the development of smaller insight reports which have been used to support service areas such as:

- The development of a prospectus which describes a 'Community model' for healthcare services in Calderdale
- A review of 'Older People' services to support a system Care Quality Commission (CQC) inspection
- Hospital services, including redesign of Outpatient Services
- An understanding of what people have told us in each of the identified 5 localities of Calderdale to support 'Calderdale Cares' and locality working

To support the delivery of the NHS Long Term Plan we have also produced a digitisation and personalisation engagement and consultation mapping report for West Yorkshire and Harrogate Health and Care Partnership. The report demonstrates how a number of organisations across West Yorkshire and Harrogate (WY&H) have started conversations at a local level regarding digitisation (digital technology) and personalisation (making care personal) and provides a baseline for any future engagement work needed at a local and WY&H level.

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

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

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

So far the work has helped us to improve our reach into the identified communities. The work is documented within the report under EDS.

6. Engagement and consultation activity April 2019 to March 2020

We ask our partners, providers and staff in the CCG to help and support the CCG to produce the Patient & Public Engagement Annual Statement of Involvement each year by gathering information so we can report on all engagement and consultation activity that has taken place across Calderdale.

NHS Calderdale CCG
Children and Young People's experience at their local GP practice
April to June 2019

Who did you engage or consult on and what did you ask?
The purpose of the engagement was to involve young people aged between 12-25 years old to understand their experience of their local GP practice. The engagement was co-delivered by Calderdale Clinical Commissioning Group (CCG), Barnardo's Positive Identities Service (BPI) and Voluntary Action Calderdale (VAC).

By gathering views, young people told us what else we need to do to ensure that the CCG can provide information to GP practices to ensure that young people are supported in the right way.

What did they tell you?
The CCG received a total of 225 responses to the survey and the key findings from the engagement are listed below:

- 62.9% responded that they would 'Discuss it with a family member', 37.1% 'Ring the GP practice' or 31.2% 'Google it' if they were worried about their health.
- 32.3% visited the GP practice 'In the last month' and 30.9% 'In the last 6 months'.
- 74.8% of parent/carers booked the GP appointment.
- 87.3% responded that 'Telephone' was the preferred method used to book appointments.
- 75.9% attend the GP practice with their 'Parent/carer' and 21.8% 'go on their own'.
- 68.3% stated they have never been offered an appointment at the GP practice without a family member.
- In terms of access to the GP practice, the main areas of concern were difficulty in getting appointments, access due to mobility and anxiety around going alone, taking in information and speaking to staff.
- For the last appointment, 65.1% 'Went to see a GP', 17.5% 'Saw nurse/nurse practitioner' and 10.8% stated they 'Saw someone but didn't know what their role was'.
- 45% rated their overall experience as 'Good' and 28.4% as 'Ok'.
- 54.6% sated it was important for the Doctor to use their birth name.

The four main areas that could make people feel more supported are:

- Communication – To use more child friendly language and inform of all choices.
- Appointments – To have a more flexible, easy to use booking system for appointments with quicker access and shorter waits to be seen.
- Gender Support – For practice to have more gender awareness of current issues and appropriate support, use pronouns, plus demonstrate inclusiveness in waiting area.

- Service – To increase support for mental health and autism. Have continuity of care and trust. Be more supportive and treat equally. To have increased funding for more services.

A number of responses stated sometimes, or that they talked to mum, and others stated they had difficulty understanding the different languages and use of medical terminology. Other comments included having a lack of information on the illness/it was complicated/not clear on what condition was.

- 67.2% felt that the Doctor or health professional understood their needs and 22.6% stated they were 'Not sure'.
- 63.6% felt they could ask the Doctor or other health professionals questions and 19.3% stated 'Not Sure'.
- 24.5% were worried that the Doctor or other health professional would discuss their personal issues with the family/carer and 60.1% did not think this was the case.

What did you do?
The report of findings will be shared with the Primary Care Equality Steering Group and Patient and Public Engagement Steering Group.

Feedback has been provided to those respondents who have requested it.

The CCG has shared the report of findings with GP practices to ensure that young people and those identifying as LGBTQ are supported in the right way. The information will be used to identify any service improvements and access to GP practices by individual practices.

Where can you find more information about this work?
Please find below link to the CCG website which contains the report of findings, videos and infographic in relation to the engagement work.
https://www.calderdaleccg.nhs.uk/children-and-young-peoples-experience-of-their-local-gp-practice/

NHS Calderdale CCG
Right Care, Right Time, Right Place Programme
June 2019

Who did you engage or consult on and what did you ask?
The Right Care, Right Time, Right Place (RCRTRP) programme has benefitted from the contribution of stakeholders in the engagement, consultation and post consultation stage. On 15 February 2019 an overarching Engagement, Equality and Communication plan was presented to the Joint Health Scrutiny Committee. This set out an approach to continue engaging local people, staff and partner organisations as the proposals for hospital and community health services are developed into detailed plans. One of the initial actions was the scheduling of a Stakeholder Event. This event took place at Brighouse Civic Centre on Tuesday 11th June 2019.

The aim of the event was to continue this dialogue and provide an update of the planned changes to hospital and community health services across Calderdale and Greater Huddersfield, and to find out how people wanted to be engaged and involved in the development and design of services.

The input and insight gathered from the stakeholder event would be used to produce a detailed action plan for engagement, which would ensure we involve the right people, in the right conversations and provide information and communication using the right media and format. Those who attended the event were from:
- Patient Reference Groups
- Healthwatch
- Kirklees Council and Calderdale MBC
- Third sector organisations
- MPs and local councillors
- Local health providers
- GP Federations
- Parish and Town Councils
- NHS England and NHS Improvement
- Political interest groups
- Unions
- Patient and carer representatives recruited through the pre-consultation engagement activity

A Stakeholder event had interactive zones which provided information and allowed participants to talk to staff about each zone and what needs to be achieved. The zones were:
- Built environment – hospital design
- Digital technology – use of technology to improve access
- Involving Children and Young People
- Travel and transport parking – bus, shuttle bus, roads and transport
- Development of clinical services

In addition there were two displays for Community model – Kirklees and Community model – Calderdale

Key questions asked at each zone:
- **What** would you like to comment on?

- **Who** should be part of this?
- **When** and **where** should we do this?
- **How** should we do it?

What did they tell you?
Clinical Services

- Patients are the experts and include disabled people and sensory and cognitive improvement
- "Seeing the same person - getting continuity of care right.
- Primary - community - secondary - digital"
- Different channels for different audiences

Travel & Transport

- Public transport – expensive, information availability, accessibility and convenience
- Car parking – availability, park and ride, prepare for electric cars
- Integration of transport – shuttlebus, PTS and community transport options

Digital

- "Say it once/record it one.
- Access to records/information Hospital and Community"
- "Assisted Technology Social Care – Telemedicine"
- "Elderly Access or people who don't have access to technology"
- NHS App!

Children and Young People

- Involve young people now
- Go to where young people are
- Use different approaches

Hospital Buildings

- Physical access to our hospital (wheelchair users)
- Users to test drive layouts, access, and signage.
- "come and talk to us"

What did you do?
The evaluation and feedback from the event in June 2019 was used to determine the on-going work that will be undertaken to ensure continued communication and involvement of members of the public, stakeholders and staff in the plans for service reconfiguration in Calderdale and Greater Huddersfield. This on-going work has been described in the Public and Stakeholder Involvement Plan which was presented to the Joint Health Scrutiny Committee on 18 October 2019.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in **June 2019.** This report can be found on this website: https://www.calderdaleccg.nhs.uk/download/report-of-findings-stakeholder-event-11-june-2019/

NHS Calderdale CCG
Alternative Provider Medical Services pre consultation engagement
July to August 2019

Who did you engage or consult on and what did you ask?
The purpose of the pre-consultation engagement was to help us to further engage patients who attend the GP services provided under the APMS contracts in Calderdale. NHS Calderdale CCG needed to review these services as the contracts for each service comes to an end at the end of March 2020. The CCG want to ensure that any future contracted GP services meet the needs of patients and the local population.

The CCG wants to make sure that the patients of these practices get the GP services they need, and that the money spent on these contracts is used to make existing GP services work better for everyone

Pre-consultation engagement took place in July and August 2019 and previous engagement activity on primary medical services that has taken place over the past five years.

The APMS contracts are provided by two service providers. This meant that the CCG had to reach patients of the practices with support of both providers. The pre-consultation engagement wanted to gather the views of:
- Patients of the practice
- Families and carers
- Staff
- Local councillors and MPs
- Other primary care services operating in the same geographical area including pharmacy services and other neighbouring GP practices.

We asked patients to tell us what aspects of the service they receive are important to them and to rate the areas of importance that they value the most. We also asked patients how they normally travel to their GP practice and far they would be prepared to travel. We also asked people to tell us anything else they wanted to share about their practice.

What did they tell you?
The CCG in total received 798 surveys from the pre-consultation engagement. The overall findings and key themes are set out below.

The most important aspects of a good service from all the responses received are:
- Good care and treatment
- Being able to book an appointment
- Location of the surgery

From both practices the majority of patients responding travel by car 53% overall, however there were a significant number of patients who walk to the practice locations 30% overall. People who walk felt they would be most impacted by the changes as this would incur additional cost.

Meadow Dale Practice comments:

- Patients told us they had a good experience of the service and valued the GPs and the care and treatment they received
- There were some comments that the reception and parking areas could be improved and some patients had reported a decline in the standard of service over the past few months. Booking appointments also required some improvements

Park and Calder Practice comments:

- The appointment system was reported as good and the walk in service and out of hours provision was valued
- Not being able to get through to the practice and locum cover resulting in a lack of continuity were commonly reported themes

General comments and concerns

- Concern that surrounding practices will not be able to cope with additional patients was a general concern
- Concern from both Todmorden and Sowerby Bridge patients that they will not have choice in their local area
- Todmorden is a long way from Halifax and so requires excellent community care which includes GP practices
- People were unclear what the CCG are proposing and there were a few comments that the timing of the process was during holiday period and a decision has already been made
- People are unsure if reviewing the contract also means that the walk in service provided at Park and Calder would be closed
- People are concerned that practice closures may increase visits to A&E
- Any replacement service needs to replicate the extended opening hours which were valued by patients
- A replacement service needs a permanent GP for continuity of care and access to a female GP
- People feel the services are much needed and worth the investment and whilst some understood costs needed to be managed most felt that the service was more important
- People stated that changing surgeries for some is unsettling and people are worried that they will have to travel outside the area to receive a service

Equality themes

- The most significant underrepresentation was for Asian/Asian British and Muslim respondents. Disabled people were also underrepresented.
- Travel and transport concerns were paramount for the respondents groups analysed, which included financial aspects for most.
- Service issues were a concern for all equality groups

What did you do?

The findings from the pre-consultation engagement report were used to inform future options for GP services. The CCG used the findings to inform the development of options which were formally consulted upon in the autumn. The findings from the pre consultation engagement were also shared with Overview and Scrutiny.

Where can you find more information about this work?

Please find below link to the CCG website which contains the report of findings from both the pre-consultation engagement work https://www.calderdaleccg.nhs.uk/apms/

NHS Calderdale CCG
Alternative Provider Medical Services consultation
October to December 2019

Who did you engage or consult on and what did you ask?
The CCG launched a consultation over a six week period from the 28th of October 2019 to 6th of December 2019 to understand the impact of allowing our current APMS contracts to expire and allocating people to alternative practices.

The consultation built upon the pre-consultation engagement that took place in July and August 2019 and previous engagement activity on primary medical services that has taken place over the past five years.

What did they tell you?
A total of 832 surveys were received. Overall findings and main themes from all previous activity and the consultation have been consistent throughout and are set out below, in no particular order:

People told us they do not want their practice to close and they are happy with the service they receive. They also told us that staff are helpful and friendly and they have good relationships and built trust with them.

The majority of respondents are concerned about the capacity of other practices taking on additional patients. People also said they are concerned about returning to a practice they have previously been registered with as they have had poor experiences.

Some people told us that they didn't have enough information to make informed choices and that they don't know where they will be reallocated to. They said they feel worried and anxious.

Access is important to people and the availability of appointments and being able to get an appointment quickly. People told us a replacement service needs to replicate the extended opening hours which are valued by patients. There was a concern for higher attendance at A&E if people cannot get appointments quickly.

Continuity of care and good quality care is also important to people. People are concerned about their ongoing treatment for long term conditions, receiving their repeat medication and appointments at other clinics such as podiatry or follow up appointments at hospital.

People are concerned about additional travel time and costs if they have to travel further. People told us that they like being able to walk to their practice and that it's close to where they live.

What did you do?
The NHS Calderdale Clinical Commissioning Group's (CCG) Commissioning Primary Medical Services Committee has now considered the findings of our consultation into the future of Alternative Primary Medical Services (APMS) contracts in Calderdale.

The CCG launched a consultation over a six week period from the 28th of October 2019 to 6th of December 2019 to understand the impact of allowing our current APMS contracts to expire and allocating people to alternative practices.

The consultation built upon the pre-consultation engagement that took place in July and August 2019 and previous engagement activity on primary medical services that has taken place over the past five years.

After careful consideration the following decisions were made:

- The Sowerby Bridge, Ovenden and Elland sites currently operated by Virgin Care LLP (Meadow Dale Group Practice) will close and the CCG will register patients with an alternative practice.
- The Park site currently operated by Locala CIC (Park & Calder Community Practice) will close and the CCG will register patients with an alternative practice.
- Having considered the clear feedback from public and the Adults, Health and Social Care Scrutiny board, the Todmorden site, currently operated by Locala CIC (Park & Calder Community Practice) will remain open. The CCG will continue efforts to secure a long-term solution for Todmorden that maintains patient choice.

Where can you find more information about this work?
Please find below link to the CCG website which contains the report of findings from both the consultation and pre-consultation engagement work
https://www.calderdaleccg.nhs.uk/apms/

NHS Calderdale CCG
Calderdale Health Forum
June, September and December 2019

Calderdale Health Forum (CHF) is managed and supported by the CCG. The forum has representatives from each of the member practices' patient participation groups (PPGs – also known as patient reference groups [PRGs]). At each meeting an engagement topic is included on the agenda providing members the opportunity to provide views. CHF are an important network and ensure the practice population have a voice in service developments. The forum is chaired by the CCG's Governing Body member for Public and Patient Involvement.

The Calderdale Health Forum was established by the CCG as a forum for representatives from each of the member practices' PPGs to get together and network.

Throughout the year engagement topics are discussed at each meeting. This gives the forum an opportunity to discuss in detail some of the main pieces of work and priorities of the CCG and to provide feedback on these.

In addition attendees take part in a 'My Space' discussion where the patient representatives bring topics which are important to them to discuss with other attendees.

What do we do with feedback we receive?
As a result of these discussions the CCG has an opportunity to use the insight received to inform programmes of work, service improvements, and to clarify any queries raised by participants, where appropriate and also to feed into the practice managers advisory group. Information gained is then fed back to attendees by way of 'You said we did' session at the following meeting.

Who did we consult with and what did we ask?
CHF meets on a quarterly basis, but members are also informed of engagement opportunities on an on-going basis. We engage with the forum as part of our decision making.

The following engagement in meeting order has taken place this year:

Meeting held on 11 June 2019
The future of primary care - the context for this discussion was around the future of primary care linked to the NHS Long Term Plan. The group was presented with a video clip of three Practice Managers which informed the group of the changes to primary care from the new Long Term Plan. Primary Care Networks (PCNs) were to be formally established from 1 July 2019. In Calderdale there would be five PCNs who may change the format of PPGs and start to look at ways of working on a locality basis. PCNs would work with the voluntary sector, local authority and other community groups. Social prescribers would be used to help patients link with the different services and community groups. Forum members then discussed the implications of the future changes and made the following comments:

- Good idea to share PPGs and work together
- Are patients involved in the redesign of PPGs?
- Attend CHF to ask how PPGs can be redesigned

- Provide more context on the responsibilities of PPGs and the changes that are happening
- What's the goal of the PPGs?
- Understand how PPGs will work
- Share a map showing where surgeries fit into the five PCNs
- Focus on strengthening the weaker PPGs
- There is no direction from the practice to PPGs, which there used to be

Meeting held on 17 September 2019

How your PPG will fit into the newly formed PCNs, working together – each PPG were grouped into their PCN localities and discussed the following:

Lower Valley PCN

- Not all PPGs receive the same information
- Two representatives from each PPG could meet together as a Primary Care Network
- Bring strength up so all equal within network

Calder & Ryburn PCN

- Attend each other's PPG meetings in PCN
- Can surgeries/staff accommodate additional community services
- Accessible premises for all surgeries

Central Halifax PCN

- Online appointments are focussed on younger generation, not all people computer literate
- Put on IT training for community to support digital technology
- Issue with medications being issued when not checked, incorrect dose
- Locums used a lot – so no consistency in care
- Need to attract younger people to PPGs
- Mixed messages when referrals/appointments are going online across practices

Upper Valley PCN/North Halifax PCN (combined grouping)

- Not aware/have any contact with any other practices in PCN
- Locums and part-time GPs are used a lot and don't want to get involved in admin/management
- How will the full-time GPs manage this?
- How will finances be divided up to practices and agreed for each PCN?
- NH PCN is already working with a social prescriber who is looking at the community activities that are run (Pilates/curling etc.)

Members also discussed Practice Champions - the context for this discussion was around the role and activities of Practice Champions in GP surgeries and how this differed to the Patient Participation Group work:

- Practice Champions start community initiatives e.g. Allotments, healthy cooking session, crochet/knitting to get people involved and out of their house.
- Learning a new skill and meeting new people.

Meeting held on 17 December 2019

The forum discussed mental health patient access and what types of possible solutions there could be, such as:

- More training needed for receptionists on mental health awareness
- Quiet room for patients/private space – can this be made available in all surgeries?
- Befriending benches in the park?
- Profiles of roles of staff in surgery, so patients aren't so reluctant to see nurses and demand GP appointments

Members also discussed patient transport which the context of the conversation being the average age of people attending GP practices is increasing and who have difficulty with mobility, restricted monies and loneliness and GPs being more aware of what patient transport is available for people to get appointments and how others could be more aware of what is available to signpost patients/carers to.

There were some actions that came from this discussion:
- PPG members to look at how patient transport is promoted in the surgery currently
- Suggestion that practice staff add code 'patient transport' to front screen on patient record on System One.
- Add information on surgery websites
- One member to bring leaflets on the service to next meeting for everyone to distribute at their own surgery
- Ask in own practice how PPG members can help to promote/navigate services to patients.

Meeting planned for 17 March 2020 was cancelled due to the Coronavirus Pandemic (COVID-19).

What did we do?
Depending on discussions and the issues/comments raised some were passed on to the relevant person to inform improvements or raise awareness of views. And some were actioned in a range of ways. Set out below are a few examples of how feedback has been used.

The future of primary care - the forum was advised that the CCG engagement team would be attending a monthly Practice Managers Network meeting which would provide a way to feedback to the Practice Managers. A Practice Manager (named representative) was also identified and asked to attend future CHF meetings to enable continued open discussions.

An issue about the lack of information on patient transport was raised and the need for this to be accessible, for patients who need transport to attend GP/hospital appointments so they can easily arrange it. We liaised with the Practice Managers group to agree that they will update their GP practice websites with a section on patient transport information so it is easily accessible for patients.

How your PPG will fit into the newly formed PCNs, working together – the practice manager who will be attending future CHF meetings will also act as the conduit between CHF and Primary Care Networks.

Where can you find more information about this work?
For more information about the Calderdale Health Forum and notes of meetings please see the links below on Calderdale CCG website:

https://www.calderdaleccg.nhs.uk/get_involved/have-your-say/

https://www.calderdaleccg.nhs.uk/?s=health+forum

Resources for Patient Reference Groups can also be found at the link below:

https://www.calderdaleccg.nhs.uk/get_involved/resources-for-your-patient-reference-group-prg/

NHS Calderdale CCG
Children and Young People’s Autism Spectrum Disorder Summit 2020: “Find Your Brave”
February 2020

In January 2019, system leaders, young people, parent carers, 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. A second summit was held in 2020.

Who did you engage or consult on and what did you ask?
On the afternoon of 5th February 2020, Calderdale Young People with Autism Spectrum Disorder (ASD) organised and led a stakeholder summit ‘Find your Brave’, at North Bridge Leisure Centre, Halifax. This took place during National Children's Mental Health Week.

A Marketplace Event was held, at which partner organisations and staff promoted their services and support for children and young people with ASD. Staff, Summit attendees and young people also attended Training2Care’s the Autism Experience, also held at North Bridge Leisure Centre.

During the Summit, our Young People told participants their personal stories and what their dreams for Calderdale are. System leaders gave an update on the pledges made in January 2019 and partners celebrated the progress made since then.

Participants identified together how we all can continue the journey together in transforming the way we think, organise and operate in Calderdale.

Creative Connections were asked by the young people to curate the conversations and provide an aspirational context for the day.

The focus of this work was for the young people to ‘Find Their Brave’ by designing and leading the Summit, this included everything from the theme, agenda, layout of furniture, artwork dreams displayed around the room, and the topics discussed on tables.

There are many stakeholders committed to improving care for children and young people with autism. This Summit gave our Young People the opportunity to be heard first-hand, to describe their experiences and their dreams for the future.

The Summit provided renewed focus, energy and commitment by partners to transforming ASD services for the Children and Young People of Calderdale.

What did they tell you?
The emerging themes were generated from the topics that the C&YP with Autism wanted to discuss such as:

- preparing and supporting children and young people with autism for and during transition from one education setting to another, and to employment;

- understanding and identifying the training needs of professionals who support children and young people with autism;

- supporting children and young people with autism on issues related to social inclusion, and what our dreams for Calderdale are.

What did you do?
The ideas and actions generated will be used to inform Calderdale system working under the 'Thrive' model of emotional wellbeing and mental health care for children and young people, and next steps for ASD, aligned to Calderdale's all-age Autism Strategy.

They will also be used to inform the work of the ASD Steering Group and other key Calderdale partners.

Where can you find more information about this work?
A report of the findings from the event summit is currently in development and will be published on the Calderdale CCG website later in the year.

NHS Calderdale, Greater Huddersfield and North Kirklees CCGs
Equality Delivery System (EDS2)
February and March 2020

EDS2 is a tool designed to help NHS organisations review and improve their performance for local people protected by the Equality Act 2010. The tool identifies what needs to done to ensure the organisation is meeting the Public Sector Equality Duty (PSED). The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Without engagement with local people and communities, it would not be possible to deliver EDS2 effectively. This year all three CCGs worked in partnership with several large healthcare providers including Calderdale and Huddersfield NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, South West Yorkshire Partnership NHS Foundation Trust and Locala to deliver a joint approach to engaging with local communities and delivering the EDS2.

Who did you engage or consult on and what did you ask?
A new model for delivery was agreed for 2019-20. Instead of the community panel model used in previous years, the EDS2 was delivered through two market place style events in Calderdale and Kirklees. The CCGs and Providers each had a stall where information was shared informally and participants had an opportunity to discuss the projects before they made an assessment. No evidence templates were sent out in advance and the more relaxed approach attracted more community interest. The events took place on the following dates:

- Calderdale – Calderdale College on 26 February 2020
- Kirklees – The Mission on 11 March 2020

The theme this year was patient experience and complaints and participants were asked to grade the CCGs as either 'Undeveloped', 'Developing', 'Achieving' or 'Excelling'..

What did they tell you?
- Whilst the CCG has been involving and working with different communities it should involve and work with more 'hard to reach' groups.
- Attendees who had been involved in the Wheelchair services review felt they had not received timely feedback and wanted to know when future promised involvement opportunities would be forthcoming.
- Translation and interpreting service provision should be improved to enable better access to mental health services for BAME communities and specifically Asylum Seekers and Refugees.
- Accessibility in health services needs improvement, particularly access and experience for disabled people and those with impairments. People specifically mentioned inaccessible online access, limited opening times and inaccessible buildings and locations without parking as barriers to equitable access to services.

What did you do?
The recommendations will be used to update our equality objectives and improve how we work with seldom heard groups.

Where can you find more information about this work?
A report of the findings from the engagement process will be produced for Calderdale and Kirklees by the end of July 2020. The reports will be published in the equality and diversity sections of the CCGs websites:
https://www.calderdaleccg.nhs.uk/equality-and-diversity/
https://www.greaterhuddersfieldccg.nhs.uk/equality-and-diversity/
https://www.northkirkleesccg.nhs.uk/about-us/equality-and-diversity/equality-delivery-system-eds2/

NHS Calderdale CCG
Improving Access to Psychological Services (IAPT)
February to March 2020

Improving Psychological Therapies Services (IAPT) is a way to enable people with low level / common mental health problems, such as depression and anxiety to access psychological (talking) therapies. It is about providing people in Calderdale with accessible and appropriate psychological support to help improve their mental health experience.

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

The CCG wanted to review how IAPT services are delivered in Calderdale and also build on engagement that took place in 2018 on adult psychological services. The purpose of the engagement is about providing people in Calderdale with accessible and appropriate psychological support to help improve and maintain their mental wellbeing. The engagement will look at what's working and what opportunities there are to provide low level mental health interventions in different ways.

The CCG wanted to look specifically at IAPT services for low level mental health and how they can be developed. And also to gather people's views, experiences and ideas from people who have used current IAPT services. As well as ideas of how they feel the service could be improved. We wanted to know more about:

- How patients manage their mental wellbeing
- What patients and staff's experience are of the IAPT service
- Exploring the use of digital technology to support managing your mental wellbeing

The feedback will be used to inform and shape a psychological service which meets the needs of local people.

The engagement was delivered over a five week period from 3 February to 6 March. The key audiences and communities were:

- Service users
- Families and carers
- Staff
- Referrers to IAPT
- People who represent the follow communities;
- Black and Minority Ethnic groups
- Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
- Young people
- People over 65

What did they tell you?

The CCG received 154 responses to the survey. The overall findings and common themes from the engagement are summarised below.

The majority of people told us that if they were worried about their mental health that they would contact their GP for an appointment. This was closely followed by contacting family or friends. Some people also said that they would check an online website or app.

There were mixed responses from people who had accessed support for their mental wellbeing in terms of whether they found the support they were looking for and whether they found it helpful or not.

- Of those that said they did find the support they were looking for there was a mixture of what types of support they received such as; medication, meditation, talking therapies, counselling, course and going to groups.
- For those that said they didn't find the support they were looking for most felt that they had to wait too long for the support.
- There were other mixed comments from people who thought some of the support they received was helpful and other aspects not so helpful. It appears from the all the comments that the experiences people had was relative to each individual person and their circumstances at the time.

The most preferred ways people told us how they manage their mental being was taking part in physical activity or talking with family or friends. Other popular ways people said they manage their mental wellbeing is by attending groups, classes, taking up hobbies or doing mindfulness and relaxation techniques.

There was a mixed response from people in terms of digital support.

- Some people told us they were aware of online apps our courses to support their mental wellbeing and others said they weren't aware.
- Of those that were aware some told us that digital support such as apps, online courses; webchats were not a preferred method of managing their mental wellbeing.
- However, people who told us they were aware and were happy with the digital support they received said they like to use them for mindfulness, mediation to ease / help with anxiety, help with OCD/depression and sleep. And that they liked the accessibility of being able to use them when they need them
- Others said that they don't use apps for reasons such as they didn't use apps were because they struggled with technology, they don't like using apps, or because of their conditions or their reasons were too complex / complicated.

People told us that one to one support, face to face contact and being able to stay in touch was important to them. As well as support not being time limited and being able to access support in the community.

- The majority of people who said they had accessed talking therapies said that they accessed it via their GP, closely followed by self-referral. And most people said that they thought it was easy to find information about talking therapies. However, there were several comments from people who said that there should be more awareness and promotion of the service.
- Receiving one to one support and practical advice

Other themes from the comments received about Talking Therapies in Calderdale were:

- People want to access to services quickly and shorter waiting times around; accessing therapy
    - referrals to use group sessions
    - to see consultants
- People wanted support which is not 'time-limited'
- People wanted services to support recovery and provide practical coping strategies
- People wanted services to be person centred
- People wanted more self-help groups
- People wanted the CCG to invest in more IAPT services

Overall the majority of people are happy with the service they received or have received. From the comments that were received from people who told us ‘what works well from their experience’ there were more positive than negative. The most common themes from people were:

- Competent, interested, non-judgemental and compassionate staff
- Building a trusting relationship and consistency of seeing the same person
- Access to the service including telephone appointments and the referral system such as being able to self-refer

What did you do?

Recommendations to further engage to address gaps in equality groups.

The next steps for the CCG will be to consider all the views and feedback within this report along with the EIA to inform the future of mental health services in Calderdale. We will do this by holding a stakeholder workshop to discuss the engagement findings and coproduce solutions.

The findings will also be shared through internal governance and with the Mental Health Innovation Hub.

The report will be published on the CCG website and next steps explained following consideration of the findings.

Where can you find more information about this work?

Please find below link to the CCG website for the engagement report of findings
https://www.calderdaleccg.nhs.uk/iapt-engagement-and-equality-report-of-findings/

NHS Calderdale CCG
Out of Hospital Care event
February 2020

Emergency admissions and prolonged hospital stays particularly in a frail elderly population leads to deconditioning and the need for higher levels of care once discharged. In Calderdale we have managed to significantly reduce delayed transfers of care however, there is more which could be done. At times of crisis or escalating needs we know it improves outcomes for people if we can keep them at home. Improved responsiveness of community services through flexible teams working in multi-disciplinary teams will improve patient outcomes whilst avoiding emergency admissions and freeing hospital bed days.

The aim of this work is:
- To provide a proactive and flexible model of community care & support, designed to support people in a person centred way;
- To maximise peoples skills and independence responding to their changing needs

There is a multi-professional stakeholder group working towards developing the model for out of hospital care. The principles underpinning this work are as a result of all previous engagement taken place since 2013 such as Care Closer to Home ('CC2H') and care homes. And also feedback from a recent engagement undertake by Healthwatch regarding the NHS Long Term Plan. To find out more about all our engagement activity please go to the CCG website here.

Who did you consult with and what did you ask?
At the end of February 2020, an engagement event was held for health and care staff from across the Calderdale system such as:
- Calderdale and Huddersfield Foundation Trust (CHFT) – both community staff, and acute staff who work in the hospital (staff from teams such as; therapies, intermediate care, community nursing etc.)
- A range of voluntary sector organisations such as Alzheimer's society and Age UK
- South West Yorkshire Partnership Foundation Trust which provides mental health services
- Calderdale Council such as; social workers and commissioners.
- End of life organisations such as Marie Curie
- Care Homes providers

The aim of the event was to provide an opportunity for staff to voice their views on the current ways of working and to share their ideas relating to how future provision could look, based on their expertise and knowledge. The key areas for focus were:
- Out of hospital/community beds
- Trusted and single assessment
- Transition from step down to step up

- Workforce and skill mix
- Stroke
- Dementia and mental health
- Rehab – what is your definition of rehab? (to enable a common language to be used going forward).

What did they tell you?
All of the notes/ideas/suggestions from the event are currently being analysed and a report is being developed. Key themes that are emerging from what people told us are below:

- Integrated working and skilled workforce and multi-disciplinary teams
- Opportunities to improve models of care and pathways
- Making sure assessments are fit for purpose and criteria is clear and simple but flexible to meet the needs of the person
- Increased use of technology

There was a general consensus about what rehab is and it was agreed that it is very broad ranging. The overall suggestion was that we should not be sticking to a rigid set of criteria if it can be demonstrated that the patient would benefit from some level of 'rehab'.

What did you do?
We are currently processing all the feedback received and as a result, updating our programme plans around the emerging themes. This will improve ways of working across existing services and inform our next steps in relation to needs for our community beds.

Further engagement with patients, carers and key stakeholders will take place later in the year with those who have experiences of these services. And ongoing engagement with staff, patients, carers and key stakeholders will continue to help inform future planning of services and the out of hospital care model.

Where can you find more information about this work*?*
Please find below link to the CCG website for the engagement report of findings
https://www.calderdaleccg.nhs.uk/out-of-hospital-care-event-february-2020/

NHS Calderdale CCG
Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
Adults Experience of their local GP practice
February to March 2020

Who did you engage or consult on and what did you ask?
The engagement was aimed at all LGBTQ Adults who are resident in Calderdale, aged over 18 years old. The engagement ran for six weeks from 03 February to 13 March 2020.

What did they tell you?
The CCG received a total of **48** responses to the survey and the key findings from the engagement are listed below:

- Over half of the responders to the survey did not identify as LGBTQ.
- Responders mainly felt comfortable discussing their gender identity and sexual orientation, with the majority of the GPs/health professionals using their preferred pronouns.
- Over half of the responders were unsure if GPs had a good understanding of LGBTQ issues but felt they had a good understanding of gender and sexual identity. More than half of the responders felt unsure if GPs and their staff were welcoming to LGBTQ patients and did not feel that gender neutral toilets were important.
- Over half of the responders had not asked about other local services to support them and the vast majority were not referred to a different service.
- The vast majority of responders were seen by a GP and nearly half were seen in the last 6 months and over a third in the last month. Over half of the responders made appointments by telephone.
- Over half of the responders had no access issues when attending their GP practice and reported to have a very good experience. The vast majority felt their GP understood their needs and felt they could ask questions.
- The most important traits of a GP/health professional were reported as respect and to be good at listening.
- Positive experiences were that appointments were on time; people felt listened to and received a professional service. Staff were respectful of relationship and appropriate language used. No assumptions were made. GP staff friendly and helpful. In consultation there was time to talk, ask questions and the GP explained. Able to make appointments on the same day.
- Negative experiences were that GPs could dismiss issue and just advise to take paracetamol, appear to not be listening, having long waits to be seen and reception staff could be unhelpful.
- Responders asked that they gain quicker access, be able to discuss more than one issue and less assumptions be made. Training for GPs on transgender treatments and training for receptionist staff on customer care and equality. Responders would also like an improved appointment system to reduce waits, with an enhanced system for urgent appointments.
- Responders suggested that GP practices need to be more welcoming and accepting of the LGBTQ community and have individual knowledge of LGBTQ concerns.

Responders identified the following improvements:

- More time, more GPs, more appointments and more funding
- Improved appointment system

- Reduce waiting times
- Training for reception staff in customer care and equality
- Practices to be more LGBTQ friendly

What did you do?
The CCG adapted the LGBTQ Young person's survey for adults to have their say on existing services using either an online or paper questionnaire. Calderdale LGBTQ Partnership gave their feedback on the questionnaire and tested out the effectiveness before it went live. The questionnaire was then shared via the LGBTQ Partnership and the CCGs stakeholder list, plus on the CCG website and the CCG social media accounts.

The stakeholder list comprised of Calderdale Council teams, Police, voluntary and community organisations, Healthwatch, NHS South West Yorkshire Mental Health Trust, Voluntary Action Calderdale and the Voluntary Sector Alliance.

The questionnaire also had the CCG Free post address for people to return their completed forms back to the CCG.

Where can you find more information about this work?
Please find below link to the CCG website for the engagement report of findings
https://www.calderdaleccg.nhs.uk/lbgtq-gp-survey/

Calderdale and Huddersfield Foundation Trust (CHFT)
Transforming hospital services in Halifax and Huddersfield design principles engagement phase
October – December 2019

The transformation process started in 2016 with a public consultation led by our CCG partners in Calderdale and Greater Huddersfield. The Department of Health awarded funding of £196.6 m to support the proposals to transform care at Calderdale Royal Hospital and Huddersfield Royal Infirmary in December 2018.

As a result, we were able to start the initial Design Principles Brief with events for our staff and invited representatives from our local populations. These ran from October-December 2019.

Who did you engage or consult on and what did you ask?
We held four Public Involvement sessions, two each at The Shay in Halifax and Briar Court in Huddersfield for invited representatives from our communities. The attendees were asked their views on a range of key issues for how the new CRH and HRI might look and deliver services in the future.

The issues were central to the future planning process and were:
- Wayfinding and Access
- Accident and Emergency
- In-patient Wards
- Waiting Areas
- Digital Technology.

We also attended an older people's fair and forums for children and teenagers as our proposals include a specialist emergency department for younger people for the first time in our area.

We also held parallel events for clinical and non-clinical colleagues at CHFT for their feedback about the new hospital to ensure they are fit for purpose for providing healthcare services for our patients and, importantly, a pleasant environment to work in.

What did they tell us?
There was lots of feedback received from Public Involvement Sessions – including input from older people's fair and children and young people's forums, themes are below

- Wayfinding and Access – clear signage and well-located co-services
- Accident and Emergency – separate areas for young patients and elderly
- In-patient Wards – single rooms as far as possible and capacity for parents/carers to stay overnight
- Waiting Areas – informal seating areas avoiding rows
- Digital Technology- more use to enhance

Themes from staff are below;
- Enhanced technological capability to connect a range of devices and equipment with full coverage
- Storage, changing and rest facilities for colleagues and multidisciplinary teams

- Good patient observation areas in ED and ward areas with flexible space to support patient flow
- Attractive work environment and natural light is key to supporting colleague's wellbeing

What did we do?

- The feedback and ideas from the Public Involvement sessions and the CHFT colleagues are – at the time of writing - being collated into key themes and findings in two reports. These will form a Design Brief report.
- All three will be presented to our JHSC in March 2020 and be shared with NHSE and NHSI partners as well as the incumbent design partner once appointed (expected March 2020)

Where can you find more information about this work?

A report of the findings from the engagement can be found on the following websites
www.cht.nhs.uk,
https://www.calderdaleccg.nhs.uk/
https://www.greaterhuddersfieldccg.nhs.uk/

Calderdale and Huddersfield Foundation Trust (CHFT)
Cancer
June and November 2019

Working across Calderdale and Greater Huddersfield the local cancer network has ensured that national priorities are implemented locally. These have included the rollout of improved bowel cancer screen which has improved take up rates; implementation of the primary HPV vaccination and engagement in the development of 16 optimal cancer pathways to establish consistency of offer across West Yorkshire and Harrogate.

Who did you engage or consult on and what did you ask?
CHFT together with Macmillan Cancer Support have been looking into the feasibility of providing 'prehabilitation' for people with a new cancer diagnosis. Prehabilitation looks at what the needs and support of an individual may be so they can help inform their own decisions as soon as possible after diagnosis. This helps to improve their own health and wellbeing and maximising their resilience to treatment throughout their cancer journey and inform personalised care plans and individualised prehab interventions.

In Calderdale engagement has taken place with people with learning disabilities and in Kirklees with South Asian communities to better understand the barriers to taking up screening.

The Macmillan information team at CHFT regularly host cancer patient focus groups of approximately 15 people who are a mix of patients and carers from a cross section of cancer groups. Key services are discussed and they are asked about their health and wellbeing, what is offered and the persons/carers experiences during this time, which provides critical feedback regarding improvements to those services.

What did they tell you?
From the Macmillan focus groups examples of the output of this group include more peer support on diagnosis and the lack of support from people living with incurable cancer. They also described the benefit of the health and well-being events however felt these would be useful earlier in the patients' journey.

Emerging national evidence suggest improving wellbeing, physical, emotional and mental wellbeing improves outcomes and access to treatments.

What did you do?
As part of the prehabilitation project CHFT will report its findings and outcomes to Macmillan to further develop this pathway and establish best practice.

The Macmillan service has also responded to feedback by setting up a volunteer befriending service that will visit newly diagnosed patients on the wards and developing the 'Thinking Ahead' course to empower and support people living with incurable cancer. The First Steps cancer programme – a health and well-being event offered to all newly diagnosed cancer patients, has also been established which also supports the delivery of key messages relevant to the prehabilitation of patients.

Where can you find more information about this work?
A report of the findings from the engagement can be found on the following website
https://www.cht.nhs.uk/services/clinical-services/oncology/information-support/

South West Yorkshire Partnership Foundation Trust (SWYPFT)
Trust staff networks to encourage a diverse workforce
April 19 - ongoing

The South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) wants to create an inclusive environment for staff; this in turn ensures that those who use our services feel included as they are supported by people who reflect the local population. The staff networks in the Trust are involving staff to ensure we can actively promote and demonstrate our commitment to equality and diversity.

Who did you engage or consult on and what did you ask?
The Trust regularly consults and involves the networks in all aspects of Trust work. Each network is set up to support improvements in the workplace and to foster good relationships between staff, service users, carers, friends and families. This also supports our work with communities. The networks are detailed below:

- The Lesbian, Gay, Bisexual, Transgender plus (LGBT+) network
- The Black and Minority Ethnic (BAME) network
- The Disability network

Each network has been set up with a view to ensure the Trust is supportive of those from the LGBT+, BAME community and those with a disability. Demonstrating a commitment to this agenda means the Trust can promote itself as a great place to work, encouraging a diverse range of staff to join. A diverse workforce means the Trust can better reflect the population we serve resulting in better outcomes for all.

What did they tell you?
LGBT+: has just defined their role as promoting LGBT+ and recognising individuals who are currently working in the trust. The network aim to, break down barriers and recognise individuals within the work place. So far there has been excellent feedback with reports of ‘it brings a smile to everyone’s face’. The flag can be seen on Facebook, Twitter and flying at our mast.

BAME: The network creates an environment whereby people support one another in celebrating their achievements, maximising potential and also challenging the Trust when things are not going well. The network, involve themselves in schemes such as Race forward and deliver an annual event for all staff. As a multicultural society The Trust want to be a multicultural organisation, where appreciating the value that diversity brings is the fundamental premise. Genuinely appreciating diversity means that we live the values of the Trust and can provide better care for the people that we are here to support.

Disability network: Members want to empower and support staff with a disability or ongoing long term health condition to achieve and/or maintain their potential by maximising on the contribution of staff in delivering the Trust’s mission, values and strategic objectives and helping to shape and influence policies and procedures within the Trust to ensure that equality is proactively considered.

In addition all staff networks support the people; who use our services and create an inclusive environment for staff, families, friends and cares.

What did you do?
All the networks are a point of contact to reach our diverse staff. The networks are engaged on issues relating to equality and diversity.

LGBT+ The recent pride celebrations in the region were also recognised in the shape of a decorated hut (our security box) at the Fieldhead site as well as a flag at our main entrance. The LGBT+ network have a commitment to raising the profile of LGBT+ throughout the organisation.

BAME: By being part of the network means staff have gained access to local and national courses with the NHS Leadership Academy. One staff member has supported the lead for inclusion and talent management with the Leadership Academy, and presented at future events.

Disability network: A newly formed group; have already looked at the policy for supporting people in the workplace. Following a review of disabled car parking spaces – two extra disabled spaces have been created. Collaboration with Learning and Development to support students with disabilities when attending training courses within the Learning and Wellbeing Centre mean staff can request any reasonable adjustments. A permanent hearing loop is now in use in the Large Conference Room. A portable loop is also available in reception which can be used in any of the other training rooms

Going forward a network for carers will be set up as part of the Trust work to deliver on the West Yorkshire and Harrogate Partnership 'Carers Passport'.

Where can you find more information about this work?
For more information about this work go to the Trust website and search the network you are interested in, follow the address: https://www.southwestyorkshire.nhs.uk/

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
Developing a 'Carers Charter'
April 2019

Work took place to demonstrate the values of the Trust by engaging, involving and working with as many diverse service users and carers in the development of the Carers charter. The Trust acknowledges that work is required if we are to ensure our commitment to carers is upheld. This means that we need to continually work to ensure the needs of family, friends and carers are addressed by embedding an approach to support and involve family, friends and carers across the organisation. Nationally the statistics surrounding family, friends and carers requires a call to action to address the fact that:

- 1 in 8 adults (around 6.5 million people) are carers
- 6000 people across the UK become a carer everyday
- There are around 260,000 unpaid carers living in WY&H. This includes young carers.
- 1 in 7 of our workforce currently balance work with their caring responsibilities, with numbers as high as 1 in 5 in some sectors

Who did you engage or consult on and what did you ask?
When we are describing 'carers' we mean 'anyone who provides unpaid care and support to a family member or friend due to their disability, health condition, frailty, mental health problem, addiction or other health and care needs'.

The concept of a charter originally came from our carers group. The idea was to co-produce a charter which:

- Identified a definition for carers
- Created a set of objectives the Trust needed to deliver on
- Described what our commitment to carers should be
- How the charter should be promoted

To help enable us to produce the 'Our Commitment to Carers' charter it was absolutely imperative we gather the views and comments of carers as well as services users, third sector partner organisation and staff.

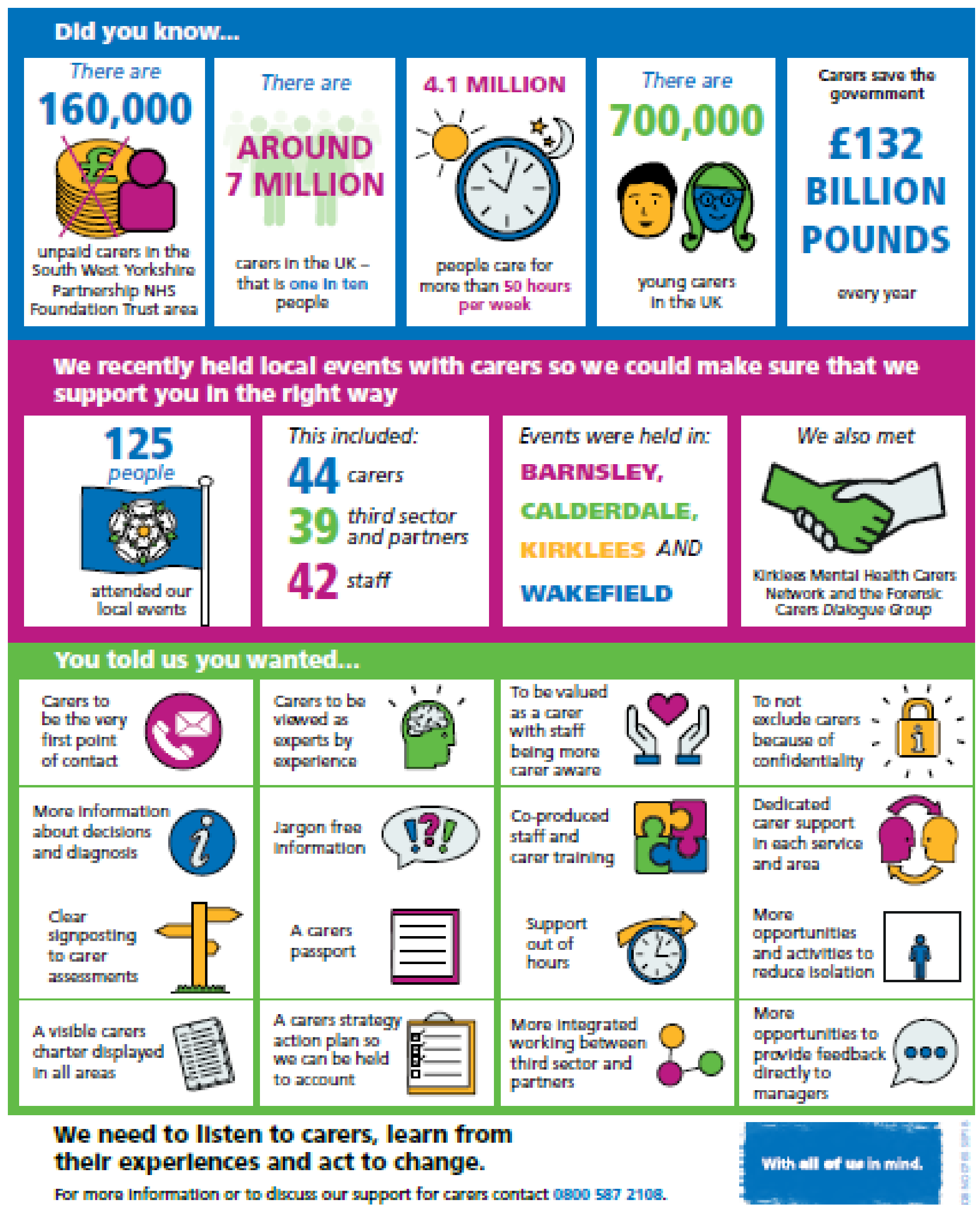
The Trust actively engaged with 125 people. Staff attended a number of events and existing carers groups across the areas of Calderdale, Kirklees, Wakefield and Barnsley.

Each conversation had a range of carers who had an interest in mental health. The Trust wanted to gather feedback to create a postcard and poster.

What did they tell you?
People told us what they wanted to see on a charter. The charter encompasses the views of all those engaged. A draft version of the charter once developed was recirculated to those who had given a view. This helped to create a final version and an infographic which are attached below:

In addition those participating identified a definition of a carer whilst co-designing the Trust charter. People told us that a carer should be defined in the context of **'Family, Friends and Carers'** to ensure anyone who identifies with the description above is included. This wider definition has now been adopted by the Trust.

Our commitment to carers



What did you do?
Following the engagement the Trust also created a version of a carer's card. The Charter and infographic are now displayed in all out-patient clinics, community centres, in-patient areas and at GP practices. In addition West Yorkshire and Harrogate Partnership and NHS England have added it to their carer's resource to share regionally and nationally.

The revised charter and info graph was very well received, in particular by the carers who found it easy to read and understand.

Where can you find more information about this work?
To find out more about this work, a copy of the charter and our commitment to carers, visit our Trust website on: https://www.southwestyorkshire.nhs.uk/

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
The Dales, improving adult inpatient wards
May – June 2019

The Dales consists of 3 wards Elmdale, Ashdale and Beechdale. Elmdale and Ashdale wards are mixed sex inpatient units for working age adults with mental health conditions. The wards are single en-suite rooms and have a number of day areas for shorter-term treatment. The unit also provides an occupational therapy service with gym facilities and therapeutic gardens. Beechdale ward is for older people. The Unit is run by South West Yorkshire Partnership NHS Foundation Trust and is based at Calderdale Royal Infirmary.

Who did you engage or consult on and what did you ask?
Occupational Therapists (OT) at 'The Dales' ward consulted with service users and carers on each of the wards. Therapists talked face to face with approximately 60 people during a period of time to find out what would help and enhance their mental wellbeing. People were asked questions and encouraged to provide responses to the following;

- What activities would they like to do during their admission to the ward?
- Service users were encouraged to ask questions about their feelings on being on the ward?
- People were asked to describe their expectations of occupational therapy?
- People were asked what therapeutic intervention they would like to do

What did they tell you?
Following a number of interviews the key areas that the team were keen to resolve from what people had told them were:

- The view from patients that there were not many activities on the wards and that they would like to find things they could do as the wards could be boring
- The suggestion from patients was to alleviate boredom by introducing creative activities to reduce this and prevent a feeling of isolation
- Patients also stated that they wanted something meaningful to be involved in

Staff worked hard to identify solutions to address each of these areas with service users.

What did you do?
The Occupational Therapists leading the work responded to the request by service users to look at solutions which would support creative approaches. The therapists spoke to 'Creative Minds' who suggested an arts café model, this had already been a successful and well established approach. Creative Minds also identified partners who could support this work. They were keen to replicate an art café in a ward environment.

A funding application supported by the Trust charity EYUP in partnership with 'Creative Minds' and using artists from partner organisations like 'Square Chapel' arts and 'Arch-way Project' were brought on to the ward to run a group which was named 'Art's Café at the Dales'.

Where can you find more information about this work?
For more information about this work contact Anthony Payne, Therapy Assistant on the following email address: Anthony.Payne@swyt.nhs.uk

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
Single Point of Access (SPA)
July – November 2019

The Calderdale and Kirklees Single Point of Access team (SPA) ensures that all, urgent, and routine referrals for Trust mental health services are processed and responded to in a timely way, following a triage process.

The team screens all referrals for urgency such as needing a response within 4 hours or 14 days or to give advice for alternative help. The team will refer all those who have been screened to need a 4 hour response (urgent referral) to the Intensive Home Based Treatment team for further triage which may lead to a face to face assessment. SPA will see people who need an assessment within 14 days.

Who did you engage or consult on and what did you ask?
Calderdale and Kirklees Healthwatch have already engaged and continue to engage local people on the SPA service.

In parallel over the past 12 months SPA has been going through a review of how it works. As part of this approach engagement events have been planned to test any findings from review activity. Some of the challenges identified in these reviews included:
- Ongoing increases in referrals
- The SPA receives many helpline calls rather than referrals for initial triage and assessment.
- Referral quality from primary care
- Getting the referral routes into services right
- Triaging and use of the triage scale
- Out of hours arrangements
- Compassionate staffing
- Support for carers
- Resourcing

An engagement event was held in July 2019 (jointly with the Trust and Healthwatch) to understand more about the areas identified in the review. People shared their views and the following themes were identified:
- Managing expectations when a SWYPFT service is and is not appropriate
- Different options for different people
- Role of 999 and 111
- Use of technology
- Streamline information
- Clear description of SPA
- Being accessible
- Signposting and SPA's role
- The need for a safe space
- SPA needs to be well-defined and this needs to be communicated
- Not telling people this isn't the right place
- Following this learning more engagement was planned for November 2019 to enable further conversations to take place. The report describes the findings from this work.

The approach to engagement was to deliver 2 workshops, one in Calderdale and one in Kirklees. The events were promoted using a flyer which was circulated throughout the Trust and partnership networks. The workshops were aimed at:

- Service users, carers and families
- Staff
- Healthwatch
- Groups that have an interest in improving mental health services
- Partner organisations including the CCG and Local Authority
- Voluntary and community sector

The events took place in a local community venue and were facilitated by staff with the support of Healthwatch. The team delivered a presentation to set the scene for the event. The discussions focused on a number of key themes that had emerged from the previous engagement activity.

Those attending were asked to consider the key themes and invited to comment on how the service could be developed and improved

What did you ask?

Those attending were asked to consider the key themes and invited to comment on how the service could be developed and improved. The 7 original key themes are identified below along with the work the Trust has already started in these areas:

Theme	Work started
Defining and communicating the SPA offer	• The new triage scale, referral process and access to new phone routes is redefining the SPA offer. • Refreshed the wording on the Trust website and we plan to relaunch the service
Knowing where to go and who to contact	• The Trust website has been updated • Developing a directory of services with commissioners • Working more closely with partners • Improving SPA staffs knowledge of partner organisations
Using technology	• Implemented a text reminder system for appointments • Working closely with GPs to develop e-referrals • Working with NHS England to pilot an Electronic Referral System for GP's and service users

Appropriate referrals into SPA	• We are working closely with GP's to develop new guidelines, referral guidance and e-referral processes • Guidance to be shared with partners
Better access to MH services	• A new helpline is in the process of being commissioned • We've been working closely with NHS 111 to improve the referral process when someone calls them
Appropriate and timely SPA Assessments	• We're trialling a new triage tool • Working towards 24 and 72 hour responses • Plans for short term interventions by SPA staff
Compassionate Staffing	• Working with staff in supervision • Team manager and admin manager reviewing calls • Team managers presence in the office

Following a review of feedback from the Calderdale session, a decision was taken to deliver the event in Kirklees using only 4 discussion topics, groups some of the 7 themes together, to avoid duplication and focus the conversations on the areas that matter most to those attending.

When reviewing the written notes from the sessions, many comments related directly to the first 3 heading. Feedback from these was captured under findings. Group discussions on the other themes are reported within these headings or recorded under 'other'.

What did they tell you?
In total we engaged 67 people who attended the events in Calderdale and Kirklees. The workshops took place on 6th November 2019 at Elsie Whiteley Centre, Halifax and on 21st November 2019 at Al Hikmah Centre, Batley. Both events ran from 10:00 – 1:30pm and light refreshments were provided at both events.

There were 21 people who attended the workshop in Calderdale and 46 people who attended in Kirklees. This section provides a high level summary of the key emerging themes from all the engagement which has taken place. The key emerging themes identified from the things that people have told us are set out below:

Theme 1: Communicating the SPA and Mental Health Support Services Offer

- A better name for the service.
- A clearer description of what SPA does.
- More clarity around the crisis offer – particularly out of hours.
- Improving information about the MH services and how to access them.
- Establishing a central place for information, both via website and leaflet.

- Better publicising of services.

Other communications considerations
- Using social media.
- Developing and using flow charts.

Theme 2: Referrals and support
- Improving and streamlining the referral process:
  - Better access routes in from primary care and Voluntary and Community Sector.
  - Improving telephone access, including from 111 directly through to SPA.
  - Capturing information only once.
  - Using technology where appropriate (whilst remaining person centred not technology centred)
- Improving support for carers, including:
  - Information packs for carers
  - for carers to prevent a crisis
  - Information for carers on the website
- Other considerations:
  - Ensuring the right levels of staffing of the service – particularly for people that do not have English as a first language, also for deaf / hard of hearing people
  - Managing confidentially
  - Using and sharing care plans

Theme 3: Timely SPA assessments
- Appropriate and expert triaging and quick determination of best course of action
- Ensure processes are in place to:
  - Respond in a timely way
  - Reduce the numbers of missed appointments (DNAs)
  - Follow up when / as appropriate.

Theme 4: Compassionate staffing
- The environment needs to feel caring; with staff responding in a caring; compassionate and supportive manner and people feeling valued and heard, including reflective practice.
- Use service users, carers and community partners to support this work.
- Recruit the right people.
- Get the Initial script right.
- Support staff and staff wellbeing.

What did you do?
The findings from the report will be used to ensure service improvements are made. The SPA service will work to continually improve the service offer to service users, carers, families, agencies and partners. As work is progressed a ‘you said, we did’ response will be posted on to the website page so people can see progress.

Where can you find more information about this work*?*
The report will be published on the Trust website under our get involved section once it is in place. People can find out more information about the SPA service on the Trust website. Go to https://www.southwestyorkshire.nhs.uk/ and search SPA (the report is published on this section for now)

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Suicide Bereavement Support Service (SBSS) August – November 2019

The West Yorkshire and Harrogate Health Care Partnership, now ICS has been working collectively across a number of organisations and in consultation with public health leads to deliver specific suicide bereavement support services across the region.
South West Yorkshire Partnership NHS Foundation Trust is the appointed lead for the West Yorkshire and Harrogate Suicide Prevention Strategy and works collaboratively with other NHS care providers, local authorities, local Clinical Commissioning groups, prison partners, emergency services partners and voluntary community partners in the design of regional services for suicide prevention.

Who did you consult with and what did you ask?
The Suicide Prevention Project Manager ran a scoping exercise and consulted with multiple local authority leads for suicide prevention, partner organisations delivering NHS care, individuals affected by suicidal thoughts and actions and families who have been bereaved through suicide. Input in the form of proposals for services, either new or already successfully established was also requested.

The Trust engaged with a number of bereaved families and third sector partners across WYICS area including some service user/carer groups in Calderdale/Kirklees. We asked the following questions:

- What is a suicide specific bereavement support service?
- What support have people experienced across the region? What worked and what was missing?
- What are the present models for postvention in place nationally and what can we learn from them?
- How do we make any service accessible to all?

What did they tell you?
Each person who provided input to the review process had a unique experience of their own loss and their own thoughts about what had worked well for them.

This varied in to knowing that some people would not access a group but would respond better to one to ones. People told us:
- Some people live in rural communities and would need help to access a group or would not be able to commit to travel to a group so would need to have support in their own homes.
- Some people work better creatively and being made aware of and having access to creative options for expression of loss was important.
- Experience of those directly and recently affected by suicide spoke of having a link person, a family liaison worker who would guide them on some practical elements of what they as a family need to consider.
- Knowing where to go to get counselling, being able to easily access counselling and not being made to wait several months before being able to get the support needed.
- People wanted a model of post-intervention delivery that represented their local communities, that was reflective of the local people
- People expressed concern that a city centre model would not work well in rural communities

- People wanted something bespoke that was grown out of the connections in their local areas already established.
- For Information leaflets or a go to place where guidance was easy – ensuring that information on what to do in the event of a death was shared.
- That GPs also advised families/friends and significant others on bereavement support services. A clearly visible and identifiable service accessible to all.

What did you do?
Based on the feedback West Yorkshire and Harrogate ICS launched a suicide bereavement support service on the 4th of December 2019. This service is commissioned to be delivered by Leeds Mind.

To date there are additional post- vention practitioners recruited to deliver Suicide bereavement support across the areas of Calderdale and Kirklees, Wakefield, Bradford, Harrogate and Craven these are in addition to the already established services for the Leeds area.

The service is in the first quarter of its delivery and the practitioners have established connections within the local community hubs. There is further development work that will take place as the service grows visibility and increases its presence across all organisations and grows connection to real time awareness of deaths in our local communities.

Each practitioner across the region is continuing to build connections to our communities and ensure visibility, accessibility and support is available. This is particularly important for prevention of future deaths through suicide and to reach all families who may be affected by suicide where there has been no contact with primary care services or secondary care services.

Where can you find more information about this work?
Lin Harrison, WY&H ICS Suicide Prevention Project Manager is available at lin.harrison@swyt.nhs.uk

Voluntary Action Calderdale (VAC)
Engagement Champions
July – November 2019

Two cohorts of new Engagement Champions received the CCG approved engagement provider training in this financial year, leading to the recruitment of 20 additional Champions from eight new organisations across Calderdale.

Who did you engage or consult on and what did you ask?
Engagement Champions are either volunteers or workers for community organisations or charities within Calderdale. They attend one full day and two half days of training from Calderdale CCG which equips them with the skills and knowledge to support people to give their views by survey or focus groups. Engagement Champions can earn funds for their charity or community groups by carrying out this work on behalf of the CCG and also enhance the profile of their organisation and the skills of the individuals who take part.

What did they tell you?
Feedback on the Engagement Champions courses is very positive. However, it can be difficult for volunteers to attend training on three separate occasions and workers can struggle to attend every session as resources for a number of charities and community organisations are very stretched. The main learning points from the training this year are below:

- Beware the use of acronyms
- Participants should be advised to speak to their management teams about safeguarding procedures in their organisations and be signposted to VAC's Safeguarding Training
- The session concerning the understanding of funding of local healthcare received mixed scores of 2, 3, 4 and 5 so on reflection this could be an area to review
- Participants indicated they would like to see more practical tasks to increase competence and confidence and this may be something that could be built into the course
- Producing a workbook as a single point of reference for all of the information given would be helpful to participants

What did you do?
NHS Calderdale CCG is currently undertaking a review of the Engagement Champions training to ensure all information is current and up to date to train further people over the next year.

Where can you find more information about this work?
A report of the participant feedback from the engagement training has been developed and can be found in the look back section of this report (section 7) was shared in February 2020.

You can find out more about this work on the CCG website below:
https://www.calderdaleccg.nhs.uk/giving-communities-a-voice/

Voluntary Action Calderdale (VAC)
West Yorkshire and Harrogate Healthy Hearts
October 2019

Engagement Champions were asked to help communities to know about the key messages of the Healthy Hearts campaign by becoming a CVD (cardiovascular disease) Champion to help spread the word now and in the future.

Who did you engage or consult on and what did you ask?
Engagement Champions were asked to express an interest in this project and then attend a CCG briefing.

Engagement Champions were asked to spread healthy heart messages in the following ways:

- Explaining the key messages about making healthier lifestyle choices to increase health and fitness, plus by looking after themselves better it will help to reduce the risk of heart attacks and strokes
- Signposting people to resources available
- Encourage take up of Active Calderdale schemes (park run, walking groups)
- Attend a webinar (online interactive presentation with a live speaker) to increase knowledge
- Support people who are on statins to ask for regular prescription reviews

What did they tell you?
This particular project was around signposting and explaining key messages rather than asking for feedback. The key themes of the engagement have been given above.

What did you do?
This project was not about collecting feedback or reporting findings. It was about explaining key messages and signposting to resources, schemes and prescription reviews

Where can you find more information about this work?
Please find below link to the Healthy Hearts website which contains lots of information, guidance and resources for the project:

https://www.westyorkshireandharrogatehealthyhearts.co.uk/

Voluntary Action Calderdale (VAC)
Alternative Provider Medical Services consultation
October to December 2019

VAC asked all Engagement Champions to attend a briefing delivered by the CCG on the topic to help distribute and support completion of surveys in the areas where there could be potential closures of a GP practice or a branch of the practice. The surveys were used to understand the impact of the closures in areas of Calderdale across all of the protected characteristics.

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

Seven Engagement Champions attended the briefing and four subsequently were involved in supporting the completion of surveys in Calderdale across the protected characteristics of disability, age, gender, religion and belief and race and ethnicity in different localities. The remaining Engagement Champions, who attended the briefings, circulated the link to the survey to their members and networks. Were there were gaps in representation for survey returns, VAC supported the CCG further by engaging with local schools in a locality where a closure was possible, advising local people of engagement events about the closures and providing information on the completion of surveys.

Surveys were used to collate information and this supported the CCG events taking place in areas with potential closures. Face to face conversations also took place at schools in areas affected by potential closures.

VAC staff members talked to local people at schools and asked if they used the practice which was about to close and if so then talked to them about the CCG events being held or gave details of the link to the survey. Engagement Champions linked in with their service users and asked if their service users used the practice which was potentially closing. If so, they supported them to complete a CCG survey.

What did they tell you?

Many people we saw said they were unaware of the potential closures as they had received no communication from the NHS. This was fed back to Calderdale CCG who advised letters were sent out alphabetically. There was some delay in people receiving their letter.

Surveys were collected and then inputted by the CCG. Engagement Champions stated anecdotally that people felt the potential closures would impact them adversely and were worried about having further to travel and being less able to get a doctor's appointment when they needed one.

What did you do?

The surveys were returned to the CCG for inputting and for analysis. The CCG then prepare a report on the findings of the surveys.

Where can you find more information about this work?

Please find below link to the CCG website which contains the report of findings from both the consultation and pre-consultation engagement work.
https://www.calderdaleccg.nhs.uk/apms/

Calderdale Council
Dementia friendly apartments at Railway Bridge View
May 2019

Engagement is an essential part of the planning and implementation stage of any commissioned service with the results helping shape and design services. This ensures that services meet the needs of the people of Calderdale, producing better outcomes.

Who did we consult with and what did we ask?

A Commissioning Officer asked for a piece of engagement to be undertaken to find out what potential needs people living with dementia and/or their partners may have when living in an extra care home. The new extra care home is situated in Brighouse. The new build will accommodate 60 apartments with 20 dedicated homes for people diagnosed with dementia.

This work was undertaken to understand what the needs of the potential residents will be and consisted of face to face conversations lasting up to an hour. The people who took part in these conversations were either people with dementia or their close family members. In total 11x one hour individual interviews were completed.

What did they tell us?

There were lots of suggestions and comments made which have been collated and put under the following themes:

- Health care needs
- Social care needs
- Family support needs
- Housing needs

What will we do next?

This report is shared with the Commissioning Officer for them to consider as part of the planning / implementation and with the people who took part in the conversations.

Where can you find more information about this work?

For further information please contact Joanna.marshall@calderdale.gov.uk

Calderdale Council
Children and young people on domestic abuse support in Calderdale
May 2019

Engagement is an essential part of all stages of the commissioning process with the results helping shape and design services. Ongoing engagement ensures that services continue to meet the needs of the people of Calderdale, achieving better outcomes.

Who did we consult with and what did we ask?
In 2018 a targeted survey was undertaken asking young people aged 11 years and over, their views on domestic abuse support. One of the recommendations from the survey report was that further in depth information was needed about the support offered in educational establishments. The recommendation suggested that holding focus group sessions with young people would enable this area to be explored in more depth. Focussed discussion sessions were facilitated by the Commissioning Engagement Officer at the following young people's groups:

- Time Out Volunteers meeting
- Calderdale's Tough Times Reference Group
- Branching Out, Hidden Harm Group
- Branching Out, Young Voices Group
- Calderdale Youth Council
- Calderdale's Young Advisors for the Safeguarding Partnership

In total 46 young people took part, aged between 11 – 20 years with the majority of young people being aged 13 – 17. Some young people who participated had personal experience either from living in a household where there was domestic abuse or through their own personal relationship. Others had no personal experience however felt they had something to offer.

What did they tell us?
There were lots of suggestions and comments made which have been collated and put under the following themes:

- Education and awareness raising sessions in schools/college
- School-based trusted adults
- Promotion of domestic abuse support services including online support

What will we do next?
This report will be given to the Commissioning Coordinator for Domestic Abuse and shared at the Domestic Abuse Strategic Board including the DA service Staying Safe and with the young people who took part.

The feedback will inform the development of planning and service delivery of Domestic Abuse Services and support in the future.

Where can you find more information about this work?
For further information please contact Joanna.marshall@calderdale.gov.uk

Calderdale Council
Bowl cancer screening
Summer 2019 onwards

This work focused on improving bowel cancer screening amongst groups in the population where participation rate in accessing bowel cancer screening is known to be significantly lower. In particular, amongst our South Asian population and people with Learning Disabilities (PWLD) in Calderdale.

Who did you engage or consult on and what did you ask?
Calderdale Public Health worked closely with key local organisations and groups such as Cloverleaf Advocacy, the Self-Advocates group and Health on the Streets (HOTS) through the local Mosques to co-produce various workshops:

- To improve knowledge on bowel cancer.
- To improve knowledge on lifestyle changes that can be made to reduce the chances of colorectal cancer.
- To improve knowledge on bowel cancer screening and how attendees can access bowel screening in Calderdale.
- To obtain feedback on what participants already know about bowel cancer screening, if they have previously taken a test and what their experiences are.
- To find out how we can further support people to complete bowel cancer screening.

Each workshop began with at least one session to understand existing knowledge around the bowel, bowel cancer and screening to ascertain a starting point with each group.

Following introductory work, a workshop was then undertaken to improve bowel cancer screening knowledge in order to improve understanding and facilitate access to bowel cancer screening. A literature search was also undertaken to understand the national evidence surrounding barriers to screening for PWLD and South Asian communities.

The qualitative sessions asked a wealth of questions to understand participant knowledge of the bowel, bowel cancer, maintaining a healthy bowel and bowel cancer screening. Approximately 15 people with a learning disability and 13 South Asian older men took part in the work in each workshop.

All the above projects involved the following stakeholders:

- NHS England Screening and Immunisation Team
- Cancer Research UK
- Cloverleaf Advocacy
- Inclusion North
- Primary Care
- Secondary Care
- Calderdale Mosques
- HOTS
- Calderdale CCG

What did they tell you?
The work with PWLD identified barriers exist across the cancer screening pathway that we must:

- Identify who to screen – who with a learning disability is eligible for screening and who has not accessed screening on an annual basis? Provide extra support in co-production.
- Provide information about screening in an easy read format- to PWLD and people who are related, work or support PWLD to raise knowledge and awareness of screening and to ensure an informed choice is made, along with reasonable adjustments.
- Reasonable adjustments need to be made (in some cases practical help) to ensure PWLD can access screening.
- Work collaboratively, it is everyone's responsibility to improve access to screening for PWLD (including the Learning Disability Nurses, family, support workers, carers, social workers)
- Work must be done with care givers to support PWLD to reduce the risk factors to Bowel cancer, by improving access to exercise, improving dietary intake, by reducing calories consumed and increasing intake of fibre.

The work with South Asian older men identified that knowledge on the bowel, bowel cancer and screening was poor prior to the session. Following the session the majority of participants said their knowledge had improved, they would take a screen and encourage family and friends to screen.

What did you do?
The workshops included information to improve knowledge around the bowel and screening and questions in response to individual situations to access screening.

Work is in progress to cascade the session to more PWLD with the SHOUT OUT group part of lead the way Calderdale (Cloverleaf Advocacy), which will include easy read information and a locally produced easy read screening timeline (includes all screening programmes) at the request of the self-advocates.

The findings have been shared with the Calderdale improving screening and Immunisation coverage. Work is in progress to share the findings and information with supported living providers, as care givers, through the provider network meeting, coordinated through contracts at CMBC.

The findings from the work identified that a National flagging system to identify PWLD in the system for screening is due out within the next year. Local support is required to ensure the successful implementation of this. The CCG lead for PWLD has been informed and linked in with the National Programme Lead for this work.

HOTS are in discussion with the Mosques about conducting further workshops based within the Mosques.

Where can you find more information about this work?
A report and presentation was presented at the Calderdale Improving screening and Immunisation coverage. For more information about this work contact kate.horne@calderdale.gov.uk

Healthwatch
Single point of access (SPA) for adults' mental health services in Calderdale and Kirklees
April 2019

Who did you consult with and what did you ask?
During March and April 2019, Healthwatch Calderdale and Healthwatch Kirklees asked people to tell us about their experience of accessing the Single Point of Access (SPA) for adult mental health services in Kirklees and Calderdale. People were asked to share their experience of contacting SPA for themselves or on behalf of someone they care about. Staff members from various organisations who contact SPA on behalf of people they work with, were also asked to contribute to the project.

What did they tell you?
People spoke favourably about the responsiveness and accessibility of the SPA service and there were some positive examples of good quality interactions and support.
People shared feedback on things they feel could be improved such as the attitude and approach of some of the staff who respond to SPA calls. People sometimes feel dismissed and that there is a lack of empathy, understanding and compassion.
Carers told us that they don't always feel well informed about available support and that sometimes their concerns are dismissed.

What did you do?
The provider of SPA (South West Yorkshire Partnership NHS Foundation Trust) is looking at the way it delivers this service as part of a wider review. The findings and recommendations will go to those who are involved in the review and Healthwatch will ensure that the voice of those who access SPA is represented at every opportunity.

Where can you find more information about this wo*rk?*
The report of findings can be found by clicking on the link below:
https://healthwatchkirklees.co.uk/wp-content/uploads/2019/08/Final-Report-Single-Point-of-Access-for-adult-mental-health-services-in-Kirklees-and-Calderdale.pdf

Healthwatch
NHS Long Term Plan
April 2019

Who did you consult with and what did you ask?
In April 2019, Healthwatch Calderdale delivered engagement by means of focus groups and two surveys (one generalised and one for people with long-term conditions) with the general public regarding the NHS long-term plan. They were promoted via Healthwatch Calderdale's social media channels and also via colleagues who work with the general public. This work was part of a much larger piece of work. All local Healthwatch across West and North Yorkshire also engaged with their local populations using the same tools described above.

Who did they tell you?
1437 responses were received from the generic survey and 233 responses were received from the long term conditions survey. The following 'I' statements represent what people told us:

- 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

What did you do?
The cumulative report is now being used by the West Yorkshire and Harrogate Health and Care Partnership to influence the 5-year strategy.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in November 2019. This report can be found on the website below:
https://www.healthwatchcalderdale.co.uk/wp- content/uploads/2019/08/LTP_Summary.pdf

Healthwatch
Enter and view visits
May and September 2019

Who did you consult with and what did you ask?
Healthwatch completed enter and view visits to Lyndhurst Hospital in May 2019 and Overgate Hospice in September 2019. We visited these services to observe and gather comments on how the services ensure that patients are able to give feedback about the care and treatment they receive and to make choices about their care.

During the visit we provided different ways for patients to feedback about their experiences. We also provided a survey for staff and visitors to complete if they were unable to speak to us on the day. The survey was also available for a short period after the visit for people to complete online.

What did they tell you?
Patients told us what they liked and had some ideas that they felt would be an improvement. Staff also shared what they thought. All findings can be found in the report at the link below.

What did you do?
The findings were shared with the providers and recommendations were made by Healthwatch Calderdale

Where can you find more information about this work?
A report of the findings from the visits can be found at the website below:
https://www.healthwatchcalderdale.co.uk/our-work-4/enter-view-reports/

Healthwatch
Children and Adolescent Mental Health Services (CAMHS)
Autumn 2019

Since 2016 Healthwatch Calderdale has heard from people through Healthwatch Calderdale's NHS Complaints Advocacy and Information and Signposting services in relation to their experiences of Child and Adolescent Mental Health Services (CAMHS). The number of calls and complaints we received in relation to the service increased in early 2019, specifically with regard to children with symptoms of Autistic Spectrum

Who did you consult with and what did you ask?
The purpose of the engagement was to discover what matters most to children and young people in terms of health and social care. We want children and young people to know that their voice is important – we will report on their experiences, sharing what they have told us with the people with the power to make change happen.

Our aim was to understand people's experiences of accessing this area of the NHS, the impact of the conditions they/their children have and their ideas for positive change. We engaged with people via an online survey.

It was promoted via Healthwatch Calderdale's social media channels and also via colleagues who work with children with symptoms of Autistic Spectrum Condition (ASC), attention deficit hyperactivity disorder (ADHD) attention deficit disorder (ADD).

Healthwatch Calderdale received 43 survey responses. It also asked people who had previously contacted Healthwatch Calderdale about CAMHS in relation to ASC, ADHD, or ADD, to ask them for more in-depth feedback in the form of a case study. Six completed case studies were received.

What did they tell you?
- Some children are missing out or falling behind in their education because of the lack of support available while they wait for assessments under CAMHS umbrella services.
- Patients continue to face long waiting times.
- Those with mental health needs and ASC are left without the support they need for both conditions, due to omissions in mental health care for people with ASC.
- Carers experience a lack of support.
- Parents cite communication concerns when dealing with CAMHS, including calls not being returned.
- The health and employment of parents/carers was negatively impacted because of dealing with their child's health and care needs and lack of support.
- All of the above gives people a negative perception of the CAMHS service locally

What did you do?
Healthwatch Calderdale met with the Open Minds Partnership in January 2020 and will attend future meetings with this partnership to work together to improve the service. Healthwatch Calderdale will attend the Children and Young People Scrutiny panel regarding this work in March 2020.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in November 2019. This report can be found on the website below:
https://www.healthwatchcalderdale.co.uk/child-and-adolescent-mental-health-services- camhs/

Healthwatch
Telephone and video outpatient clinics at Calderdale and Huddersfield Foundation Trust (CHFT)
Autumn 2019

Who did you consult with and what did you ask?
Healthwatch Calderdale and Kirklees worked with CHFT with regard to the future use of telephone and video outpatient clinics for people with certain protected characteristics. Healthwatch Calderdale engaged with these people to ascertain if these people were likely to use these services, whether or not the people in the groups listed above would be able to access the telephone/video care system without difficulty; what difficulties there may be and how these people felt that CHFT could overcome such difficulties to enable them to access telephone/video clinics. Engagement was undertaken with people with:

- A learning disability
- A sensory impairment
- A developmental disability
- A cognitive impairment
- A mental health condition
- A physical or mobility impairment
- A long-term condition
- Older people
- People who do not speak English or who only have a basic or limited command of the English language

In total Healthwatch Calderdale and Kirklees engaged with 311 people. People were asked to answer a set of questions in person or via an online survey. The survey was promoted on the social media channels of Healthwatch Calderdale and Kirklees.

What did they tell you?
If all issues with accessing telephone/video care could be mitigated for people in these groups, the feedback shows that people from these groups were favourable to having appointments via telephone/video. There were some exceptions including people with hearing difficulties

What did you do?
The findings from the engagement activity were presented to the CHFT Outpatient Transformation Board in December 2019 and have contributed to a CHFT action plan which will be used to inform and develop telephone/video outpatient appointments.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in November 2019. This report can be found on this website below:
https://www.healthwatchcalderdale.co.uk/wp-content/uploads/2019/12/Outpatient-clinic-transformation-project-final-draft.pdf

DRAFT

Disability Partnership Calderdale
Engagement with Disabled People regarding their experiences of NHS Services
November 2019

Who did you consult with and what did you ask?
We engaged with our members, who are adults with physical disabilities and sensory impairments. We also extended the engagement to the general public via a live engagement link that we posted on our Website and Facebook Page

We also ran a focus group at our 'Open Meeting', which is open to our members and the General Public. We also sent out the question via our newsletter, which is in email and printed format.

We wanted to keep the topic as broad as possible, and as such, we asked the following:
- Tell us about your healthcare experiences in Calderdale.
- What could have been better and how could it be improved?
- What most concerns you about your healthcare in Calderdale in the future?

What did they tell you?
We received lots of different feedback across a range of NHS services. There were some common themes, in particular regarding parking and transport, and BSL Interpreters for deaf people attending clinics.

Parking Anxiety & Problems. Many people told us that they were unable to get a ticket from the machine at the A&E car park at Calderdale Royal Hospital, due to it being situated on a plinth that people in wheelchairs can't reach. Some people didn't know that a pass could be obtained from reception. Others were worried about leaving their vehicles without a ticket, whilst making the journey to reception, as it takes a long time to get there, as it is at the other end of the building, and down a floor level. This also increased anxiety as the process of going to reception and back to the car may make them late for their appointment. One person was so upset they left the site and didn't attend their appointment, which had to be re-booked weeks later.

BSL Sign Language Interpreters. Our deaf members told us that a huge problem is when an interpreter is booked for their clinic appointment. They are only booked for an hour, and if the clinic is running over, the interpreter many have to leave to get to another appointment, leaving the deaf person with no means of communication.

Additionally deaf people don't know whether an interpreter has been booked for their appointments, as it isn't stated on their appointment letter. This causes anxiety as they can't telephone and check (for obvious reasons), and on several occasions, deaf people have got to their appointment to find no interpreter present and had to go away and re-book for a later date, once an interpreter is available.

Other topics. There are many other individual stories and examples from people, regarding GP's, Community Care, and others.

What did you do?
We collated all findings into a brief report, along with which we offered various simple solutions that could be easily adopted at very little cost – if any.

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Parking Anxiety solution -by putting a sign, which could simply be a piece of laminated paper on the parking meter, to state that, *'a pass can be obtained at reception'* , or, *'Parking charges don't apply for disabled people'*, or some other appropriate sentence– would alleviate the anxiety of the parking issues.

BSL Interpreter Anxiety Solution – by writing an additional sentence on a patient's appointment letter to state, *'a BSL Interpreter has been booked for you',* would greatly reduce the anxiety that arises from worrying whether an interpreter will be present or not. Additionally, if appointments could be made for deaf people at the start of each clinic, E.G the first appointment of the day, or straight after lunch, the clinic wouldn't have the chance to run over and the patients would get full use of the full hour that the BSL Interpreter has been booked for.

We sent the report to the Head of Service Improvement at Calderdale CCG and the Clinical Nursing Director at Calderdale and Huddersfield NHS Trust.

We have also met with the Clinical Nursing Director at the trust, who has taken our suggestions on board and said she will try and implement our suggestions.

Where can you find more information about this work?
A report of the findings from the engagement process was produced in February 2020. This report can be found on this website:
https://disabilitypartnershipcalderdale.org/2019/11/12/ccg-survey-what-you-said/ or by emailing julie.stott@disabilitypartnershipcalderdale.org

DRAFT

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
NHS Long Term Plan – Healthwatch engagement
April 2019

In 2018, the government announced that the NHS' budget would be increased by £20 billion a year. The following January, the NHS in England published a 10-year plan for spending this extra money, covering everything from making care better to investing more money in technology.

The plan sets out the areas the NHS wants to make better, including:
Improving how the NHS works so that people can get help more easily and closer to home;

- Helping more people to stay well;
- Making care better;
- Investing more money in technology.

For more information about the NHS Long Term Plan, visit the link below:
https://www.longtermplan.nhs.uk/

Who did you consult with and what did you ask?
The Partnership was asked to formulate a local plan in response, specifically a 5-year strategy. To ensure this reflected what local people want, our six Healthwatch organisations were commissioned by Healthwatch England to find out local people's views. To do this, we used two surveys, one with general questions and one regarding specific conditions. There were also 15 focus groups that were organised across WY&H, engaging with 1806 people in total over a period of two months.

What did they tell you?
Key Findings: General survey and focus group

- People told us that the main things they do to keep healthy and well are exercise and healthy eating. People wanted support from the NHS and its partners to make it easier and affordable to keep fit and eat healthily, as well as more pro-active support around weight loss.

- There was a commitment to self-care from people who responded to our survey. 9% of people told us that the NHS could help them with this by providing more information and advice about healthy lifestyles and how they can better monitor their own health. People were also keen for more prevention of ill health through increased access to regular general check-ups as well as screening for specific conditions.

- People want the NHS to provide easier access to appointments, mainly with their GP but also with hospitals. Access to appointments was the single most mentioned theme (18% of responses) when people were asked what the NHS could do differently to help them stay healthy and well. The speed with which people could make an appointment was cited as one of the most important things for people when talking to health professionals about their care. People wanted the option of longer appointments, more appointments outside working hours, more appointments available to book online (including same-day appointments) as well as more availability of virtual and telephone appointments.

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Mental health was a recurrent theme running throughout responses to many of the questions in the survey. The main findings were:

- People wanted mental health services to be more accessible for people of all ages, with shorter waiting times and easier and quicker assessments.
- People felt that the waiting times for counselling and therapy was far too long, risking a detrimental effect on a person's mental health during the wait.
- We were told that there needs to be better emergency support for people in mental health crisis, and current services are not working well.
- Mental health services need to be more appropriate and accessible for people with autism, deaf people and speakers of other languages who may need an interpreter.
- There should be more investment in community support before people reach crisis point.
- People want to see more of a focus on prevention of poor mental health through raising awareness around looking after your mental health and how to help yourself (e.g.: running mental health first aid courses and general awareness sessions in schools and communities).
- Children and young people's mental health services were highlighted as an area of concern. Respondents said in particular that referral thresholds were too high and waiting lists too long and they also cited concerns about the detrimental effects of children having to travel to inpatient units out of area.

- People who were using digital services told us that they were mainly booking appointments, ordering repeat prescriptions, finding information and making contact with health professionals. The positives cited for digital services were that they were convenient and easy to use. Negatives that were mentioned were that there is not enough access for online patients (e.g.: to appointments or medical records) and that some digital services needed to be more user-friendly and joined up with other health and care service systems.

- Whilst the majority of people were in favour of having the option to access the NHS digitally, more than 500 people (41% of respondents) told us about barriers to using online services. These included access to digital technology (e.g.: not having a suitable device or internet access) and lack of skills and confidence. People were concerned that too much dependence on digital technology could create inequalities in the system, where particularly older or disabled people and those on low incomes or with language or literacy issues were disadvantaged. Many people were also clear that personal contact was important to them and may be a factor in whether or not they would choose to access the NHS digitally.

- When asked where they would go for an urgent medical need (other than A&E or their GP), the majority of respondents told us that they would either call NHS 111 (31%) or attend a minor injuries unit/urgent care centre (22%) or other urgent care provider (31%). A significant number of responses (16%) indicated people weren't sure where to go. There was also much confusion around the difference between minor injuries units, urgent treatment and walk-in centres.

- The majority of respondents were satisfied or very satisfied with their experiences of the different urgent care services in the last 12 months. The highest rates of dissatisfaction were with out of hours GP services (i.e.: out of hours telephone consultations, home visits, or referral to another GP practice) which had an average dissatisfaction rate of 27%.

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- 21% of responses mentioned education as being crucial to ensuring children and young people live healthy lives and have the best start in life. This included the NHS and its partners educating parents and carers about making healthy lifestyle choices for their children.

- Schools were cited as having a key part to play and people felt that there should be a whole system approach to children's health and wellbeing, and for it not just to be the responsibility of the NHS.

- As well as education, early support was an area that people saw as key to children living healthy lives. This included supporting mothers during pregnancy, supporting families with new-born babies, early diagnosis of conditions and support through childhood.

- 22% of people who answered the survey question about personalised care were unable to give a definition of it, either because they didn't know, hadn't heard of it or said it wasn't applicable. This figure was higher for BAME communities (37%) and young people aged 15 or under (33%). Those who were able to give a definition understood some of the different elements of it. This included recognising that it is about what matters to individuals and that they are at the centre and a key partner with choice and control over their care. People also mentioned how personalised care looks at the person as a whole and includes physical and mental health, as well as other factors such as housing, family and support networks.

- Communication came up throughout the survey responses as key to good personalised care. Primarily people told us they wanted to be listened to and spoken to as individuals, as well as treated with dignity, care, compassion and respect. Particular communication issues were raised by people with sensory impairments around making information accessible and adhering to the Accessible Information Standard.

- When people were asked if they could change one thing about the way the NHS works, the most common response was that people wanted it to be more efficient. People wanted to see a change in the structure so that there is less management, more efficient administration systems and more front-line staff that are well trained, supported, and have a good work environment.

Key Findings: Specific Conditions survey

- People with physical conditions are generally more satisfied with the initial support they get than people with non-physical conditions (see p.70 for definitions of physical and non-physical conditions).
- People with physical conditions are more likely to get support quickly than people with non-physical conditions.
- People with non-physical conditions are more likely to find ongoing support inaccessible and unsatisfactory.
- Having more than one condition often makes it harder to get initial support, especially if you have non-physical conditions.
- Ongoing support is most likely to be considered helpful when it involves reliable, regular person-to-person contact.
- Respondents feel that ongoing support could be improved if it were made more reliable and personalised and if it recognised their emotional needs.

- People with mental health conditions are particularly likely to feel their ongoing support is inadequate because they have been given the wrong diagnosis or therapy.
- Cancer services often provide effective communication, whereas mental health and autism services' communications are often felt to be inadequate.
- Most people get around in their own car and are willing to travel slightly longer to see a specialist than to get a diagnosis.
- At the beginning of the care process, people prize speed over familiarity with health professionals, but once they are in a treatment routine they prefer familiarity over speed.

What did you do?
The Partnership will ensure that people's views expressed from this engagement are taken into account throughout the five-year strategy.

The findings were shared with all our priority programme leads who were asked for a response on how they intend to make best use of the findings in their work plans, other strategic partners and also with people who took time to share their views.

This engagement report was also be discussed at our leadership meetings, including the Clinical Forum; West Yorkshire Association of Acute Trusts (hospitals working together); The Mental Health, Learning Disability and Autism Collaborative; and Joint Committee of the Nine Clinical Commissioning Groups; as well as the Partnership Board which meets in public in September 2019.

The Partnership also provided a response which can be found at the link below:
https://www.wyhpartnership.co.uk/application/files/3915/6209/3526/WYaH_response_to_healthwatch_LTP_engagement_report.pdf

Each local Healthwatch involved in this piece of work will also be looking at the data for their local area to pull out any local variations and themes.

Where can you find more information about this work?
A report of the findings from all the engagement can be found on the WY&H HCP website at the link below:
https://www.wyhpartnership.co.uk/engagement-and-consultation

This report sits alongside two reports that the WYH Care Partnership have also completed. One brings together previous information regarding people's thoughts about digitalisation and personalisation; and the other is an engagement and consultation mapping report which sets out the work that has taken place in the six local areas and at a West Yorkshire and Harrogate level. Both reports can also be found by visiting the link above.

You can also find out more about this work by clicking on the link below:
https://www.wyhpartnership.co.uk/get-involved/longtermplan

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West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
Long Term Plan - unpaid carers engagement event
April 2019

Who did you consult with and what did you ask?
West Yorkshire and Harrogate Health and Care Partnership held a full days Long Term Plan unpaid carers engagement event on Thursday 4 April at Unity Hall in Wakefield with 60 people in attendance.

The purpose of the event was to bring together a range of stakeholders from across 6 WY&H including carers, carer's organisations and health and care staff to seek their views on the long term plan for carers and align the WY&H carers' strategy with the long term plan.

The event provided an opportunity for an open and honest conversation about the vision for carers in the long term plan and our WY&H five year plan. The aim of the event was to:
- Opportunity to identify gaps and refresh the carers strategy to align with the long term plan
- Show and share the good work happening already in WY&H and the work of the carers programme
- Show and share what good work is happening in other parts of the country

This event was an essential part of our engagement process and included a wide range of representatives from:
- Carers organisations
- Primary and secondary care colleagues
- Adult and Children Social Care
- Primary care acute colleagues, young carers services, LWAB, HRD, Clinical
- Community services
- Directors of children services
- Directors of adult social services
- GP federation leads

What did they tell you?
The main key theme was the lack of support for carers and working carers.
- The carers agenda needs to be a family centred approach to support and wider than just being clinically and health focused
- The need for support was a big issue for people including practical advice and support before crisis point for example finance and relationship advice and support around mental health and bereavement and better sign posting to services.
- Support for working carers with flexible approaches to working and variations across organisations need to be identifies in terms of carers polices and process. Consistency in policies

Other key themes that were important to people were;
- Contingency and emergency care planning was important to people to give carers piece of mind. Access to current emergency services is not widely used and need to be made more accessible, and include planned care services. Need to identify gaps in emergency provision for young carers
- Identifying carers and awareness raising was also important to people. Many people do not identify themselves as a carer and appropriate use of the word carer needs to be

taken into consideration. Create social movements to raise awareness, keeping language and communication simple.

What did you do?

This report of findings will be reviewed by WY&H HCP carers steering group and shared with the Carers VCS colleagues who will consider next steps to develop an action plan and timescales for delivery for the Carers programme. Following the report being shared a 'you said we did report has also been developed.

Where can you find more information about this work?

A report of the findings from the engagement event can be found on the WY&H HCP website at the link below:
https://www.wyhpartnership.co.uk/engagement-and-consultation

You can also find out more about the work WY&H HCP are doing to support carers please go to the link below:
https://www.wyhpartnership.co.uk/our-priorities/unpaid-carers

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West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
NHS Long Term Plan – Voluntary and community sector showcase event
May 2019

Who did you consult with and what did you ask?
West Yorkshire and Harrogate Health and Care Partnership held an event in May 2019 in Bradford. The purpose of the event was to bring a range of stakeholders from across WY&H to discuss the impact of the NHS Long Term Plan on our communities and, specifically, how the voluntary and community sector (VCS) can work in partnership with other parts of the system to support some key actions within the Long Term Plan around mental health, social prescribing, admission avoidance at A&E and VCS delivery as part of the primary care network model.

The aim of the event was to:

- To help create a wider understanding of the work of the Partnership so VCS can feel more involved / engaged
- To help with increased understanding of the Long Term Plan and how VCS can influence locally
- To help create more involvement at a WY&H HCP level

Over 80 people attended the event from a wide range of representatives from organisations including:

- Voluntary and community sector
- Healthwatch
- Local authorities
- NHS England
- Clinical Commissioning Groups (CCGs)
- NHS Foundation Trusts
- WY&H programme leads

What did they tell you?
Overall key messages from the event are below;

- People were concerned about making sure funding is long term and made available to create sustainability. Ensuring funding is distributed appropriately across the system to ensure allocation in the right places.
- Raising the profile of the VCS and ensuring they get the appropriate support the need was also important to people.
- Working in collaboration, sharing the learning and demonstrating what's been done well was also important to people. Along with ensuring person centred approaches and engagement with patients and public.

What did you do?
The engagement findings from the event were reviewed by WY&H HCP VCS who will consider next steps to develop an action plan and timescales for delivery for the VCS programme. They were also shared with those who attended the event and people who have previously expressed an interest the VCS work.

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Where can you find more information about this work?
A report of the findings from the engagement event can be found on the WY&H HCP website at the link below:
https://www.wyhpartnership.co.uk/engagement-and-consultation

You can also find out more about the work WY&H HCP are doing to support the voluntary and community sector please go to the link below:
https://www.wyhpartnership.co.uk/our-priorities/harnessing-power-communities

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
Young carers engagement event – 'Couldn't care less'
June 2019

Who did you consult with and what did you ask?
WY&H HCP wanted to develop a mechanism that engages young people with the health and care sector to inspire them to pursue a career in the sector. The Partnership commissioned Ahead Partnership to help them support one of the workforce recommendations set out in the strategy:

- "Increase the future supply by significantly increasing the number of people training to work in health and social care roles in West Yorkshire and Harrogate"

We wanted to raise the aspirations of young carers by helping them to identify and recognise their own skill set and encourage them to pursue a career in the health and social care sector. In addition we wanted to ensure young people are prepared for a variable and ever changing workplace by helping them develop crucial employability skills.

An engagement event was held in June in Huddersfield to provide an opportunity for young carers from across Kirklees and Calderdale to come together to develop their skill set and knowledge of roles within the Health and Care sector. A wide range of representatives attended including:

- Primary and secondary care colleagues
- First response
- Comms and tech support

The aim of the event was to:

- Increase the future workforce supply by significantly increasing the number of people training to work in health and social care roles in West Yorkshire and Harrogate.
- Develop key soft skills required in the World of Work.
- Increase awareness of the roles within the Health and Care sector.
- Provide an opportunity to celebrate the young carers.
- Offer a chance to young carers for developing their networks with similar people their age.

What did they tell you?
Feedback below gathered from surveys:

Students:

- Make the day longer
- More time doing the workshop sessions
- More stands in the afternoon to showcase more of the roles available.

Teacher:

- Provide more opportunity for the students to interact with people from different schools.
- Run at a different time of year as this may have impacted attendance due to exams.
- Suggested months of September, October or July.
- Try to speak at the local safe guarding lead meetings to showcase and promote the event.

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Volunteer:

- Potentially more of a workshop environment then stalls, as some children were shy to approach stands.

Ahead Partnership:

- Develop more robust links with local authorities and 3rdsector contacts to; better understand the cohort, ensure we have relevant representation from the sector at the event and to provide a clear path into engaging with schools and their young carers cohort
- Consider wording used to ensure young people don't feel alienated/uncomfortable - readjust language used and how we talk about the event
- Involve Amen Dhesi (former young carer) in planning of event
- Increased number of roles for afternoon activity –including social care
- WYHICS to provide data to support target attendee numbers
- Confirm 1 main day to day contact for organising logistics of event (CC other contacts in)
- Agreed timeline with deadlines to ensure project moves at a good pace
- Clarification on roles and responsibilities
- More of collaborative approach on school recruitment as we are unable to access some data that WYHIC's partnerships will allow

What did you do?

Findings gathered from the feedback will be used to help shape decisions for future young carer's events.

Where can you find more information about this work?

A report of the findings from the engagement event can be found on the WY&H HCP website at the link below:
https://www.wyhpartnership.co.uk/engagement-and-consultation

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West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
Healthy Hearts cholesterol engagement
June - July 2019

West Yorkshire and Harrogate and Harrogate Healthy Hearts is a three-year local NHS project that aims to reduce the number of cardiovascular incidents, such as heart attacks and strokes, by 10% across our region. We believe this will mean 420 heart attacks and 620 strokes will be prevented, saving the local NHS £12m. In phase 2 of our programme, which is due to launch this autumn, we'll be concentrating on cholesterol levels.

Who did you consult with and what did you ask?
The West Yorkshire and Harrogate Healthy Hearts programme has now completed its public engagement on its upcoming work to identify and treat - at scale - patients whose LDL cholesterol levels that may be better controlled through switching to a high intensity statin, and also initiating a statin in those patients at risk of developing CVD. The engagement took place from the beginning of June until mid-July 2019 and more than 200 responses were received, with some completing the online questionnaire and others giving their feedback in focus groups that took place across West Yorkshire and Harrogate.

What did they tell you?
An analysis of the work is now being undertaken with early results showing:

- 95% of respondents understand the aims of phase two of Healthy Hearts
- 88% of respondents think it will be of benefit to local people
- 80% of respondents thought our draft letter to patients, outlining why changes were being made to their prescriptions, were clear
- nearly a quarter of responses were from black and Asian minority groups

A lot of interesting data has been gathered, including valuable information on where patients are most likely to turn to if they had an issue with a prescription for statins, and where they're most likely to seek advice and guidance on leading a healthier life.
Some comments revealed that some common misconceptions surrounding statins still endure, while others have provided valuable insights into people's hopes and expectations for phase two, allowing the programme team to better understand what's important to them as patients.

What did you do?
The findings will be used to shape how the programme communicates with patients and clinicians in phase two of Healthy Hearts, which is due to begin in the autumn.

Where can you find more information about this work?
You can find out more about this work by visiting the website below:
https://www.westyorkshireandharrogatehealthyhearts.co.uk/cholesterol/cholesterol-public-engagement-

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West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
Health and Care Learning Disability Champions
August 2019 - ongoing

We want people with learning disabilities in West Yorkshire and Harrogate to receive the best possible care. We also want people with learning disabilities to feel supported to have their say as they are the experts when it comes to knowing what help, support and personalised care they need.

Who did you consult with and what did you ask?
We are working with people with learning disabilities so they can become health and care champions for our Partnership, including for priority programmes such as cancer, mental health, maternity care and hospitals working together. These health and care champions will work with us and the wider community of people with learning disabilities to further develop our plans and put them into action. We will do this by involving them in future conversations about improvement and asking them about their experience of care for people with learning disabilities. This is an approach supported by councils and NHS organisations.

We are working with an organisation called Bradford Talking Magazine (BTM) for an initial period of 12 months. They are helping us identify health and care champions with learning disabilities from communities across West Yorkshire and Harrogate. Their involvement will help us become more informed about their experiences of using health and care services so we can improve the way we plan services.

What did they tell you?
- Cancer Awareness (making sure that people understand why going for tests is important)
- Early Intervention and Prevention (this means making sure people have the right information and help to, when possible, stop them becoming ill)
- Planned Care (this means things that you might do, go into hospital, have an appointment about a condition you have with a doctor or specialist or if you are having a baby)
- Promoting the needs of people with learning disabilities (speaking to health and care organisations and people who work for them to make sure they understand what you need)

What did you do?
This work is well underway. Two of our champions presented at the Partnership Board in September, and we have showed the work we are doing with learning disability health champions to NHS England and colleagues across the country.

We are looking for health and care champions to work on prevention and early diagnosis, planned care and cancer. These themes are in line with what people with learning disabilities and our partners have said are important to them. The Cancer Alliance Team has already met with people in Bradford to talk about their experience of cancer screening and early diagnosis.

Where can you find more information about this work?
You can find out more about this work by visiting the website below:
https://www.wyhpartnership.co.uk/get-involved/health-and-care-champions

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7. Progress update on previous engagement and / or consultation activity

We recognise that it can take several months or even years before any outcomes or changes can be reported on from any engagement and/or consultation activity that takes place. With this is mind we have asked our partners if they can provide an update or progress of any previous submissions of engagement and/or consultation activity that took place between 2016 and 2018.

Previous submissions can be found under the header patient and public engagement / communications on our website at the link below:
https://www.calderdaleccg.nhs.uk/key-documents/

Calderdale Clinical Commissioning Group (CCG)

A week in the life of A&E
We know that too many people go to A&E when they don't need to - approximately 30% of people who visit A&E don't need to be treated there. With the insight gleaned from our Week in A&E work and other research we are developing a new social marketing campaign to run across Calderdale and Kirklees.

Our overall aim is to reduce the pressure on A&E departments by reducing unnecessary visits, enabling people to access services in the community where their needs could be more appropriately met.

The ambitions of our new social marketing campaign include:
- Improve patient care and access to the most appropriate services
- Raising the awareness of what A&E should and should not be used for; highlighting what is classed as an emergency and what is not.
- Help us understand the motivations of people visiting A&E and their mind set when considering a visit to A&E.
- Understand the process that healthcare professionals use when referring a patient to A&E.
- Promote benefits of not visiting A&E when other more appropriate treatment settings are available.
- Educate people on the other alternative services that provide health care in the community.
- Encourage the population of Calderdale and Kirklees to reflect on their choices and alternatives to treatment, prior to visiting A&E.
- Empower and encourage positive medical choices and behaviours.

Adult psychological services
The CCG is continuing to develop a new comprehensive model of psychological support for adults using the outputs from the engagement work undertaken in 2018-19. Further detailed engagement work around talking therapies can be found in section 6 of this report (see page 31).

Autism reality experience
Following the January 2019 Summit, two specific action groups were established: one to plan the next autism awareness system-wide event, and the other to create an integrated Autism Spectrum Disorder (ASD) pathway. Calderdale Young People with ASD, with

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support from a small planning group, designed and led a Marketplace event and stakeholder summit for system partners which took place in February 2020 (see section 6 of this report). During 2019, a separate group comprising commissioners and providers agreed and began implementing a plan to deliver the integrated neuro developmental pathway (including ASD) for children and young people aged 0-25 years. Other actions identified at the Summit were progressed by the ASD Steering Group and wider system partners. At the February 2020 Summit, leaders from the organisations supporting Calderdale's children and young people with ASD gave an update on the improvements made, and this work continues into 2020 (see section 6 for more detail of the summit in February this year).

Wheelchair services
Wheelchair services are commissioned jointly by NHS Calderdale, Greater Huddersfield and North Kirklees CCGs. Extensive engagement and consultation activity has taken place between December 2016 and October 2018 involving service users, carers, staff, stakeholders, partners and voluntary sector organisations who have an interest in wheelchair services. This led to the creation of a new service specification and a procurement process that took place between December 2018 and May 2019.

As part of the procurement process the CCGs set up a reference group that included service users and carers. The group was involved throughout the procurement process in a variety of ways including the bidder evaluations and final consensus meetings.

There is more information about service user involvement during the process in the following video: https://youtu.be/cqourbFooRg

A new provider was awarded the contract from 1 October 2019. The provider has developed its own service user engagement activity that reflects the learning and experience gained during the consultation and procurement processes.

A new provider was awarded the contract from 1 October 2019. The provider has developed its own service user engagement activity that reflects the learning and experience gained during the consultation and procurement processes.

Improving access to GP services
Since 2017/18 additional routine appointments have been made available at evenings and weekends to increase access to GP services. These are available at a number of places across Calderdale and must be arranged beforehand. To help us understand the best way of setting up the service we did some engagement. Just under half of people who responded said they would be prepared to travel up to 30 minutes for an appointment with 42% saying they would travel up to 15 minutes. People were asked what would be most important to them in the service and the top four categories were:

- Good care and treatment 92.6%
- Being able to book an appointment 90.7%
- A clean and safe place 73.7%
- Staff being able to see my medical history 69.8%
- Location 59.6%

As part of monitoring the service people who use it are asked whether they would recommend the service to others. On the whole people respond to this very positively with

the last report showing that 97% of people who responded to the question would recommend the service to others.

Right Care, Right Time, Right Place travel and transport group
Following extensive engagement in 2015/16 a consultation on the proposed future arrangements for Hospital and Community services in Calderdale and Greater Huddersfield took place in 2016. The feedback from consultation identified that one of the areas requiring further work was travel and transport. In order to ensure all travel and transport information had been considered, the findings from consultation together with any reference to travel and/or transport in other engagement; PALS or complaints intelligence; and any patient postings on travel and transport were pulled together into one composite report to provide a baseline understanding of public views.

In 2017 Calderdale and Greater Huddersfield CCGs established a Travel and Transport Working Group to consider this baseline understanding of public views and to develop plans to address the implications of changes in the configuration of Calderdale and Huddersfield hospital services in relation to public access, travel, parking and transport. The Working Group was chaired by an independent chair, had membership from a range of organisations and was supported by a reference group: set up through North Bank forum; Calderdale's Voluntary and community sector infrastructure provider. In December 2018 the Department of Health and Social Care (DHSC) allocated capital funding of £196.5m to support implementation of the reconfiguration of services.

Progress to Develop Travel Plans - an overarching 'Engagement, Equality and Communication plan' was presented to Joint Health Scrutiny Committee in February 2019. The plan set out an overarching approach to engaging local people, staff and partner organisations on the planned reconfiguration. One of the initial actions within the plan was to schedule a Stakeholder Event to allow for more detailed plans to be developed.

A Stakeholder Event was held in June 2019. The aim of the event was to continue the dialogue with diverse local communities and support future engagement in the development and design of clinical services by:

- Co-creating the engagement activity required to support the development of more detailed plans
- Supporting the programme to design specific involvement activities and
- Describing the communication material required to ensure that local people remain informed and/or involved as more detailed plans and capital cases are developed to deliver the proposed future model for clinical services across Calderdale and Greater Huddersfield.

At the event members of the public advised that Travel, transport and parking is still a major issue that requires more public involvement.

The Stakeholder event supported the development of a Public and Stakeholder Involvement Plan, which, together with the findings and recommendations of the independently chaired Travel and Transport working Group, was presented to Joint Health Scrutiny Committee in October 2019. The Involvement Plan includes a commitment that during 2020, CHFT will: Identify dedicated additional capacity to lead progress on the travel and transport recommendations and to publicly communicate the plans. This specifically includes providing update and public involvement in relation to the action plans that were produced by the Travel and Transport Working Group in 2018.

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In taking forward this commitment there are broader strategic issues and developments that impact on the response required. These include:

West Yorkshire-plus Transport Fund - A629 Corridor Improvements - £120m is currently being invested to improve travel and transport on the A629 corridor. These developments are scheduled to be completed by 2025 and coincide with the planned completion of service reconfiguration across the hospitals. The improvement of the A629 corridor will reduce journey times. Phase 4 of the development includes plans for the provision of an express bus service that will operate directly between HRI and CRH. The Trust and CCGs are currently working with both Councils regarding these plans.

Environmental Sustainability - In 2018 the UK and 200 other nations agreed action on climate change, with a much greater role strongly implied for local and regional authorities in assisting Governments to achieve their carbon emission savings. In January 2019 Calderdale and Kirklees Councils declared a climate emergency. CHFT is currently undertaking work to develop an environmental sustainability strategy that will be considered by the Trust Board in spring 2020. The overall carbon footprint of the NHS in England accounts for 25 per cent of all public sector carbon emissions and is greater than the annual emissions from all passenger aircraft departing from Heathrow airport. Patient and staff travel accounts for 16 per cent of the NHS carbon footprint and five per cent of all transport emissions in the United Kingdom are estimated to be accounted for by health care related journeys.

To progress the travel plans, as at February, 2020, CHFT is:

- Working with advisors to undertake detailed analysis of current public and staff travel data, predicted future demand and the development of a Hospital Travel Plan Strategy that will encourage public and staff sustainable travel options in the future (such as decrease in the use of single occupancy vehicles; promoting and facilitating the use of more sustainable / zero emission modes of transport; promoting the use of public transport over individual vehicle use; reducing the need to travel e.g. virtual consultations and video conferencing; preventing ill health to minimise the need for travel to hospital).
- Continuing work with Calderdale and Kirklees Councils regarding the planned improvements to the A629 corridor and the future provision of a commercial express bus service between the two hospital sites in 2025.
- Discussing with the West Yorkshire Combined Authority options to provide improved shuttle bus service between the two hospital sites that could be implemented ahead of service reconfiguration.
- Developing the plans for provision of a multi-storey car park at CRH. The aim is to provide this in the medium term ahead of service reconfiguration.

Mental health rehabilitation and recovery

In August 2018, the CCG and partners made the decision that instead of proceeding with developing a new model, they would work together to improve the existing mental health rehabilitation model. The outputs from engagement work undertaken by the CCG and partners between 2014 and 2017 have informed this improvement work. Improvements have included:

- Streamlining processes relating to the different parts of the pathway
- Reviewing all out of area placements with a view to bringing people back to Calderdale where possible

- Working with partners across the West Yorkshire and Harrogate Health and Care Partnership Integrated Care System to improve mental health rehabilitation for complex care and what we can do differently to improve outcomes for people, this work has been co-produced with people with lived experience. This work will link with local pathways
- Identifying/developing housing options to enable people with enduring mental health conditions to live as independently as possible in the community.

Care Closer to Home

The Care Closer to Home programme requires our system to collaborate and expand beyond the traditional statutory sector agencies and incorporate the important contribution made by the third sector, and independent sector organisations. This requires changing the ways in which organisations and their staff work. We need to make sure it is easier for people to make healthy choices and ensure a relentless focus on health outcomes and not just on service delivery. We need to change the nature of the relationship between people and services, and the relationship between people and their own health – changing the way our staff see their roles; their day job and the constant improvement of the work they do.

- Focusing on prevention, self-management and technology (Active Calderdale a priority in this)
- Integrating health and care commissioning
- Incentivising the development of integrated health and care models – creating seamless pathways for those who use them.
- Improving the interface between community and hospital care
- Promoting evidenced based practice and innovation.
- Locality working across Calderdale; aligning budgets and determining the spread of resources across localities

Extensive engagement and consultation activity has taken place across Calderdale from 2013 to 2019 on services that directly or indirectly related to community. This was conducted with a large range of health care community services, the hospital and primary care, staff and patients. A composite report was written to evidence the outcomes, themes and gaps which include reports produced by the CCG, providers, Healthwatch, local authority and the voluntary and community sector. This report can be found on the CCG website here.

Key themes identified from all the activity are being used to support and develop integrated service pathways with all our partners, future commissioning intentions for our community services and delivering ambitions for the Long Term Plan and for Out of Hospital Care in Calderdale. A community model for people living and working Calderdale that will:

- Help to keep them healthy and help them stay well
- Detect problems early and stop them getting worse
- Help people to stay out of hospital and long term care
- Manage admissions to hospital and long term care and make sure that when people are well enough to leave that they are supported to be discharged as soon as possible

Calderdale and Huddersfield Foundation Trust (CHFT)

Right Care, Right Time, Right Place
Work to develop the model of hospital and community services in Calderdale and Huddersfield has been underway since July 2012. Formal public consultation on proposed future arrangements took place in 2016.

The Calderdale and Kirklees Joint Health Scrutiny Committee referred the proposals to the Secretary of State for Health and Social Care in 2017 and his recommendations and the advice of the Independent Reconfiguration Panel (IRP) were published in May 2018.

During 2018 work was undertaken by local NHS organisations to develop a revised proposal that sought to address the issues identified by the Independent Reconfiguration Panel. In December 2018 the Department of Health and Social Care (DHSC) confirmed that capital funding of £196.5m had been allocated to support implementation of the revised proposal. To take this forward, approvals of a Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) by NHSI, DHSC, Ministers and HM Treasury are required.

The Strategic Outline Case was approved by CHFT Trust Board in April 2019 and published on the Trust website. The SOC builds on significant public, stakeholder and clinical engagement since 2012 and is informed by the formal public consultation undertaken in 2016 and the recommendations of the Independent Reconfiguration Panel. The SOC has been submitted to NHSE&I and it is expected that formal notification of the result of the final stage of approval will be received in early 2020. CHFT will develop the Outline Business Case during 2020.

The evaluation and feedback from the event in June has informed the plan for involving public, stakeholders and staff where CHFT, Calderdale CCG and Greater Huddersfield CCG will ensure local people; voluntary organisations, staff and key stakeholders continue to be involved in discussions to inform the delivery plans and service model across Calderdale and Huddersfield. The timeline for development of the business cases and implementation of the service reconfiguration extends to 2025 and public involvement will be scheduled over this time-period

You can find out more information by clicking on the links below:

https://www.rightcaretimeplace.co.uk/wp-content/uploads/2016/08/RCRTRP-Consultation-Report-of-Findings-August-2016.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/706458/IRP_CH__referral_advice_09.03.18.doc

https://www.cht.nhs.uk/fileadmin/site_setup/contentUploads/About_us/Publications/BoardPapers/BOD_2017/FINAL_SOC_18_April_2019.pdf

https://calderdale.gov.uk/council/councillors/councilmeetings/results.jsp?committee=250&start=01%2F10%2F2019&p_SQ_ID=5069137&phrase=N&type=agenda&end=01%2F12%2F2019&offset=0&id=206843520

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Healthwatch

Hypermobility Syndromes 2016-2018
This work is ongoing. The final report was published in August 2019 along with a case study video.

The project was the subject of an adjournment debate in Parliament on Monday, 7 October 2019: https://parliamentlive.tv/event/index/cc87468c-00ec-42c1-8cbe-659af6b03d6e?in=21:15:00&out=21:48:30

Healthwatch Calderdale has since heard from adults with hypermobility syndromes nationwide, reporting difficulties with their NHS care. Healthwatch Calderdale is liaising with NHS England and the Department of Health and Social Care with regard to all the feedback it has received on this topic. The main report was sent to local and national NHS and social care organisations. Healthwatch Calderdale is presently collecting additional feedback (by means of a survey, which is open until 9 March 2020) on primary and secondary care experiences from people with hypermobility syndromes in Kirklees and Calderdale.

All information relating to this project can be found on the Healthwatch Calderdale website: www.healthwatchcalderdale.co.uk/our-work-4/hypermobility-syndromes-project/

Adult Autism
Since the publication of the original report in May 2017, Healthwatch Calderdale has attended the Adult Health and Care Scrutiny Panel in November 2019 in this regard and is to work with Calderdale Clinical Commissioning Group and experts by experience to inform future decisions and to improve the service.

All information relating to this project can be found on the Healthwatch Calderdale website:
https://www.healthwatchcalderdale.co.uk/adult-autism-2/
https://www.healthwatchcalderdale.co.uk/our-current-work-2018/

High intensity service users
The project report was published in June 2019. Resources are available for use by other Primary Care Home Areas/Networks in Calderdale if they are seeking to better understand patients who frequently use NHS health services.

Access to health services for Syrian refugees/asylum seekers and refugees
Since the publication of the report in October 2018, Healthwatch Calderdale has heard more generally from asylum seekers and refugees from areas other than Syria about problems accessing primary and secondary care. Healthwatch Calderdale is therefore to expand this project to include refugees and asylum seekers from other area and is to run a series of focus groups with this client group in the near future in this regard.

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West Yorkshire and Harrogate Health and Care Partnership

Stroke services
Since our engagement and conversations with staff, partners and the public began in February 2017, we have continually kept people updated throughout to try and ensure everyone had the opportunity to have their say on the development of the work.
On Tuesday 6 November 2018 a report was presented to the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups (meeting in public), to provide members with an overview of stroke care and progress so far. This included the conclusions and the information considered to inform this process, recommendations and next steps. You can read the final report **here**.

The final decision from the Joint Committee of Clinical Commissioning Groups concludes the West Yorkshire and Harrogate Stroke Programme work on hyper acute stroke services. However, it is important to note that our conversations with people across the area have highlighted the importance of further improving care from prevention, hospital stroke care, community rehabilitation services, through to after care. These conversations will continue in the six local areas (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) which make up West Yorkshire and Harrogate as appropriate.

Your views are important to us and we would like to thank everyone for their involvement on the West Yorkshire and Harrogate stroke care work. You can find out how your views have shaped our work by reading the 'You said we did' **(click here).** You can also find out about all the engagement that has taken place by clicking **here.**
Following the conclusion of the WY&H stroke programme work on hyper acute services you can read the **letter** sent to all stakeholders informing them of the decision made by the Joint Committee of Clinical Commissioning groups.

You can find out more about the work by clicking on the link below
https://www.wyhpartnership.co.uk/our-priorities/stroke

Supporting carers
Carers Programme year in review 2019 have developed a look back at the work that has been done to improve support for unpaid carers in West Yorkshire and Harrogate in 2019.You can Watch or download the presentation.

You can find out more about the work by clicking on the link below
https://www.wyhpartnership.co.uk/our-priorities/unpaid-carers

Working with the voluntary and community sector
There is a wealth of expertise across West Yorkshire and Harrogate and communities are better placed than us to know what they need and to make positive change happen. If we are to genuinely work alongside communities as equal partners, then we need to change our relationships and build trust. We have good leadership from the voluntary sector, and we are attracting support from Healthwatch, NHS England, Nurture Development and National Voices to help us to think about our next steps.

To make sure our work adds the greatest value possible and supports existing projects and groups across the area we started with a number of design workshops in the summer. The aim of these were to agree a shared set of principles and a common understanding of what we mean by 'communities doing more for themselves', 'co-production', 'asset based

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community development', 'co-design' etc., and what the shared ambition for working with communities should be. This includes:

- Co-produce and co-design an approach with communities
- Work with programmes to ensure good voluntary and community sector representation on all of our work streams
- Inspire NHS senior leadership to be ambassadors for the work
- Consider how the services we commission and procure might improve the economic, social and environmental well-being of the area in commissioning and contracting across West Yorkshire and Harrogate.
- Raise the profile of and share the excellent work taking place across the area - celebrate the difference this is making in our communities on a regional and national level.

You can find out more about the work by clicking on the link below
https://www.wyhpartnership.co.uk/our-priorities/harnessing-power-communities

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8. Planned work for 2020-21

Hospital services:
To continue to support the delivery of Right Care, Right Time, Right Place programme to provide advice and support as requested and develop and deliver an action plan for communication, engagement and equality.

West Yorkshire and Harrogate Health Care Partnership:
Continue to provide advice and support to the programme office on all aspects of engagement and consultation. Develop a strategy for engagement and liaise with partners across the local footprint. To continue to support the development of composite reports for all work streams in partnership with Healthwatch to ensure the local voice continues to be reflected.

Primary care engagement and consultation:
To work with GP practices to support the delivery of engagement and consultation processes to inform any future service developments or changes.

Equality Objectives 2020/21:
To continue to deliver our two year action plan for equality which will help to identify methods and approaches to reaching groups or individuals covered by the Equality Act 2010, and ensure the CCG increase reach into these communities by 2020/21.

Community Services:
We will continue to engage where needed on the specific requirements of some services that are closer to home and supporting work around the current model for; out of hospital care and care homes.

Primary Care Networks (PCNs) and localities:
To provide advice and support to our five PCNs and localities on all aspects of involvement, engagement and consultation and continue to ensure the voice of our local communities is embedded in the work of Calderdale Cares.

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9. Contact details for NHS Calderdale CCG

If you are interested in finding out more about getting involved in the work of NHS Calderdale CCG or would like to share your views on local health services, please contact us via the following contact details;

Address:
NHS Calderdale Clinical Commissioning Group
5th floor F Mill
Dean Clough
Halifax
HX3 5AX
Tel: 01422 281300
Email: *CCG.FEEDBACK@calderdale.nhs.uk*

Please note that this email address should NOT be used if your message contains patient/personal information.

Facebook: NHS Calderdale CCG
Twitter: @calderdaleccg
Website: *www.calderdaleccg.nhs.uk*

Care Opinion
Care Opinion is an independent website about your experiences of UK health services, good or bad. They pass your stories to the right people to make a difference.

You can share your views and experiences of the healthcare you have received locally by visiting *www.patientopinion.org.uk*

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Appendix 1

Legal duties for CCGs in relation to Patient and Public Engagement

Section 14P - Duty to promote NHS Constitution

(1) Each clinical commissioning group must, in the exercise of its functions—

(a) Act with a view to securing that health services are provided in a way which promotes the NHS Constitution

Section 14U - Duty to promote involvement of each patient

(1) Each clinical commissioning group must, in the exercise of its functions, promote the involvement of patients, and their carers and representatives (if any), in decisions which relate to:

(a) The prevention or diagnosis of illness in the patients, or

(b) Their care or treatment.

Section 14Z2 - Public involvement and consultation by clinical commissioning groups

(1)This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) In the planning of the commissioning arrangements by the group,

(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

NHS Constitution (Refreshed March 2013)

The NHS Constitution produced by the Department of Health establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

A copy of the refreshed NHS Constitution and supporting handbook can be accessed via the following link;

https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. Principle Four focuses around patient engagement and involvement and is emphasised through the Patient's Rights Section.

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Principle Four
The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services

Patient Rights - Involvement in your healthcare and in the NHS:
You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:
- To provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- To work in partnership with you, your family, carers and representatives (pledge);
- To involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- To encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

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Patient and Public Engagement
Annual Statement of Involvement 19/20

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Workforce Report**	Agenda Item No.	10
Report Author	Tazeem Hanif (HR Business Partner)	Public / Private Item	Public
GB / Clinical Lead	Neil Smurthwaite – Interim Accountable Officer	Responsible Officer	Jenna McGuinness – HR Manager, North of England Commissioning Support Unit

Executive Summary							
Please include a brief summary of the purpose of the report	This paper presents an overview of the CCG's workforce as part of the annual update from the period of 1st April 2019 to 31st March 2020 (in addition to workforce data from 1st April to June 2020 with emphasis on COVID-19 activity). It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce. The paper includes the following workforce metrics: • Workforce composition • Staff turnover • Sickness absence • Equality and diversity data There is also a summary of key headlines relating to the CCG's workforce in addition to COVID-19 related activity.						
Previous consideration	Name of meeting	Senior Management Meeting		Meeting Date	08/07/2020		
Recommendation (s)	It is recommended that the Governing Body: **RECEIVES** and **NOTES** the content of the CCG workforce report update.						
Decision	☐	Assurance	☒	Discussion	☐	Other	

Implications	
Quality & Safety implications	None identified.
Engagement & Equality implications	All information in this report is presented in such a way that individuals cannot be identified from the data, in line with Information Governance requirements. Diversity information is reported to Governing Body separately as part of the Public Sector Equality Duty reporting. At the request of Governing Body, this report includes information about the Equality and Diversity of the CCG's workforce, to facilitate discussion.
Resources / Finance implications	The report provides the Governing Body with an overview of staff resource available to the CCG.

<table>
<tr><td colspan="2">Has a Data Protection Impact Assessment (DPIA) been completed?</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>x</td></tr>
<tr><td>Strategic Objectives</td><td>Achieving the agreed strategic direction for Calderdale
Improving quality
Improving value</td><td colspan="3">Risk</td><td colspan="3">None identified.</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>This paper provides the Governing Body with assurance that the CCG is operating in line with legal requirements, best practice and within agreed CCG policies and procedures.</td><td colspan="3">Conflicts of Interest</td><td colspan="3">Any conflicts arising from this report will be managed in line with the CCG’s Management of Conflicts of Interest policy.</td></tr>
</table>

1.0 Introduction

1.1 The purpose of this report is to provide Governing Body with an overview of the CCG's workforce. The information contained within this paper relates to the periods of 1st April 2019 to 31st March 2020 (in addition to some workforce data from 1st April to June 2020 with emphasis on COVID-19 activity).

1.2 The Workforce reports are presented to the CCG's Senior Management Team (SMT) by Human Resources. The information provided enables SMT to identify any patterns or trends to enable the identification of any actions that need to be taken at an operational level. It also provides a vehicle for advising SMT about any key developments in employment law, best practice or other matters that may affect the CCG's workforce.

1.3 The Governing Body report complements the reporting to SMT, providing assurance in relation to the effective management of the CCG's workforce.

2.0 Workforce Composition

2.1 The workforce composition of CCG employed staff as at 30 June 2020 was 82 equating to 72.99 Full Time Equivalents (FTE). The CCG also has arrangements in place to share staff resource with other local CCGs, particularly, NHS Greater Huddersfield CCG.

2.2 The majority of the CCG's staff are employed under Agenda for Change terms and conditions. Table 1 details the distribution of the directly employed workforce by job banding. Levels 1 to 9 are staff employed under Agenda for Change; the "other" category refers to the Very Senior Managers (VSMs). These are the Chief Officer and Chief Finance Officer / Deputy Chief Officer. Table 2 is the additional data for the end of June 2020 and the "other" category refers to the Interim Accountable Officer and Interim Chief Finance Officer.

Table 1: CCG Directly Employed Staff 2019/20 – Distribution by Job Banding

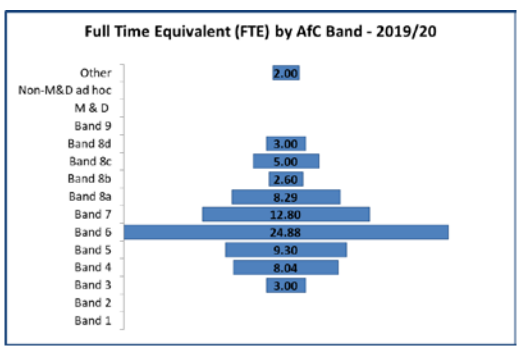
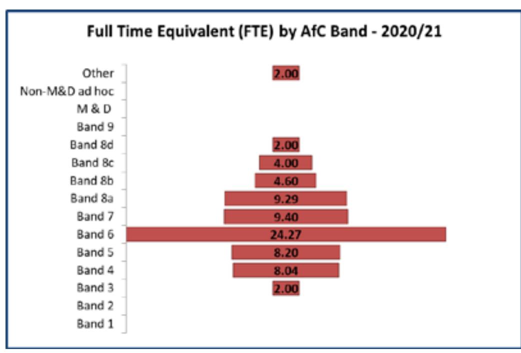


Table 2: CCG Directly Employed Staff 2020/21 – Distribution by Job Banding



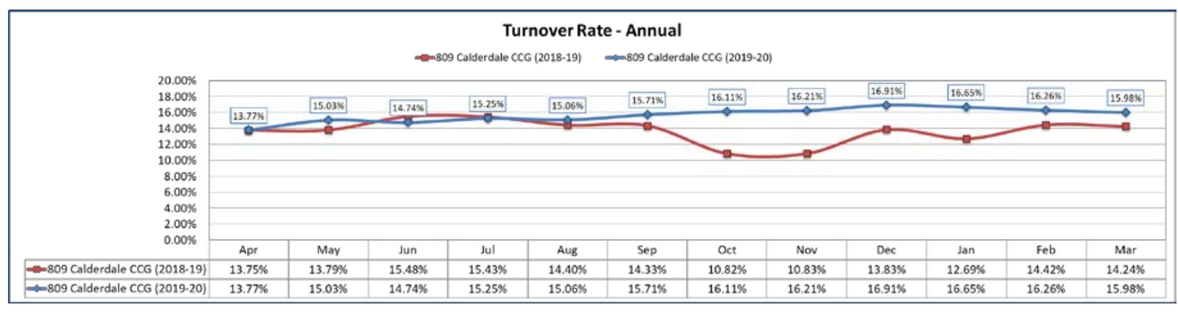
3. Staff Turnover

3.1 Staff turnover refers to the proportion of employees who leave an organisation over a set period, and is expressed as a percentage of the total workforce average. The CCG calculates turnover on a rolling annual basis. The formula which is used to calculate annual employee turnover is:

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

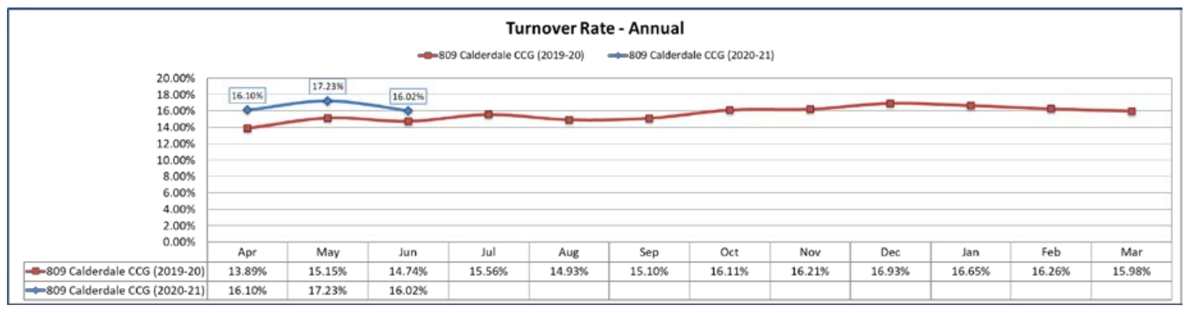
3.2 Table 3 and 4 includes the CCG's staff turnover rates is data until end of June 2020, and a comparison with turnover for the previous financial year.

Table 3 – CCG Annual Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2018-19)	13.75%	13.79%	15.48%	15.43%	14.40%	14.33%	10.82%	10.83%	13.83%	12.69%	14.42%	14.24%
809 Calderdale CCG (2019-20)	13.77%	15.03%	14.74%	15.25%	15.06%	15.71%	16.11%	16.21%	16.91%	16.65%	16.26%	15.98%

Table 4 – CCG Annual Staff Turnover



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

3.3 It is important to note that the small number of employees means that any leavers have a significant impact on the overall percentages. Rolling annual turnover reflects the total number of leavers over the past 12 months, as a percentage of the workforce. The rolling percentage at the end of March 2020 was 16.66% and reflects 14 individuals leaving the CCG between 1 April 2019 and 31 March 2020.

3.4 Where individuals have left the organisation, this has been a combination of retirement and voluntary resignation for reasons of promotion, work life balance, relocation and/or end of fixed term contract. A level of turnover is to be expected and is appropriate in any organisation.

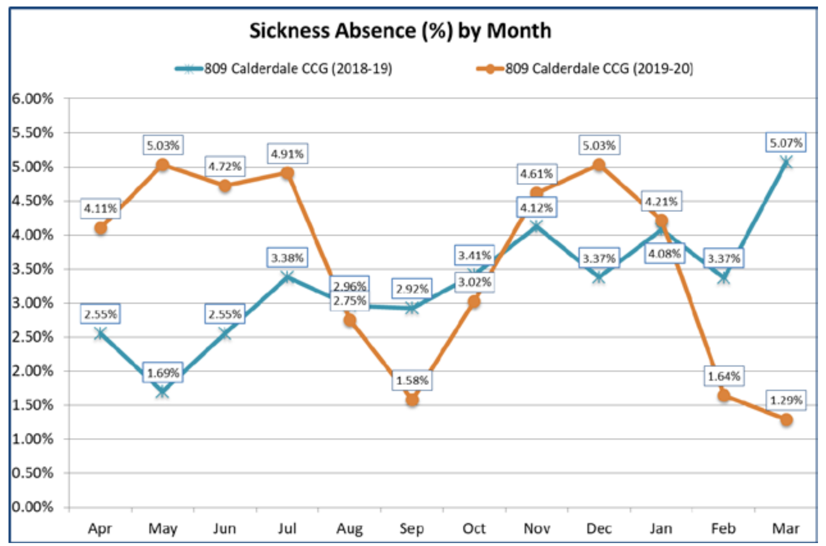
4.0 Sickness Absence

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

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

4.2 The overall sickness absence percentages for the last financial year can be found in table 5 which is both the combined long and short term sickness. Long term sickness is defined as any single instance of sickness absence, which lasts for 28 days or more.

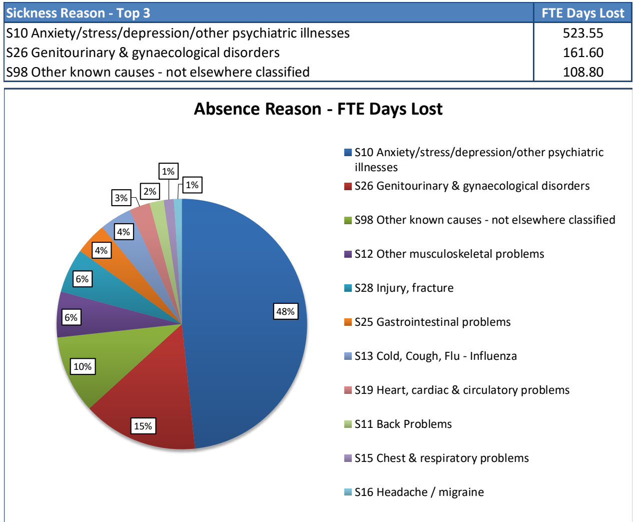
Table 5 – Combined Short and Long Term Sickness Absence



4.3 There is currently no benchmarking information available nationally from NHS Digital as a comparator against CCG sickness data. Sickness absence levels continue to fluctuate, though for the majority of the period, have been lower than the previous financial year. The majority of sickness absence continues to be driven by long term sickness, which is managed carefully on an individual basis, in line with the CCG's policies. There are no themes in relation to the reasons for long term sickness, which are deemed to be of organisational concern. Anxiety and stress is the top reason for absence which to date in most cases has been related to personal issues. Table 6 highlights the top three sickness reasons.

4.4 Sickness absence levels are discussed at SMT and the Human Resources (HR) team works with line managers to ensure that appropriate support is provided to individuals, in accordance with the Sickness Absence Policy.

Table 6 – Sickness Reason - Top 3



Sickness Reason - Top 3	FTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	523.55
S26 Genitourinary & gynaecological disorders	161.60
S98 Other known causes - not elsewhere classified	108.80

4.5 The updated Sickness Absence policy includes a clearer process for identifying when individual sickness levels need further exploration. Line managers are now able to review real-time sickness absence information for their teams, so that any patterns or concerns can be identified more quickly through ESR. To support the policy, refreshed sickness absence training was delivered to line managers during March and April 2019. 70% of line managers attended, with 97% reporting that the training met or exceeded their expectations.

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

4.7 Recent initial analysis of sickness data over the period of April to June 2020 compared to the previous year has decreased by almost 80%. Significant decreases in sickness have also been reported by Calderdale Council and neighbouring CCGs attributing this to possibly working from home, flexibility in the working hours or a better work life balance.

5. Equality & Diversity

5.1 The CCG is committed to the benefits of Equality and Diversity in all areas of its work; this includes in relation to its workforce. Equality and Diversity information is reported to SMT on a regular basis as part of workforce reports. The Equality and Diversity information is included below in table 7, and is reported in a way that ensures that data is not personally identifiable.

Table 7 – Ethnicity and Diversity Information

Disability	FTE	Headcount	%
No	65.05	70	86.42%
Not Declared	5.00	5	6.17%
Yes	5.09	6	7.41%

Gender	FTE	Headcount	%
Female	59.14	65	80.25%
Male	16.00	16	19.75%

Sexual Orientation	FTE	Headcount	%
Gay or Lesbian	=<5	=<5	=<5
Heterosexual	59.85	64	79.01%
Not Disclosed	=>10	=>10	=>10

Religious Belief	FTE	Headcount	%
Atheism	11.40	12	15.00%
Buddhism	=<5	=<5	=<5
Christianity	40.35	43	53.75%
Islam	=<5	=<5	=<5
Not Disclosed	18.10	20	25.00%
Other	=<5	=<5	=<5

Ethnic Origin	FTE	Headcount	%
Asian or Asian Britsh	=<5	=<5	=<5
Mixed	=<5	=<5	=<5
Not stated	=<5	=<5	=<5
White	67.14	73	90.12%

Age Profile	FTE	Headcount	%
20-25	=<5	=<5	=<5
26-30	=<5	=<5	=<5
31-35	=<5	=<5	=<5
36-40	7.20	8	9.88%
41-45	11.00	12	14.81%
46-50	21.31	22	27.16%
51-55	11.39	13	16.05%
56-60	15.60	17	20.99%
61-65	=<5	=<5	=<5
66-70	0.00	0	0.00%

5.2 The data demonstrates that:

- The workforce is predominantly female.
- 7.41% of the workforce declared that they have a disability.
- The majority of the workforce declared their sexual orientation as heterosexual.
- Just over 53% of staff reported that their religion is Christianity, with 25% of staff not disclosing their religion, and the next largest group being 15% declaring their religion as Atheism.
- Over 90% of staff are of white ethnic origin. The majority of staff declared their ethnic origin.
- Over 79% of the workforce is aged 41 or over, with very small numbers of staff aged below 31 and over 60.

5.3 The CCG takes a number of actions to promote equality and diversity amongst its workforce and this is particularly important in the context of a small organisation, made up of long-serving staff, and with limited recruitment, which means that opportunities to fundamentally change the demographic make-up of the workforce are limited and take place over time.

5.4 The CCG has signed up to the Integrated Care System (ICS) BAME Network action plan so that it can focus on areas such as recruitment and selection, succession planning, talent, retention and culture. Linked to this is the reporting of the Workplace Race Equality Standards (WRES) and the Equality Delivery System as part of internal facing goals and with the aim of increasing the diversity of the CCG workforce.

6. Workforce Headlines

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

6.1.1 Human Resources Policies & Procedures

6.1.2 The CCG has a comprehensive suite of 24 Human Resources (HR) policies, which are reviewed on a regular basis to ensure they remain fit for purpose and compliant with employment law and best practice. There is a plan to review the first batch of HR policies from September ahead of their review date in February 2021 to allow sufficient time for feedback and approval before reviewing the remainder of the HR policies staggered during 2021.

6.1.3 Employee Relations

6.1.4 The CCG has low levels of employee relations issues and currently there are no formal or informal grievances, disciplinary or performance cases. The policies promote the informal resolution of any issues where appropriate, and HR colleagues provide professional advice and support to line managers and individuals on an informal level in line with this approach.

6.1.5 In March 2020, there was one formal case that went to a Tribunal hearing. The claim was in relation to constructive dismissal and was successfully defended by the CCG's legal representatives. The Judge gave full reasons and did not uphold any of the claimant's alleged breaches of contract. Communication and timely responsiveness were the only areas of criticism, however, that was not a focus of the claim and was not a breach in any event. However, as part of the organisational development work a specific service review of the Continuing Care team and development plan will take place to support the team.

6.1.6 To support line management training with a focus on challenging behaviours, SMT agreed an action for ACAS to deliver two sessions to take place in October and December 2020. Spaces are limited to 12 per session (£860 plus VAT per session) and mandatory for line managers.

6.1.7 Recruitment

6.1.8 The CCG currently continues to recruit to roles that are vacant and over the last few months recruitment activity was paused with the exception of business critical posts. There is an intention as part of the WRES actions to deliver 2 refresher recruitment and selection training sessions aimed at existing or new managers by December 2020. Work is underway to refresh the training and sessions will be advertised in late August 2020.

6.1.9 Buying & Selling Annual Leave/ESR Annual Leave

6.1.10 For the annual leave year 2020/21, it was agreed in January by SMT to offer staff the opportunity to request the purchase of additional annual leave at the line manager's discretion (subject to service needs). A total of 6 requests for additional annual leave were requested and approved by the relevant Head of Service.

6.1.11 The CCG rolled out ESR manager self-service in 2018 to enable staff to submit annual leave requests through ESR in addition to being able to forecast trends to support service delivery. The CCG has actively communicated and encouraged staff to manage their annual leave within this financial leave year. This has been done via various communications methods as part of staff health and wellbeing and service resilience.

6.1.12 Staff Survey

6.1.13 The 2019 staff survey resulted in a final response rate of 91.4%. The staff survey responses have been looked at by SMT and a discussion taken place around any proposed actions.

6.1.14 The staff survey contract with Pickers ended this year and SMT approved a further three year contract at a cost of £1,080 including an option for local questions to be added. Discussions are taking place with the Chair of Staff Forum with HR/OD support to enable this and understand what areas to focus on and how this is to be measured.

6.1.15 Employee Assistance Programme (EAP)

6.1.16 The Employee Assistance Programmes (EAP) is an employee benefit programme offered by the CCG to all employees. In order to raise more awareness of the EAP services – Health Assured (EAP provider) ran two sessions for line managers on all aspects of the service in February 2020 across the three CCGs. The current contract with Health Assured was for a two year period which expired on 31st March 2020 and further extended for another year.

6.1.17 The recent usage report for EAP provides an overview of data from the period of 1st July 2019 to 30 June 2020. This accounts for a combined total of counselling cases and sessions at 24 across Calderdale CCG and its local Practices. Low mood was the most common reason followed by anxiety and work related stress. However, usage of EAP has significantly dropped between April and June 2020 and this may be attributed to staff utilising other support mechanisms that have been made available for NHS staff during COVID-19. A further discussion at Staff Forum would be beneficial in exploring the drop in usage.

6.1.18 Flu Vaccinations

6.1.19 The final take-up of flu vaccinations for 2019 for staff and Governing Body was 66%. SMT have agreed for a further two drop in sessions to take place between October and November 2020 with Flu Xpress. The intention is to promote the use of local pharmacies at the individuals' convenience and claim back the cost in addition to the drop in sessions to encourage a high uptake of flu vaccinations. Consideration around safety measures and/or another outbreak have been considered and further detail on how this will be managed will be provided to Flu Xpress to the CCG in early September.

6.1.20 Staff Engagement & Wellbeing

6.1.21 The CCG is proud of its approach to staff health and wellbeing, enabling colleagues to be physically and mentally resilient, and happy and healthy at work. CCG wellbeing activities are created and delivered by staff through Staff Forum, supported by senior leaders. "Coffee, cake and catch up" and blood pressure monitoring remain very popular. New ideas introduced include the 'Garden Swap Shop', 'Be A Ray In Someone's Day', 'You've been mugged' (an anonymous thank you in a mug), and fundraising for local and national organisations.

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

6.1.23 Learning & Development

6.1.24 The current statutory mandatory training dashboards provided to SMT as at 1st July 2020 show that overall compliance remains relatively high although there is an expectation that compliance needs to be 100%. Heads of Service are actively encouraging staff to achieve 100% on their training and reasons for not achieving 100% overall are linked to staff being redeployed in response to COVID-19 and work priorities being moved for the remainder of the staff across the organisation.

6.1.25 Workplace Race Equality Standards (WRES)

6.1.26 The CCG WRES report 2019 provided an overview of the NHS Workforce Race Equality Standard and the performance for 2018/19 against the nine indicators within the standard, enabling HR/E&D to identify specific areas for improvement. An SMT update is scheduled for August 2020 to report on 2019/20 data and proposed actions. A number of WRES actions will form part of the wider ICS BAME network actions to create one action plan and agreed with SMT in late August 2020.

6.1.27 Social Partnership Forum

6.1.28 Management and HR representatives meet quarterly with local staff side and regional Trade Union representatives facilitated by HR. Trade Union representation is regularly attended by Unison, Royal College of Nursing, Pharmacists Defence Association and Unite and the CCGs continue to work in partnership with them. Items of discussion to date have focused on COVID-19 related activity, CCG horizon scanning, running costs reduction, office accommodation, transfer of the HR service, job evaluation process, Trade Union time recording activity and changes to the IT and Data Quality structure.

6.1.29 IT and Data Quality Engagement Process

6.1.30 In light of the five year NHS plan and as a result of recent and planned retirements/changes in the IT team - an opportunity has arisen to review the IT team service to better meet the new expectations of a digital service for the future. A number of discussions have taken place with CCG senior Finance Officers and IT Managers focusing on how best the CCG can adapt its services to meet the strategic expectations of the NHS and the local place based programmes whilst ensuring continuity and improvement of core GP IT services.

6.1.31 The proposal provides a resilient team that is able to meet these expectations in terms of both strategic direction and operational provision. The team will therefore have the flexibility to adapt to future programmes; be that at an organisational, place based, ICS or regional level. Work is underway to enable this to happen through an engagement process as opposed to a consultation process during July and August.

7. COVID-19 Related Activities & Support

7.1 This section provides a summary of COVID-19 related activities, which have taken place in relation to the workforce.

7.1.1 BAME 1-1 Risk Assessments

7.1.2 In response to the growing concerns about the potential disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) people, the CCG undertook an exercise of contacting line managers in undertaking individual risk assessments with staff that identified

themselves as BAME. All BAME staff received a letter outlining the concerns regarding the emerging evidence of COVID-19 in addition to the work the organisation is undertaking to ensure individuals feel safe and supported at work through regular conversations. There were no immediate concerns highlighted in the 1-1 conversations, however, in the majority of cases there were underlying health issues highlighted including those living in the same household.

7.1.3 There were 7 risk assessments that were undertaken and received with a compliance rate of 100%. Mapped against the workforce the percentage being 8.5% of total risk assessments completed.

7.1.4 1-1 Return to Work Risk Assessments

7.1.5 Work is under way to finalise the individual 1-1 return to work risk assessment with all individuals as part of the return to work plan in line with Government and other national guidance. It is envisaged that the initial assessments are to be completed by July/August where possible so that the metrics (including BAME metrics) can be internally published and the CCG can assess and support staff falling into any of the risk categories.

7.1.6 System Wide Memorandum of Understanding (MOU)

7.1.7 At the request of the CCG and working alongside the Chief Quality and Nursing Officer an MOU was developed to support staff in response to COVID-19 pressures and ensuring that there was greater resilience across Calderdale and Kirklees. The purpose of this was for organisations to mutually accept the reciprocal agreement to support the flexible deployment and allocation of staff across system in line with appropriate employment law and governance.

7.1.8 A total of 25 MOU's were circulated to various organisations across Calderdale and Kirklees and a total of 20 signed and returned the agreement. There was a number of CCG staff redeployed to support the wider health and social care system.

7.1.9 Disclosure and Barring Service (DBS) Checks

7.1.10 In response to COVID 19 and the potential for an increase of staff to be deployed into frontline work, the Disclosure and Barring Service (DBS) has supported and prioritised recruitment in the NHS allowing for fast track adults and children's barred list checks being carried out. This temporary result outcome enabled the CCG to move staff into frontline work, as long as appropriate measures were put in place to manage the individual, until the full DBS check was received. The CCG identified 6 individuals requiring access to the fast track service. Other staff members were identified as having a current DBS check in place and this process allowed an overall check on DBS compliance across the organisation.

7.1.11 Staff Side Meetings/ HR West Yorkshire and North East HR Leads Meetings

7.1.12 In addition to the quarterly Social Partnership Forum meetings, HR has facilitated weekly (now fortnightly) staff side meetings. By working together in partnership, the CCG has been able to consult and/or discuss on a range of COVID related activity affecting the workforce and the approach to be taken on risk assessments and the continued dialogue associated with these.

7.1.13 HR has been networking with the HR leads on a daily/weekly basis in response to COVID-19. The purpose of these additional meetings has been to share learning and ensure there is a consistency in good practice across the CCGs and/or West Yorkshire where applicable. This has proven to be effective in supporting the CCGs during the pandemic with workforce related activity where a quick turnaround was required in line with changing national advice.

7.1.14 Guidance Documentation

7.1.15 There has been a number of guidance documents developed by HR and signposting of resources to deal with workforce issues that have arisen during the pandemic and to support the CCGs in protecting and supporting its workforce. Examples of such guidance has been in relation to annual leave and COVID, non-standard working hours and payment, regular HR FAQ's and line management approval of expenses for up to the value of £200 for additional purchases under COVID and managers guide to remote interviews.

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Chief Finance Officer's Report**	**Agenda Item No.**	11 a
Report Author	Lesley Stokey, Interim Chief Finance Officer	**Public / Private Item**	Public
GB / Clinical Lead	Neil Smurthwaite Interim Chief Officer	**Responsible Officer**	Neil Smurthwaite Interim Chief Officer

<table>
<tr><th colspan="5">Executive Summary</th></tr>
<tr><td>Please include a brief summary of the purpose of the report</td><td colspan="4">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.
• 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 2 financial returns.

Contracting
To update the Governing Body on the supplier relief guidance that was introduced to ensure service continuity during and after the pandemic.

Performance
This update provides an update on progress against the NHS constitutional standards.</td></tr>
<tr><td rowspan="2">Previous consideration</td><td>Name of meeting</td><td>Not applicable</td><td>Meeting Date</td><td></td></tr>
<tr><td>Name of meeting</td><td>Not applicable</td><td>Meeting Date</td><td></td></tr>
<tr><td>Recommendation (s)</td><td colspan="4">It is recommended that the Governing Body RECEIVE 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.</td></tr>
<tr><td>Decision</td><td>☐ Assurance</td><td>☒ Discussion</td><td>☐ Other</td><td></td></tr>
</table>

<table>
<tr><th colspan="4">Implications</th></tr>
<tr><td colspan="2">Quality & Safety implications</td><td colspan="2">None identified</td></tr>
<tr><td colspan="2">Public / Patient / Other Engagement</td><td colspan="2">None identified</td></tr>
<tr><td colspan="2">Resources / Finance implications</td><td colspan="2">Detailed within the report</td></tr>
<tr><td>Strategic Objectives</td><td>▪ Achieving the agreed strategic direction for Calderdale
▪ Improving quality
▪ Improving value
▪ Improving governance</td><td>Risk</td><td>1556 – Delivery of in year financial plan risk, 1557 – Delivery of CCG running cost requirements.</td></tr>
<tr><td>Legal / Constitutional Implications</td><td>None identified</td><td>Conflicts of Interest</td><td>Any conflicts of interest arising from this report will be managed in accordance with the CCG's Management of Conflicts of Interest Policy.</td></tr>
</table>

1.0 FINANCE

1.1 Key Messages

This report updates the financial position as at month 3, 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 has issued initial allocations for the period April 2020 to July 2020.
- The CCG is currently forecasting an overspend against the initial allocations due to Covid costs and other cost pressures.
- The CCG received an additional allocation of £1.26m in month 2 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.

1.2 2020/21 Temporary Finance Regime – Covid-19

In response to COVID-19, a temporary financial regime has been put in the place By NHS England (NHSE) and Improvement (NHSI) to cover the period 1 April 2020 to 31 July 2020. 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.

Calderdale CCG has been notified that original 2020/21 financial allocations for the full year have been suspended and CCGs have been given allocations for 4 months which have been based on what was spent in 2019/20 uplifted for inflation. As a consequence the CCG is receiving £4.3m less over the 4 month period than had been originally planned for.

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.

A summary of the differences between our original plan for 2020/21 (April-July) and the revised allocations for the same period are shown below:

Calderdale CCG Long Term Plan comparison to revised Financial Regime Allocations	Pre - Covid Plan 2020/21 £'000	Pre- Covid Plan Apportioned Mth 1-4 £'000	New Financial Regime Mth 1 - 4 £'000	Variance £'000
CCG Programme Allocations	-312,822	-104,274	-100,311	3,963
Primary Medical Care (Delegated Co-Commissioning)	-31,522	-10,507	-10,380	127
CCG Running Cost Allocations	-4,115	-1,372	-1,195	177
Non-Recurrent Allocations	0	0	0	0
CCG Allocation Total	**-348,459**	**-116,153**	**-111,886**	**4,267**
CCG Expenditure Budgets		-		
Acute	175,313	58,438	54,509	- 3,929
Mental Health - Adults	34,471	11,490	11,127	- 363
Mental Health - Children and Young Persons	2,059	686	664	- 22
Community Health Services	16,104	5,368	5,239	- 129
Continuing Care Services	23,431	7,810	7,996	185
Primary Care Services	4,873	1,624	2,068	444
Primary Care (Co Commissioned)	31,522	10,507	10,380	- 127
Other Programme Expenditure	54,977	18,326	18,708	383
Running Costs	4,114	1,371	1,195	- 176
Contingency	1,595	532	-	- 532
CCG Expenditure Budgets Total	**348,459**	**116,153**	**111,886**	**- 4,267**

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.

The CCG is expected to agree the start budget for this period and the Quality, Finance and Performance Committee approved this in the meeting in June 2020.

1.3 Forecast position for the period April-July 2020

The CCG submitted it's a forecast position to the end of July which is showing approximately £2.8m of pressures against the original allocation received for the period. The CCG has received additional allocation of £1.26m following the May financial monitoring submission to NHSE/I.

A high level summary is shown in the table below:

High Level Forecast position M1-M4	Programme £'000	Delegated £'000	Running Cost £'000	Total £'000
Initial Allocation - Covid Regime	- 100,311	- 10,380	- 1,195	- 111,886
Latest Forecast for M4	102,734	10,624	1,372	114,729
Net overspend	2,423	244	177	2,843
Covid costs to date M1-3	2,394	-	-	2,394
Other pressures (forecast M1-M4)	29	244	177	449
Total variance	2,423	244	177	2,843
Allocation adjustment M2	-1059	-116	-88	-1263
Net position	1,364	128	89	1,580

The makeup of these pressures can be seen in appendices A-C and summarised below:

- **Acute:** Showing an underspend due to the fact that although the block payments are higher than budgeted for, there is an underspend on NCA and Independent sector providers.

- **Mental Health**: Showing an underspend as some of the new and full year 2020/21 committed expenditure is being paid directly to NHS providers. NCA activity is lower than forecast.

- **Prescribing**: Showing a potential overspend due to the fact that NHSE assumption was 2019/20 plus 1%. We have revised our forecast down from M2 as April data has now been received; however, this still leaves a forecast overspend of £0.9m for the period April-July. Cost pressures are due to continued increases in NSCO (No Cheaper Stock Available), 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 Primary Care Network (PCN) related costs.

- **Primary Care – Delegated**: Showing an overspend as expecting costs to be in line with the original submitted plan.

- **Other / Reserves**: showing a 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. In addition Covid-19 costs in relation to the hospital discharge programme have been included here.

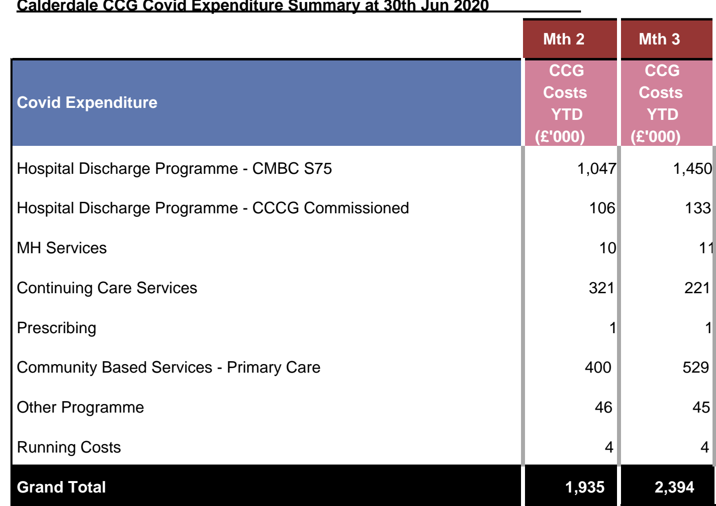
- **Running Costs**: The Allocation from NHSE has been calculated by taking 2019/20 expenditure less 11.8%. This percentage reduction is the equivalent to the planned for reductions in allocations between the 2019/20 and 2020/21. However as the CCG was already delivering a significant underspend on running 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.

It is expected that NHSE/I will review these pressures and make retrospective adjustments to allocations where they feel appropriate.

The CCG received additional allocation following the Month 2 submission to cover cost pressures incurred to date. The CCG received £1,263k additional allocation and the CCG allocated this between Programme £1,059k, Delegated Co-Commissioning £116k and running costs £88k. The remaining forecast pressures relate to month 3 and month 4. The CCG submitted its month 3 finance reports in early July and is still awaiting feedback.

1.4 Covide-19 Cost Update

Included in our forecast positions are a number of Covid-19 related cost pressures. The summary below shows a high level view of the Covid-19 costs incurred year to. Data has been collected on Covid-19 expenditure and submitted to NHSE for April to June. Our forecast to July also includes an expectation that some of those costs will continue.



Calderdale CCG Covid Expenditure Summary at 30th Jun 2020

Covid Expenditure	Mth 2 CCG Costs YTD (£'000)	Mth 3 CCG Costs YTD (£'000)
Hospital Discharge Programme - CMBC S75	1,047	1,450
Hospital Discharge Programme - CCCG Commissioned	106	133
MH Services	10	11
Continuing Care Services	321	221
Prescribing	1	1
Community Based Services - Primary Care	400	529
Other Programme	46	45
Running Costs	4	4
Grand Total	**1,935**	**2,394**

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

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

1.5 New Financial Planning – August 2020 to March 2021

NHS E/I are due to issue planning guidance at the end of June/early July with a view that a plan will be submitted by the CCG in July.

We have not yet received any planning assumptions but it is expected that we will be asked to plan on the basis that the Covid-19 infection rate continues to fall and that plans can be made to start to increase non-emergency care activities both in acute and in primary care.

1.6 Public Sector Payment Policy

The CCG has a target of 95%, and performance is currently between 96% 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 Introduction

2.1.1 A range of guidance documents have been published in relation to suppliers to ensure service continuity during and after the current coronavirus, COVID-19, outbreak and to clarify revised arrangements for NHS contracting and payment during the COVID-19 pandemic. This section summarises the actions taken in relation to the contents of this guidance.

2.2 Detail

NHS Trusts and NHS Foundation Trusts

2.2.1 The next steps on the NHS response to COVID-19 published on 17 March 2020 confirmed that payments for NHS trusts and NHS foundation trusts would move to block contract payments 'on account' for an initial period of 1 April to 31 July 2020, with suspension of the usual PbR (Payment by Results) national payment architecture and associated administrative/transactional processes.

2.2.2 Block contracts and associated values were agreed nationally. The schedules below detail the monthly block values.

Calderdale CCG Provider Name	Block Contract Value
Bradford Teaching Hospitals NHS Foundation Trust	366.4
Calderdale And Huddersfield NHS Foundation Trust	12,738.3
East Lancashire Hospitals NHS Trust	72.5
Manchester University NHS Foundation Trust	43.5
South West Yorkshire Partnership NHS Foundation Trust	1,987.9
Leeds Teaching Hospitals NHS Trust	597.9
Mid Yorkshire Hospitals NHS Trust	49.1
Pennine Acute Hospitals NHS Trust	44.3
York Teaching Hospital NHS Foundation Trust	19.2
Yorkshire Ambulance Service NHS Trust	1,011.4

2.2.3 Values are based on Month 9 Agreement of Balances (uplifted by 2.8%) and are therefore inclusive of other services delivered by the main acute provider.

2.2.4 Values are deemed to include CQUIN (Commissioning for Quality and Innovation) but the operation of CQUIN is suspended for the period from April to July 2020.

2.2.5 All contractual sanctions are suspended until further notice and normal contract management meetings and processes are suspended.

2.2.6 Further guidance on the arrangements from August 2020 remains outstanding, however, it has been clarified that there will be no requirement for commissioners and Trusts to negotiate written contracts, and agree local financial values, to take effect from 1 August 2020. Equally, it has been confirmed that the operation of the 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year and an allowance for CQUIN will continue to be included in the block payments. CQUIN payments to non-NHS providers should also continue at the full applicable rate.

2.3 Independent Sector (IS) Acute Hospitals

2.3.2 National arrangements have been agreed to buy capacity and support from acute hospitals. This covers all the inpatient facilities and the existing staff working for the providers. These nationally commissioned and funded contracts superseded local agreements and are operating from 23 March 2020 for a minimum period of 14 weeks.

2.3.3 NHS England has since extended the national contract which is now in place until the end of August.

2.3.4 An update remains outstanding in relation to a planned full competitive procurement, based on longer term forecast volumes for the next phase of support. This process is expected to ensure new longer term contracts to be in place by late August for a 1 September start date.

2.4 Other Non-NHS Providers

2.4.1 A range of guidance was published to support the approach to payment of providers to ensure service continuity during and after the coronavirus, COVID-19 outbreak. The CCG has followed guidance and communicated the relevant approach to each provider.

2.4.2 Care Homes and Domiciliary Care providers were identified as at risk to resume to normal contract delivery once the outbreak is over. Therefore, a supplier relief package was agreed for these providers in line with the Cabinet Office Procurement Policy Note and the council's Local Government Association (LGA) guidance.

2.4.3 To support care home providers to maximise availability of care and support and for them to remain operationally and financially resilient it has been agreed to apply a one-off 10% COVID-19 related uplift to current rates based on an average week occupancy rate in February as to not adversely affect any voids related to COVID-19. This initially applies for a period of 12 weeks.

2.4.4 To support domiciliary care providers it has been agreed to continue payments for care packages where patients have chosen to either cancel and/or suspend their care due to COVID-19 related reasons. It was also agreed for invoices to be submitted based on the average cost (plus the agreed uplift) for the last three months, those being December, January and February for an initial period up to the end of June 2020 and starting from April 2020.

2.4.5 In addition to this and following joint discussions with Calderdale Council, it was agreed to also apply a one-off 5% COVID-19 related uplift to current rates (based on average hours delivered in February) for a period of 12 weeks.

3.0 PERFORMANCE

3.1 This section of the report provides an update on progress against the NHS constitutional standards.

Overall system performance remains strong in the majority of areas. COVID-19 has had an impact on the volumes underpinning some indicators and where available, supplementary measures have been included to provide further context.

Planning guidance from NHSE to support the system 'reset'/ phase 3 of the COVID 19 response is expected to be published in July.

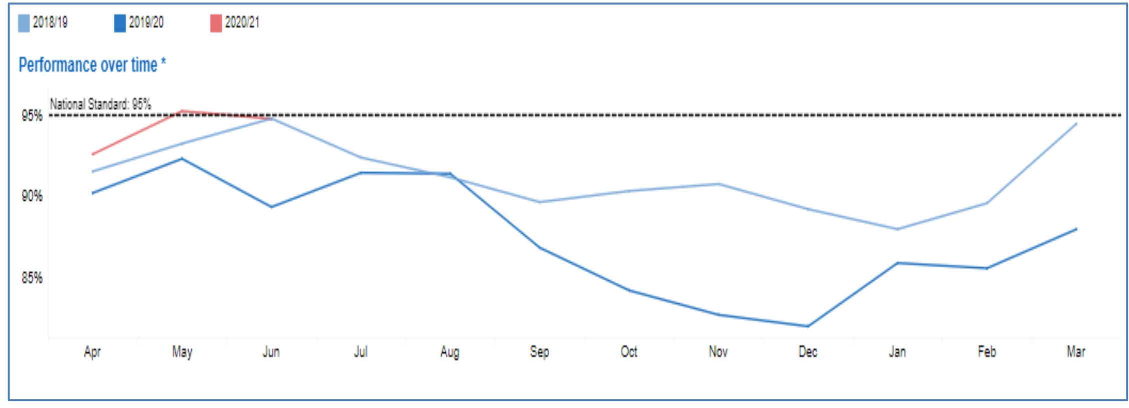
Phase	Time Period	Response
1	March – April 2020	Level 4 Incident Focus on critical care and building capacity to respond to COVID19 Supporting safe and effective discharge to communities, to free up acute beds Supporting 'vulnerable' people shielded from the virus, and other groups who are likely to be most affected by social distancing
2	April – June 2020	Immediate recovery actions post COVID!19 surge Focus on urgent activities e.g. cancer, stroke, heart attack Use if independent sector ERS back open
3	July – March 2020-2021	More comprehensive planning review Focus on building elective capacity and potential for any COVI19 second wave during winter (including testing and PPE supply)
4	April 2021 onwards	Focus on recovering and developing the NHS towards the 'new normal'

3.2 Urgent Care

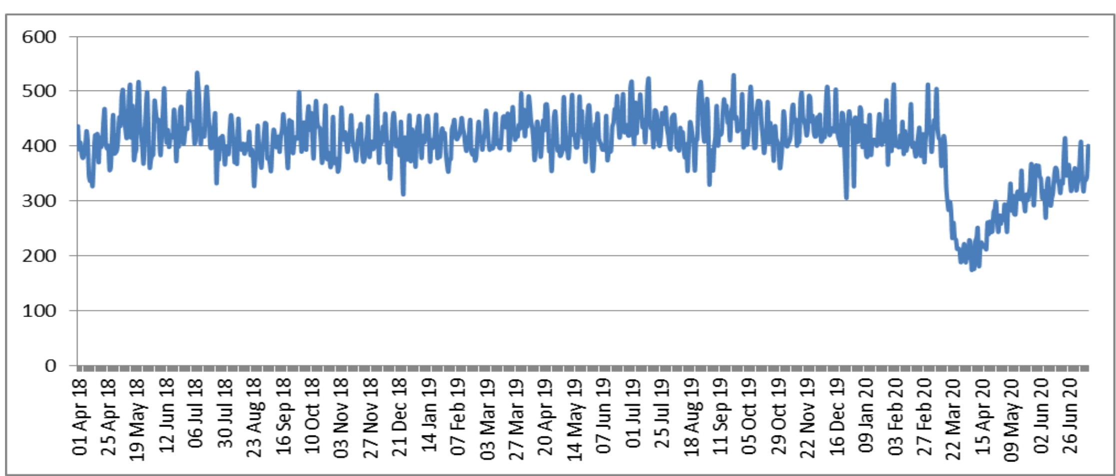
3.2.1 Sustaining the 4 hour target in A&E

The latest published figures on A&E performance for June indicates the local health and care system achieved 94.8%. Although below the constitutional standard, this level of performance compares favourably placing the system in the upper quartile both regionally and nationally.

The chart below illustrates the monthly variation in A&E performance during the last 2 years.



The impact of COVID-19 and the introduction of the 'lockdown' during phase 1 has seen a significant reduction the in volume of people attending A&E – see the chart below that illustrates the daily variation in A&E attendances during the last 2 years.



A consequence of the 'lockdown' measures and the reduction in attendance has seen performance levels improve during the same period. As the 'lockdown' measures are relaxed, the volume of attendance at A&E is beginning to approach pre COVID 19 levels.

The system has undertaken a review of A&E attendances during the lockdown period. Using the work led by the National Clinical Director for Urgent Care (Dr Cliff Man) there has been particular interest in people with high risk conditions not attending A&E during lockdown as well as an understanding of the capacity (e.g. PPE, estate, workforce) required to manage demand for urgent care in A&E and across the system safely. The findings will inform phase 3 of the COVID 19 response.

3.3 Elective Care

3.3.1 Referral to Treatment Times

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 Calderdale and Huddersfield NHS Foundation Trust) have been invited to test using the average wait for all patients on incomplete pathways as the headline measure of RTT (Referral to Treatment) performance.

3.3.2 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 1st 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.

3.3.3 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 waiting greater than 52 weeks.

> **52 Weeks**

- 18 Calderdale patients waiting > 52 weeks for treatment (as at April 2020)

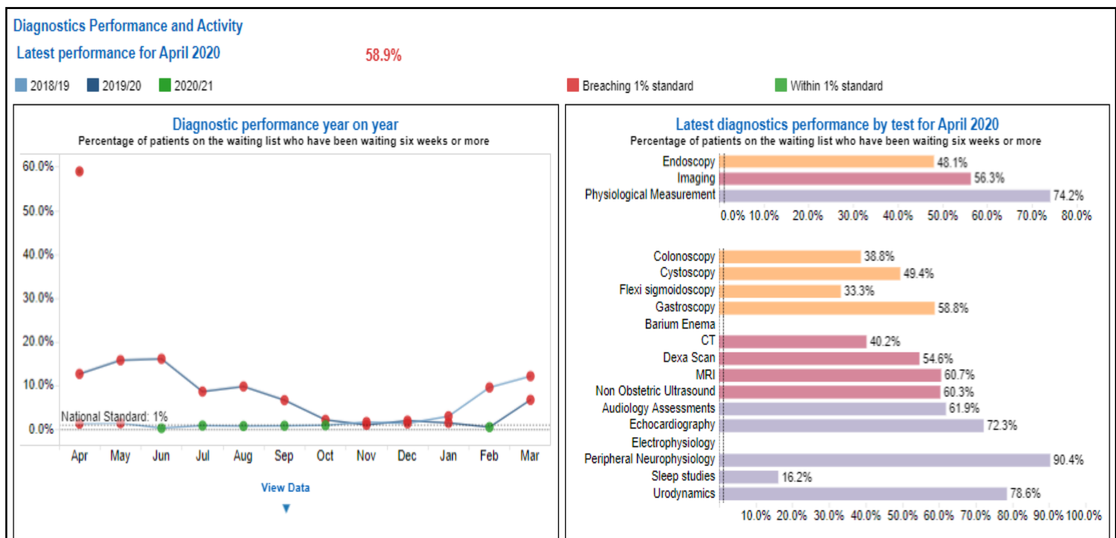
	T&O	Urol	Gen Surg	ENT	Neuro	Gynae	Plastic	Other
CHFT	5	2	2	1	1	2	1	1
LTHT	1	2						

During the phase 1 lockdown, access to elective care was limited and patient treatment clinically prioritised. In advance of the phase 3 guidance being published, work is being undertaken locally to maximise volume of elective capacity that can be made available safely across the system to treat patients in safe and timely manner.

3.6 Diagnostic Waiting Times

Patients referred for a diagnostic test should wait less than 6 weeks following their referral from a GP. The NHS Constitution requires no more than 1% of patient waits to breach this standard.

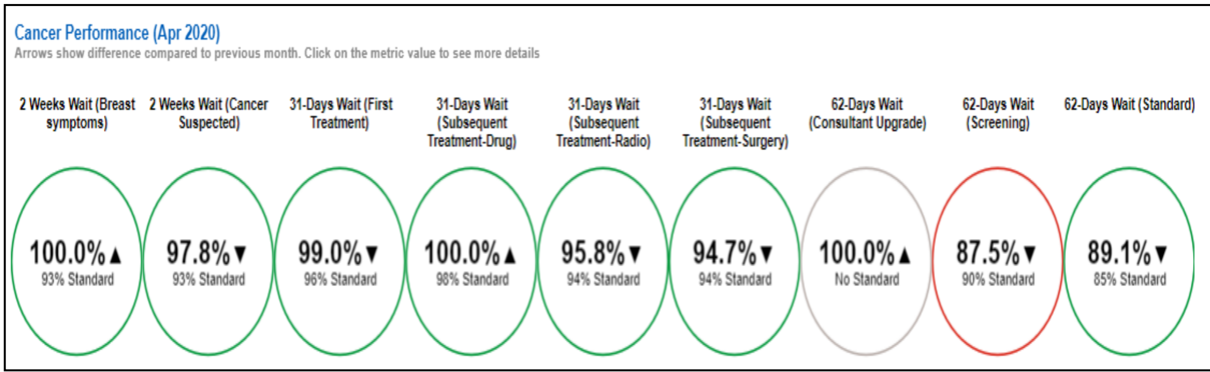
COVID 19 has had a significant impact on overall performance in this area – see chart below. In April 58.9% of patients had waits greater than 6 weeks. A similar picture was reported nationally (55.7%).



As with elective care, access to diagnostic testing was limited during the lockdown. Phase 3 of the reset will focus on maximising the volume of diagnostic capacity that can be made available safely across the system to treat patients in safe and timely manner.

3.7 Cancer Waiting Times

Performance levels against the cancer waiting times has remained strong during phase 1 of the COVID 19 response – see table below. Actions are coordinated by the Cancer Locality Group who will also be looking at the approach to phase 3 to ensure levels of access and performance levels of maintained.



4.0 RECOMMENDATIONS

4.1 It is recommended that the Governing Body **RECEIVE** the report **NOTING**:

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

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.

Calderdale CCG Resource Allocation Summary as at 30th June 2020 **Appendix A**

Centre Code	Annual	In Month (£)			Year To Date (£)			Forecast (£)		Mth 02 Forecast	
Name	Budget (£)	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
ALLOCATIONS IN YEAR	(111,866)	(28,848)	(28,848)	0	(84,193)	(84,193)	0	(111,866)	0	(110,691)	(1,175)
ACUTE	54,509	13,627	13,798	171	40,882	40,766	(116)	54,051	(458)	53,872	180
MENTAL HEALTH	11,791	2,948	2,654	(294)	8,843	8,659	(184)	11,651	(140)	12,210	(560)
CONTINUING CARE	7,996	1,999	2,243	245	5,997	6,063	66	8,051	56	7,783	268
PRESCRIBING	11,748	2,937	3,445	508	8,811	9,419	608	12,606	858	13,922	(1,316)
PRIMARY CARE	2,068	517	614	97	1,551	2,123	572	2,575	506	2,600	(25)
DELEGATED CO-COMMISSIONING	10,496	2,711	2,661	(50)	7,901	7,968	66	10,624	127	10,507	116
COMMUNITY HEALTH SERVICES	5,239	1,310	1,332	22	3,929	3,884	(45)	5,187	(51)	5,179	9
OTHER	1,824	456	510	54	1,368	1,325	(43)	1,746	(78)	1,644	102
BCF	4,288	1,072	1,121	49	3,216	3,408	192	4,541	252	4,538	2
COMMISSIONING RESERVE	1,906	1,271	290	(980)	1,694	1,842	148	2,326	420	2,696	(371)
Grand Total	**0**	**0**	**(178)**	**(178)**	**0**	**1,264**	**1,264**	**1,492**	**1,492**	**4,261**	**(2,769)**

Calderdale CCG Running Cost Allocation Summary at 30th June 2020 **Appendix B**

Centre Code	Annual	In Month (£)			Year To Date (£)			Forecast (£)		Month 2	
Name	Budget (£)	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
ADMINISTRATION & BUSINESS SUPPORT	13	3	1	(2)	10	7	(2)	10	(3)	13	(3)
CEO/ BOARD OFFICE	180	45	28	(18)	135	157	22	185	4	188	(4)
IM&T	25	6	22	16	18	46	27	50	25	30	19
CORPORATE COSTS & SERVICES	50	13	11	(2)	38	46	8	62	11	67	(6)
EQUALITY AND DIVERSITY	13	3	3	(1)	10	8	(2)	11	(2)	13	(2)
PATIENT AND PUBLIC INVOLVEMENT	33	8	10	2	25	25	0	30	(3)	32	(2)
CONTRACT MANAGEMENT	112	28	35	7	84	90	5	119	7	111	8
MEDICAL DIRECTORATE	110	27	26	(1)	82	78	(4)	104	(6)	107	(3)
HUMAN RESOURCES	15	4	4	1	11	9	(3)	11	(4)	7	4
STRATEGY & DEVELOPMENT	196	49	49	(0)	147	143	(4)	192	(4)	186	6
BUSINESS INFORMATICS	116	29	6	(23)	87	56	(31)	75	(41)	100	(25)
QUALITY ASSURANCE	127	32	24	(8)	95	80	(16)	106	(21)	114	(8)
ESTATES AND FACILITIES	80	20	33	13	60	58	(3)	77	(4)	59	17
FINANCE	179	45	38	(6)	134	111	(23)	148	(31)	146	2
GENERAL RESERVE - ADMIN	(94)	42	44	2	(49)	70	118	121	216	118	3
CORPORATE GOVERNANCE	128	32	14	(18)	96	49	(46)	72	(56)	78	(6)
Grand Total	**1,283**	**387**	**347**	**(40)**	**984**	**1,033**	**48**	**1,372**	**89**	**1,371**	**1**

Calderdale CCG Delegated Primary Medical Services Summary at 30th June 2020

Appendix C

PRIMARY CARE SERVICES:	4 Months	In month			Year To Date (£)			Forecast M03		Forecast M02	
Name	Budget	Budget	Actual	Variance	Budget	Actual	Variance	Outturn	Variance	Outturn	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	5,379	1,345	1,526	181	4,034	4,577	543	6,103	724	6,103	0
PMS	1,012	253	125	(128)	759	417	(342)	556	(456)	585	(29)
APMS	782	195	60	(136)	586	179	(407)	239	(543)	239	0
QOF	927	232	234	2	695	701	6	934	7	934	(0)
Enhanced Services	106	26	28	2	79	83	3	110	4	108	2
Premises - Reimbursed Costs	990	248	268	21	743	812	69	1,082	92	1,086	(4)
Premises - Other	159	40	18	(22)	120	53	(67)	70	(89)	70	0
Prof Fees Prescribing & Dispensing	56	14	(16)	(30)	42	10	(32)	13	(43)	52	(38)
Collaborative Payments	0	0	0	0	0	0	0	0	0	0	0
Other GP Services (inc. PCO)	172	43	94	51	129	157	29	195	23	127	68
Other Non GP Services	222	56	51	(4)	167	154	(13)	205	(17)	205	0
Pensions	0	0	0	0	0	0	0	0	0	0	0
PCN	345	86	162	75	259	509	250	679	334	695	(17)
Reserves (91811030)	293	73	0	(73)	220	316	97	53	(240)	53	0
Reserves - Contingency (91811060)	53	13	113	100	40	0	(40)	383	330	249	134
Total Primary Care Medical	**10,496**	**2,624**	**2,661**	**38**	**7,872**	**7,968**	**96**	**10,623**	**128**	**10,507**	**116**

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 30th June 2019

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	109	99.09%	£17,894,280.17	100.00%	535	97.27%	£70,355,233.62	100.00%
Non NHS	626	98.12%	£6,991,139.33	98.04%	2142	96.44%	£22,864,151.63	97.65%
Total	735	98.26%	£24,885,419.50	99.44%	2,677	96.78%	£93,219,385.25	99.42%

Appendix E

Calderdale CCG Resource Allocation Summary at 30th June 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 Adj	(1,059)	(116)	(88)
	0	0	0
	0	0	0
Grand Total	**(101,370)**	**(10,496)**	**(1,283)**

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Quality and Safety Report**	Agenda Item No.	11b
Report Author	Penny Woodhead, Chief Quality and Nursing Officer Sam Parkinson, Project Support Officer	Public / Private Item	Public
GB / Clinical Lead	Dr Farrukh Javid, GP Governing Body 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 the following routine quality and patient safety activities: • Local Care Direct Care Quality Commission inspection publication • Provider Quality Accounts This report also provides an outline of 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. It provides information of the work being undertaken by the Infection, Prevention and Control Team and Safeguarding Team, including outlining any changes to practice/assurance during the pandemic.						
Previous consideration	Name of meeting			Meeting Date			
	Name of meeting			Meeting Date			
Recommendation (s)	1. It is recommended that the Governing Body **RECEIVE** this update on the following routine quality and safety information: • Local Care Direct Care Quality Commission inspection publication • Provider Quality Accounts 2. It is also recommended that the Governing Body **RECEIVE** and **NOTE** this update on 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.						
Decision	☐	Assurance	☒	Discussion	☐	Other	

Implications	
Quality & Safety implications	This paper is applicable to vulnerable and protected patient groups. Concerns and risks relating to quality and safety are highlighted within the paper and reflected in the risk register.

<table>
<tr><td colspan="2">Engagement & Equality implications</td><td colspan="6">Not required</td></tr>
<tr><td colspan="2">Resources / Finance implications</td><td colspan="6">CQUINs has a financial value attached to outturn contract value.</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>Improving quality
Achieving the agreed strategic direction for Calderdale</td><td colspan="3">Risk</td><td colspan="3">1361 – Risk to patient safety, experience and quality of care delivered by Local Care Direct.
1317 – Risk of avoidable Healthcare Associated Infections not being prevent due to omissions in provision of care.
1565 – Risk of reduced quality surveillance and assurance due to Quality Team redeployment.</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>None identified</td><td colspan="3">Conflicts of Interest</td><td colspan="3">Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.</td></tr>
</table>

1.0 Purpose

1.1 This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

2.0 Introduction

2.1 The Quality, Finance and Performance (QF&P) Committee agreed at its meeting in March 2020 to suspend routine quality reporting during the first phase of COVID -19, therefore there is no quality dashboard reported this month. All quality and safety activity related to COVID -19 is included in this report as well as routine information.

3.0 Local Care Direct Care Quality Commission Inspection Publication

3.1 The Care Quality Commission (CQC) recently published its inspection report (11 May 2020) following its inspection of West Yorkshire Urgent Care Services provided by Local Care Direct (LCD). The overall rating for the service was "good" with each of the 5 domains also receiving a rating of "good". This remains the same rating as when last inspected in March 2015.

3.2 The report commented upon both the GP Out-of-Hours Service and Urgent Treatment Centres (Leeds). The inspection did not report on other services provided by LCD, for example Emergency Department (ED) streaming, GP Connect (Wakefield) or the `Safe Haven` services. During the inspection two Primary Care Centres (Skipton General Hospital and Airedale General Hospital) were visited in addition to the main site; Sheridan Teal House (Huddersfield). The report did not indicate any "must do" actions.

3.3 The full report can be viewed at the following link:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAK0266.pdf

4.0 Provider Quality Accounts

4.1 NHS healthcare providers are required to publish an annual Quality Account to report on quality and improvements in the services they deliver to local communities and stakeholders. Copies of the draft Quality Accounts are circulated to stakeholders for comment prior to the final versions being published on 30th June.

4.2 In light of Covid-19 pressures, the deadline for trusts to publish their 2019/20 Quality Accounts has been revised. There is now no fixed deadline by which providers must publish their 2019/20 Quality Account. However, to take into consideration the pressures caused by Covid-19, NHS England (NHSE) and NHS Improvement (NHSI) have recommended a deadline of 15 December 2020. In order to allow for scrutiny (as required by the Quality Account regulations) each trust should also agree an appropriate timescale to provide a draft Quality Account to stakeholders for comment; a date of 15 October 2020 has been suggested as a reasonable deadline.

4.3 The Quality Team will therefore be making contact with each of the CCG's main providers to discuss these arrangements and will update the Committee in due course.

Covid-19 Specific Updates

5.0 Rapid Change Process

5.1 A Rapid Impact Assessment (RIA) process has been developed in response to the COVID 19 pandemic and the need for the NHS to respond by rapidly changing commissioning and delivery of services. The RIA process combines elements from the Equality Impact Assessment (EIA) and the Quality Impact Assessment (QIA). The process and associated templates have been approved by the Senior Management Teams (SMT's) for Calderdale, Greater Huddersfield and North Kirklees CCGs.

5.2 The Quality Team coordinates and supports the RIA process end to end. Equality and Safeguarding colleagues also provide expertise for the completion of each RIA. To date there have been 13 requests for RIAs with 11 completed for Calderdale. Weekly updates are provided to the Chief Nurse and SMT.

5.3 The Quality Team is developing a process for reviewing impacts after implementation of the change has occurred. This will usually take place 1-6 months after implementation, depending on the kind of service the RIA relates to. This will provide evidence and learning opportunities for future projects.

5.4 This process will continue to be reviewed in accordance with the COVID 19 status and national guidance. It is anticipated that we will revert back to Quality/Equality Impact Assessment (QEIA) processes during Covid-19 Phase 2.

6.0 Revised Process for Quality Surveillance

6.1 NHS E/I issued a letter on 21st April 2020 outlining the principles for the monitoring of quality during the Covid-19 pandemic which includes regional decisions on levels of quality surveillance in place. It was acknowledged that quality and safety functions would need to be performed in a proportionate manner that supports the focus on the response to Covid-19 while at the same time ensuring that an oversight of quality is maintained.

6.2 Therefore a weekly hotspot quality surveillance and work stream has been developed regionally which will act as an escalation mechanism for quality monitoring by exception during this time. A mechanism to capture and escalate local quality issues at place level has also been developed, which is a weekly return, by exception, to NHSE. For those Trusts that remain in an enhanced quality surveillance process, an enhanced monitoring arrangement will be in place which includes a 2-weekly meeting with the relevant Trust Executives to monitor and assess progress against improvement requirements. This meeting will include the Care Quality Commission and the lead CCG. At present we have no providers that fall into that category.

7.0 Emergency Support Framework

7.1 The Care Quality Commission (CQC) has announced that although it has paused its routine inspections, it has now developed an emergency support framework (ESF) that will be followed during the pandemic. This interim approach will provide a structured framework for the regular conversations that inspectors are having with providers and will cover the following four areas:

- Safe care and treatment
- Staffing arrangements
- Protection from abuse
- Assurance processes, monitoring, and risk management

7.2 This approach will be used beginning week commencing 4 May 2020 and the information captured will be used along with information gathered through other channels to report publicly on how services are managing at this time of increased pressure.

7.3 This framework will be will be rolled out across all sectors but is initially being used with adult social care providers, primary care services from 18 May and hospital services end of May. The CQC has confirmed that the ESF is not an inspection and services are not being rated as a result of this. It is anticipated that the focus of ESF for hospital will be in relation to Infection Prevention and Control and compliance with recently published IPC assurance framework https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0451-IPC-Board-Assurance-Framework.pdf.

We expect existing communication arrangements with CQC inspection managers to be maintained with the CCG.

7.4 Further details can be found at the following link: https://www.cqc.org.uk/news/stories/cqc-launches-emergency-support-framework

8.0 Provider Quality Assurance

8.1 The CCG Quality Team has devised a proportionate approach to managing provider quality assurance during the Covid 19 pandemic. This is designed to ensure it is not excessively onerous for providers, whilst ensuring assurance continues to be obtained in line with the CCG's statutory functions, and to enable re-deployment of CCG Quality Team clinical staff in line with NHSE expectations.

8.2 Providers have been responsive to this proposal and have supplied the quality information still being produced. Some have invited the CCG to participate in internal quality meetings.

8.3 An assurance log is in place which confirms the agreed arrangements and planned quality schedule. No new/significant quality concerns are being reported.

9.0 Quality Monitoring

9.1 Nationally mandated updates have been received by the Quality Team throughout this period outlining CCG Quality requirements and activity as a result of COVID 19. This provides evidence of guidance sent out nationally to enable the release of capacity to support the COVID-19 preparedness and response, with some functions stopping or pausing.

9.2 This will continue to be monitored and any quality risks identified associated with Covid-19, will be included on the Risk Register.

10.0 Infection Prevention and Control (IPC) Update

10.1 There has been a significant emphasis on support, outbreak prevention and outbreak management during the pandemic, particularly in care homes. Highlighted below are a number of the actions taken:

- Information and Communication
- Care Homes support
- Personal Protective Equipment (PPE)
- Testing, including training care home staff to undertake the testing
- Establishment of system Prevention calls and development of a prevention plan

10.2 In response to the Chief Nursing Officer (CNO) letter 1 May, CCGs were asked to lead on delivery of a co-ordinated training package on IPC, PPE and testing to be offered to 100% of care homes by May 29th:

Phase 1 By Monday 4 May, **formally confirm with your LRF an offer to supply trainers** who could be mobilised immediately if requested by care homes and as directed by Local Authorities.

Phase 2 **Take immediate action to mobilise that offer** and identify as many trainers as possible. This important work must be undertaken at the direction of local authorities and LRFs as they have the oversight and relationships with all care homes in their area. The NHS is providing mutual aid support to LRFs, and to support registered care home managers with their responsibilities. Any training provided will build on the good practice and relationships already in place in each local area.

Subsequent requirements have included:

- Develop a plan and deploy:

Phase 3 training: super trainers deliver training to local trainers within 10 days of completing training, ensuring the number of local trainers trained gives coverage of at least 1 local trainer per 10 care homes.

Phase 4 training: local trainers deliver face to face training to care home staff, within 10 days of completing training i.e. by 29 May.

The CCG is required to return a Sit rep daily to the centre on the following metrics:

- Number of care homes in CCG
- Number of trained super trainers in CCG
- Number of trained local trainers in CCG
- Number of care homes where training has been delivered, either face-to-face or virtual
- Number of care homes who have declined the offer

100% offer was achieved within the required timescale, with training sessions delivered to 38 out of 48 open homes. 9 homes declined, mostly as they have already done alternative training, 3 have received training since 29th May and supplementary training sessions are being offered to deliver the information to more care home staff and begin to embed good practices. We have been asked to record the reasons for the declines and further guidance is expected on ongoing support required to the sector from the NHS. Part of the Prevention plan

is to clearly set out Phase 2 of the required support, expanding the offer to other providers and will also include audit.

Other priorities on the Prevention Plan which are being progressed are:

- Roll out of testing to asymptomatic care home staff and residents
- Bring all guidance relevant to care homes into one overarching simplified guidance
- Ensure appropriate use of PPE guidelines and routine use of masks
- Ensuring effective co-ordinated communications from Local Authority and CCG
- Identification of care homes at requiring additional input and provide enhanced support and guidance
- Establish processes to ensure all admissions to care homes from community and acute hospitals are tested in advance
- Stop staff from outbreak care homes being rotated to those that are COVID-19 free
- Cohorting of staff across an area e.g. some chiropodists only visit care homes with COVID-19
- Supporting the wellbeing of care home staff
- Monitor compliance with infection control/cleaning policies
- Investigate barriers to implementation of guidance/IPC measures. Current IPC guidelines may not be realistic and practical in care homes.

11.0 Safeguarding Children and Adults Update

11.1 Whilst some statutory duties under the Care Act 2015 have been eased for adults, the duty to Safeguard Adults at risk of abuse and neglect and the duty to safeguard vulnerable children remain a key priority for all staff across health and social care. The CCG therefore needs to continue to prioritise key safeguarding activity and work both within the CCG, and to seek assurance that our commissioned providers that critical safeguarding work continues.

11.2 Guided by NHS England guidance published 'COVID-19 Prioritisation within Community Health Services' (see link below) on the 19th March 2020 and updated in 9th April, to try to ensure that critical safeguarding work continues the Safeguarding team undertook a review and prioritised all the work and activity of the team and identifying critical functions to remain or extend:

Supportive safeguarding advice remains a critical function: The CCG Safeguarding team offer advice to support professionals, so that practitioners to know what actions to take. The CCG team extended the offer of advice and support to staff all commissioned health providers and the Local Authority Safeguarding Team to help with any concerns raised about health providers.

Responding to urgent statutory safeguarding cases: Significant statutory safeguarding cases require a response initially to ensure that appropriate information is gathered and shared so that identified learning can be shared quickly to protect children or adults who may be at risk.

Work to support Safeguarding Boards/Partnerships across all 3 CCG areas: Safeguarding Boards and Partnerships temporarily suspended meetings of most subgroups and work-streams. However some critical streams that have continued and been supported by the CCG Safeguarding team (see above statutory cases).

Seeking safeguarding assurance from commissioned providers: The Designated Nurses have attended provider Safeguarding committees via virtual processes, arranged regular contact

with main provide safeguarding team leads and have scrutinised provider safeguarding reports that detail activity and arrangements during the pandemic to seek assurance that safeguarding remains a priority and critical work is being continued.

11.3 Link to NHSE guidance: 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

12.0 Responding to Covid-19: Principles to Deliver an Enhanced Universal Support Offer to Care Homes

12.1 The Principles, developed in conjunction with CCG Directors of Nursing, Local Authorities, Skills for Care, Primary Care, Public Health, Care Home Providers and others across the region provide a framework (Appendix 1) for support to care homes which will complement and, where appropriate, enhance the support currently offered by these organisations. The enhanced offer links directly to the clinical service model outlined for national implementation in the letter to CCGs, primary care and community services of 1 May, https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/COVID-19-response-primary-care-and-community-health-support-care-home-residents.pdf.

12.2 The principles will be underpinned by a self-assessment assurance framework and impact log. The first self-assessment was submitted on 14 May. Discussions are on-going with Region about next steps. All areas for further development are included in our care home programme.

13.0 Implications

13.1 Quality and Safety Implications

13.1.1 The Committee should note that this report contains information relating to vulnerable patient groups and also contains information in relation to the quality of health services commissioned by the CCG.

13.2 Resources / Finance Implications

13.2.1 CQUINs (Commissioning for Quality and Innovation) have a financial value attached to outturn contract value.

14.0 Recommendations

14.1 It is recommended that the Governing Body **RECEIVE** this update on the following routine quality and safety information:

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

14.2 It is also recommended that the Governing Body **RECEIVE** and **NOTE** this update on 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.

15.0 Appendices

15.1 Appendix 1 – Principles to delivery an enhanced universal support offer to care homes.

Responding to Covid-19

Principles to Deliver an Enhanced Universal Support Offer to Care Homes in the North East and Yorkshire Region

Introduction

The delivery of a universal healthcare support offer, underpinned by a set of principles, will be delivered to care homes across the region. This is complementary to national guidance on Enhanced Health in Care Homes published on the 1st May 2020 and provides practical principles for implementation in the North East and Yorkshire designed by colleagues from across the Region. For the purpose of this document the term care home refers to care homes with and without nursing.

Care home residents have routine access to healthcare support in their place of residence from hospital, community and primary care health care services which is delivered according to individual need. Some examples of this are listed below:

- Infection Prevention and Control
- Respiratory conditions – recognition, monitoring and management
- Dementia
- Long Term Condition monitoring e.g. Diabetes
- Wound Care
- End of Life Care
- Continence Care
- Mental Health

However, during the COVID crisis, the care sector is experiencing significant pressure which is impacting on staff, residents and their families. The symptoms of Covid-19 are such that the care needs, including in care homes without nursing (residential homes) are increasing. The proposal is therefore to work with the sector to offer and provide additional proactive support including staff, training and clinical support visits to underpin the delivery of safe care to all residents.

Background

The care sector is an important provider of care. In the North East and Yorkshire:

- There are are in excess of 3,200 care homes (with and without nursing) with approximately 3 times the capacity/bed base that we see within NHS Trusts.
- 153,000 people are employees in the adult social care sector - 129,000 of these were within the local authority and independent sectors.
- The turnover rate of directly employed staff is 32.2%, equivalent to 39,000 leavers over the year.
- 5.9% of roles are vacant, equivalent to 7,600 vacancies at any one time.

(source: Skills for Care)

Covid-19 has presented new challenges:

- The need to care for residents with Covid-19. Modelling suggests that 90% of care homes maybe affected by an outbreak of Covid-19 in the next 6 weeks (source: PHE)
- The need to upskill in infection control procedures, respiratory disease monitoring and management and psychological support
- Concerns re the need to develop new skills, indemnity and potential impact on CQC registration

- Reduced workforce as a result of Covid-19 and additional costs of agency staff
- Access to and cost of PPE
- Responding to rapidly changing guidance
- Support for residents and families, bereavement and mental health

Significant work is taking place in many CCGs, particularly with Primary Care and Community Services, and Local Authorities (Adult Social Care and Public Health) to support the care sector. It is proposed to increase the support offering a package tailored to the needs of individual care homes and aimed at minimising the impact of infection and unnecessary deaths and supporting staff in the sector. This will build on existing work led by clinical and local authority leads at place, ICS and regional level and contribute to work that LAs are doing in respect of market management and resilience. The NEY approach will support delivery of the 1st May request that primary care and community services help in taking immediate action to support care homes.

This work will initially focus on care homes (with and without nursing) – home care is out of scope.

Principles

The offer of support is based on the following principles:

1) **Leadership Support**
   - Partners within a local system will work together to deliver a health support offer complementary to existing work and appropriate to the Place. This will include care home providers, CCGs, Local Authorities, primary care (with Primary Care Networks (PCN) as the default footprint), hospital and community trusts
   - CCG nurses will work with clinical leaders in the sector to help and support where required
   - Care homes will have a named nominated contact to provide support, direction or coordinate requests to other partners across the system. This may be provided from within the partnership and may differ according to contracting arrangements already in place
   - Each care home will have a named clinical lead

2) **Prevention**
   - Care homes will have access to infection, prevention and control (IPC) advice and receive a visit (or if appropriate a telephone call) from an IPC nurse/nurse with knowledge of IPC when this is required
   - Care homes will be offered a visit by a community nurse on a daily basis (this might take place virtually). The nurse will have a good knowledge of IPC
   - Each care home will be supported to develop plans to manage an outbreak. These will include input from the local provider of IPC
   - CCGs and LAs will have an understanding of the services and support in place within care homes and take action to address any risks/gaps
   - Calls will be made on a daily basis to all care homes who identify concerns within the Capacity Tracker. Where the Capacity Tracker is not being used care homes will be supported to do so.
   - A multidisciplinary team (MDT) of GPs, community nurses and allied health professionals (AHPs) will deliver a weekly (virtual if appropriate) round to support the care of vulnerable residents
   - Care homes residents will each have a personalised care and support plan
   - Local partners will collaborate to ensure that care homes are able to promptly access testing for residents, staff and where appropriate family members and support them to do so where they are having difficulty in this regard.
   - Visiting staff will, where possible, visit care home residents who are known to be Covid+ at the end of their working day to help to prevent the spread of infection. Collaboration between agencies providing care will help to reduce footfall into care homes.
   - Where they don't exist, the MDT will work with care home staff to develop personalised care plans (including psychological support) for all residents
   - CCGs, PCNs and pharmacists will work together to ensure a joined-up approach around medication supply, structured medication reviews, supporting reviews of new residents or those recently discharged and addressing medication queries

3) Timely access and additional Clinical Support

- Everyone discharged from a hospital to a care home will be followed up by a face to face visit by a nurse or AHP involved in the discharge, a community nurse or, where there is one, the named nurse attached to the care home. This may include a pre discharge visit to ensure that the care home is ready to receive the new resident. This maybe virtual.
- Care homes will have access to 24-hour support by video link/telephone/telehealth as required
- Remote monitoring will be used to support care home residents with suspected or confirmed Covid-19
- Staff in nursing and residential homes will have access to psychological support
- Support will be given regarding staff and resident testing as required
- CCGs and/or LAs are encouraged to set up social media groups to help to answer questions raised.
- Weekly access to a MDT of appropriate specialists should be offered – this could be through video platforms

4) Workforce

- The national Bring Back Staff campaign, coordinated by NHSE/I, will be used to support safe staffing within care homes
- Care homes will have access to specialist support to include Infection Prevention Control and End of Life Care who will, where possible use a "train the trainer" approach
- NHS providers are asked to support safe discharge to care homes by working with CCG Directors of Nursing to identify nurses with the experience of working with patients who are Covid-19+ to work within care homes
- Educational resources will be made available to care homes – local, regional and national
- Care homes will have access to virtual training to support on-site training programmes
- Staff in nursing and residential homes will have access to psychological support
- Support will be available to staff who are at high personal risk

Assurance Framework

A self assessment/assurance framework, including an impact log, is under development with the support of CCG Directors of Nursing and Local Authorities.

05/05/2020

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Reappointment to the Governing Body**	**Agenda Item No.**	12
Report Author	Andrew O'Connor (Senior Corporate Governance Officer)	**Public / Private Item**	Public
GB / Clinical Lead	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	The Governing Body is asked to approve the reappointment of Dr Caroline Taylor (Vice Clinical Chair / GP Member) to the Governing Body for a third three year term of office. Dr Taylor's current term of office will end on 2 November 2020. The matter of Dr Taylor's tenure was considered by the Remuneration and Nomination Committee at its meeting on 27 February 2020. The Committee recommends her reappointment to the Governing Body for a third three year term of office.						
Previous consideration	**Name of meeting**	Remuneration and Nomination Committee		**Meeting Date**	27/02/2020		
	Name of meeting			**Meeting Date**			
Recommendation (s)	It is recommended that the Governing Body: 1. **APPROVES** the reappointment of Dr Caroline Taylor to the Governing Body for a third three year term of officer.						
Decision	☒	**Assurance**	☐	**Discussion**	☐	**Other**	

Implications	
Quality & Safety implications	None
Engagement & Equality implications	None
Resources / Finance implications	A decision not to approve the committee's recommendation would result in the need to seek expressions of interest from qualifying GP and Nurse Practioners at Calderdale CCG Member Practices. A candidate assessment process would need to take place and, potentially, an election. This would have significant resource implications for the CCG. The Local Medical Committee would also need to be commissioned to administer an election if required. Due to the onset of the public health emergency since the committee made its recommendation, it is now very unlikely that such a process would be successful or productive in the current context.

<table>
<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
▪ Improving governance</td><td colspan="3">Risk</td><td colspan="3">None</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>The roles making up the Governing Body's membership are set out in the CCG's constitution. Vacant positions would have implications for quoracy and decision making at a Governing Body and committee level.</td><td colspan="3">Conflicts of Interest</td><td colspan="3">The individual Governing Body member to whom the recommendation relates will have a direct conflict of interest.

Conflicts of interest will be managed in line with the CCG's Management of Conflicts of Interest Policy.</td></tr>
</table>

1.0 Introduction

1.1 The paper asks that Governing Body approve the reappointment of Dr Caroline Taylor, GP Member and Clinical Vice Chair, to the Governing Body for a third three year term of office. Dr Taylor's current Term of Officer will end on 2 November 2020.

1.2 The matter of Dr Taylor's tenure was considered by the Remuneration and Nomination Committee at its meeting on 27 February 2020. The Committee recommends her reappointment to the Governing Body for a third three year term of office.

2.0 Detail

2.1 Reappointment of GP / Nurse Practioner Governing Body Members

2.1.1 As of the 1 April 2020, the CCG's Governing Body membership includes four GP members drawn from Calderdale Member Practices.

2.1.2 As set out in the CCG Constitution, an existing GP or Nurse Practioner Member who wishes to continue to serve on the Governing Body following the end of a term of office must undergo and complete a satisfactory appraisal to be considered for reappointment.

2.1.3 Moreover, at such time as a reappointment is to be considered, and the sitting member wishes to continue to serve on the Governing Body, any GP or Nurse Practioner who would qualify for appointment, having previously met the required standard via assessment within the previous three years, are invited to stand in an election.

2.1.4 If there are no eligible applicants, the Governing Body can determine to either reappoint or seek expressions of interest from the CCG's Membership.

2.2 Recommendation of the Remuneration and Nomination Committee

2.3 The matter of Dr Taylor's tenure was considered by the Remuneration and Nomination Committee at its meeting on 27 February 2020.

2.4 At the time of the Committee's meeting on the 27 February 2020, there were no eligible GP or Nurse Practioner candidates to be considered. This remains the case.

2.5 The options available to the Committee included recommending that Dr Taylor be reappointed for a third three year term of office or that expressions of interest be sought from member practices to undergo assessment.

2.6 In accordance with relevant available health service governance guidance[1] the Committee recognised the importance of regularly and progressively refreshing board memberships and of elected members regularly being submitted for re-election. Moreover, while there is no specific limitation on the number of terms of office a member could undertake set out in the CCG Constitution, that a decision to reappoint for a third term should be carefully considered and justified.

[1] he *NHS Foundation Trust Code of Governance* (2014)

2.4 In forming its recommendation, the Committee recognised:

- That the Governing Body had regularly and progressively revised its Membership in successive years, including its GPs membership, and had last sought expression of interest from the Member Practices in 2018 resulting in the appointment of Dr James Gray.

- That at the time Dr Taylor's second period of tenure was agreed in 2017, her reappointment had been subject to a potential election but the qualifying candidate determined not to stand.

- That the planned reduction in the number of Governing Body Members from seven to four as of 1 April 2020 created an immediate need for the Governing Body and CCG to retain experience and continuity of leadership at a board level and that Dr Taylor's departure at this juncture would be a huge loss to the Governing Body, CCG and wider system.

- Dr Taylor's high level of performance and significant contribution to the Governing Body, the CCG and system, including in those areas where she is the CCG's Clinical Lead.

- Her recent appointment to the role of Clinical Vice Chair and her completion of a successful appraisal in 2019[2].

2.5 On the basis of the above considerations, the Remuneration and Nomination Committee was happy to recommend that Dr Taylor be appointed to a third three year term of office.

3.0 **Next Steps**

3.1 Subject to the Governing Body's approval of the Committee's recommendation, the necessary paperwork to confirm the reappointment will be completed by the CCG Chair with support from the Senior Corporate Governance Officer and HR colleagues.

3.2 The reappointment will also be confirmed to Member Practices and CCG staff.

4.0 Recommendation

4.1 It is recommended that the Governing Body:

- **APPROVES** the reappointment of Dr Caroline Taylor to the Governing Body for a third three year term of officer.

[2] Due to the COVID 19 Pandemic, GP Member appraisals for 2020 had been postponed at the time of the Governing Body's meeting. The CCG Chair has no concerns about Dr Taylor's performance.

Name	Governing Body	Meeting Date	23/07/2020
Title of Report	**Review of policies: Health & Safety and Fire Safety Policies**	Agenda Item No.	13
Report Author	Rob Gibson, Corporate Systems Manager	Public / Private Item	Public
GB / Clinical Lead	Neil Smurthwaite, Interim Accountable Officer	Responsible Officer	Rob Gibson, Corporate Systems Manager

<table>
<tr><th colspan="8">Executive Summary</th></tr>
<tr><td colspan="2">Please include a brief summary of the purpose of the report</td><td colspan="6">▪ The Health & Safety and Fire Safety policies were last approved by the Governing Body on 14 June 2018.

▪ In line with the routine programme of policy review, these policies have been reviewed by the Corporate Systems Manager, to take account of any changes in legislation or national guidance.

▪ A couple of minor amendments have been made to these policies concerning the formatting of each document to bring them in line with other CCG policy documents and concerning the role of the Head of Corporate Affairs & Governance which no longer exists. These day-to-day responsibilities have been incorporated into the role of the Corporate Systems Manager.

▪ There have been no significant amendments to these policies during this current review.</td></tr>
<tr><td colspan="2" rowspan="2">Previous consideration</td><td colspan="2">Name of meeting</td><td colspan="2">Governing Body</td><td>Meeting Date</td><td>14/06/2018</td></tr>
<tr><td colspan="2">Name of meeting</td><td colspan="2"></td><td>Meeting Date</td><td></td></tr>
<tr><td colspan="2">Recommendation (s)</td><td colspan="6">It is recommended that the Governing Body:

▪ APPROVE the Health and Safety Policy and Fire Safety Policy, subject to any amendments.</td></tr>
<tr><td>Decision</td><td>☒</td><td>Assurance</td><td>☐</td><td>Discussion</td><td>☐</td><td>Other</td><td></td></tr>
</table>

<table>
<tr><th colspan="7">Implications</th></tr>
<tr><td>Quality & Safety implications</td><td colspan="6">None identified</td></tr>
<tr><td>Engagement & Equality implications</td><td colspan="6">None identified</td></tr>
<tr><td>Resources / Finance implications</td><td colspan="6">None identified</td></tr>
<tr><td>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>
</table>

Strategic Objectives	▪ Achieving the strategic direction for Calderdale ▪ Improving Governance ▪ Improving quality	**Risk** (include risk number and a brief description of the risk)	Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.
Legal / CCG Constitutional Implications	▪ There are no legal / CCG Constitutional implications	**Conflicts of Interest** (include detail of any identified/potential conflicts)	Any conflicts of interest arising from this paper will be managed in line with the CCG's Management of Conflicts of Interest Policy.

Item 13 a

Health & Safety Policy

Policy Ref No: 09

Version/Status:	4.1 / Draft
Responsible Committee:	Governing Body
Date Approved:	xx xxxx 2020
Author:	Corporate Systems Manager
Responsible Lead:	Corporate Systems Manager
Review Date:	xxxxx 2022

Version History

Version	Date	Author	Document Status	Commentary: (document development / approval)	Circulation
1.0	20 March 2014	Head of Specialist Advice	FINAL	Approved by Governing Body	
1.1	21 January 2015	Head of Specialist Advice	Draft	Reviewed by Head of Specialist Advice/Health and Safety- took into account: ▪ Health and Safety Audit of CCG headquarters (July 2014). ▪ Review of any changes in legislation, national guidance. No amendments required.	
1.1	2nd April 2015	Corporate & Governance Manager	Draft	Submitted to Governing Body for approval	
2.0	9th April 2015	Corporate & Governance Manager	FINAL	Approved by the Governing Body	
2.1	22 March 2016	Risk, Health & Safety Manager	Draft	Proposed amendments	
2.2	22 March 2016	Corporate & Governance Manager	Draft	Further proposed amendments to reflect new in-house risk and health and safety manager role	
2.3	10th May 2016	Risk, Health & Safety Manager	Draft	Proposed amendments to responsibilities of Risk, Health & Safety Manager and reviewed by the Senior Management Team	

3.0	9th June 2016	Risk, Health & Safety Manager	FINAL	Approved by the Governing Body	
3.1	17th May 2018	Risk, Health & Safety Manager	Draft	Reviewed by Risk, Health & Safety Manager	
4.0	14 June 2018	Risk, Health & Safety Manager	FINAL	Approved by Governing Body	
4.1	24 June 2020	Corporate Systems Manager	Draft	Reviewed by Corporate Systems Manager. Amended to new format.	Governing Body

Health & Safety Policy
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1. Introduction

NHS Calderdale Clinical Commissioning Group (NHS Calderdale CCG) acknowledges a duty of care to the health, safety and welfare of staff, visitors and contractors

This policy recognises that NHS Calderdale CCG staff have a role in the provision of a safe working environment and details the responsibilities of staff for producing effective health & safety management across the CCG.

2. Aims and Objectives

The aims and objectives of the policy are to:

- promote standards of health, safety and welfare across all CCG areas and ensure they comply fully with the Health and Safety at Work Act 1974 and all other relevant statutory provisions;
- ensure that CCG owned equipment and systems of work are safe and risk managed so as to ensure the health of employees, or others who come into contact with any of the activities of the CCG;
- ensure that agreements are in place to cover the maintenance of buildings or areas of buildings which CCG staff may work in and be responsible for and any equipment which the CCG staff use;
- ensure that first aid cover is available for staff who may become ill or injured while at work; this includes visitors and the provision of first aid equipment and training in first aid for relevant staff;
- encourage full and effective consultation on health, safety, welfare and amenity matters;
- work closely with a safety representative appointed by trade unions to achieve the above objectives;
- promote a safer workplace by increasing awareness of work related issues such as slips, trips and falls, electrical safety and use of display screen equipment;
- ensure that staff are aware of the process for reporting and investigating such incidents;
- encourage staff awareness of health and safety issues;
- ensure that staff are adequately trained in health & safety matters by complying with statutory and mandatory requirements.

The principles underlying NHS Calderdale CCG's approach are given below:

3. Scope of Policy

This policy must be followed by all staff who are employed by the CCG, including while on another organisation's premises or staff who are travelling during their working hours. This includes staff on temporary or honorary

contracts, secondments, pool staff and students. It also applies to volunteers, visitors and contractors.

Independent contractors are responsible for the development and management of their own procedural documents and for ensuring compliance with relevant legislation and best practice guidelines.

4. Duties/Accountabilities/Responsibilities

4.1 Accountable Officer

The Chief Officer has strategic responsibility for Health and Safety; however operational responsibility is delegated to the Corporate Systems Manager.

4.2 Corporate Systems Manager

The Corporate Systems Manager will support the Accountable Officer in the implementation of health & safety related policies and ensuring that NHS Calderdale CCG is compliant with all relevant health & safety related legislation.

Additionally the Corporate Systems Manager will ensure that:

- There are effective systems in place for the management of health & safety within the CCG
- That the CCG meets its legal obligations under relevant health & safety related legislation.
- A competent person is appointed to provide advice and guidance on health and safety.
- Management arrangements are in place for the reporting and reviewing of incidents, accidents, staff ill health and Occupational Health referrals.
- Senior management are provided with assurances that effective health & safety management systems are in place through regular reporting using the governance arrangements of NHS Calderdale CCG.
- There are effective arrangements in place for consulting with employees on health, safety and welfare issues.
- There is a system in place to ensure that staff have been adequately trained in health & safety matters and that allows staff to meet their statutory and mandatory training requirements.
- Report to senior management the attendance and/or any training issue that may arise. Specifically, this will be included in the reports prepared by the Risk, Health & Safety Manager for SMT/Audit Committee.

4.3 Heads of Service/Line Managers

- Heads of service/managers have day to day responsibility for ensuring that

the policy is put into practice and all employees are aware of their responsibilities.
- Ensure that actions identified from risk assessments and risk management systems are implemented promptly to prevent further risks arising.
- Ensure that staff are aware of procedures for reporting incidents, accidents and other health & safety risks.
- Ensure that all new employees receive a copy of the Staff Health &Safety Handbook.
- Ensure all new employees receive induction training.
- Ensure staff attend/complete mandatory training.
- Promote a positive and proactive approach to health & safety within their teams.

4.4 Risk, Health & Safety Manager (within role of Corporate Systems Manager)

The Risk, Health & Safety Manager has responsibility:

- To ensure that NHS Calderdale CCG is compliant with the range of legislative requirements including the Regulatory Reform Fire Safety Order 2005 (RRFO), the Health and Safety at Work Act 1974, moving and handling legislation and other applicable legislation and is operating in line with national guidance and good practice.
- To provide competent person expert advice (as defined by the Health and Safety at Work Act 1974) on all aspects relating to health and safety management, fire safety and security management, including training of staff and provision of support and advice on day to day health and safety issues.
- To be responsible for developing, implementing and reviewing relevant health and safety policies and procedures, ensuring their approval and disseminating to staff and Governing Body members as appropriate.
- To advise on risk assessments and the development of risk control strategies relating to the employees of NHS Calderdale CCG.
- To provide advice and support in response to health and safety related incidents reported through the incident reporting system.
- When required to provide assistance when liaising with the Health and Safety Executive (HSE).

4.5 Employees

All employees are to:

- Take reasonable care of their own safety and the safety of others who may be affected by their acts or omissions.
- Co-operate with management and comply with all relevant health and safety legislation, CCG policies and procedures.
- Attend or complete any mandatory and statutory training.
- Report any hazards, damage or defects to their line manager / health & safety manager as soon as reasonably practicable.

- Report any accidents, incidents or near misses to their line manager and assist with any subsequent investigation.

4.6 Responsibilities for Approval

The CCG's Governing Body has responsibility for review, monitoring and approval of this policy.

5. General Arrangements

5.1 Risk assessments

The Management of Health and Safety Work Regulations 1999 make more explicit the general duties placed on NHS Calderdale CCG under the Health and Safety at Work etc. Act 1974. In order to meet with these regulatory requirements, the CCG will ensure:

- Risk assessments are undertaken in order to evaluate and adequately control hazards, so as to ensure the health, safety and welfare of employees, and others who may be affected by the work activities of the CCG.
- Risk assessments will be regularly monitored and reviewed to ensure on an annual basis or as and when circumstances dictate e.g. legislative changes or when accidents/incidents occur.
- The outcome of risk assessments will be communicated to staff. Staff will receive instructions and/or training associated with the level of risk identified and the control measures taken to prevent or control risks.

5.2 Fire Safety

NHS Calderdale CCG has a separate fire safety policy which deals with the arrangements for the management of fire safety in the premises that the CCG has responsibility for.

5.3 First Aid

NHS Calderdale CCG is based within a low risk office environment however adequate first aid cover will be provided to minimise the consequence of injury or illness in the workplace by treating minor injuries and where necessary until professional assistance can be obtained. This will be achieved by:

- Undertaking of a risk assessment to determine the extent of first aid provisions required. This risk assessment has identified the need to have two trained first aiders.
- Providing an adequately stocked and accessible first aid kit which is stored in the kitchen of the CCG's Dean Clough office.

5.4 Accident and Incident Reporting

In the event of an accident or incident staff will ensure that a detailed DATIX incident report form is completed and their line manager notified as soon as reasonably practicable. Advice should be sought from the Risk, Health & Safety Manager on whether notification is required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
RIDDOR incidents are reported to SMT and will also be included in the Governance Assurance Dashboard which is reported to Audit Committee for assurance purposes.

5.5 New and Expectant Mothers

The law requires every employer to assess workplace risks for all their employees, and take practical action to control those risks under the Management of Health and Safety at Work Regulations 1999. The regulations require employers to take particular account of risks to expectant and new mothers. NHS Calderdale CCG must identify hazards in the workplace that could pose a health or safety risk to expectant and new mothers and take appropriate action to remove or reduce the risk.

The CCG has a Maternity, Adoption, Maternity Support (Paternity) and Shared Parental Leave Policy which documents these roles and responsibilities and the specific arrangements in place.

5.6 Display Screen Equipment

The vast majority of the work of NHS Calderdale CCG is within an office environment. Although the associated risks of working in this type of environment are low, as an employer the CCG must protect employees from the health risks of working with display screen equipment (DSE) such as PCs, laptops and smartphones.

The Health and Safety (Display Screen Equipment) Regulations 1992 apply to workers who use DSE daily, for an hour or more at a time. These are described as ‘DSE users’ and all CCG staff will be categorised as DSE users. CCG staff may use display screen equipment in a variety of circumstances:

- At a fixed work station
- Mobile workers
- Working from home on an ad hoc basis (with the agreement of their manager)
- Hot desking (employees should carry out a basic risk assessment if they change desks regularly)

The CCG fulfils its legal obligations by:

- Requiring staff to complete a DSE assessment as part of their induction
- Reducing risks, including making sure employees take breaks from DSE work or doing something different
- Having arrangements in place for ensuring employees can claim back for eye tests
- Providing training and instructions for employees via the CCG's intranet pages

5.7 Lone working

Working alone is not against the law and for the vast majority of the CCG's activities it will be safe for staff to do so. However it is that this group of staff may face an increased risk because they do not have the immediate support of colleagues or others if an incident occurs. The CCG has an organisational risk assessment in place covering all aspects of the workplace. The main control measure in this risk assessment for lone working is a separate lone working procedure which offers advice and guidance to employees. Where a one off activity takes place where the control measures in the organisational risk assessment may not be sufficient e.g. a public engagement event then an individual risk assessment for lone working should be completed.

5.8 Control of Substances Hazardous to Health (COSHH)

The aim of this legislation is to ensure that no individual is exposed to avoidable risks to their health or safety resulting from substances used within the work environment. COSHH assessments are not required for routine commercially obtainable products that are used as intended and are provided with adequate safety information, unless they are used in volume, stored in bulk or used in a process which combines them with another substance that significantly alters their nature. Employees of the CCGs are exposed to very few products e.g. washing up liquid and with normal every day usage the risks from these products are minimal.

Where contractors are employed (e.g. cleaners) the contract must stipulate that they have a COSHH file which is readily available on request.

5.9 Contractors

The majority contractors who visit Dean Clough to undertake work have already prearranged the visit with either the Dean Clough landlord or NHS Property Services and any risk assessments have already been undertaken and identified risks been appropriately managed. However it is important that any associated risks continue to be managed. This includes adequate communication on any potential risks to which contractors and CCG employees are exposed to. The risks to contractors working at the CCG's premises at Dean Clough are low however contractors must be made aware of these. This includes fire safety arrangements.

5.10 Portable Electrical Equipment

The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. However, the Regulations do not specify what needs to be done, by whom or how frequently (i.e. they don't make inspection or testing of electrical appliances a legal requirement, nor do they make it a legal requirement to undertake this annually). Nevertheless NHS Calderdale CCG takes its responsibilities for electrical safety very seriously and have a system in place for the annual portable appliance testing of all portable electrical appliance testing e.g. docking stations, laptops, desk fans etc. Any new equipment should be supplied in a safe condition and not require a formal portable appliance inspection or test. However, a simple visual check on any portable electrical equipment being used is recommended to verify the item is not damaged. Staff are not permitted to bring in any personal items of electrical equipment into the workplace e.g. portable heaters.

5.11 Provision of health & safety information

Health and safety law poster is displayed:	In the reception area of the CCG office on the 5th Floor, F Mill, Dean Clough
First-aid box is located in the kitchen of the CCG offices	First Aiders are trained and identified on the health & safety notice board in the open area near reception. The first aid box is checked and managed by the first aiders.
Fire Safety arrangements	Evacuation notices posted at each exit from the offices Copy of fire safety plan available in fire safety folder on window ledge next to main door Details of fire wardens and fire evacuation assistance on health & safety board in the open area near reception.

6. Equality Impact Assessment

NHS Calderdale CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.
Whilst there is no requirement for an Equality Impact Assessment for this policy the CCGs will monitor any themes and trends from the following:-
Identify, understand and address any trends linked to a particular building, staff group or people with an Equality Act “protected characteristic” (age,

disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)

7. Training

In line with the Health and Safety at Work Act 1974 NHS Calderdale CCG provides health and safety training to all staff, ensuring that staff are aware of their responsibilities for the provision and maintenance of a safe and healthy environment for staff and visitors. This enables employees to work safely and understand their obligations under the Act and associated legislation e.g. Regulatory Reform (Fire Safety) Order 2005.All training throughout the CCGs is recorded on an electronic system called ESR.

8. Monitoring Compliance with the Document

The Governing Body approves the policy however the Audit Committee will monitor the number of RIDDOR reported incidents via the Governance Assurance Dashboard.

9. Arrangements for Review

The policy will be reviewed as a minimum every 2 years by the Corporate Systems Manager or more frequently in the event of substantial changes occurring both internal to the CCG or statutory which impact on the policy.

10. Dissemination

Approval of this policy will be sought by the Corporate Systems Manager from the Governing Body. Once approval the policy will be disseminated and made available to all members of staff via the CCG intranet.

11. Associated Documentation

The Health and Safety Policy should be read in conjunction with the CCG's other related policies dealing with health and safety issues:

- Integrated Risk Management Framework
- Incident Reporting Policy
- Health and Safety Staff Handbook
- Fire Safety Policy

12. References

The requirements in relation to all aspects of health and safety within NHS Calderdale CCG are contained within current legislation as detailed below:

The Health and Safety at Work Act 1974
The Management of Health and Safety at Work Regulations 1999
The Workplace (Health, Safety and Welfare) Regulations 1992
The Provision and Use of Work Equipment Regulations 1998
The Manual Handling Operations Regulations 1992 (as amended 2002)
The Health and Safety (Display Screen Equipment) Regulations 1992 (as amended 2002)
The Regulatory Reform (Fire Safety) Order 2005
The Control of Substances Hazardous to Health Regulations 2002
The Electricity at Work Regulations 1989
The Health and Safety (First Aid) Regulations 1981 (as amended 2013)
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (as amended 2013)
The Health and Safety (Information for Employees Regulations) 1998 (as amended 2009)
The Corporate Manslaughter and Corporate Homicide Act 2007

Item 13 b

Fire Safety Policy

Policy Ref No: 07

Version/Status:	4.1 / Draft
Responsible Committee:	Governing Body
Date Approved:	xx xxxx 2020
Author:	Corporate Systems Manager
Responsible Lead:	Corporate Systems Manager
Review Date:	xxxxx 2022

Version History

Version	Date	Author	Document Status	Commentary: (document development / approval)	Circulation
0.1	18 Dec 2013	Jonathan Harrison *GIFireE,* Fire Safety Services, on behalf of NHS Property Services	Draft	Draft policy reviewed by and amended accordingly.	
1.0	20 March 2014	Jonathan Harrison *GIFireE,* Fire Safety Services, on behalf of NHS Property Services	FINAL	Approved by Governing Body	
1.1	31 March 2015	Ruth Nutbrown (Commissioning Support Unit)	Draft	Reviewed by Head of Specialist Advice/Health and Safety- took into account: ▪ Fire Safety Audit of CCG headquarters (Oct 2014). ▪ Review of any changes in legislation, national guidance. No amendments required.	
1.1	2 April 2015	Judith Salter	Draft	Submitted to Governing Body for approval	
2.0	9 April 2015	Judith Salter	FINAL	Approved by the Governing Body	
2.1	10 May 2016	Risk, Health & Safety Manager	Draft	Additional proposed amendments to reflect responsibilities of Risk, Health & Safety Manager	

3.0	9 June 2016	Risk, Health & Safety Manager	FINAL	Approved by the Governing Body	
3.1	17 May 2018	Risk, Health & Safety Manager	Draft	2 yearly review of policy by Risk, Health & Safety Manager	
4.0	14 June 2018	Risk, Health & Safety Manager	FINAL	Approved by Governing Body	
4.1	25 June 2020	Corporate Systems Manager	Draft	Reviewed by Corporate Systems Manager. Amended to new format.	Governing Body

Fire Safety Policy
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1. Introduction

NHS Calderdale Clinical Commissioning Group (NHS Calderdale CCG) recognises that it has a statutory duty towards the safety of their employees and others working in or visiting its premises, including visitors and contractors who might be subject to fire risk.

The main statutory requirements are found in the Regulatory Reform (Fire Safety) Order 2005, Health and Safety at Work Act etc. 1974, Management of Health and Safety Regulations 1992. The CCG will also comply with the Fire code Policy and Principles 1994.

2. Purpose and Scope

The purpose of this policy is to ensure that:

The CCG has appropriate fire safety arrangements in place for fire prevention, control measures and appropriate fire response. These arrangements include good housekeeping, raising staff awareness, fire training, fire documentation including fire risk assessment and plan and fire evacuation procedures.

This document sets out the CCG's approach to minimising the incidences of fires within its premise and the impact of fire on safety. It applies to all employees of the CCG and members of the Governing Body and their committees who must comply with the arrangements outlined in this policy. Some staff will be working in other buildings that are not owned/ controlled by the CCG, however the principles of this policy will still apply and the same standard of fire safety must be in place as per the Regulatory Reform (Fire Safety) Order.

3. Duties/Accountabilities/Responsibilities

3.1 Duties within the organisation:

NHS Calderdale CCG recognises its responsibilities to ensure that reasonable precautions are taken to provide a safe working environment and that steps are taken to prevent or minimise the causes of fire, in compliance with relevant statutory requirements (as identified above).

3.2 In pursuance of this aim NHS Calderdale CCG will:

- Provide a safe working environment paying attention to fire prevention and evacuation procedures.
- Ensure that systems are in place and regularly reviewed to ensure their adequacy, i.e. fire evacuation drills, inspections of the means of escape and maintenance of fire warning systems and fire-fighting

equipment.

- Provide appropriate information, suitable instruction and training in basic fire prevention measures and evaluation procedures, together with mandatory annual updating for all employees/Governing Body members of the CCG.
- Ensure all legally enforceable obligations are complied with, for designated use premises, under the Regulatory Reform (Fire Safety) Order 2005.
- Ensure risk assessment and fire checks are implemented to comply with statute.
- Ensure the premises has a fire plan that is regularly reviewed.
- Ensure that there are arrangements in place for the PAT (portable appliance testing) testing of all portable electrical equipment on an annual basis.

The CCGs recognise that this policy statement is implemented in pursuance of this aim.

3.3 Accountable Officer

Responsibility for fire safety rests with the Chief Officer as defined by the Regulatory Reform (Fire Safety) Order 2005 who has nominated the CCG's Corporate Systems Manager as the person with operational responsibility.

The Accountable Officer is responsible for:

- Demonstrating commitment to the promotion of fire safety within the CCG.
- Ensuring sufficient resources are allocated to implement the CCG's Fire Safety Policy and procedures.
- Ensuring that mandatory training for all employees is provided and that adequate resources are available to meet those training needs.

3.4 Corporate Systems Manager

The CCG's Corporate Systems Manager is responsible for the operational implementation of the Fire Safety Policy, and for the following:

- Ensuring implementation of the Fire code requirement.
- Ensuring provision of competent person advice (fire).
- Ensuring that all managers and staff participate regularly in fire safety training and fire drills.
- Ensuring that adequate and regular maintenance arrangements are in place for fire detection equipment within the premises controlled by the CCG
- Ensuring that firefighting equipment within the premises controlled by the CCG is serviced on an annual basis.

3.5 **Competent person (also Corporate Systems Manager)**

The Corporate Systems Manager is the competent person for fire as defined by the Regulatory Reform (Fire Safety) Order 2005. The competent person is responsible for facilitating the delivery of the Fire Safety Policy and for the following:

- Advising management on changes in legislation in relation to the fire safety management.
- Advising of responsibilities in respect of designated premises and maintaining the necessary provisions of the fire risk assessment.
- Arranging for establishing a system for carrying out fire safety checks
- Undertaking assessments of fire risk and preparing reports to the Responsible Person, recommending actions in respect of fire safety improvements.
- Undertaking Personal Emergency Evacuation Plans (PEEP) (Appendix A) where they are required and ensure they are regularly reviewed or as and when the personal circumstances change of persons that a PEEP has been undertaken for.
- Preparing content, delivery and evaluation of staff training.
- Ensuring regular fire drills are carried out, attending when required, monitoring the outcomes, recommending remedial action where necessary and arranging for records of training and drills, to be kept centrally.
- Keeping records of all actual fire incidents and investigating fires in suspicious circumstances in conjunction with police, fire services, landlord and other tenants within the building.
- Ensuring effective communication, liaison, and assurance with landlord and other organisations within the premises for fire safety, and facilitate the implementation of the fire action plan for the office at Dean Clough in conjunction with other tenants within the building.

3.6 **Line managers**

Staff in supervisory roles will ensure the effective day to day application of this policy, within their areas of responsibility. They will make arrangements for:

- Ensuring the day to day maintenance of fire safety within their area of control and that fire hazards are eliminated should they occur.
- Liaising with the competent person and landlord, on any changes within the workplace affecting fire safety to ensure compliance with this policy and associated legislation.
- Ensuring that members of staff receive initial information on fire safety and evacuation procedures specific to their work area, immediately following appointment, and are made aware of the procedures for

reporting fire hazards to management.

- Ensuring that staff take part in fire drills, no less than once a year.
- Ensure that staff complete their statutory / mandatory training in fire safety on an annual basis.
- Ensuring any staff requiring Personal Emergency Evacuation Plans (PEEP) in line with the Regulatory Reform (Fire Safety) Order 2005 are identified and a PEEP is completed using the template at appendix A.

3.7 Fire wardens

The fire wardens in conjunction with the responsible and competent persons have the responsibility for the co-ordination of fire safety within the premises. Duties will include:

- In the event of an emergency, follow the direction of the lead fire warden in terms of ensuring staff have safely evacuated the areas of responsibility of the CCG.
- Ensure weekly checks of systems and equipment are carried out by completion of the weekly check lists.
- Attend and take part in fire warden training as required by the competent person.

3.8 Fire evacuation assistants

The CCG has a system in place for persons who require specific assistance in evacuating the building in the event of the fire alarm being evacuated. Where persons who require specific assistance is required a PEEP is developed. In some situations this may require use of the fire evacuation chair to facilitate evacuation from the building. A number of staff have been specially trained to use this chair. Duties include:

- In the event of an emergency following the direction of the lead fire warden in terms of ensuring that anyone who requires use of the fire evacuation chair is safely evacuated to an area of safety.
- Attend and take part in training in use of the fire evacuation chair.

3.9 Employees

- Adhere to this fire safety policy and plan.
- Participate in fire safety training and drills.
- Be aware of their responsibilities to others (including visitors) and involve them (if appropriate) in the fire safety process.
- Ensure that any electrical equipment they use on CCG business e.g. laptops are kept in good order and any faults are reported as soon as reasonably practicable.
- Raise any fire safety concerns they have with their line manager, responsible person or competent person.

3.10 Landlord

Dean Clough acts as landlord for the CCG offices and is responsible for ensuring the management of the following for communal areas and areas occupied by the CCG:

- Fire detection system
- Fire call points

3.11 NHS Property Services (NHSPS)

NHSPS is responsible for undertaking maintenance of specific fire safety systems within the office:

- Servicing and testing of emergency lighting
- Servicing of fire extinguishers

4. Public Sector Equality Duty

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

Whilst there is no requirement for an Equality Impact Assessment for this policy the CCG will monitor any themes and trends from the following:-

Identify, understand and address any trends linked to a particular building, staff group or people with an Equality Act "protected characteristic" (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)

5. Training

New employees will receive the health and safety handbook "Health and Safety At Work" on the first day during their basic induction. Training is an ongoing process involving e-learning every 2 years and face to face learning every 2 years alternating between each mode of training on an annual basis. Fire evacuations and post evacuation reviews form part of the overall fire training which are bi-annually. Face to Face training is delivered by the competent person.

All training throughout the CCG is recorded on an electronic system called ESR.

6. Monitoring Compliance

The Governing Body approves the policy however the Audit Committee will monitor the number of fire related incidents via the Governance Assurance Dashboard.

7. Arrangements for Review

The policy will be reviewed as a minimum every 2 years by the Corporate Systems Manager or more frequently in the event of substantial changes occurring both internal to the CCG or statutory which impact on the policy.

8. Dissemination

Approval of this policy will be sought by the Corporate Systems Manager from the Governing Body. Once ratified the policy will be disseminated and made available to all members of staff via the CCG's intranet.

9. Associated Documentation

The Fire Safety Policy should be read in conjunction with the CCG's other related policies dealing with Health and Safety issues:

- Integrated Risk Management Framework
- Incident Reporting Policy
- Health and Safety Staff Handbook
- Health & Safety Policy

10. References

The requirements in relation to all aspects of health and safety within NHS Calderdale CCG are contained within current legislation as detailed below:

- Regulatory Reform (Fire Safety) Order 2005
- The Health and Safety at Work Act 1974
- Fire code Policy and Principles 1994

11. Appendices

Appendix A – Blank Personal Emergency Evacuation Plan (PEEP)

Appendix A – Blank Personal Emergency Evacuation Plan (PEEP)

PERSONAL EMERGENCY EVACUATION PLAN (PEEP)

Name:		
Job title:		
Service area:		
Work location:		
Days/times in building:		
Awareness of procedure		
The person requiring assistance is informed of a fire evacuation by:		
Existing alarm system	✓	
Visual alarm system		
Other (please specify)		
Designated assistance		
The following people have been designated to give me assistance to evacuate the building or to a refuge in an emergency		
Name: Contact details:		
Name: Contact details:		
Name: Contact details:		
Method of assistance		
Transfer procedures, methods of guidance, etc.:		

Equipment provided (include means of communication):
Evacuation procedure
A step by step account beginning from the first alarm
Safe route(s):
Name of person completing PEEP:
Designation:
Date PEEP completed:
Date fire wardens informed:
Review date:

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**Governing Body Assurance Framework – six monthly review**	**Agenda Item No.**	14
Report Author	Rob Gibson, Corporate Systems Manager	**Public / Private Item**	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair	**Responsible Officer**	Neil Smurthwaite, Interim Accountable Officer

Executive Summary	
Please include a brief summary of the purpose of the report	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. The risks are set out in the Governing Body Assurance Framework (GBAF) (Appendix 2). This is a working document and will be updated on a regular basis. The GBAF was last was presented to Governing Body at its meeting on 10 October 2019. A comprehensive six monthly review of the GBAF by their respective Senior Management Team (SMT) leads took place as scheduled during February and March 2020 and presented at the SMT meeting on 9 March; however, the GBAF was not presented at Committees or to the Governing Body at their following meetings during this period. Due to Covid19 the focus of these specific meetings evolved to primarily decision making rather than routine assurance or discussion items. This is not to say that the assurance work wasn't happening, but rather seeking to reduce the burden on staff writing routine papers for committees detailing this. This was to ensure that CCG staff were able to focus on the COVID-19 response and supporting the NHS frontline. A review of the GBAF action plan, which takes place twice year in between the six monthly review of the full GBAF, took place as planned in May and was presented at the SMT meeting on 8 June. The action plan on its own is not presented at Committee or Governing Body meetings; however, also included for the assurance of the Governing Body in this paper are any significant changes made during June's action plan review due to the larger than normal gap in time when the full GBAF was last presented to Governing Body. The GBAF did not go to the following Quality, Finance & Performance (Q,F&P) meeting on 25 June as the focus at June's meeting was on the annual assurance report which fed into the governance review. The next 6 monthly review period for the GBAF will take place in September with it being reported as normal into Q,F&P at its meeting on 24 September and Governing Body on 22 October 2020. In this next forthcoming period further development work will also take place in order to reflect the different ways of working the CCG is becoming involved in. It is intended that this development work will be part of a Governing Body development session in September. A summary of the changes made during the full February and March GBAF review and June's action plan review can be seen in Appendix 1.

<table>
<tr><td rowspan="2">Previous consideration</td><td>Name of meeting</td><td>SMT</td><td>Meeting Date</td><td>09/03/2020</td></tr>
<tr><td>Name of meeting</td><td></td><td>Meeting Date</td><td></td></tr>
<tr><td>Recommendation (s)</td><td colspan="4">It is recommended that the Governing Body CONFIRM that the GBAF provides sufficient ASSURANCE that:

1. The strategic objectives of the CCG are accurate;
2. The principal risks to the achievement of those objectives are identified;
3. The controls in place to mitigate or manage those risks are identified.</td></tr>
</table>

Decision	☒	Assurance	☒	Discussion	☐	Other	Click here to enter text.

<table>
<tr><td colspan="4">Implications</td></tr>
<tr><td colspan="2">Quality & Safety implications</td><td colspan="2">No quality & safety implications</td></tr>
<tr><td colspan="2">Engagement & Equality implications (including whether an equality impact assessment has been completed)</td><td colspan="2">No engagement has been undertaken as it is not required.
An equality impact assessment has not been completed as there are no equality implications.</td></tr>
<tr><td colspan="2">Resources / Finance implications (including Staffing/Workforce considerations)</td><td colspan="2">No resource / finance implications.</td></tr>
<tr><td colspan="2">Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)</td><td colspan="2">Yes | | No | | N/A | x</td></tr>
<tr><td>Strategic Objectives (which of the CCG objectives does this relate to?</td><td>▪ Achieving the strategic direction for Calderdale
▪ Improving Governance
▪ Improving quality
▪ Improving Value</td><td>Risk (include risk number and a brief description of the risk)</td><td>Risk is managed in line with the CCG's Integrated Risk Management Framework. Risks are captured on the Corporate Risk Register or the Governing Body's Assurance Framework (GBAF) as appropriate.</td></tr>
<tr><td>Legal / CCG Constitutional Implications</td><td>Risk is managed in line with the CCG's Integrated Risk Management Framework.</td><td>Conflicts of Interest (include detail of any identified/potential conflicts)</td><td>Any interests will be managed in line with the CCG's Management of Conflicts of Interests policy.</td></tr>
</table>

Item 4 Appendix 1

GBAF 6 monthly review March 2020 and action plan review May 2020

Summary of significant changes made during both these reviews:

- Draft Calderdale Communications Plan ready to be approved at July GB meeting, all engagement with HWBB has been completed (1.6(4))
- Patient and Public Engagement and Experience Strategy to be refreshed – GB approval (was April 2020, now July 2020)(2.1(1))
- Patient Experience and Engagement Steering Group and Patient Experience Group to be refreshed in line with Involving People Strategy – plan to go live in April 2020 (2.1(1))
- Patient Experience and Engagement Steering Group and Patient Experience Group to be refreshed in line with Involving People Strategy – plan was to go live in April 2020 – now July 2020). This will include reporting lines (2.1(2))
- Developing Involving People plan for Calderdale Cares to be presented at GB in April 2020 (now July 2020), with new reporting structure (2.2)
- New children's safeguarding arrangements to be presented in next safeguarding report (2.4(5))
- The Governing Body endorsed to the CCG Membership the proposed revisions to the CCG Constitution at January 2020 meeting (4.1(1))
- Annual compliance with statutory duties deadline of 30 November 2020 4.1(1))
- Developing proposals on integrated commissioning and provider alliance models. In terms of integrated commissioning the June 2020 ICE meeting will continue the conversations about governance and integration roadmap.(4.1.(8))
- Provider Alliance Model - work has paused as a result of the pandemic but arrangements had progressed up to March 2020 to agree partnership documentation. Next step is for the drafts to be completed and then each partners to take it to their respective Boards for sign off. (4.1(8))

Governing Body Assurance Framework - Risks Details

1. Achieving the agreed strategic direction for Calderdale

1.1

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
We do not deliver our strategic outcomes because we have not integrated our commissioning activities with CMBC	1	1		Debbie Graham	Debbie Graham	Steven Cleasby	Quality, Finance and Performance Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Chief Officer, Chair and Assistant Clinical Chair members of the Health and Well Being (HWB) Board to facilitate effective partnership working.	HWB minutes to Governing Body		n/a		
2. Single Plan for Calderdale provides a single strategic direction for Calderdale Council and the CCG.	HWB minutes to Governing Body, including an update on delivery Single Plan for Calderdale		n/a		
3. Developed the necessary governance, including the Integrated Commissioning Executive (ICE) established between the CCG, ASC, C&Y and Public Health to provide the governance on integrating commissioning activities; also oversees delivery of the BCF Plan/resources to integrate health and social care delivery. Procurement and payment mechanisms in order to meet statutory and regulatory duties	ICE minutes to SMT, the Health and Wellbeing Board, Finance, Performance and Quality Committee and Governing Body - Integrating health and social care offers - Integrating health and social care commissioning - Right Care/Hospital Services Programme Board progress reports to Governing Body -Business planning process shared with Finance and -Performance in line with work plan.		n/a		

1.2

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
There is a risk of the CCG does not deliver its strategic outcomes because we have not tackled the wider determinants of health	1	1		Debbie Graham	Debbie Graham	Steven Cleasby	Quality, Finance and Performance Committee	Amber

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments

	1. Partnership working via: 1. Calderdale Council senior staff (Director of Public Health, Adult Health and Social Care; Children and Young People leads invited to the CCG Governing Body meetings highlighting wider determinants of health and facilitating effective partnership working. 2. Single Plan for Calderdale provides single strategic direction for CMBC and CCG 3. Better Care Fund Plan for 19/20 draws on the Joint Strategic Needs Assessment and Joint Wellbeing Strategy.	1. Current HWB Strategy, Terms of Reference in place, Reports Scrutiny Committees (as required) 2. Single Plan for Calderdale and two-Year Operational Plan being refreshed as part of review of new Wellbeing Strategy 3. Calderdale Cares gone through partner governance arrangements as the CMBC response to delivering integration. 4. Calderdale Care updates to: HWB, Health Leaders' Group 5. HWB minutes to GB 6. Calderdale Cares to GB		Refreshed Wellbeing Strategy to GB	30/09/2020	
	2. Intelligence Sharing: 1. CCG strategic priorities informed by Joint Strategic Needs Assessment (JSNA), 2. Patient and Public involvement informs CCG of public's view of the wider determinants of health 3. Use of Commissioning for Value intelligence Packs produced by NHSE and review of benchmarking data comparing Calderdale position against regional and national performance data. 4. Development of an approach to Population Health Management for our system	1. Monthly updates to F,P&Q on Recovery and QIPP 2. Quarterly summary report to F,P&Q 3. JSNA – on CMBC website 4. Patient and Public Engagement Strategy – on CCG website		n/a		
	3. Governance Arrangements: 1. Integrating Commissioning Executive reports into HWB and the Finance and Performance Committee 2. Single Plan for Calderdale reports progress updates to HWB and the Governing Body	F,P&Q Committee regular items on: - ICE (inc Better Care Fund) Business Planning process – updates Integration of commissioning & delivery Right Care/ Hospital Services Board progress Business planning process updates Right Care – regular reports to Governing Body (Chief Officer's report) Business planning process shared with F,P&Q in line with work plan HWB minutes to GB		n/a		

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
4 Wellbeing Strategy for Calderdale Plan 2019-2024: 1. HWB refreshed Wellbeing Strategy confirms actions to tackle wider determinants of health 2. CCG One Year Operational Plan - 2019/20 confirms commitments to strategic outcomes in line with refreshed WB Strategy	HWB minutes to GB ICE minutes to SMT and F,P&Q Committee		n/a		
5 Internal capacity and capability to deliver strategic plan: Processes to ensure alignment of CCG roles and capacity with strategic plan delivery	Finance, Performance & Quality Committee transformation updates includes a view of capacity and capability.		n/a		

1.3

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
We do not delivery our strategic outcomes because we have not implemented new models of primary care and community services	1	1		Debbie Robinson	Debbie Robinson	Helen Davies	Quality, Finance and Performance Committee	Amber

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Refreshed Wellbeing Strategy sets out the CCG's strategic direction for a new community and primary care model, supported self-managed care and primary prevention. The one year operational plan sets the strategic direction for Calderdale CCG which is aligned to the Wellbeing Strategy and Calderdale Cares.	Updates to Finance, Performance & Quality Committee as required Assurance from GB once received		Full assurance on the refreshed Wellbeing Strategy and NHS England assurance on the one year operational plan. Impact of new NHS strategic guidance to be tested by GB	30/09/2020	

2. Partnership working through the HWB to develop an integrated model of primary and community services, physical and mental health.	1. Integrated health and social care model focuses on supported self-care and a community model which supports recovery and independence and an improved model of community provision –updates to the Governing Body. 2. Model of integrated community services and Calderdale Cares developed in line with HWB strategy - Health and Well Being Board Development Session Minutes 3. Key element of Better Care Fund (BCF) Plans – ICE minutes and Quarterly Better Care Fund standing agenda item on Finance and Performance Committee. 4. ICE minutes to F,P&Q and SMT		n/a		
3. The Better Care Fund Plan sets out how CCG will deliver supported self-managed care and primary prevention jointly with Calderdale MBC.	Integrated health and social care model focuses on delivery of prevention, supported self-care ICE Better Care Fund quarterly updates to the Finance and Performance Committee		n/a		
4. Integrated model of health and social care will specify which services the CCG will commission to deliver supported self-managed care and primary prevention	Closer to Home specification - Phase 1 approved by Quality Committee (Sept 2018) Care Closer to Home prospectus published January 2019. Prospectus scoping and updates shared through multi-professional alliance steering group (action log and agendas, latest Aug 19) Development of new alliance of providers and commissioners to deliver new model. Identification of outcomes against which to test progress		Develop mechanism to ensure that GB has oversight of governance and architecture for delivery of CC2H		Target date changed during May 2020 action plan review from 31.01.20 to 'ongoing'

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
5. Infrastructure Alliance to ensure role of third sector in development and delivery of CC2H.	Contract documentation with VCSI Alliance Alliance Leadership Team in place supported by Alliance Management Team Finance and Performance Committee paper on contracting includes reports on Alliance progress and learning for CC2H model Oversight of delivery of Alliance through ICE		n/a		

	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
1.4	We do not deliver our strategic outcomes because we have not worked effectively on a West Yorkshire footprint.	1	1		Neil Smurthwaite	Neil Smurthwaite	Steven Cleasby	Quality, Finance and Performance Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Work plan agreed by the West Yorkshire & Harrogate Joint committee and approved by CCG member practices	1. Evidence of CCG member voting (16 Feb 2017, 21 March 2018), Joint Committee approved 5.6.18		n/a		
2. Governance arrangements for WY&H HCP including West Yorkshire & Harrogate Joint committee developed. WY&H HCP provides strategic direction across WY&H linking to the Calderdale Wellbeing Strategy.	1. WY&H HCP structure diagram, minutes of each Joint Committee meeting received by Governing Body (latest received 8 Aug 2019) 2. West Yorkshire & Harrogate Joint committee MOU and Joint Committee terms of Reference supported by the Governing Body (9th Feb '17, 8 March '18)and approved by CCG membership (16th Feb '17, 21 March '18) 3. Constitution varied to establish the Joint Ctte (23 May '17).	n/a	n/a		
3. Chair and Chief Officer are active members of the West Yorkshire and Harrogate HCP.	1. Governing Body minutes (9 Feb '17, 8 March '18) 2. WY&H Joint committee of CCGs minutes and key decision points to the Governing Body	n/a	n/a		
4. WY&H HCP programme office being developed to take forward work streams	WY&H HCP programme office structure	n/a	n/a		

	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
1.5	We do not deliver our strategic outcomes because we have not delivered the planned clinical model of hospital and community services as set out in the response to the	8	4		Jen Mulcahy	Penny Woodhead	Steven Cleasby	Quality, Finance and Performanc	Amber

	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
	Secretary of State in August 2018.							e Committee	

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Process developed between CCG and CHFT in regards to managing interim service changes 2. We completed consultation on 21st June 2016 on proposed future arrangements for hospital and community health services 3. Interim service changes to cardiology, respiratory and frail elderly services have been put in place 4. The response to the Secretary of State in August 2018 requires a new SOC, OBC and FBC to be produced. 5. Regular reporting to Secretary of State for Health and Social Care (latest sent Feb 19, next due Sept 19) 5. Regular reporting through the Clinical Quality Board to Quality Committee	1. 'Go see' visits and enhanced surveillance in place 2. The Secretary of State has awarded £196.5m public dividend capital subject to a successful FBC 3. NHS England has confirmed that the Strategic Change Assurance Process will not be repeated 4. A separate quality assurance process in parallel with the production of the SOC, OBC and FBC. 5. Feb JHSC noted the approach to further stakeholder, staff and public involvement. Next meeting Oct 6. Independent activity modelling has identified potential to reduce demand on hospital by 20-40% over a period of 4-6 years. 7. CHFT's Strategic Outline Case, together with letters of support from the CCGs and the WY HCP has been approved by NHSE and I Regional Directors		n/a		

	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
1.6	We do not deliver our strategic outcomes because we have not fully developed and optimised system working on enabling functions	1	1		tbc	Penny Woodhead	Alison Macdonald	Not stated	Amber

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments

	1.System forum to be initiated to understand and develop workforce plans to deliver new models of care	1.Members of; Health Education England Group and West Yorkshire Local Workforce Board 2.Health & Wellbeing Board has agreed that workforce is a key enabler to deliver Single Strategic Plan for Calderdale (SPFC) 3. LWAB bids successful bringing capacity and capability into Calderdale		Develop strategy & implementation plan: Proposal developed to review workforce data and bring together workforce plans and strategies Money availiable from ICS to support set up in Calderdale, need to agree how to deploy and milestones - agree in September 2019 Time limited support in place to test an OD approach to system working Influencing workforce implementation plan development and responding to consultation. Scoping underway of workforce activity associated with Calderdale Cares.		Work in progress on strategy and plan in partnership with HEE/LWAB lWAB bid successful - plan to be agreed sept 2019. Regular updates to Joint SMT.

2. System response to digital transformation in service delivery	Calderdale HWB and the SPFC leadership have agreed the need to develop system thinking on digital solutions New BI model in place and creating links with health and social care records to fully understand locality priorities.		Develop strategy & implementation plan: • Convene group with interested parties from Calderdale system, initial scoping meeting • Recognise ability of shared records • Scope out strategy/plan on a page • Draft action plan with timescales and deliverables		1.6(2) - (digital) Several Population Health management meeting have been held scoping the way forward, additional support recruited to help drive a single integrated data set. Reviewed by NS 1.6(3) (estates) Given the development of primary care networks not further work has been done on this. Involvement in the WY&H estates programme continues. Not currently seen as a priority area and will be developed through locality and PCNs. Reviewed by NS

		Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
		3. System forum to be initiated to understand and develop estate plans to deliver new models of care, recognise One public estate strategy and Calderdale development plans. Recognising impact on primary care and community services	1. Building on work undertaken by CMBC as part of One Public Estate Agenda 2. Calderdale HWB have agreed the need to develop thinking through dialogue in development mode 3. WY&H Health & Care partnership (STP) has agreed to instigate a forum for all parties to share estate plans, footprints, needs, risks etc. This will enable estates colleagues to more jointly react to the system's needs and requirements.		WY&H Estate strategy is being developed which is purely health based and focused on acute and mental health requirements Local forum needed to • Convene group with interested parties from Calderdale system, initial scoping meeting • Scope out strategy/planplan on a page • Draft action plan with timescales and deliverables		1.6(3) (estates) - Given the development of primary care networks no further work has been done on this. Involvement in the WY&H estates programme continues. Not currently seen as a priority area and will be developed through the locality and PCNs. Reviewed by NS (May 2019)
		4.There are clear integrated plans to ensure high quality communications to share our narrative with stakeholders and the public.	1. Draft Calderdale Communications plan (supporting the delivery of the Wellbeing Strategy) shared with Governing Body Development Session (Sept '19) 2. Communications strategy and plans to be approved by Governing Body and Health and Wellbeing Board	n/a	n/a	31/07/2020	Action plan review - May 2020 - Ready to be approved at GB in July 2020, all engagement complete with HWBB

		Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
	1.7	There is a risk that the CCG is unable to: deliver its strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.	1	1		Debbie Robinson	Debbie Robinson	Majid Azeb	CPMS	Amber

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments

1.Engagement of Practices through the Commissioning engagement Scheme .	1. Practice Leads meeting Attendance Register 2. Slide packs and action noted from practice leads meetings		n/a		
2.Delivery Plans agreed for the main themes that address key concerns, pressures and challenges linked to workforce, workload and new models of Care	1.Map of key areas with leads 2.CCG Operational Plan		None		
3. CCG dedicated Primary Care Team in place to support transformation programme with named leads responsible for specific elements	1.Map of key areas with leads 2. CCG operational plan		None.		
1..New 5 year contractual framework implemented April 2019. 2.Establisment of 5 Calderdale Primary Care Networks from 1st July 2019.	1.CPMSC paper and minutes showing process of PCN approval	1. need to establish clear working arrangement between CCG and PCNs 2.. Need to complete the maturity assessment of each network and establish clear development plans	1. SMT development session regarding offer of support 20th September 2019 2. Head of Primary Care and Primary Care Clinical Lead to meet with Clinical Directors on a monthly basis starting September 2019		Ongoing as the GP contract continues to develop
5. Practice Managers Action Group inputs to clinical commissioning and shares information with member practices on behalf of CCG.	1.Practice Managers Advisory Group meeting Notes		Develop implementation plan for each priority area. Establish clear reporting arrangements as part of formal governance. Clarify Practice Management leadership for priority areas. Establish clear arrangements for engagement with membership.		all actions completed
6. Monthly joint CCG/LMC executive meetings	1. Minutes of the meetings 2. Joint letter to practices about working together		n/a		
8. Active participation of the GP Alliance in an integrated care system	1. Role description agreed by Governing Body 2. Memorandum of Understanding between the CCG and the GP Alliance		Development of the MOU and clear working practices		Completed
9.GP Members on the Governing Body	1.CCG Constitution		n/a		

		10.CCG is a delegated commissioner of Primary medical services to enable transformation of general practice	1.MOU with NHS England 2.CCG Constitution 3.CPMS Committee Terms of Reference		n/a		
		11. Primary Care Workforce Steering Group Established.	1.Group Terms of Reference 2. Notes of meetings		1. Work plan requested 2. Work plan being developed for implementation of the Apex Insight tool.	31/07/2020	Action plan reviewed May 2020. Target date changed to end of July 2020.
		12. Prescribing Gain Share scheme	1. Locality Sign up documents 2. Monthly forecast reports 3. Quarterly locality reports on progress		1. Potential Gains share being released for potential reinvestment in localities in 2019/20		

2. Improving Quality	2.1	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
		There is a risk that the CCG does not: improve patient experience in line with our plans due to a failure to use appropriate patient and public engagement intelligence to support service improvement and plans to change service models	6	1		Penny Woodhead	Penny Woodhead	Alison Macdonald	Quality, Finance and Performance Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Patient and Public Engagement and Experience Strategy (2013-2020) and annual improvement plan (2019-20) in place.	1. Regular patient experience report submitted to Quality, Finance and Performance Committee. 2. Engagement/ consultation reports/ findings to Quality, Finance and Performance Committee, with relevant service specifications / service models	strategy to be refreshed	GB approval April 2020		
2. Patient Experience and Engagement Steering Group (including partners) and Patient Experience Group	1.Regular patient experience report to Quality, Finance and Performance Committee (escalation in key points to GB) (including Friends Family test feedback) 2. Steering Group minutes scrutinised by Quality, Finance and Performance Committee 3. Healthwatch reports into PPE Steering Group 4. Calderdale Health Forum action notes into PPEE Steering Group	Groups to be refreshed in line with Involving people strategy - plan to go live April 2020, this will include reporting lines	New reporting arrangements will have oversight from QFP		
3. Methods included in Strategy and each engagement plan including Calderdale Health Forum	Engagement report for specification reflects patient experience		n/a		
4.Procurement Process (incorporates patient feedback)	Evidence seen through procurement documentation of patients/public involvement		n/a		
5.Contracting mechanisms for patient feedback: sections within the standard contract regarding providers' requirements to engage with patients/public	Clinical Quality Board minutes reflect patient experience metrics and improvement work		n/a		
6.Engagement assurance process for development of service specifications includes patient experience and public engagement	1. Project Management Office paperwork and flowchart 2. Quality, finance and performance Committee minutes) 3. Internal audit report on PE 4. IAF - PPI		n/a		

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
7. Lay Member for PPI on GB	Lay member job description		n/a		

2.2

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
There is a risk that the CCG is unable to: commission high quality, safe services across the system due to a failure to ensure we have the support of partners, stakeholders and the public for our plans – thereby reducing our ability to deliver the quality gap set out in the Calderdale STP and our contribution to the West Yorkshire & Harrogate partnership plan	6	1		Penny Woodhead	Penny Woodhead	Alison Macdonald	Quality, Finance and Performance Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Patient and Public Engagement and Experience Strategy (2017- 2020) and annual implementation plan 2. Patient & Public Engagement & Experience Group (PPEE) and terms of reference 3. Patient and Public Engagement Annual Statement of Involvement 2018-19 4. Equality and Diversity Strategy and Action Plan 5. Lay member PPI 6. Engagement and Equality and Diversity Assurance Process	1.Regular PPEE reports to Quality, Finance and Performance Committee. 2.Service Specifications reviewed by Quality, Finance and Performance Committee have evidence of engagement 3.Annual General Meeting 2019. Engagement reports published on website 4.Internal Audit Report (May 2017) - Full Assurance on Patient and Public Engagement and Experience 5. IAF - PPI Green	Groups to be reviewed as Involving People Strategy is approved	Developing Involving People plan for Calderdale Cares:, to be presented to GB April 2020	31/07/2020	Ready to be approved at GB in July 2020, all engagement complete with HWBB. April GB revised due to COVID 19.

2.3

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
There is a risk that the CCG is unable to: maintain and improve the quality and safety of services due to ineffective commissioning arrangements resulting in harm to patients	8	1		Penny Woodhead	Penny Woodhead	Caroline Taylor	Quality, Finance and Performance Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Quality and Safety Dashboard (information at CCG level and by main providers)	1. Quality and Safety Reports to Quality, Finance and Performance Committee, including reports from the Quality Boards and dashboard. 2. Updates to Quality & Safety re actions and outcomes 3. Quality reports including reports on patient safety and safeguarding issues to the CCG Governing Body. 4. Complaints, Serious Incidents and Serious Case Reviews (SCRs) reported into Quality, Finance and Performance Committee and SCRs in private section Governing Body.		n/a		
2. Quality outcome standards, quality schedule, patient safety and relevant targets within service specifications	Quality & Safety approval of service specifications		n/a		
3. Contract governance and monitoring processes including CQBs for all key contacts	Minutes of Clinical Quality Boards reported to Quality, Finance and Performance Committee		n/a		
4. Review and triangulation of a range of quality information (e.g. Serious Incidents, CQUINs, CQC)	Quality dashboard exception report (Quality, Finance and Performance Committee minutes would demonstrate the triangulation and Quality decision on whether to implement Quality assurance process)		n/a		
5. Quality Assurance Process (Standardised process for managing risks and escalating monitoring levels)	Quality & Safety report will demonstrate quality assurance process is used, Quality, Finance and Performance Committee minutes		n/a		

	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
2.4	There is a risk that the CCG is unable to: Provide commissioning arrangements for safeguarding that ensure that providers are effectively safeguarding children and adults due to their ineffective safeguarding arrangements, resulting in harm to children and adults.	8	4		Penny Woodhead	Penny Woodhead	Steven Cleasby	Quality, Finance and Performanc e Committee	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments

1. Safeguarding policies and procedures in place	1. Policies approved by Quality, Finance and Performance Committee in line with agreed timescales for review 2. Internal audit follow up report on compliance against accountability and assurance framework – Feb '18 (significant assurance) 3. NHS England assurance process on compliance against accountability and assurance framework. 4. Annual Safeguarding reports to Quality, Finance and Performance Committee and Governing Body	NHSE published revised guidance sept 2018 - currently under review La to audit compliance in q4 2019	review compliance againsts NHSE guidance - October 2019 IA to assess compliance - q4 2019 -2020		
2.Mandatory training within CCG, standards in place with providers	1. Training compliance reported to Governing Body bi-annual in Workforce report and annual in Safeguarding report 2. Quarterly reports, including compliance with Safeguarding training to Quality Committee		n/a		
3. Safeguarding standards included within contracts	1. Annual Safeguarding reports to Quality Committee and Governing Body 2. Contracts monitored through CCG Annual Safeguarding report		n/a		
4. Annual Section 11 Audits scrutinise provider safeguarding arrangements, (policies and procedures, training)	1. Safeguarding Board scrutiny of provider safeguarding audits 2. CCG Annual Safeguarding report		n/a		
5. Provider s11 assessments scrutinised by Safeguarding Board	1. Local Safeguarding Board reports to GB 2. Quality reports including reports on patient safety and safeguarding issues to the private section of the CCG Governing Body 3. Quality Committee scrutiny of CCG audits 4. Planned repeat audit of safeguarding arrangements against new NHSE accountability and assurance framework in 2019-20		To review reporting from new safeguarding children arrangements through 6monthly safeguarding report to QFP and annual report to GB	31/07/2020	to be presented in next safeguarding report July 2020

		6. Active member of the Local Safeguarding Children's Partnership and Local Safeguarding Adults' Board. Active member of Yorkshire and Humber Safeguarding Network ensures national policy developments reflected in local commissioning arrangements.	1. NHSE Assurance Process 2. Local Safeguarding Board/ Partnership reports to Governing Body		To review reporting from new safeguarding children arrangements through 6monthly safeguarding report to QFP and annual report to GB	31/07/2020	to be presented in next safeguarding report July 2020

3. Improving value

3.1

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
There is a risk that the CCG will not: Deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable	9	6		Neil Smurthwaite	Neil Smurthwaite	tbc	Quality, Finance and Performance Committee	Amber

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Annual review of financial control arrangements by Internal/External audit	1. Annual sign off of financial plan/budget by Governing Body and Finance, Performance & Quality Committee. 2. Regular updates on amendments/changes to plan reported and agreed through F, P & Q Committee, with minutes and actions reported to Governing Body. 3. Partnership Boards with key partners (Calderdale Council, CHFT, SWYPFT), Financial positon is standing agenda item for those 4. Integrated Commissioning Executive and Better Care Fund Programme board between CCG and Local Authority. 5. Critical risk reports to the Finance, Performance & Quality Committee and Governing Body. 6. System Recovery Group established between CCCG, GHCCG and CHFT.		Finance and Performance work plan amended to focus on recovery every month and in depth performance reports only quarterly. Recovery standard item on SMT and all meeting agendas. Action plan has been produced as part of the reporting on the critical risk. Actions monitored through the Partnership Boards and the Finance, Performance & Quality Committee.		Complete

		2. Development and delivery of short/medium term Financial Recovery plan.	1. Approval by Governing body with updates at every meeting on position. 2. Agreement on principles and approach through GB formal and development sessions. 3. Approval and detailed monitoring through Finance, Performance & Quality Committee. 4. Monthly CCG Recovery group accountable for producing and delivering schemes for recovery 5. Position reported at each Primary Care leads meeting 6. Partnership board meetings with CHFT, SWYFT and local authority have updates on financial position so system aware of pressures.		Transformation Board between CCCG, GHCCG and CHFT to develop/monitor joint cash releasing savings and ensure a balanced health economy. Joint ''System Financial Recovery Plan'' developed with revised governance between CCCG, GHCCG and CHFT. Development and ownership of joint financial recovery. Understand implications of WY&H STP financial strategy and development of Integrated Care Organisation. System risk assessment being undertaken by NHS E/I. CCG revised internal governance to focus on Recovery actions.		Completed (April 2018)
		3. 5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting to planned community services, reducing financial risk	1. Delivery on plan is monitored through Govern Body reports. 2. Right Care, Right Time, Right Place and Care Closer to Home strategies/business cases regularly updated to GB. 3. Separate meetings for RCRTRP and CC2H monitoring progress		n/a		
		4. Development of Closer to Home model to reduce increasing demand on acute services (CC2H)	1. Phase 2 of CC2H will include element around changing financial, regular reporting and updates to GB and Finance, Performance & Quality Committee. 2. Business case being developed that will include section on finances and contribution towards financial sustainability.		n/a		

4. Improving governance

4.1

Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
Failure to comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.	1	1		Debbie Graham	Debbie Graham	Steven Cleasby	Audit	Green

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Compliance with the provisions of the CCG's Constitution which has been reviewed by a legal firm, approved by the membership and approved by NHS England.	CCG Constitution (Aug 2018). Examples of compliance with Constitution, proposal to vary the constitution put to the membership (GB 10.8. 19, Practice leads 24.9.19)		CCG Constitution requires refreshing to bring into line with the new model constitution. Undergoing continual review of statutory duties however a formal review will take place by 30 November 2020.		Ignore previous comment in 'review history'. This was made in error. This action was completed at GB on 23.01.20.
2. Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework.	Committee terms of reference in place GB April 19		n/a		
3. Annual committees work plans include any statutory and regulatory reporting requirements	Annual work plans for committees in place (standing item on committee agendas)		n/a		
4. Rolling programme of policy review to ensure compliance with changes in legislation, national guidance	Policy Review Schedule in place, policies overdue identified. Internal Audit provided an opinion of High Assurance		n/a		
5. Review of compliance with statutory duties	Last completed (March '18).		annual review to be undertaken 2020 - target date amended to 30/11/20	30/11/2020	Target date amended to 30 November 2020
6.Internal/external audit reviews/reports ensuring CCG compliance to Audit Committee.	External Assurance 2018/19 Annual Governance Statement, Annual Report and Annual Accounts, head of internal audit opinion and external audit letter of assurance.		n/a		
7. Horizon scanning for any regulatory changes / guidance	KPMG technical updates, Audit Yorkshire events, legal and HR briefings circulated to relevant SMT and committees.		n/a		

	8. Any proposals on integrated commissioning or integrated care structures developed within the regulatory and legal framework.	Proposals in line with legal advice and learning from other systems.		Developing proposals on integrated commissioning and provider alliance models. In terms of integrated commissioning another conversation took place at ICE on Thursday 5/12/19 Provider Alliance Model - work is continuing on developing the MoU led by MP and DR and supported by DAC Beachcroft	31/07/2020	Developing proposals on integrated commissioning and provider alliance models. In terms of integrated commissioning the June 2020 ICE meeting will continue the conversations about governance and integration roadmap. Provider Alliance Model - work has paused as a result of the Pandemic but arrangements had progressed up to March to agree partnership documentation. Next steps was for the drafts to be completed and then each partners to take it to their respective Boards for sign off .

4.2	Principal Risk	Rating	Target	Update Since Last Review	Owner	SMT Lead	GB/GP Lead	Committee	Rag Status
	Failure to release capacity and enable the	1	1		Neil	Neil	Steven	Not stated	Green

development of new integrated commissioning, Primary Care Network and provider alliance arrangements due to low risk appetite and not having the right CCG Governance form and membership				Smurthwaite	Smurthwaite	Cleasby		

Key Controls	Sources Of Assurance	Gaps In Controls Or Assurance	Actions	Target Date	Target Date Comments
1. Robust governance structure, integrated risk management framework and systems of internal control in place.	Annual Report and Accounts 2018/19 Internal Audit work programme resulting in an opinion of High or Significant Assurance External Audit Assurance	n/a	n/a		
2. Process for regular review of governance and risk management part of internal audit annual work plan.	Internal Audit work plan 2019/20 Head of Internal Audit Opinion of Significant Assurance May 2019 Ongoing sessions with the Governing Body on risk appetite Integrated Risk Management Framework due for refresh (includes risk appetite)	1.Need to update CCG risk appetite.	Take forward outcome of risk appetite sessions and formulate risk statement Implement changes in line with risk appetite Underway - two GB Development sessions held. Risk appetite statement being formulated for approval at Jan 2020 Governing Body		
3. Annual Governing Body and committee performance assessment - identifying development needs and action plans	Development and actions contained within the Annual Governance Statement (AGS)(June '19); Committee minutes demonstrating development session and action plans (Audit, Remuneration and Nomination, Quality, Finance and Performance, CPMSC Jan-March '19);	n/a	Review of governance, requirements as part of transition to new system-wide ways of working (split in two) Review of capacity and capability requirements as part of transition to new system-wide ways of working (split in two)		On going - moving into system governance and into a higher risk appetite, slimmed down governance arrangements
4. Development of governance structures and systems of internal control in support of new integrated commissioning/care models	Calderdale Cares (March '18); Integrated Commissioning Executive (ICE) work plan (July '18) and minutes as the work moves forward.	n/a	n/a		
5. Slimmer Governing Body membership and which retains robust grip on CCG governance and compliance with statutory and regulatory duties	Compliance with NHS Act 2006 and CCG Regulations 2012 Continued robust grip on financial position, contracting, performance, quality and patient safety requirements		Governing Body OD plan to ensure effective GB and committees	30/09/2020	
6. Robust and systematic appraisals for staff and governing body members to identify any development needs.	Appraisal documentation for both Governing Body and staff; compliance schedule; SMT minutes demonstrating review of completion; Remuneration Committee mins Sept '18 (for GB member appraisals)		Development of OD plan in support of future integrated commissioning/ care models		

Name of Meeting	Governing Body	Meeting Date	23/07/2020
Title of Report	**High Level Risk Log and Report - Risk Cycle 2 2020-21 (18 May – 8 June 2020)**	Agenda Item No.	15
Report Author	Robert Gibson, Risk, Health & Safety Manager	Public / Private Item	Public
GB / Clinical Lead	Dr Steven Cleasby, CCG Chair	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 second risk review cycle of 2020-21. ▪ The Calderdale Clinical Commissioning Group Risk Register currently contains a total of 43 risks with 11 risks marked for closure. ▪ Of these open risks, there are: - 2 CRITICAL risks (scoring 20) - 8 SERIOUS risks (scoring 15-16).						
Previous consideration	**Name of meeting**	Combined Quality, Finance & Performance Committee		**Meeting Date**		25/06/20	
	Name of meeting	Senior Management Team		**Meeting Date**		08/06/20	
Recommendation (s)	It is recommended that the Governing Body: ▪ **CONFIRM** 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 2 of 2020-21. This is following a review of the risks at the combined Quality, Finance and Performance Committee meeting on 25 June 2020.						
Decision ☐	**Assurance**	☒	**Discussion**	☐	**Other**		

Implications						
Quality & Safety implications	No quality & safety implications.					
Engagement & Equality implications	No engagement has been undertaken as it is not required. An equality impact assessment has not been completed as there are no equality implications.					
Resources / Finance implications)	No resource / finance implications.					
Has a Data Protection Impact Assessment (DPIA) been completed?	**Yes**		**No**		**N/A**	X

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

1.0 Introduction

1.1 To provide assurance on the process for the detailed review of the CCG's risks.

1.2 To set out all risks rated 15 or above (see Appendix 1).

1.3 To provide a detailed report on Critical risks 1493 & 62 (see Appendix 2).

1.4 Although a comprehensive review of risks by their respective risk owners and senior managers for risk cycle 1 of 2020-21 took place during February and March 2020, the risk register was not presented at Committees or to the Governing Body at their meetings during this period. Due to Covid19 the focus of these specific meetings evolved to primarily decision making rather than routine assurance or discussion items. This is not to say that the assurance work wasn't happening, but rather seeking to reduce the burden on staff writing routine papers for committees detailing this. This was to ensure that CCG staff were able to focus on the COVID-19 response and supporting the NHS frontline.

1.5 This report has been prepared with consideration to any significant movement of high level risks that also took place during risk cycle 1.

2.0 Risk Review: Risk Cycle 2

2.1 Risk Cycle 2 commenced on 18 May 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 June 2020.

2.2 All risks were submitted to the combined Quality, Finance & Performance Committee for review at their meeting on 25 June 2020.

2.3 There were two critical risks rated 20 at the end of Risk Cycle 4 (see 2.7).

2.4 The CCG Risk Register for Risk Cycle 2 has now been archived and Risk Cycle 3 (2020-21) will commence on 17 August 2020.

Risk Register Summary: Risk Cycle 2

2.5 At the end of Risk Cycle 2, the CCG had 43 risks on the Corporate Risk Register. There are 11 risks marked for closure this risk cycle meaning there are 32 open risks (there were 27 open risks at the last risk cycle).

2.6 35 of total CCG risks (81%) are categorised as quality, finance & performance risks and 8 (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 2. There were also two at this position at the end of Risk Cycle 1.

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

Risk ID	Risk Summary	Risk Score	Risk Movement
1493	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on acute post-C19 bed plans which require minimum delayed patients.	20	Static for 1 risk cycle at the end of risk cycle 2 of 2020-21
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 2 risk cycles including risk cycle 1 of 2020-21

See appendix 2 for both Critical risk reports

2.8 There are 8 open risks rated as Serious (with a score of 15 or 16) during the current risk cycle (there were 3 as at the end of the last risk cycle) these are detailed below.

The 8 open risks rated as Serious this risk cycle are:

Risk ID	Risk Summary	Risk Score	Risk Movement
1557	The CCG fails 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.	16	New
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.	16	New
1501	Deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus.	16	Static for 1 risk cycle
1373	Access rates for IAPT (Improving Access to Psychological Therapies) in Calderdale will fall significantly due to the withdrawal of the Insight Healthcare, which provides around 70% of the activity within that service.	16	Static for 4 risk cycles

Risk ID	Risk Summary	Risk Score	Risk Movement
1366	There is a risk to patient safety, experience and quality of care for the delivery of the GP Out of Hours Service provided by Local Care Direct (LCD) via the West Yorkshire Urgent Care (WYUC) contract. Due to COVID 19 response and subsequent publication of national guidance, business as usual performance management in relation to NQRs is suspended until 31st July 2020. The focus of the current risk is responding COVID 19 pandemic and risk log is established for the delivery of service during the pandemic, changing/different interpretation of national guidelines on Personal Protective Equipment (PPE) and refusal of clinicians to see face to face patients.	16	Static for 4 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	Score of 12 during risk cycle 1 but increased during risk cycle 2 due to impact of Covid19.
202	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.	15	Score of 12 during risk cycle 1 but increased during risk cycle 2 due to impact of Covid19.
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.	15	Score of 10 during risk cycle 1 but increased to 15 reflects the reduction in routine elective slots being available at the same level as pre-COVID-19 position.

2.9 There were three risks in total which were rated as Serious during risk cycle 1. These three same risks remain on the risk register categorised as Serious during risk cycle 2 (see 2.8).

3.0 Recommendations

3.1 It is recommended that the Governing Body:

- **CONFIRM** 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 2 of 2020-21. This is following a review of the risks at the combined Quality, Finance & Performance Committee meeting on 25 June 2020.

4.0 Appendices

Appendix 1: High level risk log for risk cycle 2 as at 25 June 2020.

Appendix 2: Critical risk reports for risks 1493 and 62

Item 15 Appendix 1

Risk register for risk cycle 2 for Governing Body meeting on 23.07.20

Risk ID	Date Created	Risk Category	Risk Score	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	Q - Quality of Care	20	(I4xL5)	8	(I4xL5)	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 weekly 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 40 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) CCG and CMBC have commissioned additional bed capacity to support set down at the Retreat and Cedar Court to support D2A and step down requirements	(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	Static - 1 Archive(s)
62	13/06/2013	F&P - Performan ce	20	(I4xL5)	8	(I4xL5)	Neil Smurthwaite1	That they 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) Winter planning to be completed (e) Data to be shared with PCNs (f) View of new normal in A&E	(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	(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	(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 - 2 Archive(s)
1557	20/05/2020	F&P - Financial	16	(I4xL4)	4	(I4xL4)	Neil Smurthwaite1	The risk is we fail to manage running cost spend within the ring fenced allocation of £4.1m which means will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG. In addition NHSE/I have made some further deductions to running costs under the Covid 19 temporary financial arrangements which we are still trying to understand. There are a number of risks within the principal risk which contribute to the overall score which include the increased risk of annual pay award. The CCG has a target to reduce running costs by 20% in real terms by 2020/21. This is an absolute reduction of 11.8% in cash terms on 2019/20 allocation.	The CCG had initially developed a financial plan for 2020/21 which was set to deliver the required running cost reductions with the requirement to make only some small savings in year which we anticipate can be managed through vacancies and recruitment slippage. The CCG was able to do this as it planned for and delivered significant recurrent savings of £0.6m in 2019/20. The plan for 2020/21 was presented and agreed by Q,F&P committee in December 2019 demonstrating how savings had been delivered in 2019/20 and further savings plans agreed to be implemented. These plans had been agreed with budget holders.	Impact of pay review known and only estimated in plan. Impact of Covid 19. Impact of temporary financial regime and adjustments to allocations.	Monthly Financial Reporting systems. Internal Audit reviews on financial systems and processes. Regular budget holder meetings to review running cost budgets Discussion of risk and position in monthly F&P paper. Detailed review of impact of pay review scenarios - work undertaken to mitigate impacts Heads of Service are reviewing budgets in light of savings target, work to be completed on reviewing vacant posts.	Previous Internal audit report assurances and annual internal audit review plan. Running costs reported monthly to Finance and Performance committee and Governing Body.	None at this stage	New

1556	19/05/2020	F&P - Financial	16	(I4xL4)	8	(I4xL4)	Neil Smurthwaite1	The CCG will fail to deliver our 2020/21 planned in year breakeven and therefore fail to deliver a planned £5.5m cumulative surplus. The 20/21 financial plan submitted to NHSE included a number of pressures/risks which have been articulated in the plan approval process.. These risks include activity pressures on acute contracts, prescribing and under-delivery of QIPP. In addition, due to the impact of Covid 19, the CCG has been put under a temporary financial regime for the period April 2020 to July 2020. this has overwritten the CCGs initial financial plan. The CCG has had its allocation reduced by £4.3m over the four month period. The CCG is still working through the implications of this.	The 2020/21 initial financial plan has been approved by Quality, Finance and Performance Committee. In April 2020 it was noted at Governing Body that a new financial regime was likely to be implemented which would supersede our initial plan and the CCG was awaiting further guidance to be issued. The CCG has implemented robust procedures to capture Covid related expenditure. The CCG is planning to upload budgets based on the temporary financial guidance. The CCG will report through to QFP and Governing Body. A Quality Innovation Productivity and Prevention (QIPP) plan will have to be revised in light of guidance. There is a monthly budget monitoring process in place which reviews all expenditure against budgets and is shared with budget holders. In addition reports are produced monthly to the Quality, Finance & Performance Committee and Governing Body and also to NHS England. The financial plan includes a £1.6m contingency budget to manage in year risk.The CCG has entered into an Aligned Incentive Contract with CHFT. This should mitigate against swings in cost due to activity variation.	none identified key controls will help manage risk	Internal and external audit reports. Role of Audit Committee. Quarterly Area Team Assurance Process where the CCG financial position is assessed. Monthly reporting to Finance and Performance Committee and Governing Body	Financial Plan assured by Area Team. Significant assurance received on internal audit financial transactions report reviewed by Audit Committee from past audit reports and in year audit review plan. Deep dive by NHS England recognised level of risk and the move to a reduced surplus position.	changes to national prescribing pricing can have an unplanned for and significant impact on the CCG. Impact of Covid 19 financial guidance on CCGs allocations.	New
1501	12/03/2020	F&P - Performance	16	(I4xL4)	4	(I4xL4)	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 - 1 Archive(s)
1373	17/07/2019	F&P - Service Improvement	16	(I4xL4)	12	(I4xL4)	Lesley Stokey	That the access rates for 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.	a) The provider has been asked to provide a detailed exit plan, setting out the arrangements for responsible withdrawal from the provision of the service b) The provider has provided an overview of the risks relating to the withdrawal process c) The provider is discussing its withdrawal confidentially with the other current provider (SWYPFT) to see whether there are opportunities for SWYPFT to take on staff, and to discuss managing transition of any patients whose treatment has not concluded by the date of withdrawal of service c) The Head of Contracting has given agreement for the provider appointed under the AQP process to be advised in advance of the formal appointment process that they have reached the required standard, and to be informed of the situation around Insight, so that if they wish to have discussions with Insight around the possibility of taking on staff/premises, they can do so at an early stage.	a) Discussions to take place with the communications team at the CCG around managing the message around the changes	a) Telephone meeting held with Insight leads on 20th February; minutes taken for this meeting b) Face to face meeting arranged with Insight leads on 10th March; minutes to be taken for that meeting	To be agreed and added in	To be agreed and added in	Static - 4 Archive(s)

1366	25/06/2019	F&P - Performance	16	(I4xL4)	4	(I4xL4)	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 - 4 Archive(s)
187	19/03/2012	F&P - Contracting	16	(I4xL4)	6	(I4xL4)	Martin Pursey	There is a risk of under-achievement of 18 weeks 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.	a) High volume and high pressure specialties are discussed at the Contract Management Group. b) Regular discussions, updates and actions from lead commissioners for other acute Providers that are struggling to achieve 18 weeks.	a) Limited ability to manage referral demand from primary care. b) Effectiveness of provider management and application of agreed Access Policy. c) Effective leverage over acute providers where the CCG is an associate commissioner. d) Lack of clarity of future planning of activity due to COVID-19 at this moment in time	a) 18 weeks performance is reported to the Finance and Performance Committee.	.	a) A number of specialties are not compliant at Commissioner level b) Other Providers that are currently struggling to achieve 18 weeks are Leeds Teaching Hospital Trust, Bradford Teaching Hospitals NHS Trust and Mid Yorkshire Hospital Trust.	Increasing
240	10/06/2013	F&P - Contracting	15	(I3xL5)	2	(I3xL5)	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	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	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% Sourced from NHS Digital on a monthly basis.	1. ASI figures in March 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.	Increasing
202	26/02/2013	F&P - Contracting	15	(I3xL5)	3	(I3xL5)	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.	Increasing

Item 15, Appendix 2a

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: 14.07.20

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: 1.4.19 – 234 days delayed 1.3.20 – 475 days delayed 1.4.20 – 17 days delayed (unvalidated as no national submission) 1.6.20 – 31 days delayed (unvalidated as no national submission) 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.
-	Assessment of the issues	Delivery of reductions to formally reported delays in transfer (DTOC), and the overall number of patients waiting for discharge has been a local priority for our system for the past 2 years. This focus saw Calderdale move from a negative outlier position, to one of the top performers. However, in winter 2019/20, performance deteriorated and the Calderdale system identified a set of actions to improve performance, including the targeting of additional BCF funding to support workforce challenges being experienced by our colleagues in Calderdale MBC. This intervention was beginning to impact positively as the pandemic struck. Reductions 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. As part of its Covid response Calderdale opened additional beds to support the discharge of covid and non-covid patients out of hospital; particularly the Retreat and Cedar Court, as well as plans to open up more capacity at Ingwood and Valley View as needed. As part of a national contract, post-acute beds for covid and non-covid patients were located with independent sector providers at BMI and Spire. They system worked together to try to prevent harm to patients discharged from hospital into care homes settings, providing practical infection prevention and control and more connectivity and dialogue on support requirements.
6	Actions	The A&EDB continues to have oversight of delivery of a reduction in delays in the discharge process, and the following actions are taking place: • Developing a new Winter Plan for the system; which aims to reduce discharge delays • Continuing to ensure an appropriate range of Discharge to Assess beds are available in the community – moving towards new trusted assessor models. • Development of a plan to drive forward changes in ways of working within the hospital social work team to strengthen joint working and integration with CHFT staff. • The use of a new Reason to Reside tool which provides a much more targeted view about those in hospital – from a context of whether or not they should be receiving care outside hospital. • The continuation of weekly multi-disciplinary meetings (CCG, CHFT, CMBC) to consider actions to support discharge on a patient by patient basis. The Care Home Programme established jointly with CMBC is 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.

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: 14.7.20

Item 15, 2b

Critical Risk Report

Risk ID: 62
Risk Type: Quality, Finance & Performance
Risk Category: F&P – Performance
Date first issued: 20th December 2016

Date last reviewed: 14.07.20

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. This reduced to 220 attendances per day throughout the peak of covid (17th March – 15th April) The number of A&E attendances at CHFT from late March to date demonstrates a statistically significant increase in attendance. At the point of writing, the number was back up to 420 per day, which is back up to pre-covid (February 2020) levels. The following provides a view of performance against the 95% target. March – 87% April – 93% May – 95% June – 95%
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 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 A&E minor attendances by PCN – data pack to be shared with PCNs and other before the end of July • Reframing of communications strategy for winter • Developing a new Winter Plan for the system; which aims to reduce demand for A&E and hospital beds – protecting the capacity for those who need it most • Continuation of the work on development of urgent car hubs.
7	Identified gaps	• Understanding of the full impact of social distancing on future models of care. • Full understanding of the deficit in hospital bed capacity during the winter period

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: 14.7.20

Name of Meeting	Audit Committee	Meeting Date		23/07/2020
Title of Report	**Audit Committee Annual Report 2019/20**	Agenda Item No.		16 a
Report Author	Andrew O'Connor, Senior Corporate Governance Officer – on behalf of the Audit Committee Chair	Public / Private Item		Public
GB / Clinical Lead	Prof Peter Roberts, Audit Committee Chair	Responsible Officer	Neil Smurthwaite, Interim Accountable Officer	

Executive Summary							
Please include a brief summary of the purpose of the report	This report provides a brief overview of the workings of the Audit Committee in order to evidence the effectiveness and impact of the Committee by demonstrating compliance with the Committee's Terms of Reference and delivery of its work plan.						
Previous consideration	Name of meeting	Audit Committee		Meeting Date		13/06/2019	
	Name of meeting			Meeting Date			
Recommendation (s)	It is recommended that the Governing Body **RECEIVES** the Audit Committee's Annual Report.						
Decision	☐	Assurance	☒	Discussion	☐	Other	Click here to enter text.

Implications			
Quality & Safety implications	Not applicable		
Public / Patient / Other Engagement	Not applicable		
Resources / Finance implications	Not applicable		
Strategic Objectives	Improving Governance	Risk	Not Applicable
Legal / CCG Constitutional Implications	This report forms part of the required reporting for the CCG.	Conflicts of Interest	Not Applicable

AUDIT COMMITTEE

ANNUAL REPORT 2019-20

1.0 Purpose of Report

1.1 The purpose of this annual report is to provide a summary of the Audit Committee's activities, demonstrating compliance with the Committee's Terms of Reference, delivery of the work plan, effectiveness and impact.

2.0 Background

2.1 The Audit Committee is established as a sub-committee of the Governing Body and in accordance with the Clinical Commissioning Group's (CCG) Constitution and Scheme of Reservation and Delegation.

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

2.3 The Committee has responsibility for maintaining an overview of the adequacy and effectiveness of the systems of internal control and risk management system across the whole of the CCG's activities.

2.4 The Governing Body has delegated scrutiny of the following functions to the Audit Committee:

- Audit
- Governance, Risk Management and Internal Control
- Emergency Preparedness and Business Continuity

2.5 The Committee also has delegated authority to approve the CCG's Annual Report and Accounts and policies, guidelines and procedures in respect of all areas of the Committee's responsibilities.

2.6 The details of the roles and responsibilities are set out in the terms of reference **https://www.calderdaleccg.nhs.uk/download/audit-committee-terms-of-reference**

3.0 Membership

3.1 The membership of the Committee as set out in the terms of reference is as follows:

Members:

- Lay Member with expertise/experience in financial management/audit matters (who will act as Chair)
- Lay Member (Finance and Performance)
- Lay Member (Lay Member – Public and Patient Involvement)
- Lay Advisor
- Registered Nurse or Secondary Care Specialist
- One GP Member from the Governing Body (excluding the Chair of the Governing Body) or one GP deputy.

Required Attendees:

- Chief Finance Officer/Deputy Chief Officer or the Head of Finance
- External and internal audit representatives would normally attend meetings.

3.2 The Committee met three times in 2019-20 and has been quorate on all occasions (see Appendix 1).

3.3 In February 2020, the membership of the committee was changed to recognise that the Lay Advisor was joining the committee's membership and the Lay Member (PPI) would be required to attend each meeting. The change was agreed between meetings of the Governing Body by the CCG Chair and Chief Finance Officer/Deputy Chief Officer (now Interim Accountable Officer) under urgent powers allowed in the Constitution having consulted with two other Governing Body members. The change needed to be agreed between meetings of the Governing Body in order that the Term of Reference could be updated prior to it being included as an appendix as part of proposed revisions CCG Constitution which was scheduled to be sent to CCG Members at the end of February following endorsement by the Governing Body at tis January meeting. The change was ratified by the Governing Body at its meeting on 23 April 2020.

3.4 The Committee undertook its annual review of its Terms of Reference at its meeting on the 27 February 2020. Several proposed minor amendments were agreed. The proposed amendments will be submitted to the Governing Body for approval.

4.0 Review of Committee Activities

4.1 The Audit Committee work plan is developed in-line with the responsibilities of the Committee as set out in the Terms of Reference. It also takes a risk based approach, reflecting the changing context in which the CCG has operated over the past year. The work plan is reviewed at each meeting. All items listed in the work plan have been considered in a timely manner (see Appendix 2: Audit Committee work plan 2019/20).

4.2 Key Activities During 2019/20

The Audit Committee has had a full and productive year, working to provide the Governing Body with the necessary assurances that there are effective systems and processes in place to keep the organisation safe, to comply with statutory and constitutional requirements and to be able to deliver the CCG's objectives.

4.2.1 Annual Report (2019-20)

Approval of the final Annual Report, Annual Governance Statement and Accounts forms one of the key activities of the Audit Committee at the end of the financial year.

All members of the Governing Body and the Senior Management Team had the opportunity to comment on the draft annual report prior to approval by the Audit Committee on the 18 June 2020 under delegated authority from the Governing Body.

The committee would like to take this opportunity to express its thanks to all involved in producing the Annual Report and Accounts to a high standard.

4.2.2 Other Key Areas of Focus

Approval of Policies

Throughout the year we have approved and received updates on amendments made to a number of the CCG's policies. These have been revised as part of the routine review cycle or in response to other factors including, for example, the requirements of the Data Security and Protection Toolkit; the introduction of NHSMail; a recommendation arising from the NHS Counter Fraud Quality Assessment Visit in March 2019; and the establishment of the NHS Counter Fraud Authority

The policies approved (or non-material amendments noted) were:

- Confidentiality and Data Protection Policy
- Information Security Policy (incorporating Network Security)
- Confidentiality and Data Protection Policy
- Information Governance Policy and Framework
- Standard of Business Conduct
- Anti-Fraud, Bribery and Corruption Policy
- Local Security Management Policy

Corporate and Information Governance (IG) Governance Assurance

The committee looks continuously to refine how it receives information. At its September 2019 meeting, it began to receive a Governance Assurance report in a new dashboard format. The new style format and layout has made it easier for Committee members to identify areas of reporting where there are issues that require attention. It also marks a shift to a higher degree of risk tolerance and a reduction in the amount of operational activity-based reporting against areas where compliance is not an issue. Through the dashboard the Committee maintained oversight of and received assurance concerning:

- The completion of the IG action plan to ensure compliance with the Data Security and Protection Toolkit.

- Compliance with Data Access Legislation (Freedom of Information and Subject Access Requests) with reports provided on a “by exception” basis in accordance with agreed reporting triggers.
- The occasion and reporting of any Information Commissioner’s Office (ICO) reportable IG Incidents.
- The process for managing conflicts of interest, including any policy breaches, and receiving updates through the year on the review and amendments to the CCG’s registers of interest and offers of Gifts, Hospitality and Commercial Sponsorship.
- Any instances when the Standing Orders had been suspended, authority delegated by the Governing Body or its Committees or the Corporate Seal applied.
- The occasion and reporting of any Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents originating at the CCG.
- The effectiveness of the CGG’s emergency planning and business continuity arrangements including any incidents and the delivery of planned exercises as a requirement of Emergency Planning Resilience and Response (EPRR) core standards (complemented by an Annual Reports concerning the CCG EPRR activities and compliance against the NHS England emergency planning core standards).
- The effectiveness of the CCG’s Risk Management Process (complemented by an annual report on activities within the CCG).
- The completion of the CCG’s Governing Body Assurance Framework bi-annual review process.
- Compliance with mandatory training requirements for CCG staff and Governing Body members.

Contracting

At each meeting the committee received a report on the CCG’s contracting position through an update on the contracts register, details of contract waivers approved and completed, a forward view of intended or potential waivers and a summary of current, completed and proposed tenders for assurance purposes.

4.2.3 **Working with the Auditors**

In 2019-20, the Audit Committee was supported in its work by Audit Yorkshire (Internal Auditors, Local Counter Fraud Specialist – LCFS and the Local Security Management Specialist- LSMS) and KPMG LLP (External Auditors).

The Audit Committee approves the internal audit, counter-fraud and local security management annual plans each year and receives updates on progress against these plans at each of its meetings, as well as an annual report at the end of the financial year.

Counter Fraud

An annual assessment (self-review tool) is undertaken to test the CCG’s compliance with the NHS Counter Fraud Authority’s (CFA) Standards for Commissioners: Fraud, Bribery and Corruption. The Local Fraud Specialist is to be submitted in accordance with the CFA’s requirements. The Local Fraud Specialist is currently working toward the submission with the Audit Chair and Interim Accountable Officer.

Internal Audit

The internal auditors provide the Committee with independent and objective opinions on the degree to which risk management, systems of internal control and governance support the achievement of the CCG's objectives. They are also able to provide independent advice and support the improvement of our systems and processes. The 2019-20 Internal Audit Plan was approved by the Audit Committee on 16 May 2019, focused on the design and embedding of core processes that underpin the delivery of the CCG's strategic objectives. Areas reviewed during the year were:

- Core Financial Systems
- Quality, Innovation, Productivity and Prevention (QIPP)
- Data Security and Protection Toolkit
- Primary Care Co-Commissioning
- Collaboration
- Continuing Healthcare (Controls Improvement Audit)
- Safeguarding
- Conflicts of Interest
- Governance and Risk Management

Following completion of the planned audit work for 2019-20, I am pleased to be able to report that the Head of Internal Audit Opinion was of **Significant Assurance** that a generally sound system of internal control, designed to meet the organisation's objectives was in place and that controls are generally being applied consistently. Further detail can be found in the CCG's Annual Report and Accounts 2019-20.

The committee would like to thank all the CCG's staff for their hard work which has resulted in this Head of Internal Audit Opinion.

External Auditors

The role of the external auditors primarily is to review and report on the CCG's financial statements and to assess whether the CCG has proper arrangements in place for securing economy, efficiency and effectiveness in respect of its use of resources. KPMG has attended all the Audit Committee meetings and their contribution has continued to be invaluable in terms of providing external scrutiny and challenge as well as keeping the Audit Committee members up-to-date through the provision of technical updates.

Private discussions between audit committee member and auditors

Private discussions between Audit Committee members and the external and internal auditors, without management present, ensure that there is a good relationship of trust between the auditors, and allows those present to raise any issues or questions. The meetings allow committee members and the auditors the opportunity to discuss a range of matters without any actual or perceived management influence. As Audit Committee members we have met with the internal and external auditors on three occasions, including prior to the approval of the Annual Report and Accounts at the end of the financial year.

5.0 Reviewing the effectiveness of Committees

5.1 The Audit Committee has the role of undertaking an annual review the effectiveness of the Governing Body's committees. One of the ways in which it does this is by

receiving an annual report from each of the committees including the CCG Auditor Panel, which set-out their attendance, key activities throughout the year, delivery of their terms of reference and the outcome of their self-assessment. The annual reports were presented to the Audit Committee by a representative of each of the committees on the 18 June 2019.

5.2 The committee is pleased to be able to report that there has been excellent attendance at each of the meetings and would like to acknowledge the commitment of the members and staff in delivering the committee work plans and in discharging their responsibilities as set out in the Terms of Reference. The Annual Governance Statement, which forms part of the CCG's Annual Report 2019-20, provides a useful summary of the work of our committees during the year.

6.0 Review of the Audit Committee's Effectiveness

6.1 The Audit Committee is always looking to improve the way in which it carries out its business, as well as setting a good example to the other committees. We carried out our self-assessment in January and discussed the findings in February - agreeing a number of areas for development in 2020-21. These included:

- Scheduling a fifteen minute pre-meeting for committee members and managers prior to each committee meeting.
- Looking to use learning from a planned Governing Body development session on the Governing Body Assurance Framework to advise the future design of committee agendas and workplan.

7.0 Next Steps

7.1 Subject the committee approval, this report will be submitted to a Governing Body meeting for its assurance.

8.0 Recommendations

8.1 It is recommended that the Governing Body **RECEIVES** the Audit Committee's annual report.

9.0 Appendices

Appendix 1 - Audit Committee attendance 2019-20
Appendix 2 - Audit Committee work plan 2019-20

Appendix 1

Audit Committee attendance in 2019-20

Audit Committee 2019/20		
Member	**Role**	**Attendance**
David Longstaff	Lay Member (Audit) (Until 31 December 2019)	2/2
Prof. Peter Roberts	Lay Member (Audit) (From 1 December 2019)	1/1
Denise Cheng-Carter	Lay Advisor (from 1st December 2019)	1/1
Dr Farrukh Javid	GP Member	3/3
Alison MacDonald	Lay Member (Patient and Public Involvement) (from 1st December 2019)	1/1
John Mallalieu	Lay Member (Finance and Performance)	3/3
Prof. Rob McSherry	Registered Nurse	3/3

Appendix 2

Audit Committee Work Plan for 2019/20

Approved 16 May 2019

No.	Item	16.5.19	26.09.19	27.2.20	14.05.20	24.09.20	As approp.
Annual Report							
1.	Receive Draft Head of Internal Audit Opinion			X			
2.	Receive final Head of Internal Audit Opinion				X		
3.	Review and approval of ARA prior to Chief Officer/CFO sign off	X			X		
4.	Receive ISA 260 (external audit)	X			X		
5.	CCG Management Representation Letter (ARA)	X			X		
Internal Audit							
6.	Receive Internal Audit Operating Charter			X			
7.	Receive the Internal Audit Annual Report	X (Draft)	X (Final)		X (Draft)	X (Final)	
8.	Agree Internal Audit Work Plan			X			

No.	Item	16.5.19	26.09.19	27.2.20	14.05.20	24.09.20	As approp.
9.	Receive/review Internal Audit Reports , in-year progress against work plan and progress on outstanding recommendations	X	X	X	X	X	
Counter Fraud							
10.	Receive Approve Counter Fraud Work Plan	X			X		
11.	Receive Progress Report	X	X	X	X	X	
12.	Receive Counter Fraud Self-Assessment				X		
13.	Receive the Counter Fraud Annual Report	X			X		
14.	Receive and consider any external reports on Counter Fraud						X
Local Security Management							
15.	Receive and agree Local Security Management work plan	X			X		
16.	Receive Progress Report	X	X	X	X	X	
17.	Receive risk assessment against standards for commissioners – security management						X
18.	Receive the Local Security Management Annual Report	X			X		
External Audit							
19.	Annual Audit letter following approval of the Annual Report and Accounts		X			X	
20.	Review of External Audit Work Plan for 2019/20.			X			

No.	Item	16.5.19	26.09.19	27.2.20	14.05.20	24.09.20	As approp.
21.	Private meetings between Committee Members and Internal and External Audit	X[1]	X		X[2]	X	
Risk Management							
22.	Receive assurance report on CCG Risk Management Process	X Annual Report	X		X Annual Report	X	
23.	Receive assurance on the process for reviewing and approving the Governing Body Assurance Framework		X	X		X	X
Contracting Assurance							
24.	Receive contracting report including: – waivers – contract register by exception	X	X	X	X	X	
Governance Assurance							
25.	**Governance Assurance Dashboard**	X	X	X	X	X	
	Information Governance – review the Annual Senior Information Risk Owner report	X			X		
	Information Governance – receive toolkit updates	X	X	X	X	X	

[1] Meeting to take place prior to review of annual report and accounts so that any concerns can be raised
[2] Meeting to take place prior to review of annual report and accounts so that any concerns can be raised

No.	Item	16.5.19	26.09.19	27.2.20	14.05.20	24.09.20	As approp.
	Receive exception reports on Standards of Business Conduct/Receipt of Gifts, Hospitality, Sponsorship						X
	Review exception reports on Application of the Seal						X
	Receive Assurance – approval of Updated Registers of Interest by Audit Committee Chair in their role as Conflict of Interest Guardian: **6 monthly** - Governing Body and Cttes (GB1); SMT(1); Associates (A1) **Annual** – CCG members (CCG2), CCG staff (S1)	GB1 SMT1 A1	S1	GB1 SMT1 A1	GB1 SMT1 A1 CCG2	S1	
26.	Review of Audit Committee Work Plan/progress in implementation of Work Plan	X	X	X	X	X	
27.	Review of draft work plan for 2020/21			X			
28.	Undertake self- assessment of effectiveness of Audit Committee, inc review of Audit Committee's attendance, terms of reference and work plan).			X			
29.	Review progress against actions/commitments arising from committee Self-Assessment		X				
30.	Receive annual reports from the other sub-committees			X			

No.	Item	16.5.19	26.09.19	27.2.20	14.05.20	24.09.20	As approp.
31.	Produce Audit Committee Annual Report for Governing Body.	X			X		
32.	Annual Audit Committee development session.			X			
Policies and procedures							
33.	EPRR Compliance and Action Plan Update		X Annual Report	X		X Annual Report	
34.	Bi-Annual Review of Standing Financial Instructions (Next Due September 2020)					X	
35.	Receive reports on any issues occurring regarding compliance with Standing Orders or Standing Financial Instructions						X
36.	Losses and Compensations						X
37.	Review of the CCG's Constitution						X
38.	Anti-Fraud, Bribery and Corruption Policy		X				
Additional items in year relating to areas of potential high risk or priority							
39.	Receive assurance report on agreements for shared posts or services						X
40.	Update on collaborative commissioning arrangements (to include BCF, STP, MOUs)						X
41.	Mid- year review of internal audit performance		X			X	

Item 16 b i

Minutes of the Audit Committee Meeting
held on 27 February 2020, 2.00pm
in the Shibden Meeting Room at Dean Clough

FINAL MINUTES

Present	Prof Peter Roberts	(PR)	Lay Member (Chair)
	Farrukh Javid	(FJ)	GP Member
	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
In attendance	Neil Smurthwaite	(NS)	Chief Finance Officer/Deputy Chief Officer
	Martin Pursey	(MP)	Head of Contracting and Procurement
	Lesley Stokey	(LS)	Head of Finance
	Andrew O'Connor	(AOC)	Corporate Governance Officer (Minutes)
	Jonathan Hodgson	(JH)	Audit Manager, Audit Yorkshire
	Danielle Hodson	(DH)	Assistant Audit Manager, Audit Yorkshire
	Olivia Townsend	(OT)	Local Counter Fraud Specialist, Audit Yorkshire
	Tim Cutler	(JB)	Partner, Public Sector Audit, KPMG
	Rob Gibson	(RG)	Corporate Systems Manager (for item 5, minute no. 53/20)
	Sam Byrnes	(SB)	Senior IG Officer (for item 5, minute no.53/20)

49/20 APOLOGIES FOR ABSENCE

New members were welcomed to the committee and introductions took place.

There were no apologies.

50/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

The Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters.

51/20 MATTERS ARISING FROM THE MEETING HELD 26 SEPTEMBER 2019

The minutes from the committee's meeting on the 26 September 2019 had been approved electronically between meetings and received by the Governing Body for assurance.

Matters Arising

Action 37/19 (Waiver Training) was ongoing but would be added to the agenda for the next Governing Body Workshop. The action was closed.

52/19 CONTRACTING REPORT

MP explained that the Contracting Report provided an update concerning procurements, waivers and the CCG's Contract Register.

Comments and questions were invited.

- In response to a question, MP confirmed that the information provided indicating why a waiver had been required referred to sections of the CCG's Standing Orders. It was agreed that an extract from the waiver form would be provided in future for the committee's reference so that it was clear which part of the Standing Orders were being applied. **MP**
- In response to a question concerning the reasons for different waivers, NS explained that the different waivers were presented to relevant bodies and individuals as part of the decision process and in accordance with the CCG's standing financial instructions. Moreover, that the assurance process to the Audit Committee had developed to focus on providing the committee with assurance that the appropriate processes had been followed rather than revalidating the decision. There was an agreement that a column be added to the list of waivers indicating which individual or body had signed off the waiver. **MP**
- MP advised the committee that, since publication, 14 further signed contracts had been received.
- In response to a question concerning the level of risk presented by outstanding contracts, MP replied that the two Calderdale and Huddersfield NHS Foundation Trust (CHFT) contracts were Any Qualified Provider (AQP) contracts; that the Trust continued to provide the service; and it was an issue of the trust engaging to resolve residual issues in contracts which were supplementary to the main acute contract. He also explained that there was a perennial issue with providers of Continuing Health Care (CHC) services failing to return contracts which had been addressed regularly by the committee and that, while some contracts were still outstanding, it was now a much improved picture. MP added that Calderdale had an overall portfolio of 264 live contracts. JM recognised that significant progress had been made over time by the Contracting Team.
- In response to question concerning Community Ophthalmic Services and whether the providers would be required to return a signed contract before receiving a new one, MP replied that it would not be a requirement and that he would anticipate the contracts being extended.
- In response to a question, MP confirmed that a number of the waivers agreed had been in order to align the CCG's commissioning intentions concerning Care Closer to Home. JM concurred adding that waivers were relatively low.

DECISION:

The Audit Committee **RECEIVED** and **NOTED** for assurance the content of the report, appendices and progress.

53/20 GOVERNANCE ASSURANCE DASHBOARD

RG in presenting the dashboard explaining that it provided the committee with an overview of compliance against statutory and regulatory requirements under the CCG's governance framework. Sections marked green were noted to be for assurance. Those marked red were for the committee's attention and/or decision.

SB in presenting the IG section of the dashboard advised the committee that the CCG's position concerning the Data Security Standards had changed since publication.

- Standard 3 (Training) had increased to 71%; members of staff were being followed up.
- Standard 6 (Responding to Incidents) had increased to 100%.

- Standard 8 (Unsupported Systems) had increased to 67%. A piece of work concerning unsupported software was be finalised with recommendations being made to the Senior Information Responsible Officer (SIRO). This standard would then be complete.
- Standard 9 (IT Protection) had increased to 56%. This standard was dependent on a third party (THIS). The Head of IT was overseeing the work against this standard. Weekly meetings were taking place to provide the evidence required. Achievement of the standard was anticipated.
- The overall compliance total had increased to 87% since publication.

There were no questions on this section of the dashboard.

RG brought the following matters to the attention of the committee:

- There had been a breach relating to a Subject Access Request (SAR) in quarter 2. Reasons for the breach were outlined in the report. No complaint had been received.
- A complaint had been received from an applicant concerning two SARs submitted to the CCG. Both requests had been responded to within the statutory deadline. The applicant felt there were documents which had not been supplied. The CCG responses to the requests were being reviewed by the CCG's Information Governance Manager. While the trigger for reporting to the committee had not been met, it was being informed in the event that the individual complained to the Information Commissioner Office (ICO).
- There had been 5 FOI's that had breached the 20 day statutory deadlines for response in Quarter 3. This was due to capacity issues; measures were in place to mitigate against this happening again.

SB presented the updated Information Governance Policy and Framework for approval following review. The policy has been reviewed earlier than planned to reflect changes to two key organisational roles (the Data Protection Officer and IG Lead). The review also ensured the policy and framework remained up-to-date with the requirements of the Data Security and Protection Toolkit, national serious data security incident reporting guidance, and changes in committee reporting via dashboard. The changes were non-material and set out in the dashboard for the committee's information.

RG drew attention to Staff and Governing Body member statutory training compliance as set out in dashboard, commentary and action being undertaken.

Comments and questions were invited.

- JM noted that the statutory mandatory compliance data had been shared with the CCG Chair and himself. He also reported there may be an issue with the Safeguarding training not appearing as a requirement for Governing Body members. RG agreed to look at this. **RG**

DECISION:

The Audit Committee:

- **NOTED** the content of the dashboard.
- **APPROVED** the revised Information Governance Policy and Framework.

54/20 INTERNAL AUDIT

a) Audit Yorkshire Effectiveness Survey

JH in presenting the report explained that it provided a summary of the results from the Audit Yorkshire Effectiveness Survey undertaken by the committee on 26 September 2019 and associated actions to be taken in response to feedback. The full survey results had been provided at Appendix A. The information had been circulated to members previously on the 11 October 2020 and was being presented formally to the committee for its information.

Questions and comments were invited:

- In response to a question, JH confirmed progress would be assessed during the next annual self-assessment exercise which was scheduled for September 2020. It was agreed that, at this point, the committee would be able to consider if it would like a 6 month update to be included in the workplan on in the future.
- JH advised the committee that Audit Yorkshire would be making use of automated functions in its software to issue reminders to those managers with outstanding actions.
- LS and JH had started regularly meeting to identify if there were any outstanding actions that required escalation.
- JH confirmed that communications and engagement had consistently improved over the last 18 months.
- The report was recognised to be reflective of the conversation that had taken place.

b) Internal Audit Progress Report

JH drew attention to the following key points:

- Financial Systems and Management and Quality, Innovation, Productivity and Prevention (QIPP) final audit report had been issued and received "SIGNIFICANT" assurance.
- A Data Security and Protection Toolkit (Stage One) Advisory Report had been issued. This would be followed by a stage 2 report to provide assurance on the evidence base.
- 3 reports were in draft as set out in the report. One of the reports, Continuing Health Care was now a Controls Improvement Audit. This was explained to be a two stage process consisting of an advisory then assurance report. Audit Committee members were asked to agree this deviation from the original audit plan.
- The achievement of 100% of Key Performance Indicators.
- The number of audit days used at the time of the meeting. This stood as at 66.5 against 96 planned days. 10 contingency days had been removed at management request; these would be carried forward into 2020/21.

Questions and comments were invited:

- JH and DH confirmed there were sufficient days available to complete the required audit work.
- JH confirmed that the ongoing audit reports were in draft and subject to ongoing agreement with managers.

With regard to the completed Financial Systems and Management and Quality, Innovation, Productivity and Prevention (QIPP) audit reports DH drew attention to the following key points:

- Financial Systems and Management – an internal audit opinion of "SIGNIFICANT" assurance had been provided. It had been a detailed financial review and the vast majority of controls were found to be in place. A small number of recommendations

had been made concerning budgetary control which were set out in the report.

- Quality, Innovation, Productivity and Prevention (QIPP) - an internal audit opinion of "SIGNIFICANT" assurance had been provided. It was clear that the QIPP schemes were being managed; however, it was recommended that the decision to pass the role of the Recovery Operational Group to the Quality, Finance and Performance Committee be regularly reviewed in order to identity and to address any emerging issues.

There was a discussion concerning the process applied in determining whether to aware "significant" as opposed to "high" assurance opinions. The Chair recognised that Audit Yorkshire was operating on the same basis as most other auditors would, but expressed a preference for being able to understand the exact criteria being used.

JH concluded by noting that the two outstanding recommendations relating to Risk Management and Governance Arrangements would be addressed at the planned Governing Body Workshop in April.

c) Internal Audit Charter

JH explained that the Charter was a requirement of the Public Sector Internal Audit Charter and was being presented to the committee for its information and assurance. The committee's attention was drawn to the key elements in the charter.

Comments and questions were invited:

- In regard to the Core Principles, it was suggested "including the dissemination of best practice and innovation" might be added to "promotes organisational improvement" in order to reflect the existence of a community of learning. JH confirmed he would feed this suggestion back to the board. **JH**
- It was also suggested that the availability for organisational support around environmental and sustainability agendas might be reflected. The availability of capacity for work in these areas had been raised with Helen Kemp-Taylor by the Chair. In addition, it was also suggested that Audit Yorkshire may wish to reflect in their charter how they are responding to these agendas as a provider organisation. **JH**

d) Draft 2020/21 Internal Audit Operational and Three Year Strategic Plans

In presenting the plans, JH explained that the 2020/21 Operational Plan had been developed through the review of the 2019/20 to 2021/22 Strategic Plan, taking into account: the impact of any wider changes to the public sector and NHS; other eternal factors, both local and regional; changes to strategic operational risks; any cancelled or deferred audits and wider audit knowledge. The proposed plan had been discussed with NS and the wider Senior Management Team in February 2020. Attention was drawn to pages 3 and 4 in the plan setting out the proposed audits to be undertaken.

Comments and questions were invited:

- In response to a question concerning the reduction in the number of days allocated to Commissioning and Contract Manager audits, JH explained that Audit Yorkshire had reduced its planned programme by 20% as part of contributing to the 20% reduction in CCG running costs required by NHS England (NHSE). Also, JH explained that the day allocation was a profile of how the days were allocated and there was typically some fluctuation in response to the different requirements between years.
- In regard to the Strategic Plan, the following were suggested for future consideration:
    - Freedom of Information compliance following changes in CCG Teams.
    - Auditing of Primary Care Networks.
    - Sustainability
- There was a discussion around the total numbers of days requested. It was explained

that this was the product of a calculation around the amount of time that could be provided within the fixed price paid by the CCG. JH suggested he could report on percentage of plan in future.

d) DRAFT Head of Internal Audit Opinion 2019/20

JH in presenting the draft Head of Internal Audit Opinion explained that it was a statutory requirement as part of Public Sector Audit Standards providing assurance on the effectiveness of the internal control environment in the organisation. Changes to the document since the previous year were highlighted. These included:

- For items of low or limited assurance - some narrative would be provided summarising some of the key issues and the CCG's response to date.
- Some narrative would be added identifying any emerging issues that might pose a risk to the organisation or system that had not yet materialised

The draft Head of Internal Audit opinion would be submitted to NHSE and Improvement (NHSI) on the 13 March 2020 and the 16 April 2020 with the final version submitted with Annual Report and Accounts on the 28 May 2020. An updated draft would be circulated to committee members prior to the first submission date.

The Audit Committee :

- **NOTED** the results of the survey and the actions.
- **NOTED** the content of the progress reports.
- **APPROVED** that the change of the Continuing Health Care assurance audit to a two stage Controls Improvement Audit as a variation to the audit plan.
- **APPROVED** the Internal Audit Charter asking that the suggestion made being considered during the next review.
- **REVIEWED** and **APPROVED** the 2020/21 Draft Internal Audit Operational and Three Year Strategic Plans
- **REVIEWED** the **DRAFT** Head of Internal Audit Opinion and **TOOK ASSURANCE** from its contents and mandatory compliance under the Public Sector Internal Audit Standards.

55/20 ANTI-CRIME

OT presented an update concerning work undertaken in relation to Counter Fraud. Attention was drawn to the following key matters.

a) Inform and involve

- The planned Identity Document Training had been postponed due to bad weather. It would be rescheduled. Invitees would be broadened to include corporate services staff in addition to all recruiting managers. NS suggested that this be widened to the admin support in other CCG teams. OT confirmed she would act on this. OT
- The staff awareness survey would be issued to all staff in the near future to measure staff understanding of fraud, bribery and corruption. This was required in order to meeting the standards of set by the NHS Counter Fraud Authority while the information collected helped to develop the 2020/21 Counter Fraud workplan.

b) Prevent and Deter

- Six fraud alerts had been issued to the CGC since the last committee meeting. These were reported as set out in the report.

c) Self Review Tool Submission

The Self Review Tool (SRT) submission was due by the 13 April 2020. NS and PR would be required to have input prior to submission.

d) Local Security Management Update

At the time of the meeting no further information had been published nationally. Audit Yorkshire's Local Security Management function would continue to provide support required by the CCG.

Comments and questions were invited:

- NS assure the committee that information concerning fraud alerts had been circulated to all staff and OT had attended the recent staff workshop as part of heightening people's awareness as emails being received were appearing to be sent from ESR and NHS.net accounts. Testing earlier in the year indicated that there was a need to improve people's awareness of the risk of clicking links. This was being addressed by the Information Governance team.

DECISION:

The Audit Committee **NOTED** the content of the reports.

56/20 Review of External Audit Work Plan 2019/20

TC presented the External Audit Work Plan 2019/20 which set out the work that would be undertaken in order to audit the CCG's financial statements and value of money inclusion by the 31 May 2020. Work in support of the audit was ongoing following meetings with NS and LS in January 2020. The following key issues were highlighted:

- The executive summary at p3.
- There were no changes to the audit code for 2019/20.
- Secondary care expenditure continued to be deemed a significant risk; it being the largest part of the CCG's financial statement.
- A new significant risk concerned expenditure recognition. This was in response to Practice Note 10 which recognised that control totals incentivised decision making around cost and expenditure. KPMG had been alert to this previously and had not encountered any issues.
- The management of override controls was noted a non-rebuttable auditing standard driven risk which was always included as a significant risk.
- A materiality of £6 million had been set which was a slight increase on the previous year in response to an increase in gross resource expenditure. Any errors in excess of £6m this would be qualification issue in the financial statement. Anything below this amount down to a reporting threshold of £300k would be reported in order to advise decisions on the adjustment of the accounts. There had been no such issues previously.
- There were no value for money significant risks deemed reportable.
- Looking to the future, the National Audit Office Code of Audit Practice would change for 2020/21. This would include a change in approach to value for money. At the time of the meeting, significant risks were identified and a conclusion provided at year

end. From 2020/21, a value for money conclusion would continue be provided but there will also be prescribed programme of work culminating in a published report to go along with the ISO 260.

- IFRS 16 was not a significant risk for 2019/20 as the current requirement was to only to demonstrate the impact that it would have on the CCG's financial statements when it was fully implemented in 2020/21. KMPG would audit the disclosure in the current year's account but also provide assurance that the work underpinning the disclosure was complete and accurate accurate. This work was ongoing and further conversations concerning the implications of IFRD 16would take place at a later point. Significant changes at CCGs were not expected with the exception of leases held. NS assured the committee that the CCG was in a good position on this point.

DECISION:

The Audit Committee **RECEIVED** and **NOTED** the contents of the plan.

57/20 AUDIT COMMITTEE WORK PLANS

a.) Review of the 2019/20 Workplan

DECISION:

The Audit Committee **NOTED** progress against the 2019/20 Workplan.

b.) Draft Workplan 2020/21

The polices due to come to the committee for review during the year had been added to the Workplan (line 38-42)

The requirement for the committee to receive an Annual Report from the Auditor Panel had been added (line 30).

It was noted that the Standing Financial Instructions were due to come to the committee in September 2020 and this needed to be reflected on the workplan. **AOC**

DECISION:

The Audit Committee **APPROVED** the contents of the 2020/21 workplan as amended.

58/20 ITEMS FOR GOVERNING BODY AND/OR OTHER COMMITTEES

No items were identified on this occasion.

59/20 REFLECTIONS ON THE MEETING

It was agreed that the meeting had gone well. It was also agreed that a 15 minute pre-meeting for committee members and managers would be useful before future committee meetings. **AOC**

60/20 ANY OTHER BUSINESS

- Audit Yorkshire was running a partnership learning event on Monday 2 March 2020. Details would be circulated again as places were still available.

- There was a position on the Audit Yorkshire Board available to the CCG. PR and JM agreed to cover the position.

- Audit Yorkshire had received positive verbal feedback following its external quality assessment. The expectation was that they AY would be found compliant with all public sector audit standards. The written report would be circulated to members when available.

61/20 DATE AND TIME OF THE NEXT MEETING

DECISION:

The committee **NOTED** that the next meetings would take place as follows:

Audit Committee Private Meeting
14 May 2020, 1.30-2.00pm
Shibden Meeting Room, Dean Clough

Audit Committee Meeting
14 May 2020, 2.00-5pm
Shibden Meeting Room, Dean Clough

62/20 ANNUAL REVIEW OF COMMITTEE EFFECTIVENESS (INC TERMS OF REFERENCE)

The committee self-assessment in 2019/20 had consisted of the outgoing committee chair and Lead Officer completing a questionnaire assessing the conduct of the business of the committee in relation to the responsibilities set out in its terms of reference. AOC presented the outcomes of the committee's annual review for the committee's consideration and comment. It was explained that the outcome of the discussions would flow through for inclusion in the Committee's Annual Report and the CCG's Annual Report as well has helping to form the committee's annual development plan.

The committee's Terms of Reference were also presented with amendments for approval. It was noted that the Terms of Reference, if agreed, would be presented to Governing Body for approval at a future meeting.

A discussion followed during which the following key points were made:

- **Induction** – the committee recognised the induction arrangements already in place. It also recognised that a regular 15 minute pre-meeting had been agreed earlier in the meeting which new members had suggested would be beneficial. Issues around induction were noted to have been discussed at other committees during the self-assessment and that that a piece of work might take place after 6 months to gather the feedback of new members in order to support their ongoing development and future organisational planning. Both KMPG and Audit Yorkshire offered their support for committee member development.

- **GBAF** – questionnaire feedback had raised a concern as to whether the Governing Body Assurance Framework was used to design committee agendas and to focus committee business on issues of substance. It was noted that an upcoming

Governing Body development session would look at the design of the GBAF which in turn should enable committees to consider how it is then used to design their agendas and workplans in order to provide assurances to the Governing Body on the GBAF's delivery.

- **Governance Advice and Support –** the Chair recognised the changes that had taken place in governance support and the need to continue to monitor those changes as they bed-in.

The committee addressed the proposed changes to the Audit Committee Terms of Reference. These included:

3.1 **Members**

The Lay Advisor added as member of the committee
The Lay Member (PPI) moved to separate line in membership to reflect their being an expected attendee and the increased committee membership making achieving quoracy less of a practical concern.

3.1 Attendees

Removal of Head of Corporate Affairs and Governance. The post was no longer in the CCG structure.

5.5.1 Integrated Governance, Risk Management and Internal Control

First bullet – A change to reflect that the committee no longer recommended the disclosure statements referenced to the Governing Body for its endorsement. The committee reviewed these as part of the process signing of the CCG's Annual Report and Financial Statement.

Second bullet – A change to reflect that the committee oversaw and received assurances concerning the GBAF review and approval process biannually. The committee no longer reviewed the GBAF itself prior to it being submitted to Governing Body.

DECISION:

The Audit Committee:

1) **CONSIDERED** the Chair and Lead Officers assessment against the self-assessment questionnaire and **IDENTIFIED** development needs as set out above in these minutes.

2) **REVIEWED** and **APPROVED** the terms of reference as amended for recommendation to the Governing Body.

3) **NOTED** the change to the Audit Committee membership in the Terms of Reference agreed by CCG Chair and Chief Finance Officer/Deputy Chief Officer between meetings of the Governing Body as an urgent decision under provisions provided for this in the CCG's Standing Orders.

Item 16 6 ii (a)

Minutes of the Auditor Panel
held on Thursday 20 February 2020 at 2pm
in the Hardcastle Meeting Room, Dean Clough, Haliax

FINAL MINUTES

Present	Prof Peter Roberts	PR	Lay Member, Audit (CHAIR)
	John Mallalieu	JM	Lay Member, Finance and Performance
	Dr Farrukh Javid	FJ	GP Member
	Alison MacDonald	AM	Lay Member, Patient and Public Involvement
In attendance	Martin Pursey	MP	Head of Contracting and Procurement
	Lesley Stokey	LS	Head of Finance
	Andrew O'Connor	AOC	Corporate Governance Officer (Minutes)

01/20 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST **Action**

There were no apologies received.

There were no declarations of interest in relation to items on the meeting's agenda.

It was noted that conflicts of interest may arise during the procurement process which would need to be managed. This would depend on which bidders responded to the tender invitation.

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.

02/20 PROVISION OF AN EXTERNAL AUDITOR SERVICE – PROCUREMENT UPDATE

MP in presenting the report explained that the Governing Body had approved that a procurement be undertaken to appoint an external auditor to the CCG. It had also delegated authority to the Auditor Panel to select and appoint an external auditor having agreed and overseen a robust procurement process in-line with the organisation's normal procurement rules. The report was noted, especially the timeline for the procurement and the proposal to use the Shared Business Service Framework for this purpose. This had been provided at Appendix 1 and included a list of the approved suppliers. The Crown Commercial Services Framework had been used during the previous auditor procurement.

In response to a question concerning the implications should the panel wish to broaden the range of possible bidders to include those not on the framework, MP confirmed that it would take the procurement beyond the aggregate value for procurement and a full procurement exercise would be required.

In response to a question, MP confirmed that there were fewer potential suppliers on the Shared Business Services Framework but that he anticipated this would not impact the number of bids received.

The panel noted that the current Auditor Services Contract was due for renewal and that the incumbent provider had indicated a significant increase in fee would be required should the CCG wish to continue with its services. This had resulted in the CCG looking to procure an alternative provider. Issues with performance over the length of the contract were noted to include a change of audit manager in each year.

MP

The panel agreed to proceed with the Shared Business Services Framework. The committee asked that arrangements to ensure continuity in audit managers/management be put in place.

The Intention to Tender document was scheduled to be made public on Monday 24 February 2020. The draft was almost complete at the time of the meeting. The pricing set would include provision from Year 2 to adjust the contract value should North Kirklees CCG and Greater Huddersfield CCG merge.

MP confirmed that the 2019/20 Calderdale CCG accounts would not be affected should a new auditor service not be procured by 1 April 2020.

LS understood that there was sufficient market interest in providing audit services to the NHS and that a sufficient number of bidders could be anticipated.

A price envelope of £45K and a weighting of 50% was confirmed.

The framework conditions and supplementary elements in the specification were explained to provide assurance regarding standards of performance. An arrangement to provide notice after 18 months had been included in the previous specification.

Addressing the cost envelope, it was recognised that potential suppliers could propose a price as part of their bid if they felt that the cost envelope was not sufficient and that there may need to be a negotiation if a service could not be procured within the set value.

DECISION

The Auditor Panel **APPROVED** the process for selecting an External Audit Service.

03/20 DATE AND TIME OF THE NEXT MEETING

The Date and time of the next meeting was to be confirmed.

Auditor Panel Meeting – 20 February 2020 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments/ Completion Date
PROVISION OF AN EXTERNAL AUDITOR SERVICE – PROCUREMENT UPDATE	02/20	The committee asked that arrangements to ensure continuity in audit managers/management be put in place.	MP	Complete	

Item 16 b ii (b)

Minutes of the Auditor Panel
held on Thursday 14 May 2020 at 2pm
Online

FINAL MINUTES

Present	Prof Peter Roberts	PR	Lay Member, Audit (CHAIR)
	John Mallalieu	JM	Lay Member, Finance and Performance
	Prof Rob McSherry	RM	Registered Nurse
	Alison MacDonald	AM	Lay Member, Patient and Public Involvement
In attendance	Neil Smurthwaite	NS	Chief Finance Officer/Deputy Chief Officer
	Martin Pursey	MP	Head of Contracting and Procurement
	Lesley Stokey	LS	Head of Finance
	Andrew O'Connor	AOC	Corporate Governance Officer (Minutes)
	Brenda Powell	BP	Senior Procurement Officer

04/20 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST **Action**

Apologies were received from Dr Farrukh Javid (GP Member).

There were no declarations of interest in relation to items on the meeting's agenda.

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.

05/20 MINUTES OF THE AUDITOR PANEL MEETING HELD ON 20 FEBRUARY 2020

DECISION:

The Auditor Panel **APPROVED** the minutes of the Panel meeting that took place on 20 February 2020.

06/20 PROVISION OF AN EXTERNAL AUDITOR SERVICE – PROCUREMENT UPDATE

MP in presenting the update explained that, following the approval to proceed, a procurement process had been undertaken as detailed in the report. Two potential providers had returned Invitation to Tender documents by the deadline date. The evaluated scores were 75.5 for Grant Thornton UK LLP and 63.7 for KPMG LLP. MP observed that that the main difference between the two evaluated scores was the 5 point difference in the weighting for the price. Moreover, that a significant moderation process was unlikely to affect the outcome on the basis that the 5 point differential would remain. The committee recognised this and was supportive of the view provided. MP advised that the overall average of scores for Grant Thornton was 2.5 while KPMG achieved a scoring of 1.9. It was recognised that Grant Thornton had scored consistently higher than KMPG.

LS, NS, JM and PR, who had undertaken the evaluation, confirmed that they were

happy to proceed on the basis of using the 2.5 (Grant Thornton) and 1.9 (KPMG) average overall scoring and differential supplemented by the weighting on price.

MP confirmed that on this basis Grant Thornton UK LLP be recommended as the preferred bidder.

The Panel confirmed that it was happy with the scorings and rationale provided by the evaluators and was satisfied that a robust selection process had been undertaken in line with the organisation's normal procurement rules

DECISION

The Auditor Panel:

1. **APPROVED** the contract award to the recommended provider (Grant Thornton UK LLP).
2. **NOTED** the process for selecting the provider for the External Audit Service and **CONFIRMED** that the selection process has been robust and is in line with the organisation's normal procurement rules.

MP explained that feedback would be provided to the bidders followed by a ten day stand still period which would allow the unsuccessful to bidder to request further feedback or challenge the decision. Subsequent to this, a signed contract would be obtained.

BP confirmed that she had enough information to provide the required feedback and to respond to any further questions raised.

It was agreed that it would be appropriate for feedback to be provided to KPMG at the private meeting scheduled for the 18 June 2020.

The Panel also agreed it was happy for NS to contact KPMG, in addition to the normal notification and feedback process, as a professional courtesy.

PR advised BP and MP that he would be happy to provide support in the event of the decision being challenged.

07/20 DATE AND TIME OF THE NEXT MEETING

A further meeting of the panel was not required.

Item 16 b iii

Minutes of the Quality, Finance and Performance Meeting held on Thursday 26 March 2020, 2.00pm – 3.00pm, virtually using Microsoft Teams

FINAL MINUTES

Present:	Dr Majid Azeb	(MA)	Clinical Vice Chair and GP Governing Body Member **(Chair)**
	Neil Smurthwaite	(NS)	Chief Finance Officer and Deputy Chief Officer
	Penny Woodhead	(PW)	Chief Quality and Nursing Officer
	Dr Caroline Taylor	(CT)	GP Governing Body Member
	John Mallalieu	(JM)	Lay Member (Finance)
	Alison MacDonald	(AM)	Lay Member (PPI)
	Rob McSherry	(RM)	Registered Nurse
In attendance:	Lesley Stokey	(LS)	Head of Finance
Minute Taker:	Zoe Akesson	(ZA)	Senior Administrator, Corporate Services

001/20 APOLOGIES FOR ABSENCE **Action**

Apologies were received from Dr Farrukh Javid.

The Committee was reminded that due to the unprecedented situation, the meeting was conducted with only core committee members in attendance. The agenda had been streamlined by the Senior Management Team (SMT) and the Chair to ensure only key items were presented for decision making. The full pack of papers was provided for assurance. It was requested that any comments or questions relating to the same were sent to the leads to be addressed outside the meeting.

002/20 DECLARATIONS OF INTEREST

Members of the Committee were invited to declare any interests relevant to items on the agenda. There were no declarations of interest.

The Register of Interests can be obtained from the CCG's website https://www.calderdaleccg.nhs.uk/register-of-interests or from the CCG's headquarters.

003/20 MINUTES OF THE PREVIOUS MEETING

Minutes of the Quality, Finance and Performance Committee meeting on 19th December 2019

The attendance section was amended to include Rob McSherry. The minutes were then recorded as an accurate record of the meeting.

DECISION:

The minutes of the 19th December 2019 meeting were **RECEIVED** and **ACCEPTED** as a correct record.

004/20 MATTERS ARISING

There was one open action, relating to minute Action No 030/19 to speak to the practices that had declined to participate in the E.coli data collection. The action would be revisited in 6 months-time post COVID and was deferred to September's meeting. All other actions were closed.

005/20 MINUTES FROM THE DELEGATED AUTHORITY SUB GROUPS

At December's Committee there was an agreement to delegate authority to a sub-group to make a decision on its behalf on three specifications;

Delegated Sub Group 16th January 2020 of the Quality, Finance and Performance Committee for the General Practice Access Scheme for Calderdale CCG Member Practices Additional Urgent/On the Day Appointments 2019/20

Delegated Sub-Group 6th February 2020 of the Quality, Finance and Performance Committee for the Draft Service Specifications for Calderdale Older Adults' Mental Health Intensive Support Service and Calderdale Open Minds Partnership Thrive Service

The sub-groups approved the specifications.

DECISION:

The Committee **RECEVIED** and **NOTED** the minutes from the above delegated sub-group meetings.

006/20 PUBLIC SECTOR EQUALITY DUTY GOVERNANCE

The equalities annual report was received by the Committee for approval. The Governing Body had delegated sign-off to the QFP Committee due to the timeframe for publication, which was the end of March. PW described the document as being more accessible with links to published documents and highlighted streams of work to illustrate the range of activity.

Questions and comments were invited.

- The document was well received and the links were a useful tool.
- In relation to terminology, it was asked that the reference to people with learning disabilities to be re-worded to include 'people with neurodevelopment disorders'.
- To ensure the links were working within the document.
- The Committee was reminded that the workforce headlines should be representative of the Calderdale population and to reflect the diversity of the organisation. PW reassured the Committee this would be reflected in the report once the WRES action plan has been refreshed.

DECISION:

The Committee was in **AGREEMENT** to approve for publication.

007/20 FINANCE REPORT: BRIEF ON COVID-19 – THE CHANGING ENVIRONMENT

The finance report was received by the Committee. LS explained that in this extraordinary situation, information was being received on a daily basis and there would be significant changes to the one year operational financial plan for 2020-21 that had been submitted on 5th March 2020. The plan made a number of assumptions which would no longer be valid at the beginning of the financial year due to the specific actions received from NHSE to redirect resources. The CCG was working through these to understand the financial impact in response to the pandemic.

LS shared slides on the implications for both providers and commissioners.

In relation to Providers;

- The CCG would provide financial stability ensuring a clear cash flow for providers and a mechanism had been launched for capturing costs for reimbursement.

- The CCG had taken into account providers will be taking a reduction in their other income streams due to carrying additional costs for COVID-19 and may not be able to achieve what they were planning to do in terms of the cost improvement plans.

- Providers would be paid 2 payments in April to ensure any response to COVID-19 would not be slowed down and the efficiency payment would not be removed so providers would be paid more than the CCG intended.

- The CCG was working on simplifying invoicing for non-contracted activity to improve the cash flow.

- With regards to reimbursing and capturing costs around COVID-19, both providers and commissioners were asked to capture these reasonable costs, which would be paid promptly. It was emphasised there is a need for good data capture and governance around this process.

- The Finance team have considered their business continuity plan along with those for the CCG's payroll provider, the national SBS and financial ledger.

In relation to Commissioners:

- LS explained the CCG would not receive additional money and therefore would have to re-forecast the plan for next year based on the national priorities although some of the implications would be taken into considerations such as not applying the efficiency factor, the changes in the NCA payment arrangements and the additional costs received in relation to COIVID-19.

- The CCG was asked not to make any investment decisions during this time which would have significant implications, in particular around the Mental Health Investment Strategy.

- In relation to pressures, the CCG was receiving a numbers of asks from providers. The challenge for the CCG would be to prioritise and ensure the main NHS providers have the funds to support the pandemic.

- The CCG was reviewing its standing financial instructions to check they were fit for purpose.

In line with national guidance, the CCG would keep the Committee updated on the

current financial situation and would be clear and transparent on any decision making during this time.

There were no further comments received.

DECISION:

The Committee **ACKNOWLEDGED** the update and **RECOGNISED** the challenge of the undertaking.

008/20 MENTAL HEALTH COMMUNITY REHABILITATION SERVICE DRAFT SPECIFICATION

The Committee was asked to approve the draft specification for the Calderdale Complex Mental Health Rehabilitation and Recovery Service. The draft specification had been developed in the context of the draft emotional health and wellbeing strategy for Calderdale and the engagement work undertaken by the CCG and partners around mental health rehabilitation and recovery. As part of the Mental Health Investment Standard it would modernise the inpatient service by moving it to a community setting. The paper was supported by SMT, noting this was not a financial ask. The business case would be presented at Governing Body in April.

Questions and comments were invited.

Monitoring the duration for patients going into residential stay was raised and it was questioned how the committee could be assures patients do not remain in residential care longer than required. NS explained the specification was a generic description and that the business case would be more specific in providing detail around outcomes and performance measures.

Overall, the Committee felt it was a very comprehensive specification for a much needed service.

DECISION:

The Committee **SUPPORTED** the Mental Health Community Rehabilitation Specification.

009/20 QUALITY & SAFETY REPORT AND DASHBOARD

The paper was received and taken as read.

DECISION:

The Committee **NOTED** the update.

010/20 QUALITY, FINANCE AND PERFORMANCE COMMITTEE

- **Annual Assessment**
- **Annual Report**
- **Terms of Reference**

The papers were received for assurance. No comments were received.

DECISION:
The Committee **NOTED** and **APPROVED** the draft reports and terms of reference.

011/20 CONTRACT REPORT

The paper was received and taken as read.

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

012/20 PERFORMANCE REPORT

The paper was received and taken as read.

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

013/20 EQUALITY AND DIVERSITY REPORT

The paper was received and taken as read.

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

014/20 TRANSFORMING CARE PROGRAMME UPDATE

The paper was received and taken as read.

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

015/20 RISK REGISTER AND REPORT

The paper was received and taken as read.

DECISION:
The Committee **NOTED** the contents of the report.

016/20 GBAF

The paper was received and taken as read.

DECISION:

The Committee **NOTED** the contents of the report.

017/20 WORKPLAN

The workplan was received and taken as read.

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

018/20 MINUTES AND HIGHLIGHT REPORT

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

- Highlight report for the A&E Delivery Board meeting held on
- Highlight report for the Integrated Commissioning Executive
- Minutes of the Partnership Transformation Board held on
- Minutes of the Medicines Advisory Group held on

There were no further comments.

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

019/20 MATTERS FOR THE;

019/20-a Governing Body - Response to COVID-19

019/20-b Senior Management Team – N/A

019/20-c Partnership Transformation Board – N/A

019/20-d Local Medical Committee – N/A

019/20-e Calderdale Primary Medical Services Committee – N/A

020/20 ANY OTHER BUSINESS

020/20-a SUSPENSION OF WALK-IN SERVICES

NS informed the Committee that SMT agreed to suspend the walk-in services in Calderdale from 30th March 2020. It was noted the financial value falls within NS's delegated authority. Governing Body members were made aware and arrangements had been made to inform Joint Oversight Health Scrutiny and DOS. Communications were being prepared for the public and partners.

The CCG would be speaking to LOCALA about redeployment of workforce and exploring the possibility of delivering the service remotely.

It was emphasised this was a suspension not a closure and it was on the basis that all services in primary care were aligned during this difficult period.

020/20-b CCCG PREPARATIONS FOR COVID-19

NS updated the Committee on how the CCG was responding to COVID -19;

Workforce

- Vulnerable staff have been identified. All staff to work from home, utilising Microsoft teams. An audit of skills has been undertaken for both clinical and non-clinical staff in preparedness for redeployment.

Communications

- Daily SMT meeting (GOLD).
- Daily Business Continuity meeting (SILVER).
- CCG, Local Medical Committee Executive and Clinical Directors working together and meeting three times per week.
- Daily calls with Calderdale and Huddersfield NHS Foundation Trust and the Local Authority.
- Daily communications to staff and operational messages to primary care.

COVIC Activities

- Focussing on discharging patients from hospitals, looking at step down facilities and working with the Local Authority to support the process.
- Working with the local community hubs around volunteering and how CCG staff can be redeployed as the situation worsens.
- Efforts to mobilise Primary Care Networks, preparing messages for the public.
- Working through the vulnerable patients lists with partner organisations. A huge amount of work is ongoing, coordinated through the CCG, to amalgamate into one list to reduce duplication.

SITREPs

- Daily sitrep for CCG staff.
- LMC to provide a sitrep of staff working in primary care.
- Working with care homes to understand their sitrep positions.

In response, JM asked that the GB membership is kept up to date on the current situation in order to support executive decisions around operational issues.

020/20-c The Committee acknowledged it was MA's last meeting and thanked him for chairing the committee and wished him well.

021/20 DATE AND TIME OF THE NEXT MEETING

The Committee **NOTED** that the next meeting would take place as follows:
25TH June 2020, 2.00 – 5.30pm, Shibden Room, Dean Clough

Item 16 b iv

Calderdale Primary Medical Service Committee
Decision Notice
Circulated 21 April 2020 (by email)

Due to the COVID 19 public health emergency the meeting in public due to take place on 23 April was stood down.

A virtual Committee meeting was help with a single paper circulated for decision by the committee members via email.

FINAL DECISION NOTICE

Member Recipients			
	Neil Smurthwaite	NS	Chief Finance Officer/Deputy Chief Officer
	John Mallalieu	JM	Deputy Chair, Lay Member, Finance and Performance
	Rob Atkinson	RA	Secondary Care Specialist
	Alison MacDonald	AM	Lay Member, Patient and Public Engagement
	Prof Rob McSherry	RM	Registered Nurse
Other recipients	Debbie Robinson	DR	Head of Primary Care, Quality and Improvement
	Lesley Stokey	LS	Head of Finance

Action

1. CONFLICTS OF INTEREST

The GP committee members were declared to have a **direct financial interest** in the decision and therefore were not provided with the paper.

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. SPRING HALL GROUP PRACTICE - APPLICATION FOR NOVATION OF GMS CONTRACT

The paper recommended to approve the incorporation and was consistent with a previous application for merger which the committee had approved on 7th November 2019. It followed the agreed process for assessing such applications. The paper was circulated electronically inviting questions and comments. Committee members' responses were recorded and are held centrally by the Corporate Governance Team.

The Committee noted that there had been some valuable learning from processing these applications and requested that;

- the key learning points identified be presented in the next contracting report, these will focus on processing the applications and the benefits definitions,
- an update on the Joint Patient Participation Group within the next Head of Primary

Care Report.

In response to a question raised as to whether officers had included in the novation agreement a restriction or a need to seek approval from the commissioner on transfer of shares, it was confirmed that the novation agreement contained the following:

In consideration of the Commissioner agreeing to the novation of the Partnership's rights, obligations and liabilities under the Contract to the New Contractor, the New Contractor agrees that for a period of five (5) years commencing from the Effective Date, no shares in the New Contractor shall be transferred, sold or otherwise assigned without the prior consent of the Commissioner, such consent not to be unreasonably withheld or delayed.

DECISION:

As of 1 May 2020, the Committee:

1. **RECEIVED** and **NOTED** the content of the report.
2. **APPROVED** officers of the CCG to proceed to complete the novation of contract upon receipt of the required evidence of assurance.
3. **APPROVED** the request for the incorporation and novation of contract

The decision was supported by all committee members who were in receipt of the paper. Responses received via email had achieved the required quoracy for decision making as set out in the committee's Terms of Reference.

3. DATE AND TIME OF THE NEXT MEETING IN PUBLIC:

Thursday 23 July 2020, 11.00am Elsie Whitely Innovation Centre
(venue subject to confirmation)

Item 17 a

West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

Minutes of the meeting held in public on Tuesday 14 January 2020

Create 2 Room, 2 Brewery Wharf, Leeds LS10 1JR

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 Airedale, Wharfedale and Craven CCG
Dr Andy Withers	**AW**	Chair, NHS Bradford Districts CCG
Helen Hirst	**HH**	Chief Officer, Bradford District and Craven CCGs
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 Alistair Ingram	**AI**	Chair, NHS Harrogate & Rural District CCG
Amanda Bloor	**ABl**	Chief Officer, NHS Harrogate & Rural District CCG
Dr Gordon Sinclair	**GS**	Chair, NHS Leeds CCG
Sue Robins	**SR**	Director of Operational Delivery, NHS Leeds CCG
Dr Adam Sheppard	**AS**	Chair, NHS Wakefield CCG
Jo Webster	**JW**	Chief Officer, NHS Wakefield CCG
Apologies		
Dr Sohail Abbas	**SA**	Chair, Bradford City CCG
Dr David Kelly	**DK**	Chair, NHS North Kirklees CCG
Tim Ryley	**TR**	Chief Executive, NHS Leeds CCG
Dr Matt Walsh	**MW**	Chief Officer, NHS Calderdale CCG
In attendance		
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
Pat Keane	**PK**	Senior Programme Director, Urgent and Emergency Care
Catherine Thompson	**CT**	Programme Director - Elective care/standardisation of commissioning policies
Jonathan Webb	**JWb**	Director of Finance Lead, WY&H Health and Care Partnership
Keith Wilson	**KW**	Programme Director, Urgent and Emergency Care

3 members of the public were present.

Item No.		Action
65/20	**Welcome, introductions and apologies**	
	Apologies were noted.	
66/20	**Open Forum**	
	The Chair invited questions from members of the public. **71/20 Hip policies** • Will weight loss for people who are obese be a barrier to hip surgery? • Why is it forecast that the number of procedures will reduce? JT responded that weight loss by people who are obese would be encouraged as part of shared decision-making, but would not be a barrier. CT said that some commentators had reported a reduction in procedures as a result of shared decision making. However, any reduction in the number of procedures would be a product of that shared decision-making and would reflect the patient's involvement. SO added that we was not anticipating a reduction in procedures in his CCG. **72/20 Cataract surgery pathway and policy** • How will community optometrists be upskilled to carry out new roles? • Are outcomes in the independent sector comparable to those in the NHS? JT confirmed that outcomes were monitored and that outcomes in the independent sector were comparable with those in the NHS. CT said that a post graduate module at Bradford University was being funded to provide the necessary upskilling of community optometrists.	
67/20	**Declarations of Interest**	
	MB asked Committee members to declare any interests that might conflict with the business on today's agenda. There were none.	
68/20	**Minutes of the meeting in public – 5 November 2019**	
	The Committee reviewed the minutes of the last meeting.	
	The Joint Committee: Approved the minutes of the meeting on 5 November 2019.	
69/20	**Actions and matters arising – 5 November 2019**	
	The Joint Committee reviewed the action log.	
	The Joint Committee: Noted the action log.	
70/20	**Urgent and emergency care**	
	Adam Sheppard (AS) introduced the item, noting the stakeholder engagement that had taken place to re-set the programme, inform new workstreams and focus on key priorities.	

Item No.		Action
	Pat Keane (PK) presented the update on the Urgent and Emergency Care Programme. The update covered progress on work streams including workforce, population health management, integrated services and access to local urgent care services. The update also highlighted the arrangements for responding to winter pressures through a Winter Delivery Agreement. This included the establishment of a virtual 'Winter room' to enable closer partnership working between Accident and Emergency Boards, Acute Trusts, Yorkshire Ambulance Service and NHS England, including information sharing, trend analysis, escalation and support. AW noted that the Clinical Forum had emphasised the importance of measuring the impact of all the workstreams. HH highlighted the need to be ambitious around integrated urgent and emergency care. GS noted the important role of in hours primary care and SO highlighted the contribution of primary care networks. JW noted the need for providers and commissioners to work collaboratively across the whole system.	
	The Joint Committee: 1. **Noted** the urgent and emergency care programme update.	
71/20	**Hip policies**	
	Dr James Thomas (JT) presented hip replacement and arthroscopy policies for adoption across WY&H. The policies had been developed to align with the wider Musculoskeletal (MSK) pathway agreed by the Joint Committee. Having single policies would help to address any unnecessary variations in care. Evidence-based clinical thresholds would also mean that surgical procedures would only be carried out when they were clinically effective, and where alternative non-surgical options had been ineffective. The emphasis on shared decision-making and supported self-management would require staff development to make sure that all clinical staff within MSK and elective orthopaedic services had the right skills. JT noted the extensive engagement that had taken place, together with a comprehensive Quality and Equality Impact Assessment. JT noted that the CCGs had agreed a 12 month timescale for the implementation of new policies. RW noted the need to ensure that inequity in access to services was addressed. JT said that this was being explored in detail and CT added that each place had been asked to report back on the position in their area in response to the hip equity audit. AW highlighted the need to ensure a consistent approach across independent sector providers. GS highlighted the need to develop the approach to shared decision-making. CT acknowledged that there was further development work to be done on shared decision-making and AW added that organisational development work was taking place to support this.	
	The Joint Committee: 1. **Agreed** the policies for hip replacement and hip arthroscopy.	

Item No.		Action
72/20	**Cataract surgery pathway and policy**	
	James Thomas presented a single WY&H pathway and policy for cataract Surgery for adoption across WY&H. JT explained that cataract surgery was the most common planned surgical procedure in the UK. Across WY&H there are around 25,000 procedures every year, which is expected to increase as people live longer and the population increases Health economic modelling had shown that cataract surgery was highly cost effective and a multi-disciplinary team had worked closely together to agree the WY&H cataract pathway and policy, including through a stakeholder event. The pathway required referral directly from a community optometrist, who would be more closely involved in the early decision making process through an agreed shared decision-making tool. Community optometrists would evaluate an individual's suitability for surgery, discussing options with them before a shared decision was made. Patients who have had uncomplicated routine cataract surgery would also have their follow-up checks carried out by a community optometrist. JT said that making better use of community optometrists would release specialist capacity in hospitals to see higher risk patients with potentially sight-threatening conditions. The Programme team were working with partner organisations across eye care services to consider the options for delivering services. The Committee discussed the financial, information technology and capacity risks involved in implementing the policy. SH noted issues in relation to the role of the independent sector, SO adding that training was an issue. CT said that the same model would be followed in the independent sector and that work was underway with Health Education England to ensure that there was appropriate training. NS noted the financial and contractual risks and said that work was underway within the Task and Finish Group to address these. JW added that it would be important to fully understand and address the risks.	
	The Joint Committee: 1. **Agreed** the WY&H cataract surgery pathway and policy 2. **Approved** the principle of using primary care/community optometrists to carry out shared decision-making and post-operative checks for routine patients in order to release capacity within Hospital Eye Services (HES) and free up ophthalmologists to be able to see higher risk patients with potentially sight-threatening conditions. 3. **Requested** that the Task and Finish Group report back to a future meeting on how the risks to implementation would be mitigated.	**CT**
73/20	**Risk management**	
	Stephen Gregg presented the report that showed that there were 4 risks scored at 12 or above after mitigation. The scores for 2 risks had been reduced to below 12 since October. These risks were shown on the register, but would be removed from future versions.	

Item No.		Action
	The Joint Committee: Noted the risk management framework and the actions being taken to mitigate current risks.	
74/20	**Joint Committee governance**	
	Stephen Gregg presented the report, which included a range of proposals to further strengthen collaborative working. He updated the Committee on work to refresh the Memorandum of Understanding and the work plan. The revised MoU included proposals for the Committee to have delegated responsibility for future commissioning arrangements at WY&H level. The Committee also considered proposals for adding new service matters to the Committee's work plan, including maternity services and Assessment and Treatment Units (ATUs) providing specialist hospital support for adults with moderate to severe learning disabilities. HH updated the Committee on the development of a new operating model for ATUs. SG advised that any substantive changes to the MoU and the work plan must be agreed by each CCG, which must also ensure that all matters are properly and lawfully delegated. The Committee requested that the delegation in relation to Urgent and Emergency care be made more specific in the final version of the work plan.	
	The Joint Committee: 1. **Noted** the proposed changes to the MoU, including the draft work plan. 2. **Recommended** that the draft MoU and work plan be presented to the individual CCGs for consideration and approval, subject to the inclusion of more detail in relation to Urgent and Emergency care.	
75/20	**Any other business**	
	There was none.	

Next Joint Committee in public – Tuesday 7th April 2020, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF.

Item 17 b

West Yorkshire & Harrogate Joint Committee of CCGs

Annual report 2019/2020

Chair's foreword

I'm pleased to present the third Annual Report of the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups. The Joint Committee is part of the West Yorkshire and Harrogate Health and Care Partnership ('the Partnership') and plays an important role in delivering its priorities. The Committee's work has a real impact on people's lives. For example, the Healthy Hearts project has led to more than 8,000 people across West Yorkshire and Harrogate now having their blood pressure monitored, meaning fewer heart attacks, strokes and deaths.

The Committee brings together the Clinical Commissioning Groups (CCGs) from our local places – Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield – to take joint decisions that help improve the health and wellbeing of people across West Yorkshire and Harrogate. As the Lay Chair of the Joint Committee, I am independent of the CCGs. I'm supported by two CCG lay members and together we make sure that the Joint Committee puts people at the centre of its work and takes fair, transparent decisions.

Over the year, the Committee has agreed:

- a range of treatment pathways and policies which are helping to improve equity in access to services, reduce health inequalities and avoid the 'postcode lottery'. They include:
    - a new pathway for musculoskeletal conditions – those affecting the joints, bones and muscles
    - policies for treating shoulder, knee and hip conditions
    - a pathway and policy for cataract surgery
    - a policy to support people with diabetes, which reduces the need for 'finger prick' testing.
- simplified treatment guidance for people with high cholesterol which has reduced the number of people having heart attacks and strokes.
- new ways of providing joined up urgent care services, which have increased access to clinical advice and face to face appointments.

In March 2020, the Partnership published 'Better health and wellbeing for everyone: Our five year plan (make link). This sets out big ambitions to reduce health inequalities and improve the wellbeing of people across our localities. The Joint Committee has already made an important contribution to these ambitions and our work plan is changing to make sure that we can continue to do so. We know there is still more to do to join up strategic commissioning across West Yorkshire and Harrogate and work collaboratively with health and care providers. I am delighted that the Joint Committee will be leading this important work over the next twelve months.

The national coronavirus outbreak has highlighted the vital importance of everyone across the health and care system working together effectively. I very much look forward to working with CCG leaders to further develop the important role of the Joint Committee once we can return to business as usual.

Marie Burnham

Independent Lay Chair, West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

You can watch our meetings 'live' on the internet and find out more about the Joint Committee here: https://www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs

You can read more about the difference our Partnership is making, including case studies, here: https://www.wyhpartnership.co.uk/

The role of the Joint Committee

The Joint Committee is part of the West Yorkshire and Harrogate WY&H) Health and Care Partnership ('the Partnership'). The Committee enables the WY&H Clinical Commissioning Groups to work together effectively – making sure that when it makes sense, work is done once and is then shared across WY&H. The Committee has delegated authority from the CCGs to take joint decisions on agreed priorities. As well as formal decisions, the Committee also makes recommendations to the CCGs when a collaborative approach will help to achieve better outcomes. Each CCG agrees the Committee's Terms of Reference and its work plan, which sets out the decisions for which it is responsible.

1. Membership and attendance

The Committee is made up of two representatives from each of the WY&H CCGs – usually the Clinical Chair and the Accountable Officer. To ensure that decision making is open and transparent, the Committee has an independent lay chair and two lay members appointed from the CCGs. Representatives from the Partnership team and NHS England/Improvement also attend. The Committee met five times in 2019/20. The attendance record is at Appendix 1.

2. Public and patient involvement (PPI)

In 2018, the Joint Committee established a PPI Assurance Group made up of the PPI Lay Members from each CCG. The PPI Group provides assurance that the public and patient voice informs the Committee's decisions. Reports submitted to the Committee identify what patient and public involvement has already taken place or is planned.

We hold our Committee meetings in public and also stream then 'live' on the internet. The Committee invites questions about its business and, if there is time, answers them during each meeting. We promote the Joint Committee meetings in public and publish written answers to all questions after each meeting on our website (make link).

3. Achievements

The Committee has led important work to improve health and wellbeing across WY&H:

Reducing variation in planned care

The Committee has agreed commissioning policies which improve equity in access to services, help reduce health inequalities and tackle the 'postcode lottery':

Musculoskeletal pathway

Musculoskeletal (MSK) conditions affect the joints, bones and muscles. The Committee agreed a pathway to address high demand and variation in MSK services across West Yorkshire and Harrogate. The pathway aims to ensure that all. but the most urgent. MSK cases are managed in primary care or through referral to an MSK service and that patients receive the right care in the right place at the right time. The pathway reflects feedback from patient and public engagement, which showed support for self-management of MSK conditions, an increase in the range of services available in GP practices and better co-ordination of services.

Knee, shoulder and hip policies

The Committee agreed WY&H policies covering surgical and non-surgical procedures for a range of conditions relating to:

- shoulder pain and instability
- knee pain
- hip problems.

Having single policies helps to address any unnecessary variations in care across WY&H. Evidence-based clinical thresholds mean that surgical procedures are carried out only when they are clinically effective, and where alternative non-surgical options have been ineffective. They also require lifestyle factors like Body Mass Index and smoking status to be assessed, as they may influence long term health outcomes. Shared decision-making between patients and clinicians help patients to understand the risks and benefits of the procedures.

Cataract surgery

The Committee agreed a WY&H-wide pathway and policy for cataract surgery, which is the most common planned surgical procedure in the UK. Across WY&H there are around 25,000 procedures every year, which is expected to increase as people live longer and the population increases.

The Committee agreed proposals to make better use of community optometrists, including high street opticians. Community optometrists will evaluate a patient's suitability for surgery, discussing options with them before making a shared decision. Making better use of our community optometrists will release specialist capacity in hospitals to see higher risk patients with potentially sight-threatening conditions.

Flash glucose monitors

The Committee agreed a WY&H commissioning policy for flash glucose monitors. These are small sensors worn on the skin for monitoring the glucose levels of people with diabetes, which help people to monitor their blood sugar levels and reduce the need for 'finger prick' testing.

NHS England and Improvement Medicines Value Programme

The Committee agreed the recommendations of the NHS England and NHS Improvement Medicines Value Programme. The programme aims to increase value from the prescribing budget and reduce unwarranted variation in prescribing practice. The Committee agreed that primary care prescribers should not initiate and in many cases should de-prescribe a number of items, mainly relating to skin and cardiac conditions. These items are of low clinical effectiveness or more cost-effective products were available.

West Yorkshire and Harrogate Healthy Hearts

In 2018/19, following a recommendation from the Joint Committee, the WY&H CCGs adopted the Healthy Hearts improvement project, which built on successful work in Bradford. The project aims to identify more people with high blood pressure, help them to control it better and as a result reduce the risk of heart attacks and strokes. To support Phase 2 of the project, the Committee approved simplified guidance for treating people with high cholesterol.

By the end of January 2020, WY&H Healthy Hearts had seen an increase of nearly 8,000 patients with controlled blood pressure and in addition, more than 7,500 patients had been added to hypertension registers. Over the next five years these interventions have the potential to prevent 65 deaths, 82 heart attacks and 122 strokes.

Urgent and emergency care

In December 2018, the Committee approved a new approach to Integrated Urgent Care services which aimed to ensure that people who call 111 needing urgent medical attention receive the most appropriate help. A progress report to the Committee showed that the changes had increased access to clinical advice for patients and had also increased the ability for patients to book face to face appointments in primary care.

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4. Working better together

The Committee is leading on new approaches to enable the CCGs to work more efficiently and effectively together as commissioners and with service providers:

Commissioning futures

The Committee has led work on future arrangements for commissioning at scale across WY&H, including expanding and developing the role of the Joint Committee. Proposals for the Committee to take on new commissioning responsibilities, including maternity services and assessment and treatment units for people with complex learning disabilities, will be considered by the individual CCGs during the first quarter of 2020/21.

Quality and equality impact assessment

In 2018/19 the Committee approved a new approach to providing assurance that its decisions are supported by robust impact assessments, avoiding unnecessary duplication across the CCGs. This ‘do once and share’ approach to Quality and Equality Impact Assessment has been successfully used for all new commissioning policies and the Committee has recommended its use across the wider Partnership.

5. Governance

In March 2020, CCG Accountable Officers agreed a three month extension of the Memorandum of Understanding which established the Committee. During the first quarter of 2020/21 the individual CCGs will be asked to approve a revised MoU which reflects changes in the configuration of CCGs across WY&H and includes a new work plan for the Committee. You can read this on our website here. (add link)

The Committee maintains a register of members’ interests and declarations of interest are a standing item on all agendas. At each meeting, the Committee reviews the significant risks to the delivery of its work programme and assesses how these risks are being mitigated.

As a result of the national COVID-19 outbreak in March 2020, the Committee’s annual evaluation of its performance was postponed. It will now take place in early 2020/21. The Committee will use the learning from the evaluation to help develop its work during the year.

West Yorkshire & Harrogate Joint Committee of CCGs Annual report 2019/2020

Attendance record **Appendix 1**

Organisation and role	Member	Attendance (eligible)
Independent Lay Chair	Marie Burnham	**5** (5)
CCG Lay members (to 19/05/19 meeting) (from 01/10/19 meeting)	 Richard Wilkinson Fatima Khan-Shah Stephen Hardy	 **5** (5) **1** (1) **3** (3)
NHS Airedale, Wharfedale and Craven CCG Clinical Chair	 Dr James Thomas	 **5** (5)
NHS Bradford City CCG Clinical Chair (to 19/05/19) Clinical Chair (from 02/07/19)	 Dr Akram Khan Dr Sohail Abbas	 **1** (1) **3** (4)
NHS Bradford Districts CCG Clinical Chair	 Dr Andy Withers	 **5** (5)
NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs Chief Officer	 Helen Hirst	 **5** (5)
NHS Calderdale CCG Clinical Chair Chief Officer *(Deputy: Chief Finance Officer)*	 Dr Steven Cleasby Dr Matt Walsh *Neil Smurthwaite*	 **5** (5) **3** (5) **2** (2)
NHS Greater Huddersfield CCG Clinical Leader	 Dr Steve Ollerton	 **5** (5)
NHS North Kirklees CCG Clinical Chair	 Dr David Kelly	 **3** (5)
NHS Greater Huddersfield and North Kirklees CCGs Chief Officer	 Carol McKenna	 **5** (5)
NHS Harrogate & Rural District CCG Clinical Chair Chief Officer	 Dr Alistair Ingram Amanda Bloor	 **5** (5) **5** (5)
NHS Leeds CCG Clinical Chair Chief Executive *(Deputy: Director of Operational Delivery)*	 Dr Gordon Sinclair Tim Ryley *Sue Robins*	 **4** (5) **3** (5) **2** (2)
NHS Wakefield CCG Clinical Chair (to 19/05/19) Clinical Chair (from 02/07/19) Chief Officer *(Deputy: Chief Finance Officer)*	 Dr Phillip Earnshaw Dr Adam Sheppard Jo Webster *Jonathan Webb*	 **1** (1) **4** (4) **3** (5) **2** (2)