NHS
Calderdale
Clinical Commissioning Group

MINUTES OF THE PUBLIC SECTION OF THE MEETING OF NHS CALDERDALE CCG GOVERNING BODY HELD ON THURSDAY 28 OCTOBER 2021 AT 2PM VIA MS TEAMS

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

PRESENT

Dr Steven Cleasby (SC) CCG Chair
Robin Tuddenham (RT) Accountable Officer
Neil Smurthwaite (NS) Chief Operating Officer/ Chief Finance Officer
Lesley Stokey (LS) Director of Finance
Penny Woodhead (PW) Chief Quality and Nursing Officer
Dr Farrukh Javid (FJ) GP Member
Dr Caroline Taylor (CT) GP Member
John Mallalieu (JM) Deputy CCG Chair, Lay Member (Finance and Performance)
Alison MacDonald (AM) Lay Member (Patient and Public Engagement)
Prof Peter Roberts (PR) Lay Member (Audit)
Dr Rob Atkinson (RA) Secondary Care Specialist
Prof Rob McSherry (RM) Registered Nurse
Denise Cheng-Carter (DCC) Lay Advisor
Deborah Harkins (DH) Director of Public Health, Calderdale Council
Iain Baines (IB) Director for Adult Services and Wellbeing, Calderdale Council

IN ATTENDANCE

Rhona Radley (RR) Deputy Head of Service Improvement (item 8)
Rob Gibson (RG) Corporate Systems Manager (for items 12 &13)
Emily Kennedy (EK) Project Support Officer - Improvement (meeting support)

MINUTES

Zoe Akesson (ZA) Corporate Governance Officer

Contents

54/21 APOLOGIES FOR ABSENCE

Apologies were received from Dr James Gray.

55/21 DECLARATIONS OF INTEREST

The Chair invited Governing Body (GB) members and those in attendance to declare any interests relevant to items on the agenda. There were no interests declared.

56/21 MINUTES OF THE LAST MEETING

The Chair asked members of the Governing Body to consider and agree the minutes of the public section of the last meeting held on 29 July 2021.

The Governing Body **APPROVED** the minutes of the Governing Body meeting held on 29 July 2021.

Matters Arising

The one outstanding action from the last meeting (25/21), around developing a patient story on the long COVID-19 pathway, would be actioned in due course.

Decision Notice

GB Members formally noted the decision notice, approving the proposal to implement a contract waiver to fund and utilise the available capacity within The Nuffield.

57/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

58/21 PATIENT STORY - PATIENT STORY 'LIVING WITH DEMENTIA'

The Chair invited Penny Woodhead to introduce the patient story, which was a powerful short film by Wendy Mitchell from Healthy Minds. The film focusses on how dementia affects people in different ways and the importance of time to allow people to process their actions and thoughts. Penny asked GB members to raise awareness of the condition by sharing the film through their networks.

Following the film, GB members reflected on the importance of giving time and the following comments were raised:

- it can take time to reach diagnosis, during which there is a need to ensure

patients receive extra care;

- there is a need to enhance the work with people with dementia, through reviewing processes and future proofing support by considering individuality and personalizing care;
- the film and comments from the discussion would be shared with the Dementia Steering Group, that operates across the Calderdale partnership, to incorporate into their work.

ACTIONS: To share the link to the film and comments from today's discussion with the Dementia Steering Group (PW)

The Governing Body **RECEIVED** the Patient Story

59/21 ACCOUNTABLE OFFICER'S REPORT

The Chair invited Robin Tuddenham to introduce the item. Robin drew the GB members' attention to the following key points:

New Premises - not detailed in the paper, Robin reflected on the office move to Westgate House. Thanks were given to the staff involved in the smooth and timely transition. The new accommodation provides a greater opportunity for the organisation and CMBC to work more collaboratively in the future.

Vaccination Programme - remains challenging, as work continues with the booster phase and vaccinations for 12-15year olds. The public health team were thanked for their shift in work with schools and young people, around the risks of covid, which is now showing a positive impact on infection levels.

CCG Assurance Process - the second assurance place process for Calderdale took place on 08/10/21 with partners, NHSE and the Integrated Care System (ICS). It focussed on the functioning of its health and care system, covered the challenges with elective recovery, urgent and emergency care, and the continued need to respond to the pandemic.

ICS Transition - work continues, planning for the new health and care system model with the development of the Integrated Care Board (ICB) and the place-based partnership arrangements. Calderdale Cares Partnership Board will be the key

forum for decision making and bringing together commissioners, providers, and partners for Calderdale place from 01/04/22. Governance and staffing issues are being worked through.

Individual Funding Request (IFR) Policies - Robin asked GB members to review and approve the minor amendments to the joint IFR policies with Kirklees CCG. The policies were updated, following the name change, due to the merger of Greater Huddersfield and North Kirklees CCGs. The policies are:

- Operating Framework for Managing Individual Funding Requests
- Commissioning Policy for Individual Funding Requests

DECISION: The Governing Body **RATIFIED** the Individual Funding Request policies detailed in section 10 of the report.

New Appointment - GB members were made aware of the appointment of Calderdale and Huddersfield Foundation Trust's (CHFT) new Chief Executive, Brendan Brown and on behalf of the Governing Body congratulated him on his new appointment.

The following comment was made during the discussion:

- RA commented on the JCVI's guidance on the booster and 3rd dose vaccination for the clinically vulnerable group, which is causing confusion. A short discussion ensued around the importance of approaching the correct people. In response DH agreed to send out local communications clarifying who is eligible. The Chair suggested a sense check of the immune supressed patient's journey to review their experience and to see if anything can be learnt from the process.
  ACTION: To clarify and make clear for patients/public in Calderdale the 3rd course is for the immune supressed only and the clinically vulnerable will receive a booster (DH).

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

60/21 INTEGRATED CARE BOARD – DEVELOPMENT AND STAKEHOLDER INVOLVEMENT

The Chair welcomed Neil Smurthwaite to introduce the item. Neil explained the paper recommends that we take a whole partnership approach to developing the ICB constitution and involving stakeholders. The approach was endorsed by the Joint Committees of CCGs and is now being taken through individual CCGs for their agreement. The paper was taken as read and there were no further comments.

DECISION: The Governing Body **AGREED** to take a 'whole Partnership' approach and that the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) co-ordinates:

- the development of the draft Integrated Care Board (ICB) constitution
- stakeholder involvement on the constitution

61/21 URGENT COMMUNITY RESPONSE

The Chair welcomed Rhona Radley to the meeting and invited Rhona to introduce the item.

Rhona explained the mandated programme, through NHSE, was due to be implemented by April 2022 but recognising local pressures there has since been an ask to implement at pace by December 2021. Learning was taken from the accelerator sites and Calderdale will be implementing the programme for the whole adult population. It has been through a number of governance routes; and is overseen by the Community Collaborative Programme Board. The Standard Operating procedure was agreed at the last Quality Finance and Performance Committee.

GB members noted the financial risk that NHSE are providing £1m from the Ageing Well fund however this does not cover the level of provision required for the proposed 8am - 8pm service. Finance for the programme was discussed at the Integrated Commissioning Executive where a recommendation was made to use the Better Care Fund for the shortfall of £0.5m on a recurrent basis from April 2022.

Gb members recognised the financial risk associated with recurrent funding allocations in the longer term, and the risk associated with a potential move to a 24/7 model. GB members were asked to approve the full annual cost of £1.5m

The following comments were raised during the discussion:

- PW commented on this important piece of work to transform community services, commending the team on the engagement work, working at pace and how it reflects a partnership approach and Calderdale Cares and as we move forward,
- JM highlighted that following a conversation at Quality, Finance and Performance Committee the Standard Operating Procedure (SOP) has been strengthened and now clarifies both face to face and telephone appointments are available for the 8am-8pm service,
- LS explained it is a potential risk at the start of a new service provision, as funding is only guaranteed for 3 years with the expectation funds will be available in the future, however it has been flagged nationally and the general consensus is this is the right direction of travel for community working and hospital avoidance.

DECISION: The Governing Body **APPROVED** the full annual cost of £1.5m and the expected funding streams of NHSE funding £1m and Better Care Funding of £0.5m.

62/21 CALDERDALE AND HUDDERSFIELD RECONFIGURATION – LETTER OF SUPPORT

The Chair invited Lesley Stokey to introduce the item. Lesley explained that the purpose of the paper was to seek approval from Governing Body for the CCG to provide letters of support for the latest stages of the hospital reconfiguration programme.

Lesley talked through the 3 financial principles detailed in the paper that GB members were asked to consider, pointing out they are not providing financial due diligence on the actual business case.

1. Does it improve the financial position?
2. Do we agree with assumptions being made?
3. Are the plans affordable?

In the absence of seeing the business case, GB members were assured that the 3 tests had been met through discussions with the Trust and NHSE. Savings are

beneficial to the system and the plans, including the additional ambulance cost, will be affordable.

The following comments were raised during the discussion:

- RT explained the business case will experience inflationary pressures following the pandemic, but the reconfiguration process will still deliver savings. An analysis is currently been undertaken on the business case that will provide reassurance in this area and partners within the ICS are working to mitigate these risks going forwards.
- PR declared his position chairing the CHFT committee that dealt with CHFT's declaration, Chair of the Kirklees Climate Commission and Member Calderdale Climate Working party before raising his concern around climate and the need to consider carbon taxes within the business plan. The Chair acknowledged this was an important issue and for a conversation to take place outside the meeting or at a GB development session to seek assurance in this area.

DECISION: The Governing Body **AGREED** that two letters of support are provided from the CCG to NHS England and Improvements in relation to the Full Business Case for Huddersfield Royal Infirmary and the Outline Business Case for Calderdale Royal Hospital

63/21 DIRECTOR OF FINANCE'S REPORT

The Chair invited Lesley Stokey to introduce the item.

Finance

Lesley highlighted that for H1 the CCG is expecting to deliver a break-even position in line with plan. During this time £1.2m of the QIPP target has been delivered, with the remainder being met through the contingency budget.

Planning guidance was received on 30/09/21, the key points noted are:

- the H2 allocations are based on the first half of the year and adjustments for efficiency requirements, pay awards and other inflation and capacity funding and inflation impacts,
- there is an increased efficiency requirement for H2,
- block payment arrangements will remain in place,
- additional capacity funding is available for urgent and emergency care,

- hospital discharge programme funding will cease on 31/03/22,
- contingency requirement has been reduced from 0.5 to 0.25%,
- final plan submissions from the ICS to NHSE is on 16/11/21,
- there is an expectation the CCG will deliver a break even plan however this is subject to a consolidation process across the ICS of all the CCG and provider plans.

As there is no Governing Body meeting in advance of the 16/11/21 a recommendation was put to members to approve an urgent decision-making process to approve the activity and financial plans.

DECISION: The Governing Body **AGREED** the use of the urgent decision-making arrangements for the approval of the CCG planning submissions in November.

Contracting

Lesley highlighted the following key points from the report:

- the block payment arrangements remain, and non-NHS independent sector capacity continues to be on an activity delivery basis. There is under delivery on our plans due to capacity issues in the independent sector,
- YAS and 111 continue to show significant activity pressures and levels over pre-covid levels,
- not stated in the report but in relation to planning guidance, NHSE signalled an expected return to a normal contracting cycle of signed contract arrangements with NHS providers in 2022-23. Further guidance is expected. Members noted that this would lead to significant workload impact over the winter period,
- assurance was given to members that even though there has been no requirement to audit the Mental Health Investment Standard this year this remains a priority and the CCG is committed to ensure investment is ring fenced and we continue to meet the standard going forward.

With regards to Performance, Lesley highlighted that:

- pressures continue around capacity and demand especially in Accident and Emergency which is monitored by the Urgent and Emergency Care Board and is focussing on key priority areas outlined in the report,
- elective recovery position continues to improve,

- pressures continue for diagnostic waiting times, but a strong performance is being reported for cancer waiting times,
- focussed areas of work include children and young people's eating disorders and serious mental illness health checks,
- key performance metrics for the H2 planning round are highlighted in the report.

The Governing Body **NOTED** the Director of Finance's report.

64/21 QUALITY AND SAFETY REPORT AND QUALITY DASHBOARD

The Chair invited Penny Woodhead to introduce the item. Penny highlighted a few key points from the paper along with updates that have taken place since its publication:

- both the quality and equality impact assessments for the BCG new-born pathway have been completed at a West Yorkshire level and CHFT are implementing. Penny acknowledged the contribution and leadership of the CCG's Head of Quality who took the lead role to coordinate this piece of work within a very short timeline,
- there is a high-level risk associated around care homes. The CCG is working with CMBC to ensure best clinical support for homes, ready for CQC inspections,
- the report provided an update on the medical examiner progress.

Penny alerted GB members to the system pressures and the discussions that have taken place with clinical colleagues around the impact for patients from a quality and safety perspective. Penny and Iain Baines are hosting a quality impact conversation with partners in November, where quality priorities for place and an understanding of the current system pressures will be discussed.

The dashboard was received, and Penny reminded GB members that this was reviewed at the CCG's Quality, Finance and Performance Committee in September and that the quality managers continue to attend the quality committees of all our partner organisations.

The following comments were raised during the discussion:

- RM reminded GB members it is important to recognise staff during the quality conversations. Penny assured these conversations are happening and that a place arrangement, the Calderdale People Plan, has been put in place to build resilience for the future,
- RA acknowledged and welcomed the alternative solutions put forward to ensure the safe care of patients,
- CT reminded GB members of the independent workforce wellbeing offer, Calderdale Cares for Us, for workers who live and work in Calderdale and how well it has been well received.

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

65/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 3 2021-22

The Chair invited Rob Gibson to introduce the item. In presenting the report, Rob highlighted there are 3 critical risks, and 5 serious risks. There was a change to R1734 which has now been split into 2 risks 1941 and 1942 to reflect pressures in the whole system not just pressures in primary care.

A comment was received from DCC around R187 and for the risk to be updated to reflect the recent measures that have been put in place to mitigate the risk.
ACTION: Risk owner to be asked to update risk187 (RG).

The Governing Body was **ASSURED** that the high-level risk register represents a fair reflection of the risks experienced by the CCG at the end of risk cycle 3 2021-22.

66/21 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL UPDATE

The Chair invited Rob Gibson to introduce the item. Rob explained that the paper reflects the paper that was presented to Audit Committee and highlighted the following points:

- details of the CCG's exercises some focussing on cyber security and fishing emails,
- focus on cyber security next month and continue promoting awareness to staff,

- Calderdale CCG now has its own on-call manager rota replacing the shared arrangement with Kirklees.

EPR annual assurance, completion of the core standards, report full compliance supported by Audit Committee, signed by NS as accountable lead and submitted to NHSE within deadline.

The Governing Body **RECEIVED** and **NOTED** the arrangements in place to support Emergency Preparedness (EP) and activities undertaken throughout the year.

67/21 COMMITTEE MINUTES

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

- Commissioning Primary Medical Services Committee (CPMSC) held on 26 August 2021 and the single item CPMSC meeting held on 1 October 2021

68/21 EXTERNAL MEETINGS

The Governing Body **RECEIVED** and **ACCEPTED** the minutes of the West Yorkshire and Harrogate Joint Committee of CCGs meeting held on 6 July 2021.

69/21 KEY MESSAGES FOR MEMBER PRACTICES

The Governing Body **AGREED** the following messages for member practices:

- The funding approval for the Urgent Community Response and implementation over the next few months.
- Recognition of the letters of support for the latest stage of the hospital reconfiguration business case.
- The engagement and consultation process of the Integrated Care Board constitution.

The Audit Chair asked for the fraud prevention teaching materials, provided by Audit Yorkshire and raised at Audit Committee in October, are shared with member practices for awareness. The Chair and JM would review ahead of circulation.

70/21 DATE AND TIME OF THE NEXT MEETING IN PUBLIC

Thursday 27 January 2022, 2.00pm, venue tbc.

The Governing Body Meeting 28 October 2021 – Action Sheet

Report Title	Minute No.	Action required	Lead	Current Status	Comments / Completion Date
Patient Story	05/21	To develop a patient story as part of the Learning Disability Mortality Review	PW/SR	**Closed**	Work has taken place. Shared at HWBB, staff workshop / briefings.
Workforce Report	09/21	To review the process for recording and for the workforce report to be commented on and supported by Remuneration & Nomination Committee in advance of presenting to GB.	NS/JM	**Closed**	The process is in place and the report was shared with Rem & Nom ahead of July's GB meeting.
Patient Story	25/21	To develop a patient story on the long COVID-19 pathway	PW/FJ	C/fwd	Colleagues have been asked to share stories, once received will consider bringing into the GB meeting. Action remains open.
Patient Story	58/21	To share the link to the film and comments from today's discussion with the Dementia Steering Group.	PW	Open	

Accountable Officer's Report	59/21	Director of Public Health to clarify and make clear for patients/public in Calderdale the 3rd course vaccination is for the immune supressed only and the clinically vulnerable will receive a booster.	DH	Open	
Risk Register	65/21	Risk owner to be asked to update risk187.	RG / DG	Open	

PATIENT STORY:

OPEN MINDS/THRIVE PERSONALISED HEALTHCARE BUDGETS (PHB) FOR CHILDREN AND YOUNG PEOPLE

NHS Calderdale CCG
Governing Body,
27th January 2022

BACKGROUND PERSONAL HEALTH BUDGETS (PHB'S)

PHBs are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with healthcare needs more choice, control and flexibility over their healthcare.

Calderdale part of the PHB Collaborative in 2019. £15k national funding was received to develop and implement a pilot project on PHB's.

Calderdale partners choose to focus on and work with 6 young people identified via the medical needs team

Northpoint Wellbeing (an Open Minds CAMHS provider) acts as budget holder

Project board established, referral criteria, processes and reporting pathways developed

Care Navigator recruited

THRIVE IN CALDERDALE

- Person-centred, whole system approach; responsibility for meeting the emotional wellbeing and mental health needs of needs of children and young people is everyone's business.
- Helping children & young people build on their strengths and bolster their resilience.
- Services work closely together in partnership and share knowledge so a young person should only tell their story once.
- Children & young people receive support at any time from the most appropriate services and resources that meet their needs – rather than fitting into a specific service, or driven by a specific diagnosis/severity of issue.
- Their needs are met by a wide range of partners (e.g. statutory mental health providers, the third sector, education) who offer a rich diversity of support.
- Children & young people decide what success looks like for them.
- Support and help is evidence-based, to achieve children & young people's goals.

ONE YOUNG PERSON'S STORY

Background:

- Didn't attend school.
- Didn't leave the house
- Not fully engaged with services or tells them what he feels they want to hear
- Been in crisis – attempted suicide
- Repeat referral into services

Issues:

- Isolated.
- Social anxiety
- Not connected with his dad.
- Not going out with friends.
- Negative opinions of services.

Support:

- Discussed his interests – eg: Music
- Recognised that he expresses how he feels through music (but won't in therapy)
- Talking sessions
- Went on the bus.
- Supported him to attend the gym
- Supported with connection with his Dad

Progress:

- Wrote and recorded a song with his dad
- Started a band with a few friends with support of his dad
- A more positive attitude towards services
- Gym attendance and going to the gym with his dad
- Aspirations to do music at college

HOW I FEEL.

PILOT PROGRESS

- Worked with 6 young people now (full cohort)
- Some excellent outcomes achieved by the young people
- Developing new partnerships including Active Calderdale and social prescribers
- Person-centred culture also offering choice to young people about where and how they access services
- Choice and innovation

LEARNING

- Focus on young person rather than their mental health
- Finding the right starting point for them e.g., communicating through parent, via zoom/text
- Building a good relationship with the young person is key
- Parents need to be involved and often part of the approach i.e., getting out of "stuck" routines, supporting and providing challenge for situations.

NEXT STEPS

- Broaden criteria to access PHBs
- Continue to develop partnership working with new partners
- Consider links/support to Thrive 'Getting Risk Support' (GRS) ways of working/multi-agency partners
- Link with wider PHBs across Calderdale Children's services

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	**Accountable Officer's Report**	**Agenda Item No.**	6
Report Authors	Robin Tuddenham, Accountable Officer Neil Smurthwaite, Chief Operating Officer	**Public / Private Item**	Public
Clinical Lead	-	**Responsible Officer**	Robin Tuddenham, Accountable Officer

Executive Summary
This report updates the Governing Body on current issues. The report provides assurance on the depth of work being undertaken by the CCG. A number of key points to note are the significant work that went into the mobilisation of the covid vaccination programme in December and the delay in legislation meaning the CCG will be operating until the new target date of 1 July 2022 for Integrated Care Boards. This is covered within the Director of Finance report on the latest planning guidance.

Previous Considerations

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

Recommendations
It is recommended that the Governing Body: 1. **NOTES** the content of the report

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

Implications

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

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

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

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

1.0 Introduction

My report to the Governing Body provides an update as we experience another extremely busy period testing the resilience of our health and care system, and asking yet more from our brilliant colleagues and teams across all local organisations. January is an extremely challenging period for health and social care with the peak of the omicron variant impacting in addition to the booster vaccine programme and usual winter pressures.

Governing Body members will be updated in the Director of Finance report on the latest planning guidance. This includes the delay in the Health and Care Bill with a new target date of July extending the operation of the CCG for three more months. Calderdale and West Yorkshire are in a good place to adjust to this, though we will need to ensure business and governance continuity during that time and deal with the added burdens on the budget and audit process. This doesn't slow the development of place-based arrangements and you will have seen the recruitment for the place-based chairs and independent members advertised. As the CCG will continue past March 2022, we will be reviewing what formal governance we will need in place for the short term, recognising there will still be statutory decisions to undertake such as signing off accounts, quality issues and the approval of the 2022-23 financial plan. We are not planning to just roll forward the current timetable but will review work plans and discuss with committee chairs timing and the need for formal meetings after March.

2.0 COVID-19 Vaccination Programme

2.1 Latest headline data for Calderdale, up to 6 January 2022

- 443,000 vaccines have been administered in total to Calderdale practice patients since the programme began.
- 36,717 vaccines have been administered between 16 December 2021 – 6 January 2022 (33,181 boosters and 3,536 1st or 2nd doses).
- 82% have received 1st dose; 76% received 2nd dose in JCVI Cohorts 1-15
- 78% of those in cohorts 1-9 (over 50 years and with under lying health conditions) who are at risk of the worse outcomes of Covid have also receive received their booster.
- 93% of care home residents and 92% of housebound residents have had a booster.

2.1.1 Booster vaccinations started at the beginning of October in Calderdale. Following this date there were many challenging announcements, including the announcement on 29 November, which required everyone over 18 years to be offered a booster within 91 days of their 2nd dose. This was subsequently superseded with a three weeks' timeline to offer these doses, by the end of December, in a race against the omicron variant. This meant that 96% of those over 18 years in Calderdale became eligible for their booster.

2.1.2 A huge thank you to all our sites and their teams and all the volunteers that came forward to help. Calderdale provided this capacity "to offer everyone who was eligible a booster." Approx. 37,000 people came forward for their vaccine, over this period in Calderdale, which is nearly 10% of the total number of vaccines administered to Calderdale patients since the start of the programme.

2.1.3 There are currently circa 18,000 people in Calderdale eligible for their booster and circa 20, 000 people who had a 2nd dose who become eligible in the coming months. Through engagement it is understood that the people that didn't come forward over the Christmas holidays, didn't want the booster, didn't want side effects during the holiday period or they had Covid within the last 28 days. The programme has now become complex and based on feedback the following key messages have been agreed with partners to share with the public over the coming weeks:

- It's never too late to get your first and second dose.
- Your vaccine is waiting for you, book online, call 119. Over 18s should get boosted now.
- Recent data shows two doses of the vaccine are not enough to stop people becoming unwell from Omicron but suggests a booster significantly increases protection against the variant.
- There are lots of appointments and walk-in clinics available to get your vaccine in Calderdale.
- 1st and 2nd doses should be the same vaccine type. In line with JCVI advice Pfizer or Moderna is being given for boosters. If people are unable to have this vaccine type due to a medical reason it may be possible to have AstraZeneca, after discussion with a health professional.
- If you have had COVID-19 you need to wait before getting the vaccine. Four weeks for over 18s and 12–17-year-olds at high risk of COVID-19, and 12 weeks for 12–17-year-olds.

2.2 **Delivery Model**

2.2.1 The programme now includes 11 Community Pharmacy sites (7 new sites for Phase 3 boosters), including one temporary pharmacy pop-up site at Salem Methodist Church, led by Medicare Pharmacy. CHFT Hospital Hub site re-opened for boosters to ensure all CHFT employees could access their Covid vaccination.

2.2.2 The roving inequalities team led by Calder & Ryburn PCN have continued to take vaccinations to groups and communities where these users would not likely access a site. Since boosters have begun the team have been back to St Augustine's, the Basement, the Gathering Place, Ravenscliffe School, Co-located a Clinic with SWPFT for people with Serious Mental Illness (SMI) and at a specialist clinic jointly provided by CHFT and practices for People with Learning Disabilities (PWLD). First, second and boosters have all been administer to vulnerable people. Thank you in-particular to Sue Rosborough who has done an amazing job in managing the project, along with Dr Fawad Azam and Dr Lisa Pickles.

2.2.3 Dr Lisa Pickles will be stepping back from the role as Clinical Lead for the programme with the intention of returning to her previous role at Brig Royd. Lisa has kindly offered to support the programme through project work and continue to be the clinical representation at the local JCVI group until the programme is reviewed in the spring. Lisa has been a huge asset and I want to put on record my thanks and that of the CCG for the difference she has made in the last year.

2.2.4 Practices continue to invite their own patients for a vaccination, with the majority of people receiving a national invitation as well. Three out of five PCNs have the option/ list their clinics on the National Booking System and all five PCNs can list their clinics on the following Grab-a-jab walk-in site.

2.3 **Looking Ahead**

2.3.1 Calderdale is planning further pop-up clinics to offer vaccines to: those Homeless; those accessing foodbanks; asylum seekers and refugees; those with SMI; PWLD; Black and Minority Ethnic communities; pregnant women.

2.3.2 During the winter term Calderdale will be offering second doses and firsts to 12–15-year-olds in school and will be expanding the out of school offer in Calderdale to offer more choice to this age group. Boots, Halifax will mark their first vaccine anniversary on 14 January.

2.3.3 Once again a huge thank you to all involved including the programme team, Clinical Directors, all our practices, sites, teams, volunteers including CCG staff and partners across the system. The energy and commitment to ensure vaccines are administered to as many people as possible in Calderdale has been fantastic.

3.0 Burnt Bridges Action Plan Update

3.1 An update was shared with Quality, Finance and Performance Committee on progress made against the Burnt Bridges action plan.

3.2 The areas of significant progress made since last presented in the AO's report in July are:

- A Multi Partner Community and Primary Care Group has been established to focus on improving access to services for this client group. This has resulted in practitioners delivering services in different ways e.g. provision from Calderdale and Huddersfield Foundation Trust Community Matron into the Gathering Place, who co-ordinates input from registered GP as required.
- Training provided on Burnt Bridges findings to the CCG contracting team to raise awareness around the impact on people and service responses and to help in understanding their role in the monitoring contracts with service providers.
- Population Health Management alignment in both a) an MDT approach with wider partners to ensure plans are in place for those people known to services who are at risk and b) identifying a small group to understand how to identify those at risk of homelessness (currently at data gathering stage).
- Data sharing agreements are needed to be in place to implement the population health management approach. Progress has been made, and this will benefit not only this project but also the implementation of the Population Health Management approach across Calderdale.

- Developing opportunities in offering rapid access for people with multiple and complex needs (MCN). An initial workshop has been completed and good progress made to understand and identify the key priorities. However, progress is behind schedule due to workforce capacity issues.
- A standardised narrative has been developed and is embedded in all future CCG specifications, Quality Impact Assessments and Contracts.
- Trauma informed training for general practice presented at the GP practice learning event in October 2021, with further approaches to training of GP practice staff being explored.

4.0 Service Improvement Update

4.1 Diabetes Programme Update

4.1.1 Flash Glucose Monitoring

NHSE issued guidance in March 2019 on the national arrangements for the funding of flash glucose monitoring for relevant patients with type 1 diabetes. The WY ICS policy has recently been updated to enable patients with Learning Disabilities access to Flash Glucose Monitoring in line with this policy. All people with Type 1 diabetes or insulin treated Type 2 diabetes who are living with a learning disability and recorded on their GP Learning Disability register are eligible for Flash.

4.1.2 Low Calorie Diet

A new pilot for Low Calorie Diet, will commence roll out in January 2022. The Diabetes ICS Programme submitted an expression of interest and were successful. The focus of the allocation will be targeted at areas where there are likely to be inequalities; including areas; of highest deprivation, who have not previously had access to remission interventions, are areas of high diversity, or where vulnerable eligible populations are concentrated.

4.1.3 Weight Management

NHS Digital Weight Management Programme which launched on the 1 July 2021, offers digital support for adults living with obesity plus either diabetes, or hypertension, or both, to help manage their weight and improve their health.

4.1.4 Healthy iO

The 'Minuteful Kidney test' by Healthy.iO, has been commissioned across the area by West Yorkshire Health and Care Partnership and is funded for delivery in Calderdale CCG. Of the 13,000 people with diabetes in Calderdale, there are just under 8,000 who have not completed the NICE recommended kidney health urine check as part of their annual health review in the last 12 months. By offering ACR home testing to at-risk patients through our GPs practices, screening for urinary albumin will improve, helping GPs to identify over 300 cases of previously undiagnosed CKD enabling early intervention which would prevent escalation of the condition. This would reduce cardio-vascular risk in Calderdale - the consequent reduction in heart attacks, strokes and end stage renal disease over the next five years would save the CCG around £2m in long term care costs. This health economics modelling is from two studies commissioned by Yorkshire and Humber AHSN. In terms of next steps, we continue to work to target practices who are at different stages in their journey with implementation and recognise process changes should support uptake.

4.2 **Long Covid and Post Covid Clinics - All Age**

4.2.1 Long covid pathways were shared and agreed by LMC in March 2021. These had been developed jointly by clinical leads in both the CCG and CHFT.

4.2.2 In April 2021 the adult long/post covid pathway commenced as a soft launch and was fully launched in August 2021. The Paediatric long covid pathway was initiated from September 2021 (information on both adult and paediatric pathways have been shared with all practices through a variety of communication messages i.e., practice key messages, videos, webinars etc).

4.2.3 A Long Covid Enhanced Service has been developed to support general practice in managing long covid, recognising the key role general practice play in supporting both adults and children with long term symptoms of Covid-19. This includes assessing, diagnosing, referring where necessary and providing longer term holistic support of patients.

4.2.4 In Calderdale all practices have signed up to this enhanced service. This additional funding allows practices to plan training, workforce and infrastructure to support patients with this condition.

4.2.5 Below shows the number of referrals received from practices during Qtr 1 (April-June 2021): -

- April = 7 referrals received from 5 practices
- May = 9 referrals received from 6 practices
- June = 18 referrals received from 12 practices
- **Total – 34 referrals received from 14 practices** (qtr 2 data has been requested)

4.2.6 Calderdale Council's Public Health Registrar has undertaken a piece of research to estimate the burden of long Covid in the Calderdale population. The estimated figure for people in Calderdale with post covid is circa 3,000 (across all ages) with the greatest burden being in the middle age population and a greater burden being in females (profile expected to change over time).

4.3 **Covid Virtual Ward/Covid Early Supported Discharge**

- This service is run by the Community Respiratory Team and is for people who have had Covid-19 and still require support at home following discharge, for example, to wean them off oxygen.
- Individuals have daily intervention for a week, then reduced in the second week (as a general rule).
- The individuals are given a pulse oximeter and the Community Respiratory Team monitor them.

4.4 **Pulse Oximetry @Home**

- Local Care Direct ('LCD') is now providing the Pulse Oximetry at Home service for all Calderdale CCG patients.
- LCD are providing all aspects of the service including delivery and collection of oximeter packs, daily monitoring, and clinicians to support patients who trigger an escalation. The service identifies patients at risk of deterioration early, enabling better outcomes for patients.
- LCD receive the daily list of people who have tested positive for Covid-19 and contact them to see if they require an oximeter.
- Communications have been sent to practices informing them of how they can also refer patients who may need one:

4.5 **Urgent Community Response (UCR)**

4.5.1 In December the new service ‘Urgent Community Response’ was launched in Calderdale.

4.5.2 This exciting service development in health and social care is taking place across the whole country, and means those who need it, will have fast access to a range of qualified professionals who can address both their health and social care needs. People will be able to access a response from a team of skilled professionals within two hours, to provide the care they need to remain independent and avoid an admission to hospital.

4.5.3 Engagement workshops took place in November via Microsoft Teams to raise awareness of the service with all stakeholders, and to enable them to understand the criteria, pathway and referral of the service.

4.6 **Dementia Diagnostic Pathway**

4.6.1 Calderdale’s performance against this target has fluctuated over the past year. The most recent data report shows Calderdale is achieving 59.9% against the KPI of 66.7% target.

4.6.2 The Calderdale Dementia Diagnostic Pathway guidelines have been updated and will support us to improve performance. During covid there was a fall in the number of older people attending with concerns about their memory. The refreshed guideline is timely in supporting colleagues with the anticipated increase in people presenting requesting a diagnosis. To support recovery, spending review monies have funded additional outpatient capacity.

4.7 **Talking Therapies**

4.7.1 As we know, Covid has had a negative impact on the emotional health of population, with certain cohorts of population more impacted. Early intervention and easy access to talking therapies is important in supporting people to self-manage, build resilience, and prevent need for more intensive interventions. Providers have proactively worked with a wide range of partners to increase the awareness of talking therapies offer with a particular focus on cohorts disproportionately impacted by covid. including those impacted by the broader social determinants. It should be noted that providers have developed a range of additional

approaches including the development of direct bookings for GPs, a more culturally appropriate offer particularly to south asian communities, and an enhanced focus on long term condition pathways.

4.7.2 Benchmarking data (July 2021) indicated a fluctuating picture for the performance of Calderdale Talking Therapies providers compared to both the national and comparative data. Challenges include self-referral rates and the number of people who ended their referral before treatment. Referrals have increased slowly and from September 2021 providers achieving the access targets. As referrals increase, both providers are working to support people to reduce the number of people ending their referral before attending an assessment or entering treatment. Workforce challenges remain, with providers focusing on the emotional health and resilience of staff to maintain capacity to manage waiting lists which are increasing. This is currently particularly challenging with high sickness rates.

5.0 Integrated Care Partnership Development Update

5.1 Before Christmas all five places within the ICS undertook an exercise to establish their readiness to transition to new ICS arrangements from 1 April 2022. This work was supported by Audit Yorkshire who has been commissioned by West Yorkshire to help provide assurance that the ICS is ready for the new arrangements. Overall Calderdale's arrangements are on track and were rated as amber – 'in progress'. No key issues have been identified at this stage, however further information on Integrated Care Board arrangements is required in order to further develop some of our local plans.

5.2 On 24 December the 2022-23 NHS planning guidance was released, indicating a delay to the planned ICS transition. It is now expected that Integrated Care Boards and all associated arrangements will be established on 1 July 2022, rather than on 1 April. This delay allows Calderdale and neighbouring places to better embed shadow arrangements ahead of the formal transition. The delay does, however, also carry risks around finance and governance; these risks are manageable for a delay of three months but would become a greater concern if there was a further delay.

6.0 CCG Governance - Committee Self-Assessments

6.1 It is identified in the terms of reference for each CCG committee that they will undertake an annual self-assessment. The annual assessment will include a review of performance against the committee's annual plan, membership and terms of reference. This self-assessment shall form the basis of the annual report from each respective committee. As detailed in letters issued in March 2020, and more recently in December 2021, NHS England and Improvement continues to be committed to reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic and allow them to prioritise workload. In terms of board and sub-board meetings this concerns reducing the burden of governance including the streamlining of papers. The CCG has taken the decision not to complete committee self-assessments for the current year (2021-22). However, the annual review of each committee's terms of reference will take place as usual. A committee annual report detailing membership and activity throughout the year will continue to be written and presented at their respective meetings.

7.0 West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

7.1 Due to the cancellation of January's Joint Committee of CCGs, the minutes from the meeting that took place on the 5 October 2021 still require approval and therefore are not available for sharing.

8.0 Recommendations

8.1 It is recommended that the Governing Body **NOTES** the contents of the report.

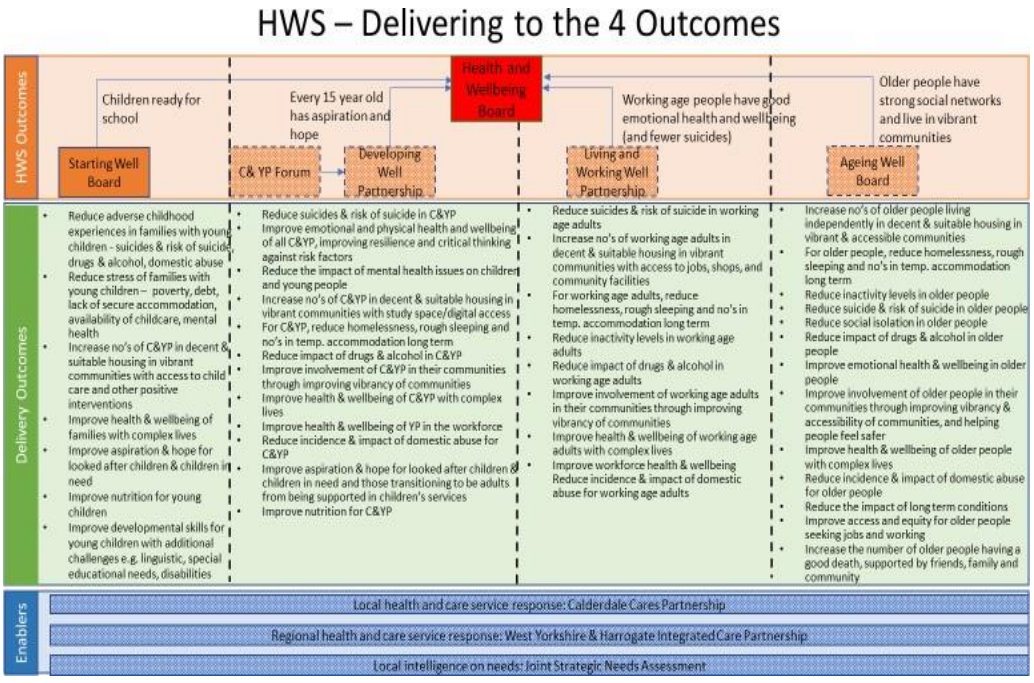
9.0 Appendices

9.1 Appendix 1 Calderdale Covid Vaccination progress as of 13 January 2022.

As of 13/01/22

	Cohort Size	Cohort Vaccinated 1st Dose	**Dose 1 %**	% Variance vs previous week	Cohort Vaccinated 2nd Dose	**Dose 2 %**	% Variance vs previous week	Booster Eligible Cohort Size (3 months from 2nd vaccine)	Cohort Vaccinated Booster Dose (any dose after 2nd vaccine)	**Eligible Booster % (of eligible cohort size)**	**Booster % (of total cohort size)**	% Variance vs previous week
1. residents in a care home for older adults and their carers	2438	2397	**98%**	-	2384	**98%**	-	-	1451	-	**60%**	3% ↑
1a. residents in a care home for older adults	963	950	**99%**	-	945	**98%**	-	940	851	**91%**	**88%**	1% ↑
1b. carers for residents in a care home for older adults	1475	1447	**98%**	-	1439	**98%**	-	-	600	-	**41%**	4% ↑
2. all those 80 years of age *Not including H&SCW	9265	8912	**96%**	-	8857	**96%**	-	8825	8428	**96%**	**91%**	-
3. all those 75 years of age and over	8265	8001	**97%**	-	7978	**97%**	-	7970	7662	**96%**	**93%**	-
4. all those 70 years of age and over and clinically extremely vulnerable individuals	18713	17454	**93%**	-	17147	**92%**	-	17077	15200	**89%**	**81%**	-
5. all those 65 years of age and over	10385	9782	**94%**	-	9686	**93%**	-	9621	8987	**93%**	**87%**	1% ↑
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality	20338	18244	**90%**	-	17606	**87%**	1% ↑	17111	14107	**82%**	**69%**	1% ↑
7. all those 60 years of age and over	8677	7972	**92%**	-	7907	**91%**	-	7779	7215	**93%**	**83%**	1% ↑
8. all those 55 years of age and over	11330	10184	**90%**	-	10045	**89%**	-	9442	8823	**93%**	**78%**	1% ↑
9. all those 50 years of age and over	12655	11201	**89%**	-	10988	**87%**	-	9999	9123	**91%**	**72%**	1% ↑
10. all those 40-49 years of age and over	28627	23696	**83%**	-	22863	**80%**	-	20119	17144	**85%**	**60%**	2% ↑
11. all those 30-39 years of age and over	29797	22288	**75%**	-	20733	**70%**	1% ↑	16172	12495	**77%**	**42%**	2% ↑
12. all those 18-29 years of age and over	29282	20934	**71%**	-	18644	**64%**	1% ↑	13797	8607	**62%**	**29%**	2% ↑
13. all those 16-17 years of age	5430	3427	**63%**	-	1933	**36%**	2% ↑	0	146		**3%**	-
14. all those 12-15 years of age at risk	289	182	**63%**	1% ↑	87	**30%**	1% ↑	0	2	-	**1%**	-
15. all those 12-15 years of age	11263	5347	**47%**	1% ↑	311	**3%**	1% ↑	0	8	-	**0%**	-
JCVI cohorts 1-9 total	**102066**	**94147**	**92%**	-	**92598**	**91%**	-	**88764**	**80996**	**91%**	**79%**	1% ↑
JCVI cohorts 10-12 total	**87706**	**66918**	**76%**	-	**62240**	**71%**	-	**50088**	**38246**	-	**44%**	2% ↑
JCVI cohorts 13-15 total	**16982**	**8956**	**53%**	2% ↑	**2331**	**14%**	1% ↑	**0**	**156**	-	**1%**	-
JCVI cohorts 1-15 total	**206754**	**170021**	**82%**	-	**157169**	**76%**	-	**138852**	**119398**	**86%**	**58%**	2% ↑

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	Age Friendly Calderdale	**Agenda Item No.**	7
Report Author	Rhona Radley	**Public / Private Item**	Public
GB / Clinical Lead		**Responsible Officer**	Debbie Graham

Executive Summary	
Please include a summary of the purpose of the report	Calderdale CCG are being asked for commitment to support an Age Friendly Calderdale developed by the World Health Organisation (WHO) in consultation with older people. The attached report produced by Ken Barnsley, Acting Consultant in Public Health has been shared with the Calderdale Health and Wellbeing Board and Health Leaders, encouraging all partners to agree to this. The report frames the steps on the journey for an Ageing Friendly Calderdale. and aligns with the direction of travel set out in the Calderdale Health and Wellbeing Strategy and the ageing well cohort (see below) 

Previous consideration	**Name of meeting**	Senior Management Team	**Meeting Date**	17/11/2021
	Name of meeting	SOG (as above)	**Meeting Date**	Click here to enter a date.

Recommendations	The Governing Body are asked to: 1. **Commit** support for an Age Friendly Calderdale						
Decision	☒	**Assurance**	☒	**Discussion**	☐	**Other**	Click here to enter text.

Implications							
Quality & Safety implications							
Engagement & Equality implications (including whether an equality impact assessment has been completed)							
Resources / Finance implications (including Staffing/Workforce considerations)							
Has a Data Protection Impact Assessment (DPIA) been completed? (Please select)		**Yes**		**No**		**N/A**	X
Strategic Objectives (which of the CCG objectives does this relate to?		**Risk** (include risk number and a brief description of the risk)					
Legal / CCG Constitutional Implications		**Conflicts of Interest** (include detail of any identified/potential conflicts)					

Calderdale MBC

Wards Affected All

Cabinet

Age Friendly Calderdale

Report of Directors of Public Health and Adult Services and Wellbeing

1. Purpose of Report

This briefing sets out the initial steps on the road to an Age Friendly Calderdale. We acknowledge that we will need the concerted efforts of our citizens, communities, business and partners to take all the steps needed but in line with our key strategic priorities, we make the commitment to become an Age Friendly Community.

The purpose is to give consideration to the following steps towards an Age Friendly Calderdale

1. Agree policy objective to become a World Health Organisation (WHO) Age Friendly Community
2. Agree to Membership of the UK Network for Age Friendly Communities
3. Agree to commit to and sign the Centre for Ageing Better and Public Health England Healthy Ageing Consensus Statement
4. Agree to encourage the Health and Wellbeing Board and partners to sign the Healthy Ageing Consensus Statement
5. Agree in principle the Age Friendly Calderdale Involvement Plan.

2. Need for a decision

2.1 Key policy decision following consultation with Cabinet Member for Adult Services and Wellbeing.

3. Recommendation

3.1 That the Council be recommended to approve a policy objective to become a World Health Organisation Age Friendly Community

3.2 That the Council be recommended to agree to become members of the UK Network for Age Friendly Communities

3.3 That the Council be recommended to agree to commit to and sign the Centre for Ageing Better and Public Health England Healthy Ageing Consensus Statement

4. Background and/or details

4.1 Background

Age Friendly Cities were set up by the World Health Organisation (WHO) in 2007 and since then Cities all around the Globe have signed up. In the UK the Network for Age Friendly Communities includes Cities and communities from Torbay to Sunderland and from Brighton to Glasgow.

The Age-friendly Communities Framework was developed by the World Health Organisation (WHO), in consultation with older people. It is built on the evidence of what supports healthy and active ageing in a place (Age Friendly Cities Checklist Attached).

In age friendly communities, older residents help to shape the place that they live. This involves local groups, councils, businesses and residents all working together to identify and make changes in both the physical and social environments, for example transport, outdoor spaces, volunteering and employment, leisure and community services.

The **UK Network of Age-friendly Communities** is a growing movement with over 40 member places across England, Scotland, Wales and Northern Ireland. The UK Network is affiliated to the World Health Organisation's Global Network for Age-friendly Cities and Communities. It marks out Age-friendly Communities as places where people of all ages are able to live healthy and active later lives. These places make it possible for people to continue to stay living in their homes, participate in the activities that they value, and contribute to their communities, for as long as possible.

The **Healthy Ageing Consensus Statement** was developed by Public Health England and the Centre for Ageing Better in 2019. It has been created and supported by a range of organisations across national and local government, charity and voluntary organisations, public health, academics and the NHS, and has been facilitated by Public Health England and the Centre for Ageing Better. Its purpose is to set out shared commitments on healthy ageing and to demonstrate leadership for the World Health Organization's Decade of Healthy Ageing 2020-2030.

The vision is:

> *"for England to be the best place in the world to grow older, giving everyone the opportunities and support they need to have a healthy and good quality later life and making the best use of the strengths, skills and experience of older people"*

The Healthy Ageing Consensus Statement marks out five fundamental principles:

1. Putting prevention first and ensuring timely access to services and support
2. Removing barriers and creating more opportunities for older adults to contribute to society
3. Ensuring good homes and communities to help people remain healthy, active, and independent in later life
4. Narrowing inequalities
5. Challenging ageist and negative, culture and practices.

These are set out in full in the statement attached.

4.2 Context

Our society and our daily lives are changing at a rapid pace with increasing use of technology and digital innovation. At the same time the UK population is undergoing a massive shift and in the next 20 year one in four of us will be aged 65+. This transformation of the age structure is a testament to improvements in Public Health and Health Care and reflects better technologies and quality of care. People are living longer but not necessarily experiencing increased quality of life. Social isolation and loneliness are one of the greatest public health challenges and have associated issues of poor health and wellbeing. Growing demands, nationally and locally, mean that we need to respond differently to people's needs and take a more preventative approach. Over the last year and a half, the COVID Pandemic has driven new ways of working and innovation in service development and delivery along with increasingly data driven responses to a highly dynamic and rapidly changing picture.

Calderdale is home to **40,100 people aged 65+,** an increase of almost a quarter (23%) over the last ten years. Significant growth in the age group is forecast and Calderdale and estimates suggest an increase of 14,500 by 2040 (+27%)

Over the last decade life expectancy which has been steadily increasing since the 1840s has stalled and in 2020, the impacts of the Pandemic saw the largest drop in life expectancy, setting the national figures back ten years to 78.7 years for men and 82.7 years for women.

In Calderdale life expectancy for men and women are significantly worse than the national average as is life expectancy at age 65. Men aged 65 in Calderdale can expect to live a further 18.2 year while women can expect a further 20.3 years compared with national rates of 19.1 and 21.3.

However, our data do have some positive features and Healthy Life Expectancy for people aged 65+ which is considered one of the better indicators of future quality of life, is better than nationally for men and significantly better for women. This means that although people in Calderdale aged 65+ are likely to live shorter lives, a greater part of that (59%) will be in good health compared with the national figure (56%).

These are small but important differences, and the Borough level data masks key inequalities between neighbourhoods with a more than 10-year gap in life expectancy between the most deprived and least deprived wards.

4.3 Policy Links

This approach has significant policy connections:

Health and Wellbeing Strategy 2018 - strategy across the life course: Starting Well, Developing Well, Living and Working Well and Ageing Well. Age Friendly will align with Ageing Well and outcomes.

Vision 2024 – an Age Friendly place will link in strongly with Vision 2024, Age Friendly Calderdale will tie into the great distinctiveness about the place, it will hook into the kindness and resilience of people and communities and exhibit the talent and enterprise of older people

Inclusive Economy – reducing inequality and creating a sustainable future

Calderdale Local Plan – Age Friendly will have an important contribution to make to the design and liveability of Calderdale now and in the future linking in with local

design initiatives and health improvement ambitions of the Local Plan and Supplementary Planning Document. Supporting liveable streets and neighbourhoods and zero carbon Calderdale. Public Health currently fund a planning officer to ensure that these key links are realised.

Active Calderdale – working with Active Calderdale to support older people to be more active and lead more fulfilling lives

Digital ICT Strategy – linking in with ambitions for digital inclusion and innovation, improving access to superfast broadband and increasing digital skills for older people to ensure the benefits are across the life course

Housing Strategy - a significant role to play in placemaking and ensuring a place is age friendly

4.4 Involving Older People and Communities

More than a third of the population of Calderdale comes within the World Health Organisation 50+ age group and one in five is aged 65+. We have more than 11,000 citizens aged 65+ who live on their own and at great risk of loneliness.

Our commitment is to involve older people and communities as much as we are able in the development of, planning and delivery of Age Friendly Calderdale:

Age Friendly Alliance – multi sector board responsible to the Health and Wellbeing Board for Age Friendly Calderdale and Ageing Well.

Developing Age Friendly Communities – working with the five Localities to involve older people and communities to understand their stories about Age Friendly now and how it could be.

4.5 Age Friendly Involvement Plan

Between now and the end of 2021 we will put all the pieces in place to become and Age Friendly Community. This will involve

Leadership	Leadership briefing and involvement for Portfolio Holders, Corporate Leadership and Cabinet Development of an Ageing Well Alliance with involvement and membership across all sectors.	Aug - Dec
UK Age Friendly Communities Network	Membership submitted	Aug
Healthy Ageing Consensus Statement	Cabinet Agreement Health and Wellbeing Board Individual Partners	October
Engagement and Involvement of Older People	Initial engagement - what makes your place age friendly? Community Engagement/Appreciative Inquiry Partnership Involvement	August Sep-Nov
Age Friendly Calderdale Baseline Review	Review WHO Age Friendly Criteria 1. Outdoor space and buildings 2. Transport 3. Housing 4. Social participation 5. Respect and social inclusion 6. Civic participation and employment 7. Communication and information 8. Community support and health	Aug - Sep
Age Friendly Plan	Age Friendly Baseline Develop Age Friendly Plan for Calderdale: Vision, Aims, Objectives, Plan, Outcomes	Sep - Nov
Age Friendly Settings	What do Age Friendly Settings look Like? Schools, workplaces, streets, town centres, faith settings, leisure and cultural facilities, GP practices, faith settings	Ongoing commitment
Communications and Campaigns	International Day of Older People 1/10 Campaign - Website, social media, Calderdale Imagery and stories	October Aug - Nov

5. Options considered

In relation to Age Friendly Calderdale and the Healthy Ageing Commitment Statement, the options available are to:

1. Adopt the recommendations of this report or,
2. Make no change to existing policy and ambition for Calderdale.

In adopting the recommendations of this report, the Cabinet is recognising that population ageing is one of the biggest social transformations in the 21st century. Between 2015 and 2050, the proportion of the world's population over 60 years will double from 12% to 22% and is expected to is expected to total 2 billion. Further that the older population of Calderdale is growing and that by 2040 almost one in four people in the Borough will be aged 65+.

Environments that are age-friendly help to foster functional ability both by removing barriers and developing policies, systems, products and services that:

- promote health and build and maintain intrinsic capacity across the life course; and
- enable people experiencing capacity loss to continue to do the things they value.

Efforts to enhance functional ability help ensure older people age safely in a place that is right for them, are free from poverty, can continue to develop personally and can contribute to their communities while retaining autonomy and health. When actions also take into consideration social exclusion and barriers to opportunity, efforts to build and maintain the level of functional ability can also serve to overcome inequities between groups of older adults.

Age-friendly places design and adapt their natural and built environment for residents of all ages and different capacities. An age-friendly community is barrier-free, designed for diversity, inclusive and cohesive. For example: accessible and safe road and transport infrastructure, barrier-free access to buildings and houses, and public seating and sanitary facilities, among others. Age-friendly environments enable people to stay active, connected and able to contribute to the economic, social, and cultural life in their community. Becoming age-friendly can make a community and community of choice for all generations – a great place in which to live, have a family and grow older.

These facets of Age Friendly Boroughs will contribute to improving health and wellbeing and reducing health inequalities. The full benefits cannot be understood until the Age Friendly Baseline and the Age Friendly Plan have been produced. Cabinet will be advised at that time of the costs and benefits of the delivery of the plan will be and be able to decide on how the policy is implemented.

6. Financial implications

6.1 At this stage Cabinet is being asked to approve a policy objective to become a WHO Age Friendly Community, agree to become members of the UK Network for Age Friendly Communities and commit to and sign the Centre for Ageing Better and Public Health England Healthy Ageing Consensus Statement. Although these commitments will have no immediate and direct financial implications, the potential financial implications of delivering upon the objectives of these commitments cannot be understood until the Age Friendly Baseline and the Age Friendly action plan have been produced. Cabinet will be advised

at that time what the financial implications of delivery of the plan will be and be able to decide on how the policy is implemented.

7. Legal Implications

7.1 The policy commitment has no direct legal implications

8. Human Resources and Organisation Development Implications

8.1 There are no HR & OD staffing implications to consider as part of this report.

9. Consultation

9.1 This report and the issues in it have been developed in collaboration between the Director of Public Health and the Director for Adult Services and Wellbeing

9.2 The Cabinet Member for Adult Services and Wellbeing has been consulted and briefed and will continue to be updated monthly

9.3 This report was presented to and agreed by CLT on 17th August

9.4 It is proposed to brief and consult

9.4.1 Health and Wellbeing Board

9.4.2 Adults Health and Social Care Scrutiny Committee

9.4.3 Health and Care Leaders

10. Environment, Health and Economic Implications

10.1 Part of the process of developing the Age Friendly Calderdale Plan will involve development of a baseline and consideration of the environmental, health and economic impacts

11. Equality and Diversity

Progress to an Age Friendly Borough recognises that ageing is a characteristic shared by everyone. It is important to recognise that the population becomes more, rather than less, diverse as we age. Just because someone is a certain age doesn't necessarily mean they are like someone else of a similar age. For example, there are large differences in the age at which different people experience disability and/or ill health, directly associated with their socioeconomic circumstances.
The Equality Impact Assessment will enable consideration of the differing experiences of, for example, older Black, Asian and Minority Ethnic people compared with older White people; older women compared with older men; etc. The intersection of other protected characteristics with age and have a significant influence on different experiences for those older people:

Race – there are significant disparities between ethnic groups in wealth, debts and pensions, in home ownership and levels of poverty with Black and Minority Ethnic groups likely to be disadvantaged in comparison with White groups. Evidence from COVID studies has highlighted the older people are more likely to have experienced the damaging effects

of COVID and within this cohort Black and Minority Ethnic groups are more likely to have been cases, hospitalised and for COVID to lead to death.

Gender – there are significant gender gaps as people age with a large gender pay gap for people aged 50 onwards, employment rates lower for older women compared with men, disparities in preparedness for a comfortable retirement.

Sexual Orientation – there are concerns in LGBT communities in relation to housing choice in later life and that supported and extra-care housing may not reflect or respect their identity. LGBT people are more likely to report poor self-rated health and more likely to have a long term illness.

Disability – people with a physical and/or learning disability are more likely to have a shorter life expectancy, less likely to work aged 50+ due to ill health or disability.

It is also clear that the inequalities that have been exposed by COVID have disproportionately affected older adults compared with other age groups

Employment – almost one in three key workers are over 50; people aged over 50 who have lost their jobs are more likely to suffer long term employment and many have in effect taken involuntary early retirement.

Digital Exclusion – digital communication has increased amongst 50-70 year olds in lockdown, but many activities, services and information sources have moved exclusively online, creating a risk of exclusion for older people without digital access.

Ageism – COVID-19 reinforce negative stereotypes of older people portraying them as expendable, frail and vulnerable and at times portraying older people as somehow outside of society.

In the development of the Age Friendly Calderdale Plan there will be significant consideration of the impact on protected groups and the inequalities and inequities that may be consequent.

12. Summary and Recommendations

12.1 Summary

This briefing sets out the initial steps on the path for an Age Friendly Calderdale. We acknowledge that we will need the concerted efforts of our citizens, communities, business and partners to take all the steps needed but in line with our key strategic priorities, we make the commitment to become an Age Friendly Community.

12.2 Recommendations

12.2.1 That the Council be recommended to approve a policy objective to become a WHO Age Friendly Community

12.2.2 That the Council be recommended to agree to become members of the UK Network for Age Friendly Communities

12.2.3 That the Council be recommended to agree to commit to and sign the Centre for Ageing Better and Public Health England Healthy Ageing Consensus Statement

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For further information on this report, contact:

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E-mail:	ken.barnsley@calderdale.gov.uk

The documents used in the preparation of this report are:

1. WHO, Global Age Friendly Cities Guide
2. WHO, Age Friendly Cities Checklist
3. PHE and Centre for Ageing Better

The documents 2 and 3 are attached.

Name of Meeting	Governing Body	**Meeting Date**	27th January 2022
Title of Report	Calderdale Cares Partnership Agreement	**Agenda Item No.**	
Report Author	Rachel Bevan, Programme Manager for Place Based Partnership Development	**Public / Private Item**	Public
Clinical Lead	N/A	**Responsible Officer**	Robin Tuddenham, Accountable Officer for NHS Calderdale CCG

Executive Summary

In February 2021 the Department of Health and Social Care published a white paper which set out intentions to establish statutory integrated care systems. In doing so the white paper emphasised the need for place-based collaboration between the NHS, local government and wider key partners such as the voluntary and community sector.

In developing Calderdale's place-based partnership – the Calderdale Cares Partnership – an agreement has been developed which sets out how health and care partners have agreed to work together for the benefit of Calderdale's population. This report presents the proposed Calderdale Cares Partnership Agreement to the Governing Body for approval.

Previous Considerations

Name of meeting	NHS Calderdale CCG Governing Body Workshop	**Meeting Date**	9th December 2021

Recommendations

It is recommended that the Governing Body:

1. Approves the content of the Calderdale Cares Partnership Agreement.
2. Recommends that the Agreement is finalised and shared with the Health and Wellbeing Board for ratification.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	The Calderdale Cares Partnership governance model – once finalised – will set out the framework for how quality and safety matters will be overseen and assured within Calderdale, linking to the appropriate mechanisms at the West Yorkshire level. Our partnership board will include representation with accountability for quality and safety.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	The aim of the new architecture would be to support delivery of the outcomes agreed by the Health and Wellbeing Board as part of the refresh of the wellbeing strategy – this includes outcomes related to health inequalities. A Communications, Engagement and Equalities Collaborative has been launched across partners – as reflected within the Calderdale Cares Partnership governance model – which supports even greater focus on collaboration across those three disciplines and ultimately will support Calderdale in building plans based on the needs of communities.
Resources / Financial Implications (including Staffing/Workforce considerations)	The Integrated Care Board will shape the financial framework – this is a work in progress. Discussions are taking place about the future resourcing of the programme office which sits behind our new approach and architecture.
Sustainability Implications	Calderdale will retain its focus on sustainability and will continue supporting West Yorkshire's ambition on climate change.

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

Strategic Objectives (which of the CCG objectives does this relate to?)	The approach being developed would link to each of the CCG's strategic objectives.	**Risk (include risk number and a brief description of the risk)**	The three month delay to the CCG transitioning to be part of the West Yorkshire Integrated Care Board has associated risks around finance and governance.

Legal / CCG Constitutional Implications	It is anticipated that the CCG will transition to be part of the West Yorkshire Integrated Care Board under the new integrated care system arrangements from July 2022.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	N/A – however whilst there are no direct conflicts of interest associated with this paper, identification and mitigation of risks associated with conflicts of interest will be a key feature of our new architecture.

1. Introduction

1.1 Calderdale Cares began in 2018 as the Calderdale place-based model for integrated health, care and wellbeing. At the heart of Calderdale Cares were the principles of better wellbeing for all, harnessing the strengths of people and communities, seamless services for those that need help, and partners working collaboratively to make that all happen.

1.2 The aim was to create strong collaboration across Calderdale where organisations, including the NHS, Calderdale Council and the voluntary and community sector work together and share resources to deliver a range of support to meet each person's individual needs, within their own community.

1.3 Since the inception of Calderdale Cares collaborative working has continued to progress, further accelerated by organisations' joint response to the Covid-19 pandemic.

1.4 In February 2021 the Department of Health and Social Care published a white paper which set out intentions to establish statutory integrated care systems. In doing so the white paper emphasised the need for place-based collaboration between the NHS, local government and wider key partners such as the voluntary and community sector.

1.5 In response to the white paper each place within the West Yorkshire Health and Care Partnership is further developing their place-based partnership. In Calderdale it is recognised that what this requires is an evolution of the original Calderdale Cares concept, building on the strong foundations already developed and moving forwards as the Calderdale Cares Partnership.

1.6 The Calderdale Cares Partnership is rooted in local knowledge, shifts in power, distributed leadership, and most importantly its innate values and behaviours of kindness and resilience. As a place Calderdale has strong relationships across its Partnership and with its people, continually seeking to listen and learn from communities and those who use services and to work together as equals.

1.7 As the Partnership progresses the original aims of the Calderdale Cares model will continue to be pursued, driven through a relentless focus on reducing health inequalities and starting with prevention, meaning Calderdale is not only a great place to visit, but is – most importantly – a place to live a larger life.

2. Background

2.1 A Partnership Agreement has been developed across the Partnership's organisations to lay out the ways in which partners have agreed to work together for the benefit of Calderdale's population. The Agreement sets out the key commitments of the Partnership, including:

2.1.1 The vision of the Partnership and the vision's supporting objectives.

2.1.2 The shared principles, values and behaviours that the Partners have agreed to adopt throughout their joint working.

2.1.3 The governance structures and supporting arrangements underpinning the Partnership.

2.2 The Agreement is not legally binding and does not impose any legal obligations on any partners, nor does it add to or override any existing contractual obligations held by any partners. In endorsing the Agreement partners will fully retain their organisational sovereignty and continue to be accountable for their respective statutory responsibilities.

2.3 As it has done to date, the Calderdale Cares Partnership will continue to evolve over years to come; so too should the Partnership Agreement to reflect the Partnership's development.

2.4 In particular section 9 of the Agreement – Governance Model – will require updating as the Partnership's supporting arrangements are finalised. Within this context the Agreement will first be reviewed in April 2023 – a year after the Agreement's commencement date.

2.5 As part of its development the draft Agreement was shared across partners during November and December 2021. Partners fed back that the Agreement feels appropriate for Calderdale and supports the Partnership's direction of travel.

2.6 As part of this process the draft Agreement was shared at the CCG's Governing Body Workshop on 09 December 2021 where it was positively received.

2.7 Since that time the Agreement has been updated in response to feedback from partners, alongside minor formatting changes having been made:

2.7.1 An overview of the membership of the Calderdale Cares Partnership Board has been added.

2.7.2 An updated version of the governance model has been inserted to reflect updates in language (no substantive changes made).

2.7.3 The commencement date has been updated following agreement at the Calderdale Health and Care Leaders Group that the final Agreement should be taken to the Health and Wellbeing Board following partners' approval.

2.7.4 The West Yorkshire Health and Care Partnership's principles and values have been clarified within the background section.

2.8 The above amendments were recommended for inclusion by the Integrated Care Partnership Development Group on 13 December 2021 and approved by the Health and Care Leaders Group on 17 December 2021.

2.9 Since that time minor amendments have also been made to reflect the delay to transitioning to new integrated care system arrangements, with the transition target date now set as 01 July rather than 01 April.

3. Consultation and Next Steps

3.1 As part of its development the draft Agreement was shared across the Calderdale system, both with partner boards and with groups such as the Adult Health and Social Care Scrutiny Board, during November and December 2021.

3.2 The next steps for the Agreement are as follows:

3.2.1 January 2022 – February 2022: The updated Agreement is being taken to signatory partners' formal Boards / Cabinet / Governing Body for approval.

3.2.2 03 March 2022: The final Agreement will be taken to the Calderdale Health and Wellbeing Board for ratification.

3.2.3 07 – 11 March 2022: Signatures for the Agreement will be collected.

3.2.4 01 April 2022: The Agreement takes effect.

4. Implications

4.1 Quality and Safety Implications

4.1.1 As described on page 2.

4.2 Engagement and Equality Implications

4.2.1 As described on page 2.

4.3 Resources / Finance Implications

4.3.1 As described on page 2.

4.4 Data Protection Impact Assessment

4.4.1 As described on page 2.

4.5 Risk

4.5.1 As described on page 2.

4.6 Legal / CCG Constitutional Implications

4.6.1 As described on page 3.

4.7 Conflicts of Interest

4.7.1 As described on page 3.

5. Recommendations

It is recommended that the Governing Body:

1. Approves the content of the Calderdale Cares Partnership Agreement.
2. Recommends that the Agreement is finalised and shared with the Health and Wellbeing Board for ratification.

6. Appendices

Calderdale Cares Partnership Agreement

CALDERDALE CARES PARTNERSHIP AGREEMENT

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1. CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

2. CALDERDALE LOCAL MEDICAL COMMITTEE LTD

3. CALDERDALE METROPOLITAN BOROUGH COUNCIL

4. HEALTHWATCH CALDERDALE

5. LOCALA COMMUNITY PARTNERSHIPS CIC

6. NHS CALDERDALE CLINICAL COMMISSIONING GROUP

7. SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

8. VOLUNTARY AND COMMUNITY

CALDERDALE CARES PARTNERSHIP AGREEMENT

Contents

CALDERDALE CARES PARTNERSHIP AGREEMENT

This Partnership Agreement ('this Agreement') is made between:

1. **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** of Acre Street, Lindley, Huddersfield, West Yorkshire, HD3 3EA;
2. **CALDERDALE LOCAL MEDICAL COMMITTEE LTD** of E139 Dean Clough Mills, Halifax, HX3 5AX;
3. **CALDERDALE METROPOLITAN BOROUGH COUNCIL** of Town Hall, Crossley Street, Halifax, West Yorkshire, HX1 1UJ;
4. **HEALTHWATCH CALDERDALE** of The Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax, HX1 5ER;
5. **LOCALA COMMUNITY PARTNERSHIPS CIC** of Beckside Court (First Floor), Bradford Road, Batley, WF17 5PW;
6. **NHS CALDERDALE CLINICAL COMMISSIONING GROUP** of 2nd Floor, Westgate House, Halifax, HX1 1PW;[1]
7. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP; and
8. **VOLUNTARY AND COMMUNITY** of Resource Centre, Hall Street, Halifax, HX1 5AY.

Together these organisations are referred to as 'the Partners' and as a collective form the formal leadership for the Calderdale Cares Partnership ('the Partnership').

1. Background

1.1. Calderdale Cares began in 2018 as the Calderdale place-based model for integrated health, care and wellbeing. At the heart of Calderdale Cares were the principles of better wellbeing for all, harnessing the strengths of people and communities, seamless services for those that need help, and partners working collaboratively to make this all happen.

1.2. The aim was to create strong collaboration across Calderdale where organisations, including the NHS, Calderdale Council and the voluntary and community sector, work together and share resources to deliver a range of support to meet each person's individual needs, within their own community.

1.3. Calderdale is one of five places within the West Yorkshire Health and Care Partnership, a partnership of places, provider collaboratives and system. The West Yorkshire Health and Care Partnership is grounded in its agreed principles:

[1] In endorsing the Agreement Partners recognise that it is anticipated NHS Calderdale Clinical Commissioning Group will transition to be part of the NHS West Yorkshire Integrated Care Board from July 2022.

1.3.1. We will be ambitious for the people we serve and the staff we employ.

1.3.2. The West Yorkshire Partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.

1.3.3. We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.

1.3.4. We will undertake shared analysis of problems and issues as the basis of taking action.

1.3.5. We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.4. Additionally the West Yorkshire Health and Care Partnership is underpinned by a set of shared values:

1.4.1. We are leaders of our organisation, our place and of West Yorkshire.

1.4.2. We support each other and work collaboratively.

1.4.3. We act with honesty and integrity, and trust each other to do the same.

1.4.4. We challenge constructively when we need to.

1.4.5. We assume good intentions.

1.4.6. We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

1.5. In February 2021 the Department of Health and Social Care published a white paper[2] ('the white paper') which set out intentions to establish statutory integrated care systems (ICSs). In doing so the white paper emphasised the need for place based collaboration between the NHS, local government and wider key partners such as the voluntary and community sector.

1.6. In response to the white paper each place within the West Yorkshire Health and Care Partnership is continuing to develop their place based partnership, bringing together the NHS, local government, and other partners. In Calderdale it is recognised that what this requires is an evolution of the original Calderdale Cares concept, building on the strong foundations already developed and moving forwards as the Calderdale Cares Partnership.

2. Status and Purpose of this Partnership Agreement

[2] *Integration and Innovation: working together to improve health and social care for all* (Department of Health and Social Care, February 2021: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf)

2.1. The Partners have agreed to work together on behalf of the people of Calderdale to work collaboratively and to further develop the Calderdale Cares Partnership. In doing so the Partners will identify and respond to the health and care needs of the Calderdale population and deliver integrated health, support and community care to develop – and ultimately deliver – improved health and care outcomes for the people of Calderdale.

2.2. This Agreement sets out the key agreements of the Partnership, including:

2.2.1. The vision of the Partnership and the vision's supporting objectives.

2.2.2. The shared principles, values and behaviours that the Partners have agreed to adopt throughout their joint working.

2.2.3. The governance structures and supporting arrangements underpinning the Partnership.

2.3. This Agreement is not legally binding and does not impose any legal obligations on any Partners, nor does it add to or override any existing contractual obligations held by any Partners. In endorsing the Agreement Partners fully retain their organisational sovereignty and continue to be accountable for their respective statutory responsibilities.

3. Approvals

3.1. Each Partner acknowledges and confirms that it has obtained the required authorisation to enter into this Agreement and that its own Board / Cabinet / Governing Body has approved the content of this Agreement.

4. Duration and Review

4.1. This Agreement shall take effect on 01 April 2022 and will continue in full effect until such time the Partners agrees that alternative arrangements would better serve the needs of the Partnership.

4.2. The Partners will initially review the terms of this Agreement in April 2023 and at such intervals thereafter as the Partners may agree. The Partners may agree to update the Agreement to reflect developments as appropriate.

Part A: The Partnership's Vision, Objectives, Principles, Values and Behaviours

5. Vision and Objectives

5.1. The Partners have agreed to work towards a common vision for Calderdale as follows:

'Our vision for Calderdale is for a place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past.

We aspire to be a place where talent and enterprise can thrive.

A place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope.

Calderdale will stand out, be known and be distinctive.

A great place to visit, but most importantly, a place to live a larger life.'

5.2. In pursuit of the vision the Partners have agreed to work towards the following objectives:

5.2.1. Reducing health inequalities across the borough of Calderdale.

5.2.2. Investing in prevention and 'home first', helping people to avoid admission to care homes and hospital beds wherever possible.

5.2.3. Developing a sustainable health and care system for Calderdale.

5.2.4. Integrating services and their supporting workforce to deliver joined up care.

5.2.5. Looking after our workforce and ensuring they are happy and fulfilled at work.

5.2.6. Making best use of Calderdale's resources and getting the most out of the 'Calderdale pound'.

5.2.7. Working in partnership with our localities, communities and citizens.

6. Principles, Values and Behaviours

6.1. The Partners have agreed to adopt the following principles in their work together as a Partnership:

6.1.1. We start with prevention and invest in keeping people as well as they can be.

6.1.2. We take a person-centred approach in all we do, joining up services around the needs of citizens.

6.1.3. We value and support Calderdale’s unique health and wellbeing assets and help people to benefit from them.

6.1.4. We work together with people and communities and help empower them to be healthy and independent.

6.1.5. We work relentlessly to reduce inequalities in health and wellbeing.

6.2. The Partners have agreed to adopt the following values in their work together as a Partnership:

6.2.1. Honesty and integrity.

6.2.2. Compassion and kindness.

6.2.3. Trust and respect.

6.3. The Partners have agreed to adopt the following behaviours in their work together as a Partnership:

6.3.1. We focus on making a difference for Calderdale people and communities.

6.3.2. We support each other and work collaboratively.

6.3.3. We challenge constructively and hold one another to account.

6.3.4. We use strengths-based approaches.

Part B: Delivering the Vision, Objectives, Principles, Values and Behaviours

7. Problem Resolution

7.1. The Partners agree to approach problem resolution in a way which recognises the objectives, principles, values and behaviours set out above and which:

7.1.1. Seeks solutions within a shared culture of 'no fault, no blame'.

7.1.2. Seeks to resolve any disputes in an open, amicable and communicative manner.

7.1.3. Treats the Partners as equal parties within the resolution of any dispute.

7.1.4. Seeks solutions which are mutually beneficial as far as possible.

7.1.5. Accepts that confrontational attitudes waste time and other resources and should be avoided at all times.

7.2. If any Partner receives a formal enquiry or complaint from a party external to this Agreement and the enquiry or complaint relates to this Agreement, the receiving Partner will agree the contents of their response with the full Calderdale Cares Partnership Board before the response is issued.

8. Partners' Roles and Responsibilities

8.1. Each Partner agrees to:

8.1.1. Work collaboratively with the other Partners in line with the Calderdale Cares Partnership vision, objectives, principles, values and behaviours.

8.1.2. Work collaboratively with the other Partners and with colleagues more widely to deliver the ambitions of the West Yorkshire Integrated Care Partnership strategy and the NHS West Yorkshire Integrated Care Board (once established).

8.1.3. Work collaboratively to best serve Calderdale's population rather than pursuing organisational interests.

8.1.4. Work collaboratively with the other Partners to further develop the Calderdale Cares Partnership.

8.1.5. Work collaboratively with the other Partners to develop and provide a single place based response to parties external to this Agreement where requests for information are made.

Part C: Governance Arrangements

9. Governance Model

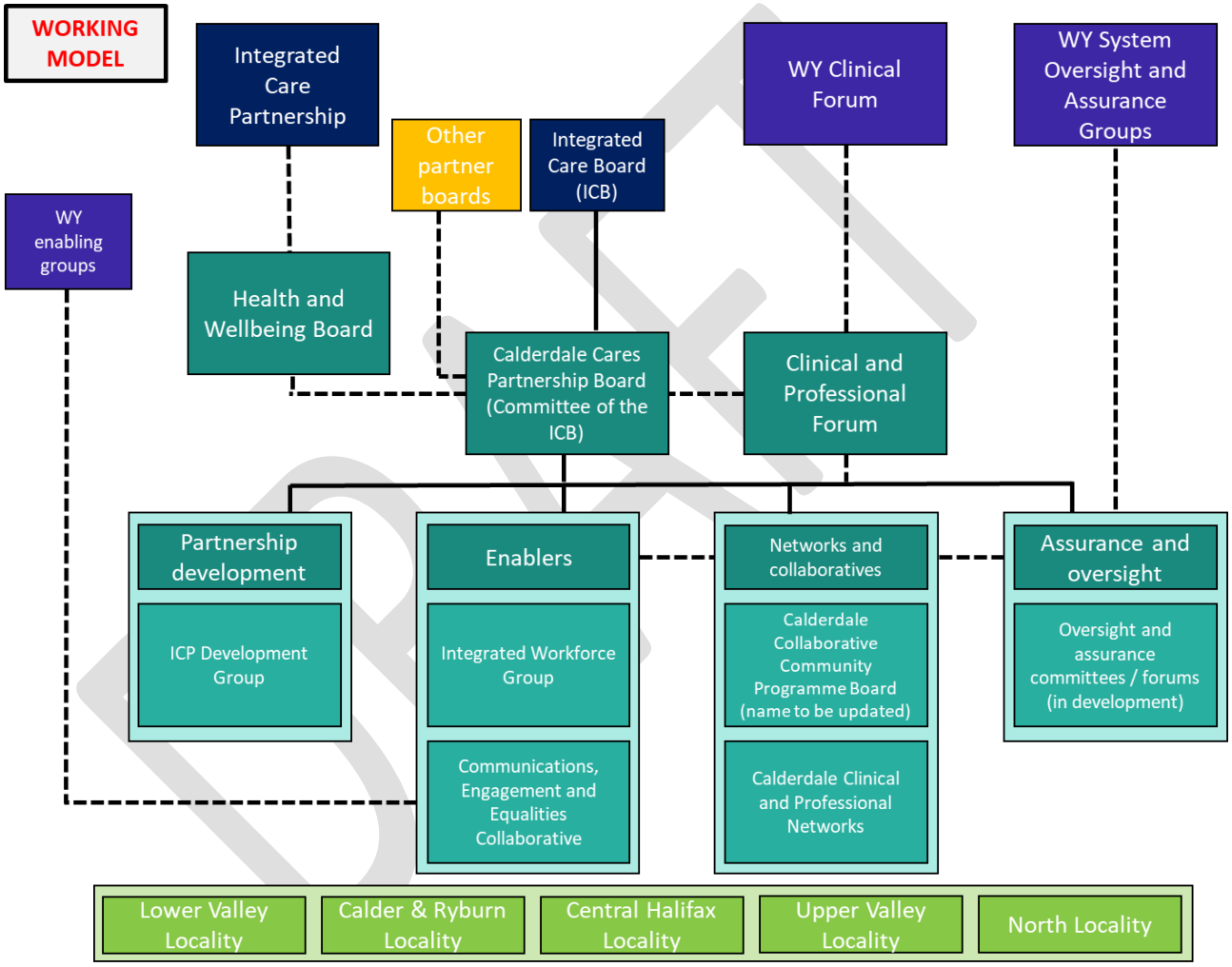
9.1. In addition to the Partners' own Boards / Cabinet / Governing Body, which retain their existing responsibilities and accountability, the governance model for the Calderdale Cares Partnership arrangements (as shown below) comprises:

9.1.1. The Calderdale Cares Partnership Board;

9.1.2. The Health and Wellbeing Board;

9.1.3. The Clinical and Professional Forum; and

9.1.4. Delivery and assurance infrastructure.



Calderdale Cares Partnership Board

9.2. The Calderdale Cares Partnership Board provides the formal leadership for the Calderdale Cares Partnership. The Board provides oversight for Calderdale health and care business and provides a forum through which to make decisions on those matters which are best addressed collectively.

9.3. From July 2022 the Board will be a committee of the NHS West Yorkshire Integrated Care Board and from that time will be responsible for matters delegated to it in

accordance with the Integrated Care Board's constitution and scheme of reservation and delegation.

9.4. The Board is led by an independent Chair and includes representation from: independent lay members; Calderdale Metropolitan Borough Council; NHS West Yorkshire Integrated Care Board; Calderdale Local Medical Committee; Calderdale and Huddersfield NHS Foundation Trust; Healthwatch Calderdale; Locala Community Partnerships; South West Yorkshire Partnership NHS Foundation Trust; the voluntary and community sector; general practice; the Calderdale Clinical and Professional Forum; public health; quality and safety; finance; and performance.

Health and Wellbeing Board

9.5. The Health and Wellbeing Board provides a forum through which political, clinical, professional and community leaders come together to develop a shared ambition for improving health and wellbeing and addressing health inequalities in Calderdale. The Health and Wellbeing Board is responsible for setting the Health and Wellbeing Strategy for Calderdale and holding to account the Calderdale Cares Partnership Board for the health and care service contribution to that strategy. The Health and Wellbeing Board continues to be responsible for undertaking Calderdale's Joint Strategic Needs Assessment.

Clinical and Professional Forum

9.6. The Clinical and Professional Forum provides clinical and professional leadership to the Partnership and makes recommendations to inform decisions made by the Calderdale Cares Partnership Board. The Forum acts as a gateway to the Calderdale Cares Partnership Board, whereby proposals first go to the Clinical and Professional Forum (unless it is agreed that the content of the proposal is not relevant to the Forum) before going to the Board for a decision.

Delivery and assurance infrastructure

9.7. Reporting into the Calderdale Cares Partnership Board are a number of groups leading on and overseeing programmes and initiatives to deliver positive outcomes for Calderdale's population. Alongside these groups sit oversight and assurance functions to support the Partnership in adopting and maintaining a place based approach to shared priorities in matters such as quality and safety. Especially key to the delivery of outcomes and high quality care will be Calderdale's five localities, coterminous with

Calderdale's five primary care networks, through which strategic ambition will be effected at a more local level.

10. Information Sharing and Conflicts of Interest

10.1. Subject to compliance with the law the Partners agree to share all information relevant to the work of the Partnership in an honest and timely manner.

10.2. The Partners will:

10.2.1. Share the details with other Partners of any real or potential conflict of interest which does or may arise in connection with this Agreement or the operation of the Calderdale Cares Partnership Board as soon as they become aware of the conflict of interest.

10.2.2. To the best of their ability ensure that their representatives on the Calderdale Cares Partnership Board comply with the above when acting within the remit of this Agreement.

CALDERDALE CARES PARTNERSHIP AGREEMENT

PARTNER ENDORSEMENTS

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE LOCAL MEDICAL COMMITTEE LTD** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE METROPOLITAN BOROUGH COUNCIL** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **HEALTHWATCH CALDERDALE** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **LOCALA COMMUNITY PARTNERSHIPS CIC** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **NHS CALDERDALE CLINICAL COMMISSIONING GROUP** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **VOLUNTARY AND COMMUNITY** [DATE]

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	Enhanced Service Specifications	**Agenda Item No.**	9
Report Author	Emma Bownas, Deputy Director of Improvement – Primary Care	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson, Director of Improvement – Community and Primary Care

Executive Summary

The CCG holds a number of enhanced services contracts with our practices. There are a number of these that expire at the end of this financial year. A review of these was presented to the Quality, Finance and Performance Committee on the 16th of December 2021. The paper (attached at appendix A for information) reported the outcome of a review of the local enhanced services and supported the recommendation to extend the current service for a further 3 years. The specifications have been reviewed and approved by Quality FP and therefore not included

A number of the contracts have been agreed through the use of delegated authority and approved by the Chief Operating Officer and Director of Finance.

Due to the contract value of the Treatment Room Service, approval of the extension needs to be provided by Governing Body.

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	16th December 2021
Name of meeting		**Meeting Date**	

Recommendations

It is recommended that the Governing Body:

1. **APPROVE** the contract extension for the Treatment Room Service for a further 3 years.

Decision ☒	Assurance ☒	Discussion ☐	Other:

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	Approval of the extension to the Treatment Room Service will ensure that there is continuation of services for patients in Calderdale
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Approval of the extension to the Treatment Room Service will ensure continuation of services for patients in Calderdale and the specification was reviewed and strengthened to support equality of provision
Resources / Financial Implications (including Staffing/Workforce considerations)	The resources identified are available and ring-fenced for primary care enhanced services within the CCG Core Budget. The total budget of the service over 3-year contract length is £846,182 (this will vary slightly with list size adjustment each year)
Sustainability Implications	None Identified

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

Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale. Improving Quality	**Risk (include risk number and a brief description of the risk)**	None Identified
Legal / CCG Constitutional Implications	CCG Standing Orders in respect of tender waiver. Compliance with NHS Procurement, Patient Choice & Competition Regulations 2013 and Public Contract Regulations 2015 (Light Touch Regime)	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1. Introduction

1.1 A comprehensive paper was considered by Quality, Finance and Performance Committee on 16th December 2021 where the Treatment Room Enhanced Service was reviewed and approved.

1.2 The Quality, Finance and Performance Committee also supported the recommendation from the review that the service should be extended for a further 3-year period.

1.3 This request was supported due to the scale and priorities and the possibility that the Integrated Care Board at West Yorkshire may result in a review across places of enhanced services, payment and funding, recognising this is unlikely to take place and be completed in the first 2 years.

1.4 The cost per annum is estimated at £282,060.65 making an estimated total contract value of £846,182 over the 3-year period. This will vary slightly each year as the payment is based on list size and registered population.

1.5 Due to the contract value of the Treatment Room Service, the decision to extend the contract is required by Governing Body.

1.6 It is likely that the move to the Integrated Care Board at West Yorkshire may result in a review across all WY places of their enhanced services, payment and funding, to try to get consistency in service. We recognise this is unlikely to take place in the short term and may be completed in its first 2 years.

2. Next Steps

If approved, then the appropriate waiver documentation will be completed.

3. Recommendation

It is recommended that the Governing Body **APPROVE** the contract extension for 3 years from 1st April 2022-31st March 2025.

4. Appendices

Quality, Finance and Performance Committee, Enhanced Service Specifications.

NHS
Calderdale
Clinical Commissioning Group

Name of Meeting	Quality, Finance and Performance Committee	**Meeting Date**	16th December 2021
Title of Report	Enhanced Service Specifications	**Agenda Item No.**	
Report Author	Emma Bownas, Deputy Director of Improvement – Primary Care	**Public / Private Item**	Public
Clinical Lead	Dr Majid Azeb Clinical Lead for Primary Care	**Responsible Officer**	Debbie Robinson, Director of Improvement – Community and Primary Care

Executive Summary

This paper provides the Quality, Finance and Performance Committee with the outcome of a recent review of 6 Enhanced Services and included consideration as to whether any new services should be offered.

The services reviewed were:

- Anticoagulation Monitoring Service
- Gonadorelin Analogues
- Near Patient Testing
- Treatment Room
- Ring Pessary
- Diabetes Level 3 Calderdale primary care provision of enhanced care and support for adults with diabetes stabilised on injectable therapies

The review includes proposed changes to the specification, details of an approach to delivery at scale and ensuring 100% coverage of the population, monitoring requirements and a proposed approach to contracting

Previous Considerations

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

Recommendations

It is recommended that the Quality, Finance and Performance Committee

1. Approve the changes to the following specifications,

a. Anticoagulation Monitoring Service
b. Gonadorelin Analogues
c. Near Patient Testing
d. Treatment Room
e. Ring Pessary
f. Diabetes Level 3

2. Approve the approach to delivering at scale and ensuring 100% coverage. Including that the services remain commissioned at practice level with the option for practices to sub-contract the service to another practice or deliver at scale.

3. Note the approach to monitoring and the opportunity to extract the reporting directly from the system through data quality, recognising this may be a challenge to resources.

4. Approve a waiver for 3 years. This will also allow for evaluation of the impact of ear wax removal introduced in January 2020 on secondary care as the service offer has been disrupted due to the impact of Covid-19 and reporting has been suspended for acute trusts over this time period and also any developments as a result of the wound management work planned with primary and community care. There is also a possibility that the move to the West Yorkshire Integrated Care Board may result in a review across places of enhanced services, payment and funding.

5. Agree that the totality of resources available for these enhanced services remains ring fenced for primary care

6. Agree to the development of a spirometry service based on the NHS Commissioning Guidance for Spirometry and note that funding of this will be agreed through Commissioning Primary Medical Services Committee as part of the delegated co-commissioning budget.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	No major changes have been made to the specifications and therefore advice has been received from the quality team that Quality Impact Assessments were not required. All specifications include detail regarding the workforce competency and skill requirement All specifications reference clinical guidelines including NICE and Royal College where appropriate
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	As above, the specifications do not contain any major service changes and therefore engagement has not been required for this review. Wording in relation to equality and inclusion has been strengthened within all the specifications

Resources / Financial Implications (including Staffing/Workforce considerations)	The resources identified are available and ring-fenced for primary care enhanced services within the CCG Core Budget. If reporting is moved away from practice submissions and to data quality then there is a potential resource challenge for the data quality team.
Sustainability Implications	None Identified

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

Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale. Improving Quality	**Risk (include risk number and a brief description of the risk)**	None Identified
Legal / CCG Constitutional Implications	Obligation to provide primary medical services to the local population	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

1. Introduction

1.1 A review has been undertaken by the CCG of the following Enhanced Services that are due to end on the 31st March 2022.

- Anticoagulation (Activity Based)
- Gonadorelin Analogues (Activity Based)
- Near Patient Testing (Activity Based)
- Treatment Room (List Size)
- Ring Pessary (Activity Based)
- Diabetes Level 3 (Activity Based)

1.2 This review does not include the Phlebotomy Enhanced Service as work is underway with General Practice and Calderdale and Huddersfield Foundation Trust through Working Together to Get Results with a view to informing future service provision and commissioning arrangements.

1.3 A comprehensive review of enhanced services was carried out in 2014, where it was concluded that the services named above were suitable to be offered as list-based services, with list base being defined as:

A service that it is in the patient's best interests to be provided by their registered practice. This may be because:

- it relates to a test for which the practice is potentially required to take immediate action
- the practice has additional knowledge of elements of the patient's condition/care which may impact on the service being provided
- it is part of a treatment pathway with the rest of the pathway being provided by the GP practice
- where the practice has the direct clinical and managerial responsibility to follow up on the necessary actions resulting from the service provision.

1.4 The review also recommended that the budget described in this paper be regarded as ring-fenced for primary care and this was approved through Governing Body on 16th January 2014.

1.5 A further service need has been identified following changes in the training and competence requirements for performing and interpreting spirometry from March 2022. It was been agreed that we will work with the Local Medical Committee (LMC) to achieve a suitable and ideally collaborative arrangement at scale for this service going forward. This will be influenced by the "NHS England Spirometry Commissioning Guidance" published in March 2020 Details of the specification will be presented to the Quality, Finance and Performance Committee for approval and if supported will be taken to the Commissioning Primary Medical Services Committee for financial approval as funding will be from the primary care delegated co-commissioning budget.

1.6 Development of an additional specification was underway relating to Healthy Hearts and improving the management of people with Cardiovascular Disease. This was overtaken by the announcement of a national Cardiovascular Disease Directed Enhanced Service due to commence in April 2022.

1.7 Engagement has taken place with members of the Quality, Engagement, Equality, Safeguarding, Contracting, Service Improvement and Finance Teams during the review period.

2. Detail

2.1 Stakeholder Engagement

2.1.1 Throughout the review the Calderdale LMC have been involved, with particular input into the following principles that were agreed and adopted as part of the review:

- That the total financial envelope currently invested in enhanced services remained or was increased
- That the burden on reporting for Practices be kept to a minimum
- That the CCG does not pay twice for a service
- That the services represent good practice and are available to 100% of the Calderdale registered Population
- That services will be considered at PCN level where the activity and or expertise required makes sense.

2.1.2 Clinical Engagement has been sought from:
Dr Majid Azeb, (Calderdale CCG Clinical Lead for Primary Care)
Dr James Grey (Calderdale CCG Clinical Lead for Prescribing)
Helen Foster (Calderdale CCG Head of Medicines Optimisation)
Deborah College (Calderdale CCG Associate Nurse Specialist)
Lucy Walker (Calderdale CCG Quality Manager)
The LMC

Details of further stakeholder engagement are provided in the service specific reviews included below and include secondary care, public health and local authority colleagues.

2.2 Approach to Opportunities to deliver at Scale

2.2.1 One of the principles described above is to ensure that the enhanced services are available to 100% of the registered population and that, where it makes sense, practices have the option to deliver the enhanced services as a Primary Care Network.

2.2.2 The services will continue to be offered at practice level and it will be the decision of the practice or practices within a Primary Care Network to deliver any service at network level.

2.2.3 In order to facilitate this from a contracting perspective the following scenarios could apply.

- If there is one practice in a PCN that does not wish to sign up to a certain enhanced service, then the PCN will make arrangements to ensure there is coverage for the whole PCN registered population
- There is an option for practices to deliver services at scale through Primary Care Networks
- The CCG is to be notified of the Practice intentions if the circumstances set out above apply

2.2.4 The above scenarios could translate as follows into contractual arrangements with individual practices. If these scenarios are agreed then standard wording would be added into all contracts as below:

- If a practice within a PCN does not wish to sign up to a certain enhanced service, then they need to decide whether they want to sub-contract the service from another practice or practices within the PCN. They would retain contractual responsibility (and are still paid by the CCG) and are required to formally write to the CCG and request for permission.

- If a practice within a PCN does not wish to sign up to a certain enhanced service and they do not wish to sub-contract, then the practices within the PCN need to make arrangements in terms of which practice or practices would deliver the service and the CCG would write this additional coverage into their contract. Contractual responsibility would be with the practice that delivers the service, and they would receive payment direct from the CCG.

- Where PCNs wish to deliver services at scale the CCG would still continue to commission services direct from practices but there would be an additional form of words added to the contracts to reflect the circumstances that are agreed, this could include payments to be directed to a different lead practice within the PCN, different responsibilities in terms of any reporting requirements, etc

2.2.5 If this approach is agreed then engagement with practices through the LMC, and PCNs will have to be undertaken in order to operationalise this approach.

2.3 Quality, Equality, Safeguarding, Engagement

2.3.1 The quality, equality and safeguarding leads have approved the strengthening of wording in each of the service specifications.

2.3.2 In previous years the enhanced specifications have included the requirement for providers to submit numbers of incidents as part of the quarterly monitoring

requirements. This approach duplicates the reporting required through Datix. On review of the reporting over the past three years, no incidents have been reported by practices through the quarterly monitoring. The CCG monitors incidents reported by General Practice through Datix, reporting themes and trends from incidents to the Quality, Finance and Performance Committee. This would highlight any issues with providers related to service delivery of enhanced services and therefore it is recommended that the quarterly reporting of incident numbers as a requirement of the enhanced service specifications is removed.

2.3.3 As there has been no material changes to the specifications then there has been no requirement to undertake patient engagement.

2.3.4 In reviewing the services, it has not been possible to analyse any patient experience data relating to most of the enhanced services as they are offered to patients as part of the general practice offer and separate experience data is not collected. Throughout 2021/22 the friends and family test has been suspended as a result of the Covid -19 pandemic.

2.4 Approach to Monitoring

2.4.1 Historically, the CCG has adopted a “light touch” monitoring approach to the Enhanced Services. Both the activity and list-based service specifications include quarterly activity reporting as a requirement.

2.4.2 For the list-based Treatment Room Enhanced Service this activity has historically been incomplete, and this has impacted on the ability to use data to review the services. The decision not to actively monitor the contracts has been taken using a risk-based approach to commissioning, considering both the financial value of the contract and the level of clinical risk.

2.4.3 Where audits are required the CCG has reserved the right to request these from practices and is not routinely enacted. The audit may be requested where concerns were emerging from a quality and safety perspective regarding a provider. The Committee is asked to consider whether this approach should remain or whether assurance should be sought through requesting the audit results from a sample number of practices on an annual basis. This would require CCG resources to analyse the audit and provide feedback to practices.

2.4.4 To reduce the reporting burden further for practices there is opportunity for practices to use the standard codes within the specification and data quality to run reports and automate reporting. It is acknowledged that this would place additional burden on the data quality team and this needs to be further explored to understand whether it is feasible.

2.5 Summary of the Review by Specification

2.5.1 All the revised specification are attached within the appendices and proposed changes highlighted in yellow.

2.5.2 **Anticoagulation Monitoring Service (Appendix A)**

This specification has been clinically reviewed by Dr James Gray, (Clinical Lead for Prescribing, Calderdale CCG), Dr Majid Azeb (Clinical Lead for Primary Care, Calderdale CCG), Helen Foster (Head of Medicines Optimisation, Calderdale CCG) and shared with the Local Medical Committee for comment.

2.5.3 The specification is activity based and aims for participating practices to offer a service in which:

(i) therapy may be initiated in primary or secondary care for recognised indications for specified lengths of time

(ii) maintenance of patients should be properly controlled

(iii) the service to the patient is convenient

(iv) the need for continuation of therapy is reviewed regularly

(v) the therapy is discontinued when appropriate

2.5.4 This service ensures that monitoring takes place through the GP Practice meaning care is delivered closer to home.

2.5.5 Consideration was given as to whether the anticoagulation monitoring service should be extended to cover Direct Acting Oral Anticoagulants or Novel Oral Anticoagulants, however it has been recommended that the service is not extended to include these as they are GP initiated medicines (green drugs) like many others that require a level of monitoring as part of clinical responsibility. The service specification is in place for amber drugs which require a shared care arrangement in place.

2.5.6 Monitoring requirements include quarterly submission of the number of patients being monitored by the service and an annual service review that includes an audit of 5 patients per 2,000 registered patients, recorded on the proforma included in the specification. This will include any outcomes identified as part of the audit. The CCG may request a copy of the audit for assurance.

2.5.7 **Gonadorelin Analogues (Appendix B)**

2.5.8 This specification has been clinically reviewed by Dr James Gray, (Clinical Lead for Prescribing, Calderdale CCG), Dr Majid Azeb (Clinical Lead for Primary Care,

Calderdale CCG), Helen Foster (Head of Medicines Optimisation, Calderdale CCG) and shared with the Local Medical Committee for comment. Engagement has also been sought from the secondary care oncology team who stated that there were no issues with the current service.

2.5.9 This service is activity based and covers the administration of goserelin, triptorelin and leuprorelin for prostate cancer and endometriosis under agreed shared care guidelines approved by the South West Yorkshire Area Prescribing Committee. The service also includes the administration of goserelin for breast cancer which is classified as green specialist initiation by the South West Yorkshire Area Prescribing Committee. This reduces the need for patients to attend clinics in secondary care and moves care closer to home.

2.5.10 Following a review of the specification an addition has been made to include the administration of gonadorelin analogues for breast cancer and the specification has been updated to include the main source for advice for patients with endometriosis or breast cancer.

2.5.11 The specification includes updated guidance and also provides a statement in relation to the changes expected to the South West Yorkshire Area Prescribing Committee which will change to the West Yorkshire Area Prescribing Committee in 2022/23.

2.5.12 Monitoring requirements remain unchanged in the form of a quarterly submission.

2.5.13 **Near Patient Testing (Appendix C)**

2.5.14 This specification has been clinically reviewed by Dr James Gray, (Clinical Lead for Prescribing, Calderdale CCG), Dr Majid Azeb (Clinical Lead for Primary Care, Calderdale CCG), Helen Foster (Head of Medicines Optimisation, Calderdale CCG) and shared with the Local Medical Committee for comment.

2.5.15 This activity-based specification ensures that certain defined medicines which require initiation or supervision by a specialist and regular ongoing monitoring (which normally involves blood testing) can be safely transferred to primary care. These medicines are classified as amber by the South West Yorkshire Area Prescribing Committee which produces shared care guidelines that define the responsibilities of specialist and primary care prescribers, with the purpose of ensuring that these medicines are used safely. Patients benefit from receiving monitoring and the supply of their medicines from their primary care provider.

2.5.16 Following review of this service specification no major changes have been made. The changes that have been made include a reference to the changes in the Area Prescribing Committee as detailed in paragraph 2.7.9.

2.5.17 **Treatment Room (Appendix D)**

2.5.18 This specification has been clinically reviewed Dr Majid Azeb (Clinical Lead for Primary Care, Calderdale CCG) and Deborah Colledge (Practice Nurse Associate – Calderdale CCG) and shared with the Local Medical Committee for comment.

2.5.19 This list-based service covers the provision of the following treatment room procedures in primary care:

- Suture/staple removal
- Prescription/provision and application of dressings
- Removal of earwax (ear irrigation / syringing) for adults in primary care settings if the earwax is contributing to hearing loss (NICE Guideline NG98 - Hearing loss in adults: assessment and management. Guidance 1.2 Removing Earwax. Published June 2018)

2.5.20 The specification of this service is designed to cover enhanced support to services within the treatment room, all of which are considered to be beyond the scope of essential or additional services.

2.5.21 The removal of ear wax was added to this service in January 2020 with an additional 25p per registered patient being added to the financial envelope. Since that time the service has been disrupted due to the Covid-19 pandemic and therefore it has not been possible to collect or understand the amount of ear wax removal activity that has been undertaken in General Practice and what impact that has had on secondary care activity. As stated earlier, we are aware that this service is valued by patients. It is recommended that this service is extended for a further 12 months to understand the activity patterns in General Practice and secondary care and also consider future commissioning options.

2.5.22 Work is also planned in relation to wound care management across community and general practice, and this may result in changes to the treatment room specification.

2.5.23 To assist with the review of this specification it is recommended that the data quality team provide quarterly activity reports, based on the codes included in the specification, and that this is reviewed by the primary care/contracting team.

2.5.24 **Ring Pessary Insertion (Appendix E)**

2.5.25 This specification has been clinically reviewed Dr Majid Azeb (Clinical Lead for Primary Care, Calderdale CCG) and shared with the LMC for comment.

2.5.26 Pelvic organs prolapse is common, affecting up to 50% of parous women, with one in five reporting prolapse related symptoms and with half of women over the age of 50 experiencing symptoms and 1 in 10 women by the age of 80 having surgery for prolapse.

2.5.27 Pelvic organs prolapse is characterised by descent of any of the pelvic organs into the vagina and at times beyond the introitus. It is normally caused by pregnancy and childbirth, prolapse occurs when the pelvic floor muscles holding the organs within a woman's pelvis (uterus, bladder, and rectum) are weakened or overstretched and the organs bulge from their natural position into the vagina.

2.5.28 Insertion of ring pessaries has previously been provided by the Obstetrics and Gynaecology consultants at the Trust and in primary care. The aim of this service is to enable more women who fit the agreed criteria to undergo insertion of a ring pessary in Primary Care. A proforma will be used to refer the patient where appropriate.

2.5.29 Additional quality recording requirements have been added in line with best practice guidance and it is expected that these are clearly recorded in the patient records.

2.5.30 Due to the relatively small numbers of procedures undertaken across practices, the specification has been updated to state explicitly that although the service is offered at practice level, the practice may sub-contract to another practice or arrange for it to be delivered at Primary Care Network level. This may assist from a workforce perspective and enable competencies to be maintained more easily.

2.5.31 Monitoring requirements are a quarterly activity submission.

2.5.32 **Diabetes Level 3: Calderdale primary care provision of enhanced care and support for adults with diabetes stabilised on injectable therapies (Appendix F)**

2.5.33 This specification has been clinically reviewed Dr Majid Azeb (Clinical Lead for Primary Care, Calderdale CCG), Deborah Colledge (Practice Nurse Associate – Calderdale CCG), Dr James Gray (Clinical Lead for Prescribing, Calderdale CCG), Helen Foster (Head of Medicines Optimisation) and shared with the Local Medical Committee for comment. Discussions have also taken place with Helen Wraith (Service Transformation, Calderdale CCG) and AniAjit Kumar (Diabetes Specialist Nurse, Calderdale, and Huddersfield NHS Foundation Trust).

2.5.34 A review of the activity-based service specification considered whether the service should be continued and whether the requirements were covered elsewhere in the GP contract. Although elements of diabetes monitoring are included in other GP contractual requirements, the management of patients stabilised on injectable therapies has been recognised as requiring an enhanced service. There is a risk that removing this service will result in patients under level 3 care being transferred back to the care of the secondary care specialist teams when they can be safely managed in General Practice.

2.5.35 The specification does include a link to a level of funding with the secondary care provider relating to the provision of specialist support and training. It is recommended that these update sessions are included in Practice Learning Time and that any individual specialist support required from the diabetes team is in line with what is offered from a specialist

team. It is recommended that the funded element currently provided to the secondary care provider be reviewed.

2.5.36 Quarterly monitoring is expected through submission of activity and the numbers of patients that had received good Hba1c and blood pressure management. It is recommended that this is actively monitored throughout 2022/23 as this contributes to improving health outcomes for this group of patients and links to the West Yorkshire Healthy Hearts Programme.

2.6 Contracting and Finance

2.6.1 A one-year waiver was agreed in January 2021 in order to review the services and where possible to align with community services. This review has indicated that for the services reviewed there is no value in making any large changes to the service specifications. All the services require liaison and close working with specialist teams and secondary care and are well established.

2.6.2 The indicative budget for 12 months for the enhanced services listed is:

Service	Finance - Annual	Finance - Service Level	Activity or List Based
Anti-coagulation Monitoring	£ 38,096.48	£ 2.64	Activity
Diabetes Level 3	£ 148,643.10	£ 25.00	Activity
Gonadorelin	£ 64,386.18	£ 43.54	Activity
Near Patient Testing	£ 123,623.24	Level 1 - £2.64 Level 2 - £23.06 Level 3 - £25.04 DV - £3.16	Activity
Phlebotomy (Awaiting Review)	£ 226,536.90	£ 1.02	List Size
Ring Pessary Insertion	£ 23,279.22	£ 30.65	Activity
Treatment Room	£ 282,060.65	£ 1.27	List Size
Totals	**£ 906,625.77**		

2.6.3 If approved this will be updated based on the activity undertaken in 2021/22. The funding is available from the core CCG budget.

2.6.4 It is recommended that the enhanced services reviewed within this paper are extended until March 2025 (3 years). This will also allow for evaluation of the impact of ear wax removal introduced in January 2020 on secondary care as the service offer has been

disrupted due to the impact of Covid-19 and reporting has been suspended for acute trusts over this time period and also any developments as a result of the wound management work planned with primary and community care. There is also a possibility that the move to the West Yorkshire Integrated Care Board may result in a review across places of enhanced services, payment and funding.

3. Next Steps

3.1 Once approval has been received in relation to the specifications and recommendations within the paper then a waiver will be completed, and the services will be offered to practices to sign up with a view to deliver from April 2022.

4. Implications

4.1 Quality and Safety Implications

4.1.1 No major changes have been made to the specifications and therefore advice has been received from the quality team that Quality Impact Assessments were not required.

4.1.2 All specifications include detail regarding the workforce competency and skill requirement.

4.1.3 All specifications reference clinical guidelines including NICE and Royal College where appropriate.

4.2 Engagement and Equality Implications

4.2.1 As above, the specifications do not contain any major service changes and therefore patient engagement has not been required for this review.

4.2.2 Wording in relation to equality and inclusion has been strengthened within all the specifications.

4.3 Resources / Finance Implications

4.3.1 The resources identified are available and ring-fenced for primary care enhanced services within the CCG Core Budget.

4.3.2 If reporting is moved away from practice submissions and to data quality then there is a potential resource challenge for the data quality team.

4.4 Data Protection Impact Assessment

4.4.1 Not required

4.5 Risk

4.5.1 None Identified

4.6 Legal / CCG Constitutional Implications

4.6.1 Obligation to provide primary medical services to the local population.

4.7 Conflicts of Interest

4.7.1 Any conflicts of interest will be managed in line with the CCG's policy for managing Conflicts of Interest.

5. Recommendations

It is recommended that the Quality, Finance and Performance Committee

1. Approve the changes to the following specifications,
   a. Anticoagulation Monitoring Service
   b. Gonadorelin Analogues
   c. Near Patient Testing
   d. Treatment Room
   e. Ring Pessary Insertion
   f. Diabetes Level 3

2. Approve the approach to delivering at scale and ensuring 100% coverage. Including that the services remain commissioned at practice level with the option for practices to sub-contract the service to another practice or deliver at scale.

3. Note the approach to monitoring and the opportunity to extract the reporting directly from the system through data quality, recognising this may be a challenge to resources.

4. Approve a waiver for 3 years. This will also allow for evaluation of the impact of ear wax removal introduced in January 2020 on secondary care as the service offer has been disrupted due to the impact of Covid-19 and reporting has been suspended for acute trusts over this time period and also any developments as a result of the wound management work planned with primary and community care. There is also a possibility that the move to the West Yorkshire Integrated Care Board may result in a review across places of enhanced services, payment and funding.

5. Agree that the totality of resources available for these enhanced services remains ring fenced for primary care

6. Agree to the development of a spirometry service based on the NHS Commissioning Guidance for Spirometry and note that funding of this will be agreed through

Commissioning Primary Medical Services Committee as part of the delegated co-commissioning budget.

6. Appendices

Appendix A: Anticoagulation Monitoring Service
Appendix B: Gonadorelin Analogues
Appendix C: Near Patient Testing
Appendix D: Treatment Room
Appendix E: Ring Pessary Insertion
Appendix F: Diabetes Level 3

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	**Director of Finance Report**	**Agenda Item No.**	10
Report Author	Lesley Stokey, Director of Finance	**Public / Private Item**	Public
GB / Clinical Lead	-	**Responsible Officer**	Neil Smurthwaite, Chief Operating Officer

Executive Summary

Finance

- The CCG continues to operate under temporary financial arrangements due to the impact of Covid-19.
- The CCG submitted a financial plan in April for the period April 2021 to September 2021. The CCG submitted a draft financial plan in November for the period October 2021 to March 2022. The plans submitted for both periods are breakeven plans.
- The CCG is currently forecasting an overspend due to expenditure items which currently fall outside of our baseline allocation. Additional allocations are expected to be received to match against these costs.
- The CCG has a QIPP target of £2.0m for H1 and £2.2m for H2, giving a total of £4.2m across the financial year.
- The CCG has developed plans to deliver the Mental Health Investment Standard in 2021/22.
- The CCG will not receive any additional uplift to budgets for the 3% Agenda for Change pay award for 2021/22.
- Financial planning guidance for 2022/23 has not yet been published.

Contracting

The report provides an update on the Month 6 (or Month 7 where contract monitoring reports were available) contract position highlighting issues where appropriate.

Performance

The report provides an update on the planning guidance for 2022-23 and progress against the NHS constitutional standards including the impact of covid 19 on the restoration of access levels to NHS services. Key points to note are:

- the impact of the pandemic continues to have a significant impact on the progress being made towards achieving the standards set out in the NHS Constitution as well as the plans to recover the position for all NHS services,
- Covid is also having a major impact of NHS workforce availability due to a combination of illness and the requirements to isolate,
- the latest published data does not reflect the latest wave of the pandemic and full impact of the omicron variant on the delivery of services.

Previous Considerations

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

Recommendations
It is recommended that the Governing Body: 1. Notes the financial forecast and the expected mitigating allocations. 2. Notes the QIPP requirement and forecast. 3. Notes the financial risks and mitigations. 4. Notes the contracting update. 5. Notes the planning guidance 2022-23 6. Notes the progress being made towards achieving the standards set out in the NHS Constitution and the impact covid 19 is having on the restoration of access levels to NHS services.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	None identified.

Resources / Financial Implications (including Staffing/Workforce considerations)	None identified.
Sustainability Implications	

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

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

1.0 FINANCE

1.1 Key Messages

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

- The CCG continues to operate under temporary financial arrangements due to the impact of Covid-19.
- The CCG submitted a financial plan in April for the period April 2021 to September 2021. The CCG submitted a draft financial plan in November for the period October 2021 to March 2022. The plans submitted for both periods are breakeven plans.
- The CCG is currently forecasting an overspend due to expenditure items which currently fall outside of our baseline allocation. Additional allocations are expected to be received to match against these costs.
- The CCG has a QIPP target of £2.0m for H1 and £2.2m for H2, giving a total of £4.2m across the financial year.
- The CCG has developed plans to deliver the Mental Health Investment Standard in 2021/22.
- The CCG will not receive any additional uplift to budgets for the 3% Agenda for Change pay award for 2021/22.
- Financial planning guidance for 2022/23 has not yet been published.

1.2 Financial Planning Update 2022/23

At the time of writing this report the financial aspects of the planning guidance for 2022/23 are awaiting publication. The financial planning guidance is expected to be published in late January 2022.

1.3 CCG Financial forecast 2021/22

The CCG is forecasting to meet the financial plan however there are a number of variances to note. The CCG is expecting to receive additional allocations of £2.97m to cover costs currently outside of baseline allocations namely some Covid and hospital discharge related costs and some primary care additional roles costs. The makeup of these variances can be seen in **Appendices A-C** and summarised below: -

- **Acute:** Currently forecasting £0.7m underspend. The CCG has block contract arrangements in place with NHS providers. Independent sector activity is charged on an activity basis which is showing some underspends.

- **Mental Health**: Is showing a forecast underspend due to a reduction in some individual high-cost placements and lower than expected IAPT activity. Plans are in place to meet the MHIS and are being refreshed in light of this variance and also the Agenda for Change settlement.
- **Prescribing**: Currently forecasting an underspend of £0.5m based on the latest prescribing data. Cost pressures may emerge due to potential increases in NSCO, Cat M and general price increases and potential under delivery of QIPP due to COVID pressures.
- **Primary Care (Not delegated)**: Forecasting £0.1m underspend.
- **Primary Care – Delegated**: Currently forecasting an overspend of £0.9m. This is in relation to the value of Additional Roles forecast spend over the budget currently included in the baseline.
- **Community:** forecasting an overspend of £0.27m.
- **Continuing Healthcare:** currently forecasting an underspend of £0.16m.
- **Other / Reserves**: Showing an overspend due COVID-19 related hospital discharge costs which will be matched by additional allocations and also due to budget alignment issues.
- **BCF**: Forecasting online and includes the increase in the planned 21/22 BCF contribution.
- **Running Costs**: The CCG plan for running cost has a requirement for £100k savings in order to meet the running cost allocation of £4,116k for the year. There are a number of vacant posts in the structure, and it is forecast that the planned savings target will be met through vacancy savings. The forecast includes the impact of the Agenda for Change pay uplift of 3%.

1.4 **Public Sector Payment Policy**

The CCG has a target of 95%, and performance is currently between 95.8% and 99.9% across NHS and Non-NHS invoices. **Appendix D** shows the public sector payment policy in more detail.

1.5 **QIPP**

The CCG has a QIPP target of £2m for H1 and £2.2m for H2 giving an annual requirement of £4.2m. As outlined in budget setting this is a challenging target and there is currently a level of unidentified QIPP. The table below summarises the M9 QIPP forecast position. The forecast risk on delivery of QIPP for the year is £1.8m. The CCG is utilising the contingency to mitigate against QIPP under delivery whilst further QIPP plans and mitigations are being developed.

Calderdale CCG QIPP Forecast and Mitigations as at 31st December 2021

QIPP		Target £'m	Risk Adjustment %	Projected Delivery £'m	Risk £'m
Prescribing	R	0.50	100%	0.50	0.00
CHC	R	0.50	100%	0.50	0.00
Other	NR	1.42	100%	1.42	0.00
Gap	NR	1.80	0%	0.00	(1.80)
Total QIPP		**4.22**		**2.42**	**(1.80)**
Mitigations					
Contingency	NR		100%	1.21	1.21
Other measures	NR		100%	0.59	0.59
Total Mitigations				**1.80**	**1.80**
Net		**4.22**		**4.22**	**0.00**

1.6 WY& H ICS Financial Position

The ICS consolidated month 8 financial position is showing a year-to-date position of a £3.7m surplus and a full year forecast position of breakeven. The forecast scenarios collated for the ICS show a worst-case scenario of £26.4m deficit and best case of £24.1m surplus. The ICS has submitted an overall balanced financial plan for the full year.

1.7 Risks and Mitigations

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

- Risk of QIPP delivery against the new £4.2m QIPP target.
- Risk of overspends on prescribing.
- Risk of increase on independent sector activity above budgeted levels.
- Risk of overspend on continuing healthcare.
- Mitigation of development of further QIPP savings plans.
- Mitigation of identification of non-recurrent underspends and savings opportunities.
- Mitigation of use of the contingency budget.

2.0 CONTRACTING

2.1 Acute and Independent Sector providers

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic remain in place until March 2022. Therefore, no CCG contracts are in place with NHS providers and contracted NHS acute providers are paid on a nationally set block amount.

Work continues with Calderdale and Huddersfield NHS Foundation Trust in relation to Elective Recovery with insourcing and outsourcing opportunities implemented. Increased demand continues to be experienced at the A&E department causing pressures in the system.

Further direct award of contracts had been completed for Spire Elland and BMI Huddersfield under the Increasing Capacity Framework for Half 2 of 2021/22, however, a new national contract for Quarter 4 of 2021/22 has been agreed and will be in place from 10 January 2022 until 31 March 2022.

Calderdale CCG is now a party to the SpaMedica contract led by Wakefield CCG.

2.2 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic will remain in place until the end of March 2022. Payments to SWYPFT will be in accordance with the related guidance for Half 2 of 2021/22, which was released on 30 September. For Mental Health, the Half 2 envelopes will reflect the remaining element of the full-year funding notified at the beginning of Half 1. Therefore, no contracts are in place and SWYPFT are paid on a nationally set block amount. The national target (95%) for the percentage of people on CPA (Care Programme Approach) who were followed up within 7 days of discharge was met in Month 7 (100%). The national target for EIP (Early Intervention in Psychosis) was also met- 100% of people referred in Month 7 received a NICE approved package of care within 2 weeks of referral, against the national target of 60%.

2.3 Yorkshire Ambulance Service (YAS) 999 Ambulance

Initial performance information for Month 7 for Calderdale shows that the 999 service responded to 2,758 incidents. Of this number, 9.4% were ‘Hear and Treat’ responses,

62.9% were ‘See, Treat and Convey’ responses and 27.7% were ‘See, Treat and Refer’ responses. YAS overall responded to 70,674 calls in Month 7.

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

IUC overall in Month 7 showed 176,300 received calls, which was 16.3% above the Annual Business Plan baseline volume. Calls answered in Month 7 were 12.1% lower than the number of calls answered in the same month last year. Validated overall WYUC activity for Month 6 (Month 7 unavailable at time of writing this report) shows 18,860 cases, a decrease of 2,265 (10.7%) compared to the previous month (21,125). Activity was 7.6% down on Month 6 of 2020/21 (20,410).

2.5 **Posture and Mobility (Wheelchairs) Service (Ross Care)**

Total new referrals decreased 220 in October (240 September). For Calderdale there were 54 adult referrals and 12 paediatric referrals.

2.6 **Procurements**

Service description	Status	Contract start date	CCG Annual contract value
Mental Health Choice Market Test	Completed	Not Applicable	Not Applicable
Community Dermatology Service	Procurement paused	01.10.2022	£350,000
Community Phlebotomy	Procurement completed	December 2021	£44,200
Continuing Healthcare Domiciliary Care	Council led Procurement - Re-opened window for Approved Provider List underway	From 01.04.2021	Approximately £1m across all contracted providers
Community Based Day Opportunities	Council led Procurement underway	01.04.2022	Approximately £3m across all contracted providers (CBMC & CCG)

Continuing Healthcare Outreach and Sitting Service	Council led Procurement underway (re-opened window for APL with CCG joining)	01.08.2022	Approximately £83.5k across all contracted providers
Intermediate Care Beds Lead Provider Model	Market Test closed and next steps discussions ongoing	01.04.2022	To be confirmed
IAPT AQP	Accreditation Window Procurement underway	01.04.2022	To be confirmed

3.0 PERFORMANCE

3.1 NHS Planning Guidance 2022/23

On 24th December 2021, NHS England published the initial guidance outlining the planning and priorities for 2022/23.

The focus for 2022/23 will continue the restoration of services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. These are reflected in the 10 priorities outlined below:

a) Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care
b) Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
c) Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
d) Improve the responsiveness of urgent and emergency care build community care capacity. Supported by eliminating 12-hour waits in emergency departments and minimising ambulance handover delays.
e) Improve timely access to primary care – expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
f) Improve mental health and learning disability services – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

g) Continue to develop population health management, prevent ill-health and address health inequalities
h) Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
i) Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
j) Establish integrate care boards and collaborative system working – ICSs to develop a five-year strategic plan

At the time of writing, the NHS is operating within a Level 4 National Incident in response to the emergence of the Omicron variant. The timeline to support the planning process has been adjusted to reflect the pressures these are placing on the health and care system:

17th March Draft submission
28th April Final submission

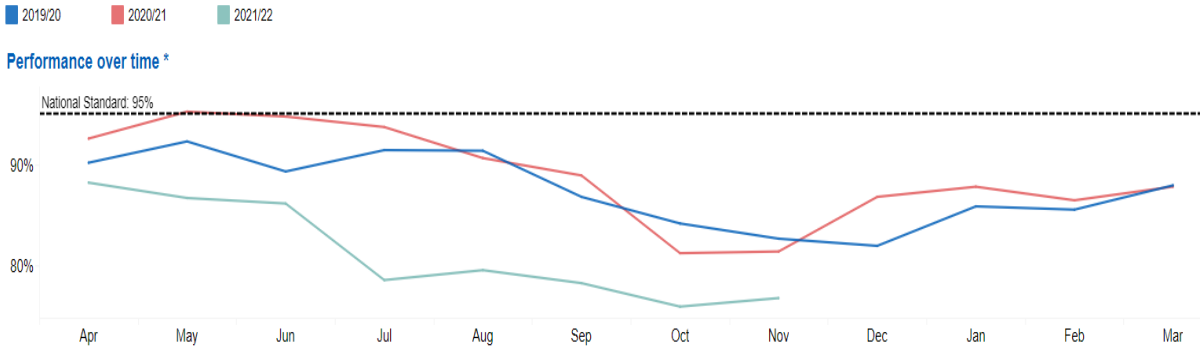
To support the development of plans West Yorkshire ICS are hosting weekly meetings to provide updates and coordinate the development of plans.

In Calderdale we have begun sharing the guidance with partners and establishing forums to review the planning requirements and the implications of the plans locally.
Regular updates will be provided to SMT and the Quality, Finance and Performance Committee.

3.2 Urgent and Emergency Care

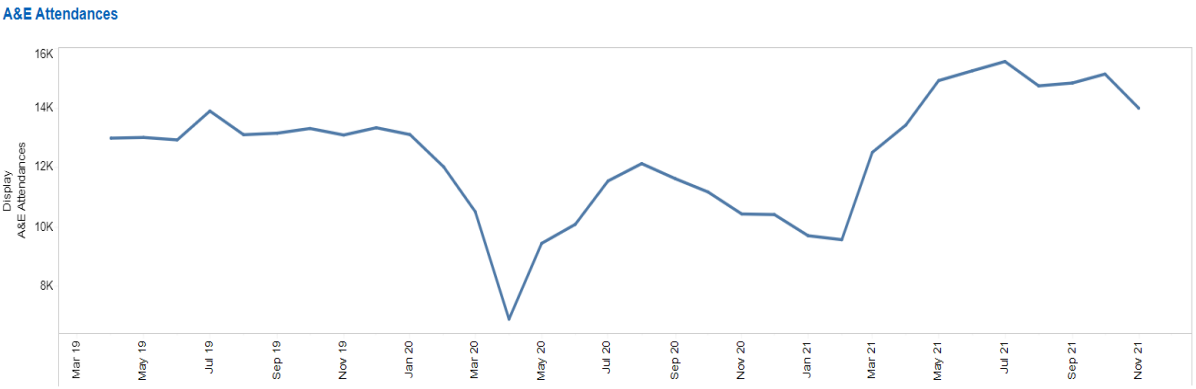
3.2.1 A&E - % waiting under 4 hours

A&E performance refers to the percentage of patients discharged, admitted or transferred within 4 hours of arrival at the A&E Department. Calderdale performance is aligned with the performance achieved by the local acute provider Calderdale and Huddersfield Foundation Trust (CHFT).
A&E performance achieved 77% in November 2021. This is below the national standard (95%) however this level of performance is stronger than the national average (74.0%) and ranks 5th in the region (North East and Yorkshire – 74%).



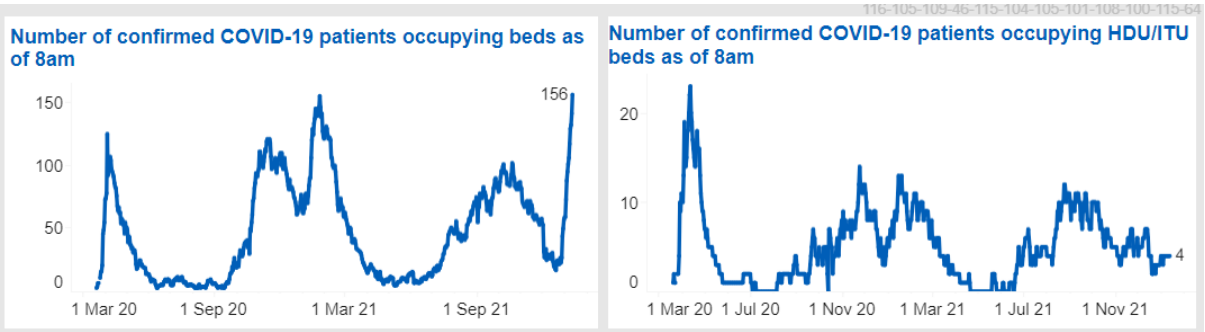
3.2.2 Attendance

The chart below compares the volume of A&E attendances to CHFT by month during the last 3 years. The impact of the pandemic on the volume of attendances can be noted during 2020/21. Since the start of 2021 there has been significant and continual increase in the volume of attendance to A&E which have surpassed pre-covid levels of activity.



3.2.3 Impact of Covid 19

Omicron is the latest and now dominant variant of covid in Calderdale. This variant is now driving the latest surge in admissions to hospital - see chart below. The requirements to support these patients safely is placing significant pressures on the bed base/ staffing resource available within the hospital to support the wider NHS recovery programme. The severity of illness associated with Omicron and developments in covid treatments has contributed to easing the demand for high dependency support.



3.2.4 Calderdale and Greater Huddersfield Urgent and Emergency Care Board (UECB)

The Board continues to monitor and have oversight of urgent and emergency care system across Calderdale and Kirklees. The system is currently facing unprecedented challenges due to; increasing demand, increasing acuity due to late presentation and deconditioning, and significant staffing pressures. All organisations are reporting very high levels of staff absence due to; sickness, fatigue and covid contact, and the direct impact this is having on their ability to deliver high quality care and reduce patient harm. Our pressures are being exacerbated by the challenges faced by our social care providers, and their ability to provide resilient home care and care home offers. The pressures in the social care market have been compounded with the introduction of mandatory vaccinations and a more visible CQC presence.

The Board has continued to work on its key priorities:

1. Implementation of Urgent Community Response Services – which went live on 6 December 2021
2. Implementation of Hubs in both Emergency Departments in order to meet the increasing demands for patients attending for minor injuries and minor ailments (an immediate model went live in July, and we are working on an interim model which transitions into the urgent care offers which are a part of the hospital reconfiguration model on which we consulted). An options paper for the interim model is currently being developed. Currently we are seeing high proportions of patients going through the Hub, and CHFT is reporting that this is having a positive impact on the majors' pathways and on ambulance turnaround performance
3. Improving discharge processes throughout the transfer of care pathway – including allocation of additional recurrent and non-recurrent BCF funding to strengthen 7-day working in the Hospital Avoidance Team and maximising assessment capacity to ensure a flow of patients back to their home

4. Working with general practice on winter schemes to improve access
5. Acceleration of risk stratification work to identify those at rising risk, and utilisation of system MDT and care-coordination approaches to prevent potential exacerbation and access to urgent and emergency care
6. Targeted support for care homes who have higher levels of admission and re-admission - through practical support and quality improvement offers. Also maximising support from our Enhanced Care Home Team
7. Winter communications programme, that builds on the exiting winter system comms, but also provides targeted support for those on a waiting list for elective care and a copy of the Winter Wise booklet to each home in Calderdale

In addition, the Board has developed its Winter Plan for this year. The work has been underpinned by three system 'perfect storm' sessions. Initial self-assessment has rated the plan as green/amber – under the criteria developed NHSE. The assessment rating was based on the fact that our system is working together and understands the challenges faced this winter, but we cannot guarantee delivery of key performance targets and mitigate patient harm throughout the winter period.

The system continues to come together daily/ weekly as part of silver call arrangements, where we identify organisations' status, risks and any asks for mutual aid. Both CCGs are supporting internal CHFT gold meetings which take place twice a week. These meetings identify operational issues where the CCGs and the broader system can provide support. The CCG representatives continue to be the conduit into the wider system.

The Calderdale and Huddersfield Urgent and Emergency Care Board has clear links to the West Yorkshire UECB, and its three work-streams: pre-hospital, hospital, and post hospital.

3.3 **Elective Care**

3.3.1 Referral to Treatment (RTT)

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

Twelve field sites (including CHFT) had been invited to test using the average wait for all patients on incomplete pathways as the headline measure of RTT performance.

The standard for the field testing would continue to use incomplete pathways as the cohort of patients that performance is measured against. But it is important to note that field test sites would not be assessed using the existing standards for elective care and *will be excluded from national reporting during this period*.

The change in focus to monitor the average wait for these patients is expected to drive significant behavioural changes, both clinical and managerial. The intention is that the focus clearly shifts to a position where every day on a patient's pathway counts in order to establish good performance against the standard.

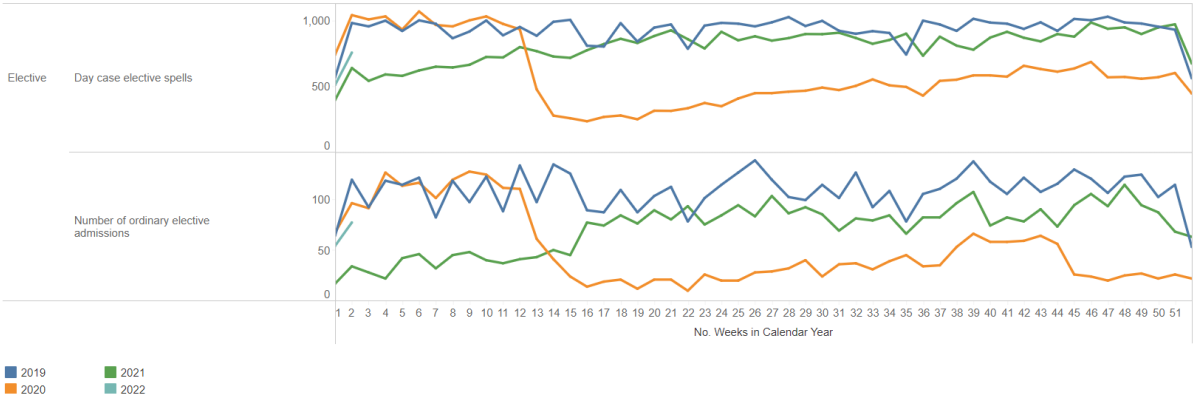
A new reporting and performance management regime commenced on the 1st August 2019 and the pilot was initially expected to last 4 months, but the development of the field test has been suspended during the NHS response to covid. We await further updates from NHS England on the next steps**.**

3.3.2 System Recovery Post Covid

The latest national planning programme placed greater emphasis on returning activity levels to those reported pre-covid. Provisional data (from NHSE) up to 28th November 2021 (week 48) – see charts below - illustrates the increasing volume of inpatient and outpatient activity being undertaken since the initial lockdown was introduced in March 2020:

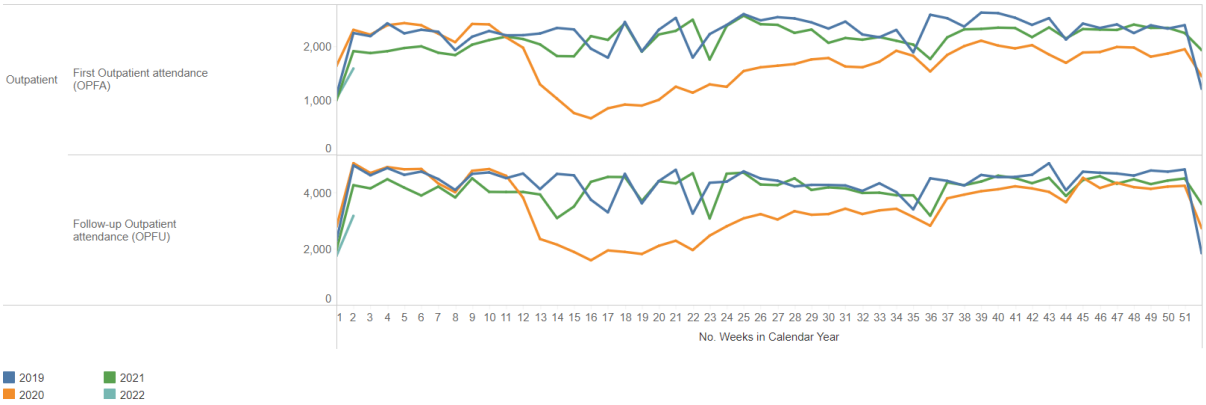
Inpatient Recovery

- Daycases - currently reporting Q3 2021 activity at 95% of pre-covid levels reported in Q3 2019
- Inpatient electives - currently reporting Q3 2021 activity at 78% of pre-covid levels reported in Q3 2019



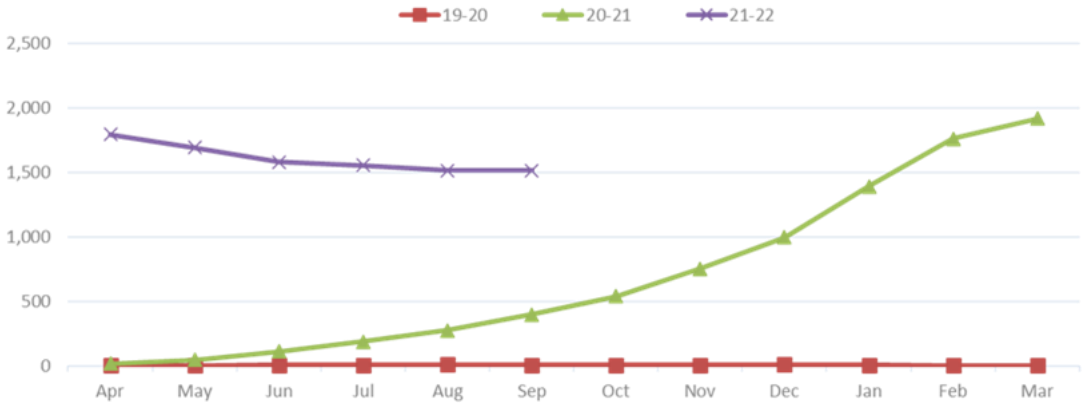
Outpatient (OP) Recovery

- First OP appointments - currently reporting Q3 2021 activity at 99% of pre-covid levels reported in Q3 2019
- Follow up OP appointments - currently reporting Q3 2021 activity at 98% of pre-covid levels reported in Q3 2019



3.3.3 Long Waiters and High Priority Patients

Given the significant number of patients whose care has been delayed due to the NHS response to the pandemic, returning access to services to those experienced pre-covid will only form part of the picture as the NHS begins the process to address long waits. The chart below illustrates the volume of patients (1518) who have been waiting over 52 weeks since their referral to treatment. This includes 59 patients who are waiting >104 weeks.



Due to the scale of the pressures facing CHFT (covid and non covid urgent care demand and the coordination of elective capacity), the CCG has provided support to the elective recovery by embedding a number of CCG staff within the CHFT divisional structures. Their focus is twofold:

- increasing elective capacity through the insourcing of providers to deliver additional clinics and theatre sessions at weekends.
- ensuring all patients waiting greater 104 weeks have individual plans in plans with a large emphasis on addressing the needs of those patients classified as P5 and P6.

Specialty areas to focus on have been prioritised based on clinical risk and length of waiting times, taking account of both people waiting for outpatients appointments and people waiting for operations.

The most pressured specialty is ENT. As a result of the work undertaken so far, contracts have been agreed which has enabled approximately 70 additional patients per week to be seen since the beginning of August. An additional 8 patients per week have been receiving their operations since the beginning of September.

A second provider working for CHFT started providing clinics from the 25th September. As a result of the work being undertaken the number of people waiting longer than 12 months for an ENT appointment in CHFT is now 14, down from a peak of 376.

Ophthalmology also has a large number of patients waiting where the clinical risk is high. Additional weekly Glaucoma Diagnostic clinics have been contracted and commenced from the middle of September, with General Ophthalmology clinics starting every weekend from the beginning of October. There are now only 6 people currently waiting over 52 weeks, a

reduction from 60. The insourced provider for Ophthalmology will also be provide additional capacity by undertaking weekend operating lists on Saturdays and Sundays.

Neurology clinics commenced on the 18th September where an additional 32 appointments per week have been agreed. Approximately 75% of these appointments were expected to take place virtually. Technical difficulties and challenges associated with prescribing slightly delayed the introduction of these clinics which are being delivered face to face, offering the same additional capacity.

Additional Orthopaedic clinics started on the 9th October resulting in a further 60 patients who have agreed to be transferred to the independent sector to receive their first appointments.

To support additional operating activity we continue to work closely with the local Independent Sector providers and CHFT to deliver an aligned recovery where possible.

The team supporting CHFT is also working to identify insourcing providers who are able to supply theatre teams to increase the weekday capacity in CHFT and provide more resilience to elective operating.

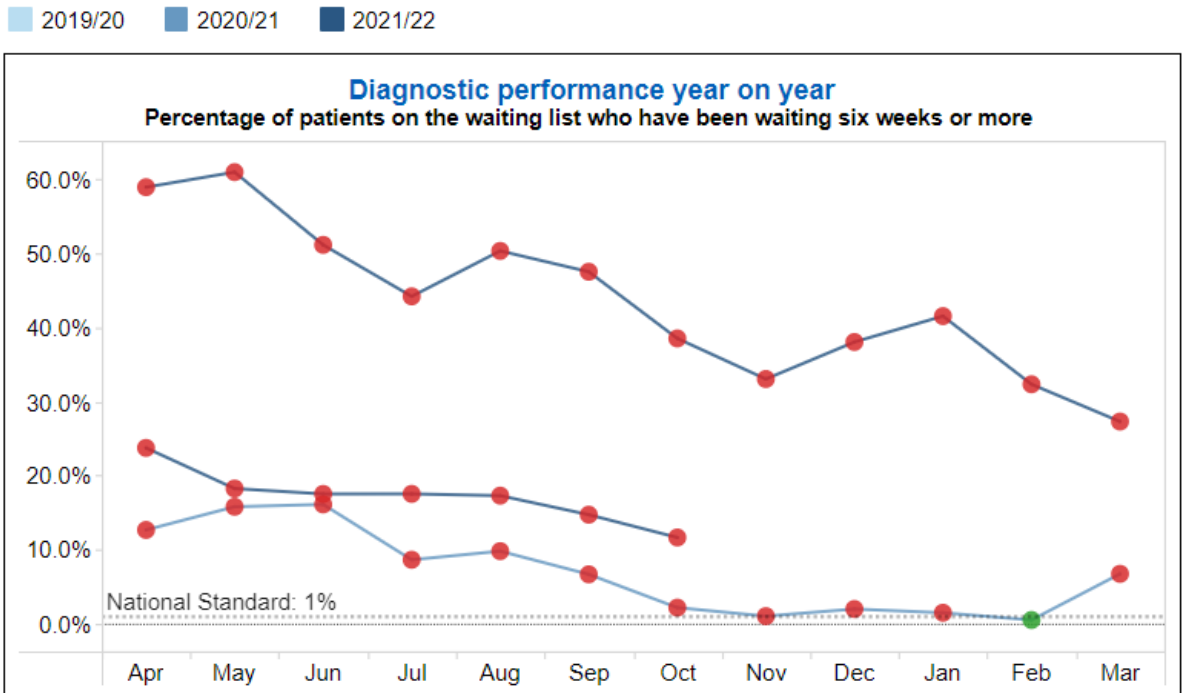
The Leeds Nuffield has offered and opportunity to do and additional 20 joint replacements a month which we are working to secure.

We will continue to work across the system, replicating the learning from these examples, to provide as much additional capacity to the highest priority areas over the remainder of the financial year.

3.3.4 Diagnostic Waiting Times

Patients referred for a diagnostic test should wait less than 6 weeks following their referral from a GP. The NHS Constitution requires no more than 1% of patient waits to breach this standard.

Covid has had a significant impact on the overall performance reported in this area – see chart below. In October 2021, 11.6% of patients experienced waits greater than 6 weeks across the spectrum of diagnostic tests. The national average is 25% and the regional average is 26%.



Overall performance levels are expected to improve in the coming months as the volume of activity, with a particular focus on endoscopy, increases – a combination of theatres now operating at full capacity post and the insourcing of additional capacity to support the recovery.

The transformation work coordinated by the Elective Care Improvement Group maintains oversight of the diagnostic waiting list and the prioritisation of patients.

3.4 Cancer Waiting Times

The table below summarises the performance levels for the cancer waiting times standards.

Indicator Details	Latest Period	Target	Value
Cancer - % seen within 2 weeks (breast symptoms)	September 2021	93% and above	98.3%
Cancer - % seen within 2 weeks	September 2021	93% and above	98.6%
Cancer - % treated within 31 days	September 2021	96% and above	91.1%
Cancer - % treated within 31 days (Drugs)	September 2021	98% and above	100.0%
Cancer - % treated within 31 days (Radiotherapy)	September 2021	94% and above	81.1%
Cancer - % treated within 31 days (Surgery)	September 2021	94% and above	77.4%
Cancer - % treated within 62 days (Consultant Upgrade)	September 2021	No target	100.0%
Cancer - % treated within 62 days (Screening)	September 2021	90% and above	0.0%
Cancer - % treated within 62 days	September 2021	85% and above	91.8%

3.4.1 The volume of referrals remains higher than normal, and this is consistent across the region however CHFT continues to benchmark strongly. The majority of the breaches reported are connected to:

- capacity constraints with providers
- complex patient pathways

CHFT continue to put on additional clinic capacity to cope with the demand and maintain the performance standards.

Cancer networks have focused their efforts to ensure theatre capacity has been available for cancer patients so they can receive their treatment in a timely fashion however the impact of covid on capacity and workforce remains a challenge.

Performance against all the cancer waiting times continues to be reviewed by the Cancer Locality Group and Cancer Network across West Yorkshire & Harrogate (WY&H).

The West Yorkshire and Harrogate Cancer Alliance continues to work across all tumour sites to improve consistency of approach and introduce new ways of working aligned to best practice. Increasingly the inclusion of pre-referral checks and tests undertaken in primary care will support the improvements in quality of referrals and will ultimately support the implementation of rapid diagnostic hubs

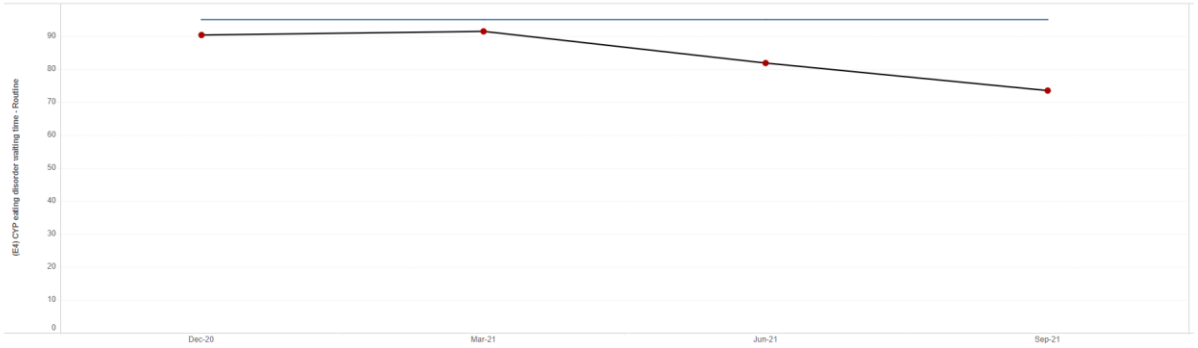
3.5. **Mental Health**

There is significant pressure and challenges across the mental health system which has supressed the planned improvement against core indicators. Key areas of variance to note include:

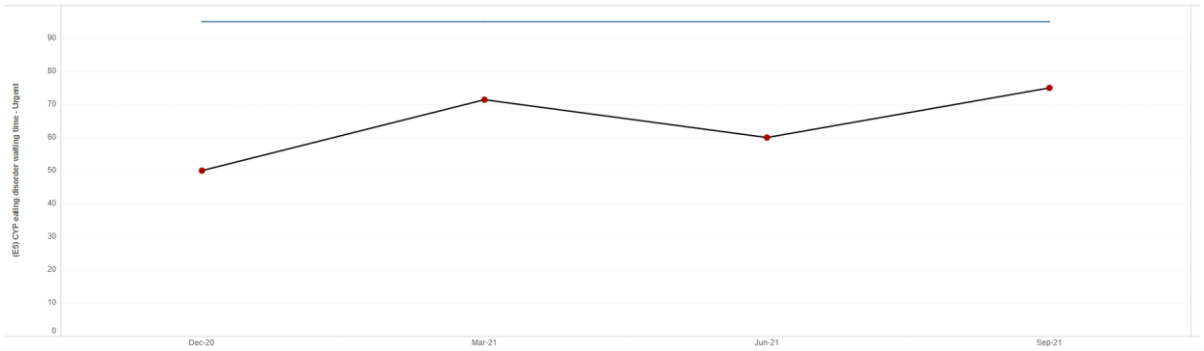
3.5.1 Children and Young People (CYP) Eating Disorders Waiting Times

This remains an area of pressure, despite non recurrent investment, demand continues to increase. Access to Tier 4 beds is an issue and a CAMHS escalation group has been established to focus collaboratively on reducing the impact on CHFT and improving user experience. Work continues both at ICS level and in place to address the increased waiting list and intervene at an earlier opportunity.

Routine – % seen < 4 week

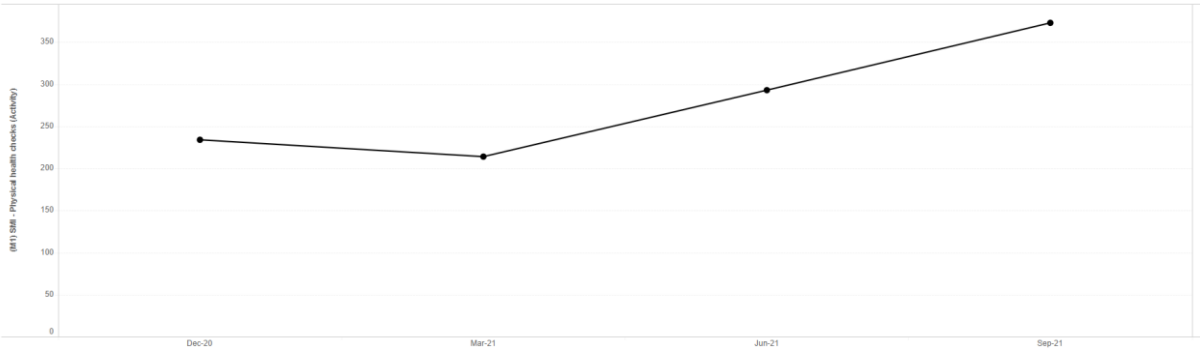


Urgent – % seen < 1 week



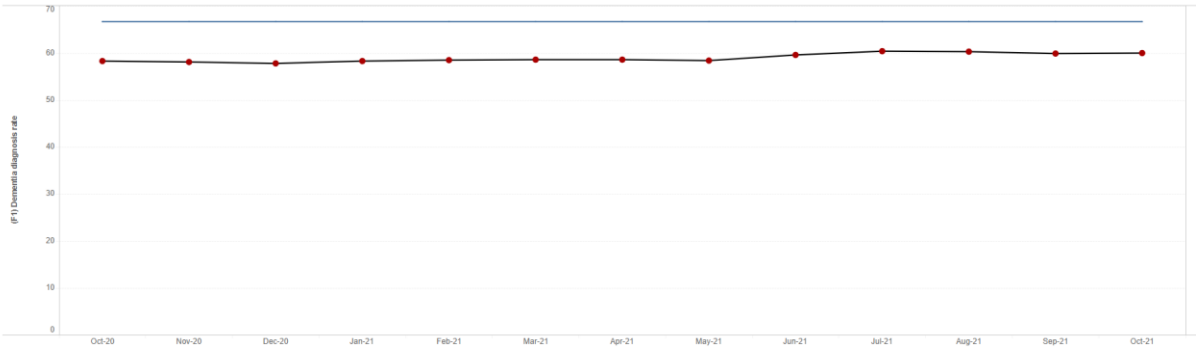
3.5.2 Serious Mental Illness (SMI) – Activity

The volume of health checks completed Q2 has increased to 373. The yearend target is to undertake 720 health checks. A workstream established to review the learning from the successful approach used with people with learning disabilities and look to apply the principles to increase the take up of health checks by people with complex mental health needs. Focused work shared with PCN's includes monthly performance data, alongside a suite of patient templates, correspondence coproduced with people with lived experience, designed to bolster understanding of and uptake of health checks.



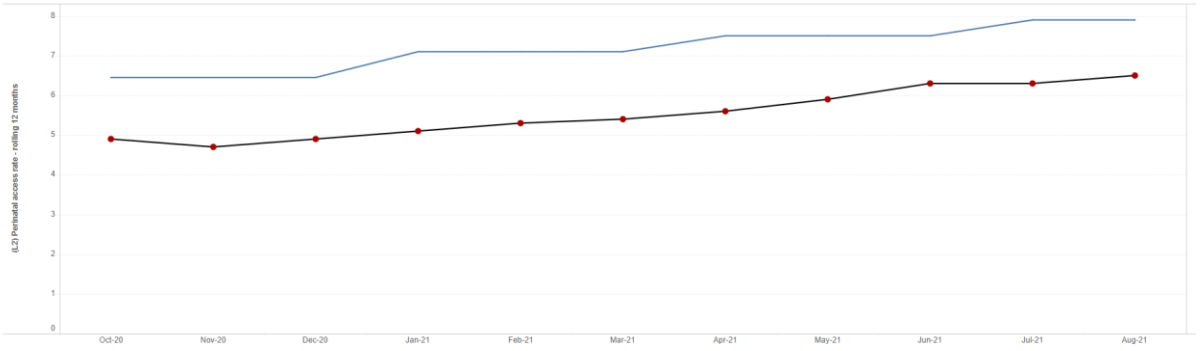
3.5.3 Dementia Diagnostic Rate

The dementia diagnostic guidelines are being updated and will be recirculated. Spending review money will fund additional memory clinics which benefits both the waiting list and diagnostic rate**.**



3.5.4 Perinatal Access Rate

A recovery plan is in place to achieve the access rate by Quarter 4.



4.0 RECOMMENDATIONS

4.1 It is recommended that the Governing Body:

1. Notes the financial forecast and the expected mitigating allocations.
2. Notes the QIPP requirement and forecast.
3. Notes the financial risks and mitigations.
4. Notes the contracting update.
5. Notes the planning guidance 2022-23
6. Notes the progress being made towards achieving the standards set out in the NHS Constitution and the impact covid 19 is having on the restoration of access levels to NHS services.

5.0 APPENDICES

Appendix A – shows a summary of the CCG's programme budgets.

Appendix B – shows a summary of the CCG's running cost budgets at cost centre level.

Appendix C – shows a summary of the CCG's delegated primary care budgets.

Appendix D – shows a summary of the CCG public sector payment policy target performance.

Appendix E – shows a summary of the CCG's allocation.

Calderdale CCG Programme Allocation Summary as at 31st December 2021 **Appendix A**

Centre Code	Annual	In Month (£)			Year To Date (£)			Forecast (£)		Mth 8 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	(359,153)	(30,955)	(30,955)	0	(269,242)	(269,242)	0	(359,153)	0	(358,454)	(699)
ACUTE	193,552	16,485	16,277	(208)	144,467	144,498	31	192,900	(652)	192,674	227
MENTAL HEALTH	42,228	3,805	2,391	(1,414)	31,289	29,906	(1,382)	41,442	(787)	41,279	163
CONTINUING CARE	23,611	1,953	2,160	207	17,752	17,790	37	23,657	46	23,450	207
PRESCRIBING	36,491	3,044	3,017	(27)	27,360	27,028	(333)	36,039	(452)	36,017	23
PRIMARY CARE	6,781	536	481	(55)	5,172	5,040	(133)	6,671	(110)	6,673	(1)
DELEGATED CO-COMMISSIONING	34,056	3,230	2,912	(318)	25,922	26,158	236	35,000	944	35,000	0
COMMUNITY HEALTH SERVICES	4,154	296	375	79	3,266	3,324	58	4,422	267	4,408	13
OTHER	2,374	193	240	47	1,793	1,783	(10)	2,341	(33)	2,323	17
BCF	12,949	1,021	1,087	66	9,887	9,746	(141)	12,979	30	12,984	(6)
COMMISSIONING RESERVE	3,559	607	2,602	1,996	2,547	5,409	2,862	7,281	3,722	7,074	207
UNIDENTIFITED QIPP	(1,817)	(1,129)	0	1,129	(1,129)	0	1,129	(1,817)	0	(1,817)	0
CONTINGENCY	1,213	914	0	(914)	914	0	(914)	1,213	0	1,213	0
Grand Total	**0**	**0**	**587**	**587**	**0**	**1,439**	**1,439**	**2,975**	**2,975**	**2,824**	**151**
Anticipated HDP costs reclaim	0	0	(374)	(374)	0	(1,144)	(1,144)	(1,921)	(1,921)	(1,770)	(151)
Anticipated COVID costs	0	0	(14)	(14)	0	(59)	(59)	(109)	(109)	(110)	1
Anticipated ARRS costs	0	0	(199)	(199)	0	(236)	(236)	(945)	(945)	(944)	(1)
Expected year end surplus	**0**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**(0)**	**0**	**0**	**(0)**

Calderdale CCG Running Cost Allocation Summary at 31st December 2021 **Appendix B**

Centre Code / Name	Annual Budget (£'000)	In Month (£'000) Budget	In Month (£'000) Actual	In Month (£'000) Variance	Year To Date (£'000) Budget	Year To Date (£'000) Actual	Year To Date (£'000) Variance	Forecast (£'000) Outturn	Forecast (£'000) Variance	Month 08 (£'000) Outturn	Month 08 (£'000) Movement
SUPPORT	40	3	3	0	30	28	(2)	39	(2)	39	0
CEO/ BOARD OFFICE	624	52	50	(2)	468	447	(21)	591	(33)	598	(6)
IM&T	84	7	31	24	63	93	30	215	131	166	50
CORPORATE COSTS & SERVICES	168	14	19	5	126	142	17	192	24	185	6
EQUALITY AND DIVERSITY	40	3	3	(0)	30	26	(4)	35	(5)	37	(2)
INVOLVEMENT	82	7	5	(2)	61	43	(18)	58	(24)	61	(3)
CONTRACT MANAGEMENT	359	30	36	6	270	304	34	390	31	398	(8)
MEDICAL DIRECTORATE	406	34	54	21	304	291	(13)	401	(4)	377	24
HUMAN RESOURCES	36	3	4	1	27	27	(0)	36	(0)	36	(1)
STRATEGY & DEVELOPMENT	633	53	55	2	475	469	(5)	631	(2)	627	4
BUSINESS INFORMATICS	361	30	21	(9)	270	183	(88)	258	(102)	259	(1)
QUALITY ASSURANCE	377	31	30	(2)	283	259	(23)	351	(26)	352	(1)
ESTATES AND FACILITIES	163	14	5	(9)	122	121	(1)	206	43	206	0
FINANCE	495	41	30	(11)	372	293	(78)	398	(98)	398	0
GENERAL RESERVE - ADMIN	(100)	(8)	(43)	(35)	(75)	186	261	87	187	147	(60)
CORPORATE GOVERNANCE	348	29	40	11	261	174	(87)	228	(121)	231	(3)
Grand Total	**4,116**	**343**	**343**	**0**	**3,087**	**3,087**	**0**	**4,116**	**0**	**4,116**	**(0)**

Calderdale CCG Delegated Primary Medical Services Summary at 31st December 2021 **Appendix C**

PRIMARY CARE SERVICES: / Name	Annual Budget	In month Budget	In month Actual	In month Variance	Year To Date Budget	Year To Date Actual	Year To Date Variance	Forecast Outturn	Forecast Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
GMS	19,169	1,597	1,566	(32)	14,377	14,171	(206)	18,882	(287)
PMS	2,475	206	205	(1)	1,856	1,852	(4)	2,467	(8)
APMS	762	63	63	(0)	571	571	(0)	762	(0)
QOF	3,081	257	253	(4)	2,310	2,306	(4)	3,081	(0)
Enhanced Services	425	39	48	9	310	364	54	495	69
Premises - Reimbursed Costs	3,263	272	277	5	2,447	2,492	45	3,322	59
Premises - Other	81	7	7	(0)	61	60	(0)	80	(0)
Prof Fees Prescribing & Dispensing	180	15	19	4	135	138	3	164	(16)
Other GP Services (inc. PCO)	323	27	33	6	242	327	85	390	68
Other Non GP Services	961	80	108	28	721	884	163	1,079	118
PCN	3,169	653	333	(320)	2,765	2,992	227	4,110	941
Reserves - Contingency (91811060)	168	14	0	(14)	126	0	(126)	168	0
Total Primary Care Medical	**34,056**	**3,230**	**2,912**	**(318)**	**25,922**	**26,158**	**236**	**35,000**	**944**

Appendix D

Calderdale CCG Public Sector Payments Policy (PSPP) Summary as at 31st December 2021

Supplier	In Month				Year To Date			
	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target	Number of invoices paid within target	% within target	Value of invoices paid within target	% within target
NHS	56	93.33%	£17,530,334.20	100.00%	443	96.94%	£158,357,686.60	99.97%
Non NHS	757	98.31%	£8,986,59142	99.95%	6,340	97.84%	£78,111,922.91	95.80%
Total	813	97.95%	£26,516,925.62	99.98%	6,783	97.78%	£236,469,609.51	98.56%

Calderdale CCG Resource Allocation Summary at 31st December 2021 **Appendix E**

Resource Allocation	Programme Costs (£'000)	Co-Commissioning Costs (£'000)	Running costs (£'000)
H1 Running Costs			(2,058)
H1 Delegated Co-commissioning		(16,787)	
H1 Core Allocation	(155,419)		
CCG Covid allocation - From H1 Plans	(1,428)		
Primary Care: GP IT Infrastructure and Resilience	(12)		
Primary Care: Improving Access	(337)		
Mental Health: SDF: CYP community and crisis	(129)		
Mental Health: SDF: 18-25 young adults (18-25)	(39)		
Mental Health: SDF: MHST 20/21 sites wave 3&4 (MHST20/21)	(281)		
Mental Health: SR: Children & Young People's Eating Disorders (CYPED)	(23)		
Mental Health: SR: CYP community and crisis	(87)		
Mental Health: SR: Adult Mental Health Community (AMH Community)	(112)		
Mental Health: SR: Adult Mental Health Crisis (AMH Crisis)	(25)		
Mental Health: SR: (IAPT)	(62)		
Mental Health: SR: 18-25 young adults (18-25)	(25)		
Mental Health: SR: Memory assessment services	(31)		
Mental Health: SR: Discharge	(168)		
Mental Health: SR: Physical health outreach	(23)		
Maternity: LTP - SBL Pre-term Birth	(18)		
Primary Care: Improving Access	(337)		
Distribute H1 Ageing Well SDF to places 21/22	(506)		
Distribute Primary Care SDF - COVID support 21/22	(453)		
PCT FELLOWSHIPS	(51)		
PCT SUPPORTING MENTORS SCHEME	(7)		
PCT FELLOWSHIPS	51		
PCT SUPPORTING MENTORS SCHEME	7		
GP IT Infrastructure and Resilience	(12)		
SDF Crisis monies H1 allocation	(61)		
CMH Transformation H1 funding	(177)		
ERF Transfer	(79)		
Hospital Discharge Programme	(360)		
Distribute assessment funding for long COVID	(87)		
Enhanced occupational health fund-place grant	(50)		
Workforce capacity and demand digital primary care scheme	(80)		
To cover DQ support 21/22 from ICS Diabetes Programme	(9)		
Primary Care for Long Covid		(110)	
ERF Transfe	(11)		
Carry Forward Historic surplus - 2019/20	(5,569)		
H2 Delegated Co-commissioning		(16,787)	
H2 Running Costs			(2,058)
H2 Core Allocation	(159,578)		
Primary Care: Funding to support PCN leadership and management	(159)		
Primary Care: GP IT Infrastructure and Resilience	(24)		
Primary Care: Improving Access	(674)		
Mental Health: SDF: CYP community and crisis	(129)		
Mental Health: SDF: 18-25 young adults	(39)		
Mental Health: SDF: MHST 20/21 sites wave 3&4	(281)		
Mental Health: SR: Children & Young People's Eating Disorders (CYPED)	(23)		
Mental Health: SR: CYP community and crisis	(87)		
Mental Health: SR: Adult Mental Health Community (AMH Community)	(112)		
Mental Health: SR: Adult Mental Health Crisis (AMH Crisis)	(25)		
Mental Health: SR: Memory assessment services and recovery of the dementia diagnosis rate (Memory/Dementia)	(31)		
Mental Health: SR: Improving Access to Psychological Therapies - adult and older adult (IAPT)	(62)		
Mental Health: SR: 18-25 young adults (18-25)	(25)		
Mental Health: SR: Discharge (number not rounded to match planning)	(280)		
Mental Health: SR: Physical health outreach and remote delivery of checks (PH Checks)	(23)		
Maternity: LTP - SBL Pre-term Birth	(18)		
Emergency & Elective Care: NHS111 H2 Capacity Funding	(278)		
COVID-19 Vaccination Programme - Operatrions centre - Q2	(88)		
COVID-19 vaccination costs - Additional costs for reducing inequalities - Q2	(5)		
Hospital Discharge Programme - Q2	(580)		
Cervical Screening Programme -	(1)		
DPC FY allocations at system level IIF part 2 - julia.gray13@nhs.net		(372)	
Winter pressures contact: tara.mchugh@nhs.net	(73)		
COVID Funding Transfer from 18NOV21 plans	(1,359)		
Winter pressures contact: tara.mchugh@nhs.net	(73)		
Ageing Well SDF - Q3	(253)		
Primary Care Networks SDF	(121)		
Personalised Care Options MOU Place Based Allocation	(28)		
Removal of duplication - Winter pressures contact: tara.mchugh@nhs.net	73		
Top Funding Transfer	397		
ERF	(1)		
Q3 Vacc Programme	(63)		
Distribute long COVID treatment funding	(279)		
CMH Transformation	(177)		
Crisis Alternatives funding	(60)		
NEPTS Pathfinder Programme funding	(120)		
Grand Total	**(330,666)**	**(34,056)**	**(4,116)**

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	Quality and Safety Report and Quality Dashboard	**Agenda Item No.**	11
Report Author	Lucy Walker, Quality Manager Debbie Winder, Head of Quality	**Public / Private Item**	Public
Clinical Lead	Dr Caroline Taylor	**Responsible Officer**	Penny Woodhead, Chief Quality & Nursing Officer

Executive Summary

This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

The report also includes a copy of the Quality Dashboard for January 2022, providing quality and safety information on our main providers, as well as updates on the following:

- Summary Plan for Emergency Care and Treatment (ReSPECT) project
- System Pressures and Quality Impact
- Calderdale Care Homes update
- National Patient Survey – provider results
- System Quality Group (SQG) update

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	17.12.2021
Name of meeting		**Meeting Date**	

Recommendations

It is recommended the Governing Body:

Receives this update on Quality and Safety information to provide assurance regarding its main providers, plus the following updates:

- Summary Plan for Emergency Care and Treatment (ReSPECT) project
- System Pressures and Quality Impact
- Calderdale Care Homes update
- National Patient Survey – provider results
- System Quality Group (SQG) update

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	This paper is applicable to vulnerable and protected patient groups. Concerns and risks relating to quality and safety are highlighted within the paper and reflected in the risk register. No Quality Impact Assessment required.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	Not required
Resources / Financial Implications (including Staffing/Workforce considerations)	N/A
Sustainability Implications	N/A

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

Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale	**Risk (include risk number and a brief description of the risk)**	1944- There is a risk of an increasing number of care homes being found to have quality and safety concerns which were previously unknown due to limited visits as a result of the pandemic. 1635 – There is a risk to timely management of infection outbreaks in Calderdale due to the staffing, capacity and demand of the provision within the infection control team. 1927- There is a risk that CHFT Maternity services will not be able to deliver the nationally mandated changes to the newborn BCG delivery from administration prior to postnatal discharge to 28 days of age due to commencement of the SCID pilot screening programme on 1st September.
Legal / CCG Constitutional Implications	None identified	**Conflicts of Interest (include detail of any identified / potential conflicts)**	None identified

1. Purpose

1.1 This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

2. Introduction

2.1 The quality dashboard received at the CCG's Quality, Finance and Performance Committee provides a high-level overview of the main acute, mental health and learning disabilities, ambulance, and community care providers through the monitoring of key quality and safety measures. These include national quality requirements, the outcomes of CQC inspections, clinical and patient related outcome measures and patient and staff experience measures.

2.2 The quality dashboard seeks to provide the Quality, Finance and Performance Committee with a view of individual areas of concern, shown on the exception report, and an overall summary of the provider. The aim is for the Quality Committee to agree the level of surveillance for each provider organisation and for any individual areas that are performing below expected levels.

2.3 For any providers that have areas of concern showing enhanced surveillance, a plan will have been agreed, with timescales, and can be monitored for improvement by the Quality Committee. Individual areas that are on enhanced surveillance do not mean that the organisation as a whole is on enhanced surveillance, but that further scrutiny is being given to the areas causing concern. The outcome of this is then shared with the Governing Body through the report

2.4 Further information on these can be found in the Quality Dashboard, Appendix 1.

3. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) project manager role

3.1 The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals, to understand what matters to them and what is realistic in terms of their care and treatment. Patient preferences and clinical

recommendations are recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

3.2 The ReSPECT process can be used for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

3.3 Calderdale, Kirklees and Wakefield CCGs have collaborated to develop an opportunity to appoint a dedicated project manager who will work with key stakeholders for health, social care, community and the voluntary sector to implement the ReSPECT project in line with the implementation roadmap and other resources developed by Resus UK.

3.4 Further information and the national guidance can be found at the following link: ReSPECT guidance

4. System Pressures and Quality Impact

4.1 Led by the CCG Chief Nurse system partners across the Calderdale and Huddersfield NHS Foundation Trust (CHFT) footprint met in November 2021 to discuss emerging and continued risks plus the quality impact on services due to the sustained current system pressures. Operational escalation meetings continue to take place and colleagues are working hard to minimise risks of harm to patients, including thinking creatively about possible solutions and opportunities. This forum sets the intention to have focused discussions with senior leaders to consider ways of knowing the impact on service users across the partnership, what the system quality priorities are and how system quality impact can be assessed.

4.2 In advance of the meeting partners were asked to consider the following to support the discussions:

- What is your routine quality monitoring telling you (safety and experience)?
- What Enhanced Quality Assurance processes have you put in place?
- Have any targeted quality monitoring/assurance visits taken place and if so, what were the outcomes?

4.3 This facilitated discussions on what partners feel the priority areas of concern are from a quality impact perspective, from both an organisational and a system point of view and will inform actions as well as identification of future shared Place based quality priorities. They also facilitated shared agreement that acceptance of lowering of standards would not be tolerated by any system partners.

5. Calderdale Care Homes Update

5.1 The Quality Team continue to actively support a number of Calderdale Care Homes in order to facilitate service improvements. Homes are prioritised if CQC inspections rate them as inadequate or requires improvement, or RAG rated as red, according to concerns identified. Work continues with Local Authority colleagues to progress robust processes of early risk identification and increase proactive responses.

5.2 As well as monitoring and supporting delivery against CQC improvement action plans the quality team undertake proactive 'Quality support walkabout visits' to identify areas of good practice and areas of concern using the NHS England 15 steps approach. The walkabout is designed to focus on observations that are aligned to the CQC essential standards. They explore if the area feels welcoming, safe, clean, caring and involving, well organised and calm.

5.3 An example of this work is the support offered to The Calderdale Retreat following safety concerns in August 2021. The Quality Team undertook several quality walkabouts and, working in partnership with the Care Home Provider identified key priorities. A primary quality improvement focus was medication safety. Supported to utilise Quality Improvement methodology the Care Home have implemented a range of improvements. The Quality Team have supported this work by analysing data to evidence sustained improvements. Furthermore, training has now been delivered to the Senior Carers to enable them to undertake Quality Improvement projects and evidence impact and outcomes effectively.

6. National patient surveys – provider results

6.1 The results of two national patient surveys have recently being published:

- Urgent and Emergency Care 2020
- Adult Inpatient 2020

6.2 A summary of both the national and local picture for each survey is provided at appendix2. Results will be discussed, and internal action plans developed as necessary.

7. System Quality Group (SQG) update

7.1 In the position statement released in May 2021 the National Quality Board (NQB) set out the key requirements for quality oversight within Integrated Care Systems (ICSs), which identifies two overarching quality responsibilities:

1. To ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation.
2. To continually improve the quality of services, in a way that makes a real difference to the people using them.

7.2 To meet the NQB quality expectations, all systems are mandated to develop existing Quality Surveillance Groups into System Quality Groups (SQG) with Terms of reference below:

Terms of Reference of System Quality Groups	
Purpose	A proactive and collaborative forum, providing systems with: • A mechanism to identify system risks to quality and opportunities for improvement, including variation • A mechanism to escalate quality risks from place to system, and system to region (in collaboration with regulators and wider stakeholders/forums, e.g. safeguarding boards) • Opportunities to coordinate actions to drive improvement, respecting statutory responsibilities • Opportunities to identify, share and celebrate learning and best practice across the system.
Scope	A focus on population health and system quality priorities, e.g. across pathways/settings with particular emphasis on reducing inequities in access, experience and outcomes.
Membership	System-led. Membership expanded, with at a minimum Regional NHSEI teams, local authorities, CQC, HEE, public health, primary care, maternity, patient safety collaboratives, patient safety specialists, provider collaboratives and at least two lay members (inc Healthwatch).
Assurance	Accountable to the ICS Board (subject to legislation) and to Regional NHSEI teams for the quality of care of services. Responsible for ensuring good quality oversight, management of risks, sharing intelligence and working with regulators.

7.3 The inaugural West Yorkshire System Quality Group (WYSQG) took place on 7 October 2021.. The West Yorkshire Quality Leads meeting will continue to share surveillance, intelligence and risks with WYSQG as well as working collectively on quality improvement.

7.4 Place based Quality Committees will escalate into and contribute to WYSQG as well as receiving updates. This provides the opportunity to identify quality priorities from Place and work on system quality priorities together and sharing quality improvements and learning.

8. South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) NHS Community Benchmark Report Results 2021.

8.1 The NHS Community Mental Health Survey Benchmark Report 2021 for SWYPFT was published in early December. Although the results have not changed significantly from previous years in both deterioration and improvement the majority of the results remain around the national average.

8.2 The best service user experience was:

- Crisis care help: services users getting the help needed when they last contacted the crisis team
- Communicating changes in care due to Covid-19: informing service users of changes in care due to Covid-19
- Support with physical health needs: service users being given support with their physical health needs
- Support with financial advice: service users being given help or advice with finding support for financial advice
- Friends/Family involvement: service user's family/someone close to them is involved in their care as much as they like

8.3 Areas where service user experience could improve was:

- Crisis care contact: service users knowing who to contact out of hours in the NHS if they have a crisis
- Who organises care: service users being told who is in charge of organising their care and services
- NHS Talking Therapies: service users being involved in deciding what NHS talking therapies to use
- Support with work: service users being given help or advice with finding support for finding or keeping work
- Care agreement: service users agreeing with someone from NHS mental health services what care they will receive

8.4 The Quality Manager continues to work closely with the Trust to gain assurances regarding any comments and actions following publication of the survey results.

9. Implications

9.1 Quality and Safety Implications

9.1.1 The Governing Body should note that this report contains information relating to vulnerable patient groups and also contains information in relation to the quality of health services commissioned by the CCG.

9.2 Resources / Finance Implications

9.2.1 The Governing Body will be provided with a verbal update on the implications of the pandemic on the resources and capacity within the CCG Quality team due to the constantly changing situation and responses necessary.

10. Recommendations

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

- Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) project manager role
- System Pressures and Quality Impact
- National Patient Survey – provider results
- System Quality Group (SQG) update

11. Appendices

11.1 Appendix 1 – Quality Dashboard
Appendix 2 – National survey – provider results and actions

Calderdale CCG Quality Dashboard
November 2021

CCCG Exception Report

Indicator	Target	Month/ Quarter	Month data from	YTD 2020-21
C-Diff	24	1	July 2021	11
MRSA	0	0	July 2021	0
MSSA	No target	8	July 2021	19
E-Coli	155	10	July 2021	37
Pseudomonas	9	2	July 2021	4
Klebsiella	38	2	July 2021	7

Healthcare Acquired Infections (HCAI). PHE has released the national objectives where applicable and these have been updated on the dashboard accordingly.

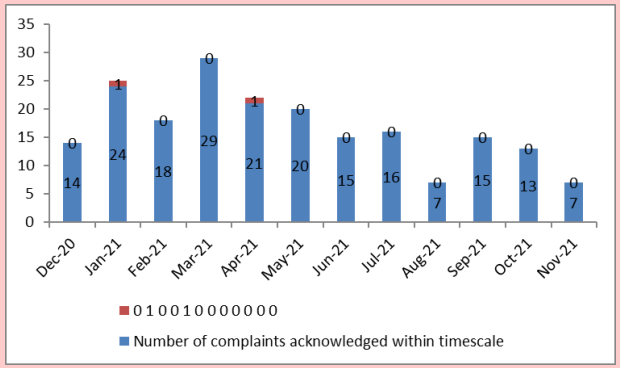
Broad Spectrum antibiotics:

The prescribing of broad spectrum antibiotics as a % of all antibiotics prescribed over a 12 month period up to June 2021 has slightly decreased against March 2021 to a value of 7% which is well within the NHSE target of 'at or below 10%'.

Total antibiotic prescribing per 1000 STAR-PUs:

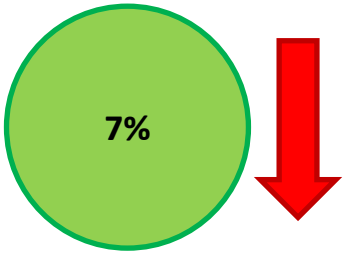
This is currently well below the NHSE target from April 2019 of 965 or below – but significantly above the England average. Following the nationwide drop in prescribing during the pandemic, there has been an increase after April 2021 - this pattern has reflected in Calderdale. However the increase means Calderdale is once again only just outside the worst quartile for prescribing of antibiotics. There remains concerns around remote prescribing of empirical antibiotics.

Complaints – acknowledged within 3 working days

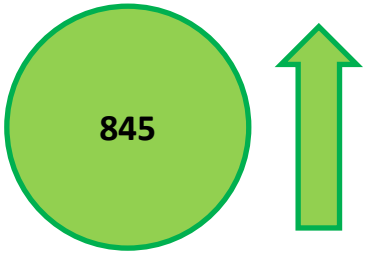


The number of complaints, concerns and enquiries acknowledged within timescale is once again at 100%.

Although the complaints team have continued to receive complaints and enquiries about GP appointments it has been noted that the number reduced during the Quarter. The Complaints Manager feels the generic information provided to e.g. MPs in previous Quarters has contributed to this reduction.



Broad spectrum antibiotics as % total antibiotics prescribed
June 2021
(updated August 2021)



Total antibiotic prescribing items per 1000 STAR PUs
June 2021
(updated August 2021)

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – November 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Central Alerting System (CAS)/National Patient Safety Alerts (NPSA).	Following the publication of the CQC insight report the Trust continues to show as an outlier with regards to CAS/NPSA alert indicators. Progress on this indicator is not yet evident. The Trust have noted the slow progress and do not benchmark favourably nationally.	The matter was escalated to the Company Secretary and a quality assurance review has been undertaken to review the standard operating procedures and governance processes. The review highlighted weaknesses in regards to the ownership of CAS alert actions and the processes for recording and subsequent closure of the alert. Assurances on the progress and achievements of CAS alert and associated actions are received through the attendance at the Trust Internal Quality Committees. The Trust are monitoring this indicator on a monthly basis via internal monitoring meetings which include updates on individual alerts including mitigations and risks to the organisation.	A revised process is in place and an increase in timely closure of the data is expected in the coming months but this will take time to become embedded within the Trust.

Calderdale and Huddersfield NHS Foundation Trust
Overview/triangulation

This page provides a summary in relation to the Quality and Safety of services provided at Calderdale and Huddersfield NHS Foundation Trust (CHFT) for the period up to October 2021.

Serious Incidents – Never Event

In June 21 the Trust escalated that a historical Never Event had been identified. The incident related to an investigation performed in 2020 and a retained foreign object. The Trust were unaware of the incident until February 21. The incident was logged and uploaded to the Strategic Executive Information System (StEIS) and the National Reporting & Learning System (NRLS). The completed investigation has been received by the CCG Serious Incident Team and is currently undergoing CCG review processes.

Central Alert Systems (CAS) Indicators

Although the Trust are in arrears in the current data set assurances continue to be received regarding this indicator. The indicator continues to remain off track and the Trust recognise that they benchmark worse than expected nationally. The Trust have established mechanisms to monitor individual alert timescales on a monthly basis that is presented as a position statement. Papers continue to be shared with commissioners to detail information relating to patient safety alerts including monthly progress against all open within timescale and overdue alerts. Individual patient safety alert titles are included and mechanisms in place for the Trust to monitor this in a robust efficient way.

Complaints

Making Complaints Count was allocated as one of the Trusts focussed quality priorities this year. Regular progress updates continue to be received via the Trust internal Quality Committee which is attended by the CCG Quality Manager or wider team. Progress against the priority is reasonable but the Trust recognise the elements that are required to progress this further. Risks identified in relation to the staffing provision within the complaints team have been identified and actions in place to mitigate while recruitment is ongoing.

Although some slippage in the indicator was noted in the previous month the Trust continue to strive to maintain and embed the positive changes in relation to complaints closed within target timeframe which has proved challenging for the Trust in the past.

Percentage Non-elective #Neck of Femur (NOF) Patients With Admission to Procedure of < 36 Hours – Best Practice Tariff (BPT) based on discharge

Commissioners have received a paper that details the ongoing review of organisational performance against the 36h admission to surgery target within the BPT. The review is ongoing and although was due for completion in September this has been delayed due to clinical pressures and availability of key specialist staff involved within the work piece. A number of key themes have been identified to action and improve performance. Key themes identified are:

- **Reducing the variables –** A full process mapping exercise to be completed to identified areas for efficiencies.
- **Development of the fractured Neck of Femur Pathway –** This will be inclusive from admission to discharge including clear roles and responsibilities for each task.
- **National Improvement Initiative –** The National Hip Fracture Database are welcoming applicants for a national quality improvement collaborative. A business case is in development to request funding for participation from the Trust.

An action plan is under development and updates will be shared with commissioners once the final outputs of the service improvement review and update on delivery of the associated action plan.

Calderdale and Huddersfield NHS Foundation Trust
Overview/triangulation

This page provides a summary in relation to the Quality and Safety of services provided at Calderdale and Huddersfield NHS Foundation Trust (CHFT) for the period up to October 2021 in relation to Serious Incidents occurring in Quarter 1 & 2 (Information provided by the CCG Serious Incident Team).

The Trust have continued to engage virtually and continue to report Serious Incidents throughout the pandemic. Clinical staff who would have supported the investigation processes have been redeployed into clinical duties to meet the pressures and demands of the pandemic. The Trust risk team have also faced a number of staffing challenges. It is encouraging that these staffing challenges are resolving with a number of new appointments both permanent and flexible now established.

The Senior Risk Manager continues to engage across the patch with colleagues in WYATT to seek assurance and new ways of working. MYHT and CHFT CCG Heads of Services are also working closely together to drive improvements and good working relationships have been established.

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – November 2021

Quality Domain	Indicator	Reporting Frequency	CHFT			Trend information																		
						Direction of Travel			2020-21										2021-22						
			Period Target	Month/ Period	YTD 2021-22	Month / Period / Year data from	Previous Month / Period	Corresponding month 2020-21	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
Safe	C Diff	Monthly	tbc	1	9	Sep-21	↓	↑	2	2	4	2	6	4	1	3	1	2	4	1	0	1	-
	E Coli	Monthly	n/a	3	19	Sep-21	↔	↓	0	0	0	0	0	0	0	0	4	4	0	5	3	3	-
	MRSA	Monthly	0	0	0	Oct-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA	Monthly	n/a	5	9	Sep-21	↓	↓	0	0	0	0	0	0	0	0	0	0	0	2	2	5	-
	Never Events	Monthly	0	0	1	Oct-21	↔	↔	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Serious Incidents	Monthly	n/a	8	27	Oct-21	↓	↔	2	4	2	1	3	5	2	2	4	2	6	1	2	4	8
	Overall essential safety compliance	Monthly	>=90% Green >=90%<85% Amber <85% Red	93.22%	-	Oct-21	↓	↓	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	93.93%	93.81%	93.22%
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	20.0%	-	rolling 6 months - May - Oct 21	↓	↓	34.5%	37.5%	36.4%	30.0%	27.0%	15.0%	31.0%	16.7%	27.3%	0.0%	0.0%	0.0%	22.2%	30.0%	20.0%
	VTE Risk Assessment	Monthly	>=95%	96.32%	96.33%	Oct-21	↑	↑	96.14%	95.46%	95.37%	96.13%	95.74%	95.67%	95.97%	96.03%	95.55%	95.10%	95.22%	95.31%	96.28%	95.93%	96.32%
Caring	EMSA	Monthly	0	0	0	Oct-21	↔	↔	0	0	2	3	0	0	0	1	0	0	0	0	0	0	0
Responsive	% Complaints closed within target timeframe	Monthly	100%	71.43%	74.10%	Sep-21	↑	↑	71.0%	62.0%	44.00%	50.00%	41.70%	63.00%	52.90%	60.00%	100.0%	87.5%	100%	69.44%	51.10%	71.43%	in arrears
	No of complaints re-opened	Monthly	n/a	9	39	Sep-21	↑	↓	4	3	1	0	0	0	0	3	4	3	0	6	10	9	in arrears
	% Last minute cancellations to elective surgery	Monthly	< 0.65%	0.43%	0.38%	Oct-21	↑	↓	0.36%	0.38%	0.30%	0.23%	0.00%	0.16%	0.07%	0.32%	0.41%	0.34%	0.27%	0.09%	0.54%	0.61%	0.43%
	Percentage Non-elective #NoF Patients with admission to Procedure of < 36 hours	Monthly	>=85%	41.30%	57.05%	Oct-21	↑	↑	51.06%	74.36%	75.68%	67.39%	61.70%	45.83%	64.29%	65.85%	62.50%	72.30%	41.18%	60.90%	58.54%	67.57%	41.30%
	12 hour breaches in A&E (A&E trolley waits)	Monthly	0	2	3	Oct-21	↓	↓	0	0	15	21	0	0	0	0	0	0	0	1	0	0	2

Arrow key:

↑ improvement against target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

Calderdale and Huddersfield NHS Foundation Trust
Quality Dashboard – November 2021

Good **CQC Inspection rating** June 2018	101.91 **SHMI** - One year rolling data Apr 20 – May 21 Updated Oct 2021	90.0 **HSMR** - One year rolling data May 20 – June 21 Updated Oct 2021
Staff Survey – satisfied with the quality of care to patients/SUs 80.3% Improvement from previous year (78.4%). Below national average (82%) Annual – updated April 21	**Staff Survey** – recommend as a place to work 63.8% Improvement from previous year (57.4%). Below national average (66.9%) Annual – updated April 21	
CQC Inpatient Survey – respect and dignity 9.3 about the same as other trusts Annually – updated Nov 21 (next publication Oct 2022)	**CQC Inpatient Survey** – involved in care decisions 7.1 about the same as other trusts Annually – updated Nov 21 (next publication Oct 2022)	

Calderdale and Huddersfield NHS Foundation Trust
Exception Report – November 2021

Routine Monitoring

Proposed indicators to return to Routine Monitoring:

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – November 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Complaints closed with in 40 days	Prior to Covid-19 (March 2020) the Trust had reached 78% against a target of 80%, which was significant progress from the 20% baseline. Since reopening the complaints process in July 2020 they have seen : •Increased number of complaints •Increase in complexity •Reduction in availability of clinical investigators due to commitments and response to Covid 19 pandemic.	• A pilot of a new set of key performance measures on timeframes for handling complaints has recently been approved by the executive management team as a pilot to run between April to July 2021. • The pilot will categorise the complaints as complex, moderate or low and each category will be assigned a set amount of working days to be closed. Ranging from 25 to 60 days depending on severity. • All complaints are risk assessed to ensure there is no risk to patient safety and not detrimental to health and well being. • SWYPT have identified complaint handling as a quality priority within their annual Quality Account. • The Trust are extending complaint handling training to enable more staff to be lead investigators.	Due to retirement there has been a change of portfolios for the assistant directors of nursing within the Trust. The CCG Quality Manager has asked the Assistant Director of Nursing with complaints and experience within their portfolio to provide an update the pilot and trajectory for improvement. They will be meeting in November to discuss further and updates will be provided

South West Yorkshire Partnership NHS Foundation Trust
Exception Report – November 2021

Enhanced Surveillance

The following indicators are below expected levels of performance and are an elevated risk to Quality and Safety. It is recommended that the Committee has a focus on these areas.

Area under performance	Why off plan	Proposed actions	When expected back on track
Number of records with up to date risk assessment – Inpatient and Community (Target 95%)	During September and early October 2020 services have moved from the Sainsbury tool on SystmOne to the FIRM (formulation of informed risk assessment) tool which supports the Trust values.	• Business Delivery Unit Governance Groups will be accountable to drive forward and oversee the quality of clinical risk practice in their areas. This will include the quantitative performance around the completion of the clinical risk assessment and subsequent care planning, regular qualitative dip sampling within each area of the quality of the assessment, and to ensure that the subsequent plans have captured the assessed risks. • Audits and exceptions are reported into the Clinical Governance Group for escalation to the Clinical Governance and Clinical Safety Committee • The Quality Improvement Assurance Team will undertake an annual audit of FIRM to support the focus on improvement, and 360 Assurance are reviewing our approach to governance around clinical risk assessment and clinical risk management between January and March 2022. .	The trajectory was 80% completion of FIRM by Q3 and 90% completion by Q4. Although there has been improvements to performance in this area for over the last twelve months it remains off target. Given FIRM risk management tool was implemented a year ago the CCG Quality Manager has asked for an update on the Trusts proposed actions and trajectory for improvement within this area.

South West Yorkshire Partnership Foundation Trust
Overview/Triangulation

The following 2 pages provide a summary in relation to the quality and safety of services provided at South West Yorkshire Partnership Foundation Trust (SWYPFT) for the period of up to 4th November 2021, dashboard data to September 2021.

Review of Dashboard & Integrated Performance Report (IPR) Data

- No. of records with up to date risk assessment (Inpatient) 57.6% against target of 95%. This is downward trend from the previous month
- No. of records with up to date risk assessment (Community) 64.6% against a target of 95%. This is an improvement from previous month
- Complaints closed within 40 days: 33% against a target of 80%. This is an improvement from the previous month and no complaints have been reopened this month.
- CAMHS - under 18's admitted to adult wards is 0 for the first time in 13 months
- The number of restraint incidents was 166 in September, an increase of 30 since August
- There was 12 Information governance breaches reported in September, an increase in 8 from August
- Out of area bed usage increased in September to 311 days
- No avoidable pressure ulcers were reported in September.
- There has been an increase in falls in September, 69 compared to 43 falls in August. Increases relate to Wakefield and Kirklees wards in particular and are linked to acuity of the patient group. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

Safer Staffing Inpatients

September continued a sustained period of significant staffing challenges in all areas. There are various reasons for this including an increase in sickness, the continued vacancy factor as well as sustained increase in acuity and Covid related issues. The Trust's task and finish groups looking at staffing issues including recruitment and retention, workforce planning and flexible staffing are ongoing. Although safe and effective staffing remains a priority in all teams, and there has been a systems wide increase of requests for additional staffing on all inpatient areas. Maintaining safety and well-being of staff and service users, reducing ward sizes and improving recruitment and retention have been identified as key areas for action.

Complaints

There were 28 new formal complaints in September 2021. Of these 3 have a timescales start date, 1 is no contact/consent and 24 are awaiting consent/questions. 14% of new formal complaints (n=4) have staff attitude as a primary subject. Customer services closed 9 new formal complaints in September 2021. Due to complexity of complaints many are taking longer to investigate, respond and close. 16 compliments were received

South West Yorkshire Partnership Foundation Trust
Overview/Triangulation

Learning From Serious Incidents Quarters 1-2 2021/22

There were 12 serious incident investigation reports received from SWYPFT during Quarters 1 -2

- 10 X Apparent/actual/suspected self inflicted harm incidents
- 1 medication incident
- 1 slip/trip/fall incident

No route causes were identified from these investigations and the top categories for provider lessons from the investigation were

- Education and Training (6)
- Care Deliver (5)
- Documentation/ Record Keeping (4)
- Governance and Audit (4)

Concerns: Capacity issues remain within the investigation team at SWYPFT, there are still delays in allocating investigators for serious incidents and submitting reports within the agreed timeframes. Some investigators have left the team due to career progression and others are due to retire in coming months therefore the Trust are progressing with recruitment. The CCG has supported SWYPFT by approving "watching briefs" and de-logs of incidents that do not meet the Serious Incident threshold. Evidence review meetings between SWYPFT, CCG Quality Manager and SI team have been established for assurance of learning and embedding changes.

Assurance: Positive relationships, engagement and assurances continue between the CCG and the provider. The Trust holds a weekly internal panels to assess incidents which may be considered as an SI following a 48 hour review. Serious Incidents are maintained as business critical within the organisation. SWYPFT have been successful in obtaining serious incident accreditation with the Royal College of Psychiatrists.

CAMHS

Quality Manager was invited to attend quality monitoring visit of CAMHS service for Calderdale and Kirklees. The process involved a site visit to review the environment, processes and service delivery. Areas for improvement were identified in regards to the environment from a staff and service user perspective. We spoke to managers and staff of varying grades and roles to understand more about the service, day to day capacity, the culture, ways of working, what was going well and areas for improvement. Team work and supportive culture was evident throughout and evidence of transformation and innovation to proactively improve quality of assessments and waiting lists. From speaking to six families who have a child or young person currently in the service feedback on the whole was positive, praising staff for going above and beyond in their care and support. However common concerns was waiting lists, no indication of when they will be seen and difficulties moving between pathways. Others also cited not being offered carers assessments. There has been positive co-production work with families and young people that have produced welcome to CAMHS leaflet and waiting list letters/sign posting information in language service users and families understand. Risk Assessments and care/support plans were also reviewed, some were very good, person centred, detailed and reviewed regularly. Others were lacking information and had incomplete data. Medical care plans were said to be good quality and contained in depth information. Verbal feedback given to the leadership team at the end of the visit and a full report is currently being produced.

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – November 2021

			SWYPFT				Trend information																	
							Direction of Travel		2020-21											2021-22						
Quality Domain	Indicator	Reporting Frequency	Period Target	Month/ Period	YTD 2021-22	Month/ Period/Year data from	Previous Month/Period	Corresponding month 2020-21	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O
Safe	Never Events	Monthly	0	0	0	Oct-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	Monthly	n/a	3	13	Oct-21	↓	↓	2	6	1	0	3	2	1	0	2	4	0	1	3	2	0	3
	NPSA Safety Alerts - CAS alerts completed within deadline	Monthly	≥ 90% - green < 90% - red	90.0%	-	rolling 6 months - May 21- Oct 21	↔	↓	100.0%	100.0%	100.0%	100.0%	100.0%	93.0%	92.0%	92.0%	91.7%	91.0%	83.3%	100.0%	100.0%	100.0%	90.0%	90.0%
Effective	% Admissions Gate kept by SRS Teams	Monthly	95%	99.1%	-	Sep-21	↑	↑	96.8%	96.4%	95.2%	100.0%	100.0%	98.0%	100%	99.1%	99.1%	100.0%	100.0%	99.1%	100.0%	98.9%	99.1%	-
	No. of records with up to date risk assessment – Inpatient	Monthly	95%	57.6%	-	Sep-21	↓	↓	84.3%	93.4%	81.0%	20.9%	46.6%	54.0%	55.5%	53.0%	53.2%	61.6%	68.3%	56.1%	59.1%	60.3%	57.6%	-
	No. of records with up to date risk assessment – Community	Monthly	95%	64.6%	-	Sep-21	↑	↓	70.0%	74.6%	77.4%	37.3%	47.7%	51.9%	56.0%	63.2%	57.3%	51.8%	46.9%	68.9%	70.4%	54.7%	64.6%	-
Caring	EMSA	Monthly	n/a	0	0	Sep-21	↔	↔	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Responsive	Complaints closed within 40 days	Monthly	80%	33%	-	Sep-21	↑	↑	100%	-	30%	60%	73%	11%	50%	0%	58%	39%	29%	42%	20%	14%	33%	-
	No of complaints re-opened	Monthly	n/a	0	5	Sep-21	↔	-	0	-	0	0	2	2	0	1	0	2	0	-	3	0	0	-
	CAMHS - under 18's admitted to adult wards	Monthly	tbc	0	14	Sep-21	↑	↑	0	3	3	2	4	2	2	1	3	3	3	3	3	2	0	-
	Delayed Transfers of Care	Monthly	3.5%	2.3%		Sep-21	↑	↓	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1.8%	1.6%	1.8%	1.2%	1.1%	1.3%	1.9%	2.9%	2.3%	-
	% Service users on CPA followed up within 7 days of discharge	Monthly	95%	100.0%	-	Sep-21	↑	↑	100.0%	98.8%	99.1%	98.9%	100.0%	100.0%	98.90%	100.0%	97.0%	96.8%	98.8%	98.1%	99.3%	99.1%	100.0%	-
	Out of Area Beds Days	Monthly	-	311	-	Sep-21	↓	↓	336	224	177	106	88	122	91	78	82	122	204	170	117	170	311	-
Well-led	Information Governance Confidentiality Breaches	Monthly	<12	12	57	Sep-21	↓	↑	25	17	19	12	17	12	12	13	13	7	8	11	11	8	12	-

Arrow key:

↑ improvement against target
↓ movement away from target
↔ no change at/above target
↔ no change below target
↔ no change no target set

South West Yorkshire Partnership Foundation Trust
Quality Dashboard – November 2021

CQC Inspection rating published August 2019

Good

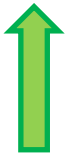
Staff Survey – satisfied with the quality of care to patients/SUs

81.9%

Improvement from previous year (81.5%). Below national average (82.3%)
Annual– updated April 21

Staff Survey – recommend as a place to work

69%



Improvement from previous year (61.5%) . Above national average (67.7%)
Annual – updated April 21

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	**Workforce Report**	**Agenda Item No.**	12
Report Author	Tazeem Hanif (HR Business Partner)	**Public / Private Item**	Public
Clinical Lead	Steven Cleasby (Clinical Chair)	**Responsible Officer**	Neil Smurthwaite (Chief Operating Officer)

Executive Summary
This paper presents an overview of the CCG's workforce data between the periods of 01 April to 31 December 2021. It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce. The paper includes the following workforce metrics: • Workforce composition • Staff turnover • Sickness absence • Equality and diversity data • Workforce headlines relating to the CCG's workforce.

Previous Considerations

Name of meeting	Senior Management Meeting	**Meeting Date**	11 January 2022 (electronically circulated)

Recommendations
It is recommended that the Governing Body: **RECEIVES** and **NOTES** the content of the CCG workforce report update.

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	None identified.
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	All information in this report is presented in such a way that individuals cannot be identified from the data, in line with information governance requirements.

	Diversity information is reported to Governing Body separately as part of the Public Sector Equality Duty reporting. At the request of Governing Body, this report includes information about the Equality and Diversity of the CCG's workforce, to facilitate discussion.
Resources / Financial Implications (including Staffing/Workforce considerations)	The report provides the Governing Body with an overview of staff resource available to the CCG.
Sustainability Implications	None identified

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

Strategic Objectives (which of the CCG objectives does this relate to?)	Achieving the agreed strategic direction for Calderdale Improving quality Improving value	**Risk (include risk number and a brief description of the risk)**	None identified.
Legal / CCG Constitutional Implications	This paper provides the Governing Body with assurance that the CCG is operating in line with legal requirements, best practice and within agreed CCG policies and procedures.	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any conflicts arising from this report will be managed in line with the CCG's Management of Conflicts of Interest policy.

1. Introduction

1.1 This paper presents an overview of the CCG's workforce data between the periods of 01 April to 31 December 2021. It also provides the Governing Body with detailed information and assurance on matters pertaining to the CCG's workforce.

1.2 The quarterly workforce reports are presented to the CCG's Senior Management Team (SMT) by Human Resources (HR). The information provided enables SMT to identify any patterns or trends to enable the identification of any actions that need to be taken at an operational level. It also provides a vehicle for advising SMT about any key developments in employment law, best practice or other matters that may affect the CCG's workforce.

1.3 The Governing Body report complements the reporting to SMT, providing assurance in relation to the effective management of the CCG's workforce. The recommendation to Governing Body is that it receives and notes the content of the CCG workforce report update.

1.4 Please note that this document is in an accessible format except for data within tables 1-7. The information can be supplied in accessible format on request.

2. Workforce Composition

2.1 The workforce composition of CCG employed staff as of 31 December 2021 was 92 equating to 85.42 Full Time Equivalent (FTE). The CCG also has arrangements in place to share staff resource with other local CCGs, particularly, NHS Kirklees CCG which accounts for roughly 21 staff.

2.2 The majority of the CCG's staff are employed under Agenda for Change terms and conditions which represent job bandings 1 to 9. The other category refers to the Very Senior Managers (VSMs).

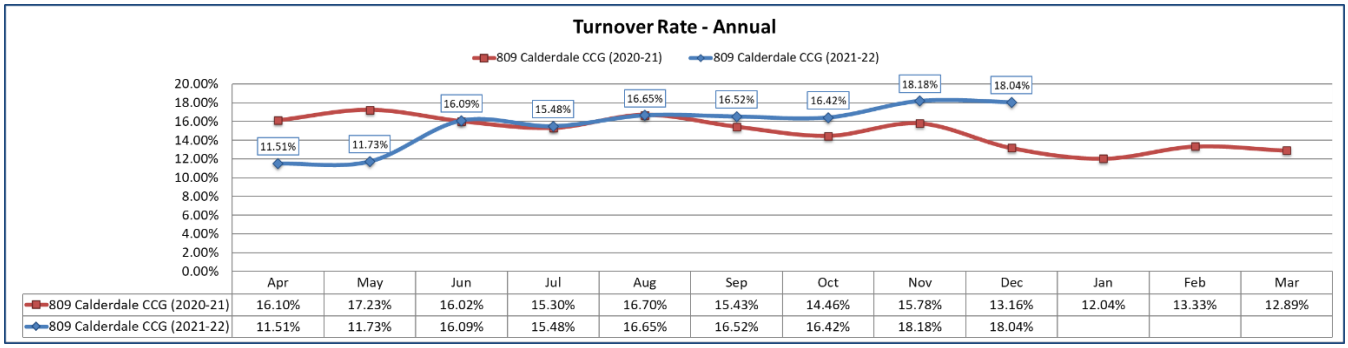
3. Staff Turnover

3.1 Staff turnover refers to the proportion of employees who leave an organisation over a set period and is expressed as a percentage of the total workforce average. The CCG calculates turnover on a rolling annual basis. The formula which is used to calculate annual employee turnover is:

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

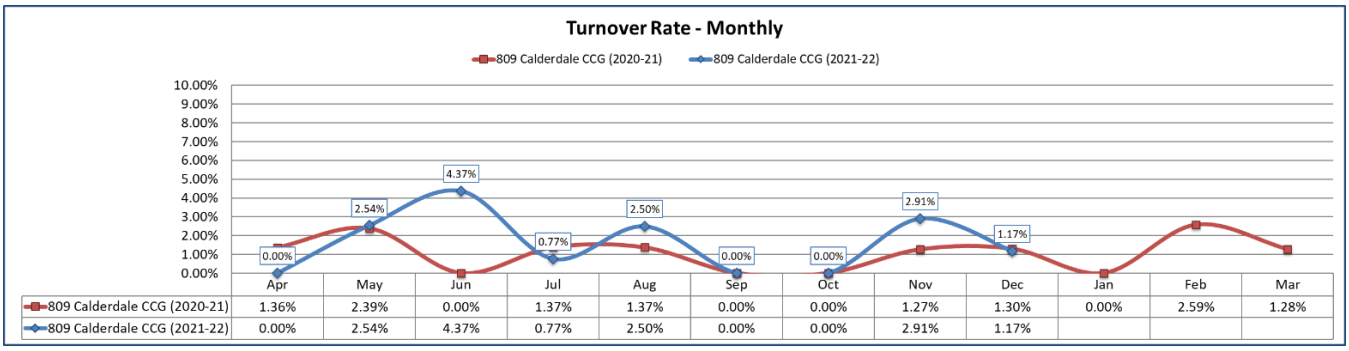
3.2 The data set out in Table 1 and 2 includes the CCG's annual and monthly staff turnover rates from 01 April to 31 December 2021 and a comparison with turnover for the previous financial year.

Table 1 – CCG Rolling Annual Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	16.10%	17.23%	16.02%	15.30%	16.70%	15.43%	14.46%	15.78%	13.16%	12.04%	13.33%	12.89%
809 Calderdale CCG (2021-22)	11.51%	11.73%	16.09%	15.48%	16.65%	16.52%	16.42%	18.18%	18.04%			

Table 2 – CCG Monthly Staff Turnover



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	1.36%	2.39%	0.00%	1.37%	1.37%	0.00%	0.00%	1.27%	1.30%	0.00%	2.59%	1.28%
809 Calderdale CCG (2021-22)	0.00%	2.54%	4.37%	0.77%	2.50%	0.00%	0.00%	2.91%	1.17%			

3.3 It is important to note that the small number of employees means that any leavers have a significant impact on the overall percentages. Rolling annual turnover reflects the total number of leavers over the past 12 months, as a percentage of the workforce. Annual turnover has increased reflecting 13 leavers between April to December 2021 compared to 10 from the previous year. A level of turnover is to be expected and is appropriate in any organisation.

3.4 Where individuals have left the organisation, this has been a combination of the following reasons: -

- Retirement
- Voluntary resignation for reasons of promotion, work life balance and relocation.
- Return to front line clinical practice
- End of fixed term contract
- Retire and return

3.5 All line managers are provided with a leaver's pack that includes a manager's checklist as guidance and although the completion of exit interviews is optional; conversations are taking place with line managers in understanding the reasons for leaving. Three exit questionnaires have been received which referred to feedback on work life balance and development. Where there are any areas of concern or risk related – these are discussed between the HR lead and the relevant service lead for that area in terms of organisational learning.

4. Sickness Absence

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

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

4.2 The overall sickness absence percentages can be found in table 3, 4 and 5 which is the overall sickness absence including both short and long-term sickness. Long term sickness is defined as any single instance of sickness absence, which lasts for 28 days or more.

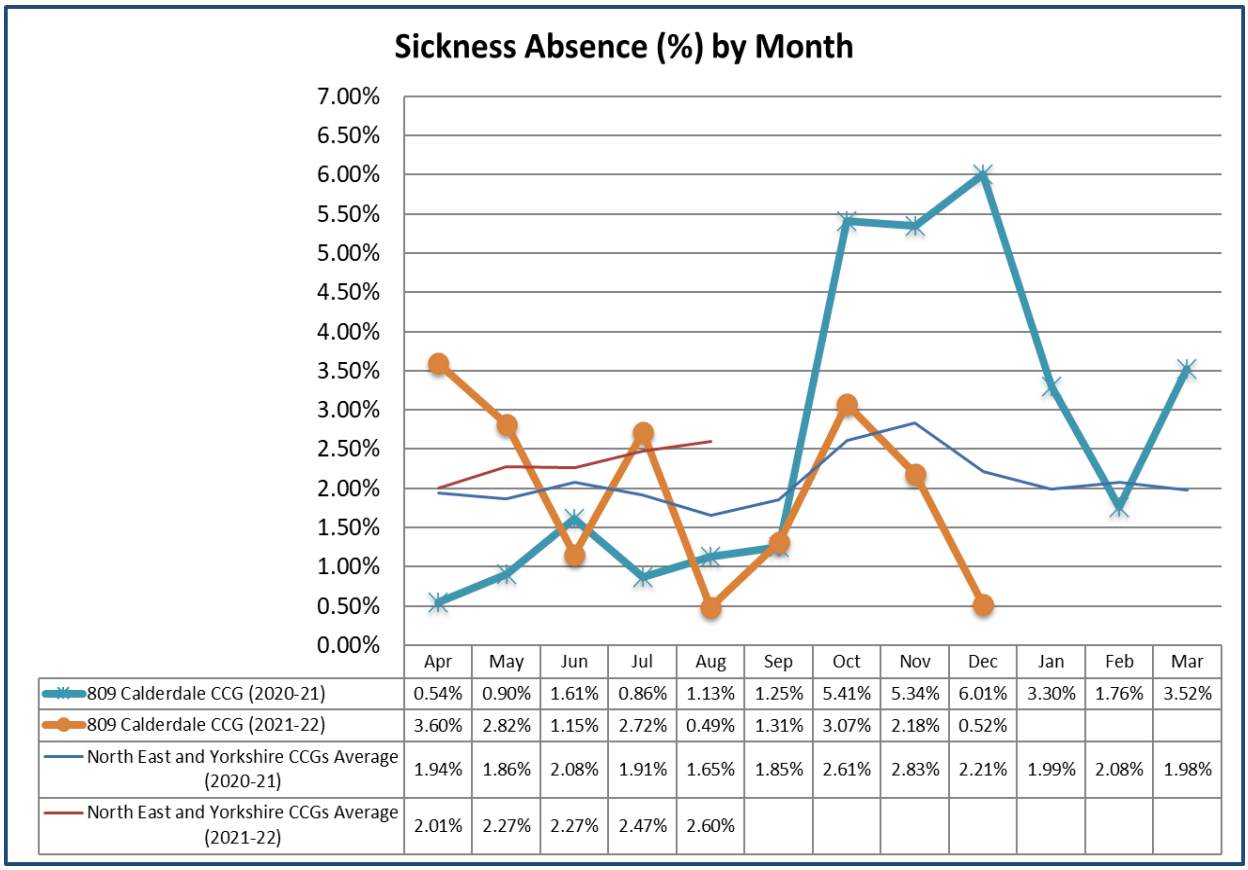
4.3 Sickness benchmarking information is available nationally from NHS Digital as a comparator against other NHS organisations. However, any available national data does not break sickness down to short or long term and therefore the comparisons are difficult to make. Previously, the North East and Yorkshire CCGs have been used as a comparator and the only available current national data is up to August 2021.

4.4 Sickness absence levels continue to fluctuate for short term sickness highlighting an increase in most of quarter 1,2 and 3 than the previous year. Reasons associated with the short-term episodes ranged from coughs and colds, chest/respiratory, stress, back problems, gastrointestinal, ear/nose and throat.

4.5 Overall, long term sickness has also continued to fluctuate showing an increase in some quarters and a decrease in others compared to the previous year. Long term sickness is managed carefully on an individual basis, in line with the CCG's policies. Anxiety and stress are the top reason for absence which to date in most cases has been related to a combination of personal and work-related issues, injury, and headache/migraines (resulting in low mood and muscular weakness). There are no themes in relation to the reasons for short- and long-term sickness, which are deemed to be of organisational concern. Table 6 highlights the top three sickness reasons.

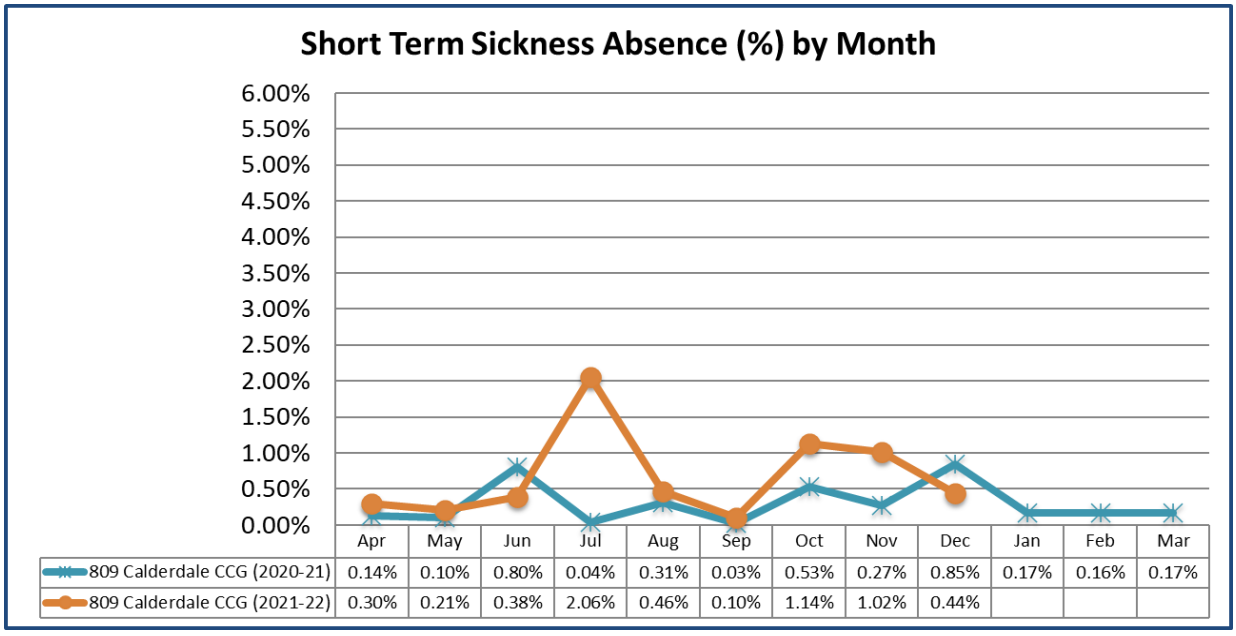
4.6 The CCG has several support mechanisms in place such the Employee Assistance Programme, additional Mental Health First Aiders, and access to Occupational Health advice. Staff feedback through recent surveys and sickness management meetings has been positive about the benefits of these services in supporting them to remain at work and to return to work more quickly. Where an individual requires additional support – this will be identified, or they will seek specialist support/referral via their GP.

Table 3 – Overall Sickness Absence



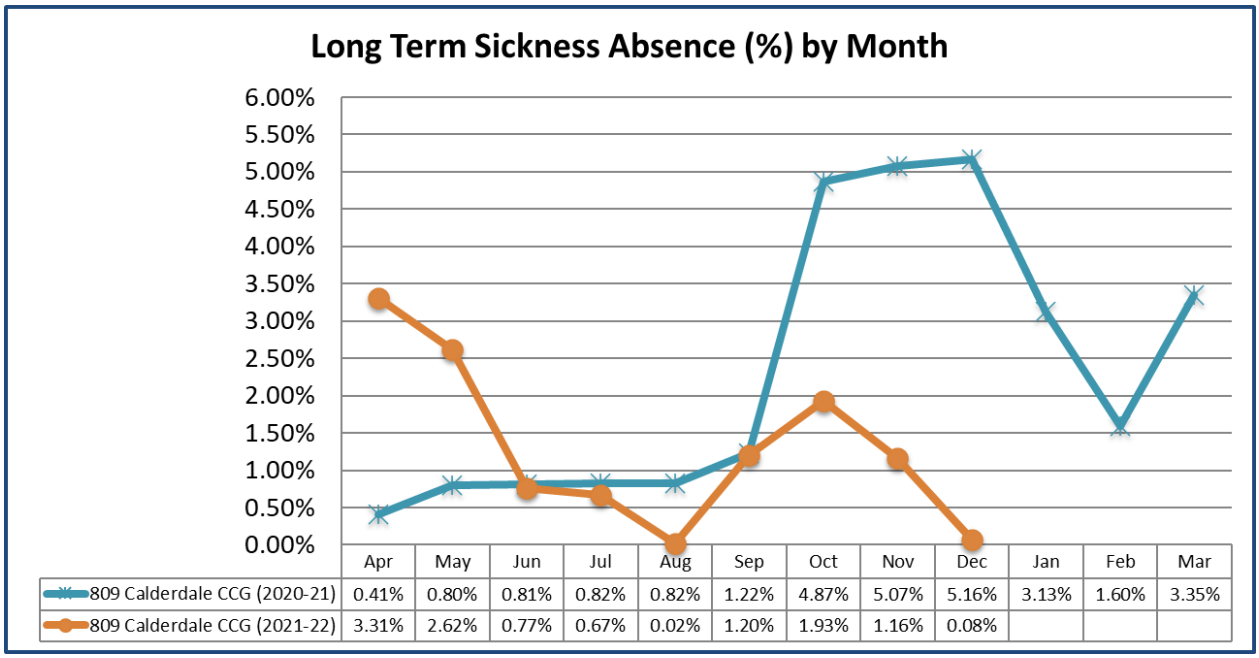
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	0.54%	0.90%	1.61%	0.86%	1.13%	1.25%	5.41%	5.34%	6.01%	3.30%	1.76%	3.52%
809 Calderdale CCG (2021-22)	3.60%	2.82%	1.15%	2.72%	0.49%	1.31%	3.07%	2.18%	0.52%			
North East and Yorkshire CCGs Average (2020-21)	1.94%	1.86%	2.08%	1.91%	1.65%	1.85%	2.61%	2.83%	2.21%	1.99%	2.08%	1.98%
North East and Yorkshire CCGs Average (2021-22)	2.01%	2.27%	2.27%	2.47%	2.60%							

Table 4 – Short Term Sickness Absence



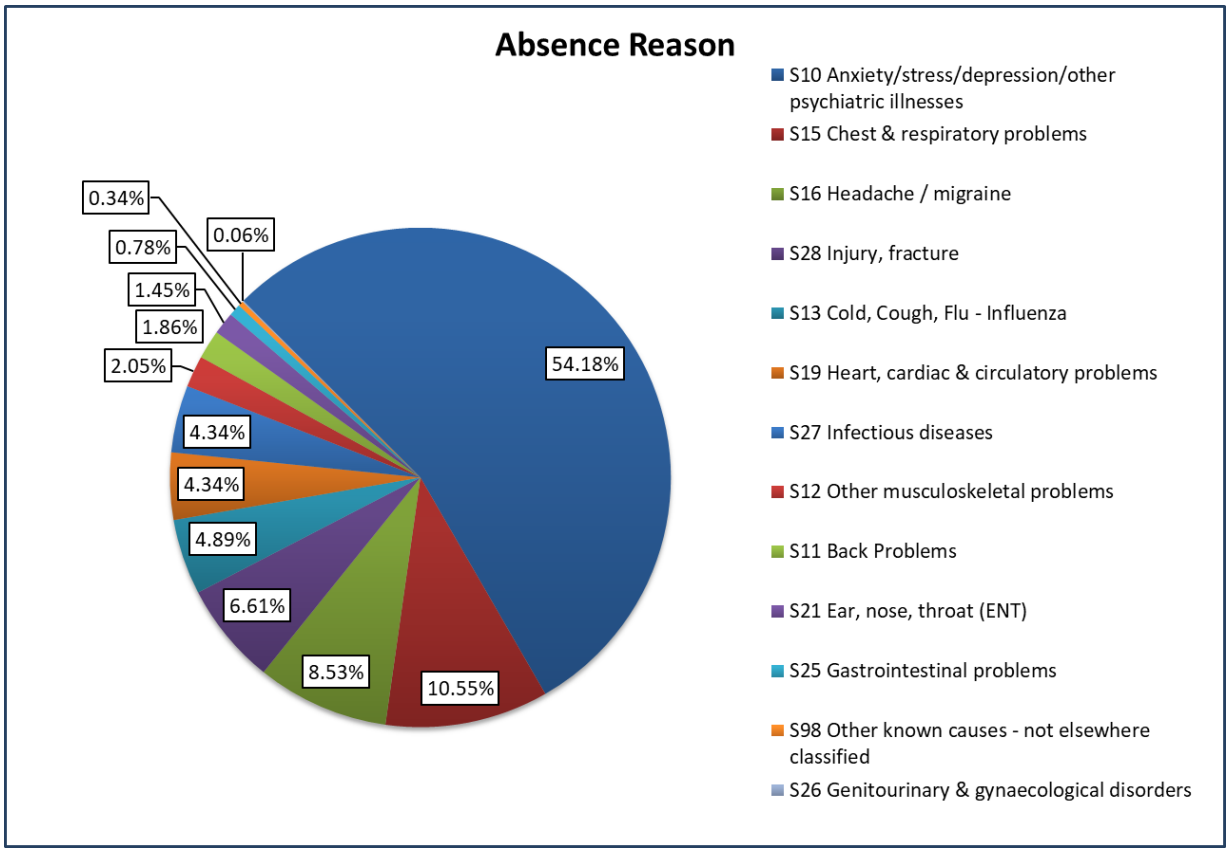
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	0.14%	0.10%	0.80%	0.04%	0.31%	0.03%	0.53%	0.27%	0.85%	0.17%	0.16%	0.17%
809 Calderdale CCG (2021-22)	0.30%	0.21%	0.38%	2.06%	0.46%	0.10%	1.14%	1.02%	0.44%			

Table 5 – Long Term Sickness Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
809 Calderdale CCG (2020-21)	0.41%	0.80%	0.81%	0.82%	0.82%	1.22%	4.87%	5.07%	5.16%	3.13%	1.60%	3.35%
809 Calderdale CCG (2021-22)	3.31%	2.62%	0.77%	0.67%	0.02%	1.20%	1.93%	1.16%	0.08%			

Table 6 – Absence Reason - Top 3



4.7 Sickness absence levels are discussed at SMT and the Human Resources (HR) team works with line managers to ensure that appropriate support is provided to individuals. The updated Managing Sickness Absence policy includes a clearer process for identifying when individual sickness levels need further exploration. Line managers are now able to review real-time sickness absence information for their teams, so that any patterns or concerns can be identified more quickly through the Electronic Staff Records (ESR).

4.8 Compliance via ESR on return-to-work sickness meetings is regularly checked and HR actively chases line managers to ensure that these meetings are taking place and any risks being managed. The current compliance rate for return-to-work interviews as of 31 December 2021 was 100%.

5. Equality & Diversity

5.1 The CCG is committed to equality and diversity in all areas of its work. The equality and diversity information are included in table 7 and is reported in a way that ensures that data is not personally identifiable. The data demonstrates that:

- The workforce is predominantly female.
- Several staff have declared that they have a disability.
- Most of the workforce declared their sexual orientation as heterosexual.
- Most of the workforce declared their religion.
- Most staff have declared their ethnic origin.
- A large percentage of the workforce is aged 41 or over.

Table 7 – Equality and Diversity Information

Disability	Headcount
No	85
Not Declared	≤5
Yes	6

Gender	Headcount
Female	75
Male	17

Sexual Orientation	Headcount
Gay or Lesbian	6
Heterosexual or Straight	72
Not stated (person asked but declined to provide a response)	12
Other sexual orientation not listed	≤5
Undecided	≤5

Religious Belief	Headcount
Atheism	13
Buddhism	≤5
Christianity	50
Islam	6
Not Disclosed	19
Other	≤5
Sikhism	≤5

Ethnic Origin	Headcount
Asian or Asian Britsh	9
Black or Black British	≤5
Mixed	≤5
Not stated	≤5
White	80

Age Profile	Headcount
20-25	≤5
26-30	≤5
31-35	≤5
36-40	8
41-45	9
46-50	24
51-55	21
56-60	15
61-65	≤5
66-70	0

5.2 The CCG takes a number of actions to promote equality and diversity amongst its workforce and this is particularly important in the context of a small organisation, made up of long-serving staff, and with limited recruitment, which means that opportunities to fundamentally change the demographic make-up of the workforce are limited and take place over time.

5.3 The CCG has signed up to the Integrated Care System (ICS) BAME Review action plan mirroring its focus on areas such as recruitment and selection, succession planning, talent, retention, and culture. This aligns to the CCG workforce equality action plans derived from the analysis and reporting of the Workplace Race Equality Standard (WRES), Workplace Disability Equality Standard (WDES), internal facing goal of the Equality Delivery System and the staff survey. The action plan describes the CCG actions to improve the representation, experience, and outcomes for CCG staff as a whole and particularly those staff from protected groups.

5.4 The WRES and WDES report and data for 2020-21 has been presented to SMT and is supported by an agreed action plan.

6. Workforce Headlines

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

6.1 Employee relations

The CCG has low levels of employee relations issues and currently there are no formal or informal grievances, disciplinary or performance cases. The policies promote the informal resolution of any issues where appropriate, and HR colleagues provide professional advice and support to line managers and individuals on an informal level in line with this approach.

6.2 HR policy review

Recent changes were made to the Mandatory Vaccination Policy and Procedure considering further legislation. Minor amends have been made to the policy to reflect the scope of who this policy applies to with respect to regulated activity. The Remuneration and Nomination Committee have been made aware of the changes.

The Remuneration and Nomination Committee also agreed to the proposal of rolling over 19 HR policies to April 2024 to bring them in line with the remainder of the HR policies as part of the three-year review cycle. These will be updated accordingly and communicated to staff.

6.3 Supporting Working Carers

The CCG has been working in partnership with several organisations to build awareness of the growing need to identify and support working carers with the aim of promoting:

- A carer-friendly workplace.
- Enabling staff to continue working while caring for someone.
- Preventing the loss of valuable talent for the CCG.
- Understanding carers' needs and issues in the workplace.
- Developing carer-friendly policies and creating a supportive work environment.
- Implementing staff awareness and line manager training.
- Helping carers to identify themselves as carers and to understand what support is available locally.

A comprehensive project plan was developed to support this work which included a phased approach of implementation and an update to SMT on the following key deliverables –

- Staff awareness raised at staff workshops.
- CCG now operating a Carer Passport scheme, as part of the CCG's approach to supporting staff who look after family or friends who have a disability, illness or who need support in later life. This is an important ongoing tool for conversations to take place between an employee and their line manager.
- ESR recording guidance developed so staff can confirm in ESR that they are a working carer. To date 1 individual has completed a carers Passport and have identified themselves in ESR as a carer.
- Manager's guidance developed with training identified to support them.
- Communication sent out to staff to join the Wakefield CCG Carers' Network.
- Changes to the HR policy made to allow for carers provision for a week's paid leave. The policy has been agreed by SMT, Trade Unions and approved by the Remuneration Committee.
- Appraisal document, induction checklist updated to reflect carers support
- Disclaimer added to NHS Jobs re CCG as carer friendly organisation.
- The CCG has a carers' champion in place for advice and support.

The work to raise awareness will continue and discussions are also taking place around aiming for the accreditation through Carers UK into the new organisation post July 2022.

6.4 Employee Assistance Programme (EAP)

The Employee Assistance Programme (EAP) is an employee benefit programme offered by the CCG to all employees. NHS Kirklees CCG currently hold the contract which includes Wakefield and Calderdale CCGs.

To raise more awareness of the EAP services – Health Assured (EAP provider) ran a session at a staff workshop in December 2021 for all staff.

The recent usage report for EAP provides an overview of data from the period of 01 November 2020 to 31 October 2021 and this accounts for zero calls in the last quarter. Usage of EAP has significantly dropped since COVID and through engagement surveys – this has been attributed to staff utilising other support mechanisms that have been made available for NHS staff during COVID-19 in addition to CCG staff resilience and HALSA wellbeing sessions.

6.5 **Staff Survey**

The national staff survey administered by Picker went live on 04 October and closed on 26 November 2021. The staff response rate was 84.9% (73 respondents from an eligible sample of 86 staff). The average national CCG response rate was 78.5%.

All staff were reminded and encouraged to participate in the survey as an opportunity for an open dialogue where individuals can be heard, and their opinion valued. Pickers the staff survey provider has enabled its system to generate automatic reminders for those who had not completed the staff survey as it assigns a random generated number to each participant as a prompt. The results and management report will be made available in the new year and an action plan reviewed and agreed for implementation.

6.6 **Annual Leave**

The CCG rolled out ESR manager self-service in 2018 to enable staff to submit annual leave requests through ESR in addition to understanding patterns/trends for reporting purposes. It is important that staff continue to utilise this functionality for the management of annual leave.

The CCG actively reviews, communicate, and encourages staff at a team/organisational level to manage their annual leave as part of staff health and wellbeing. As part of the ongoing due diligence work and staff transfer – a communication went out to all staff to confirm with Head of Service approval that staff are permitted to carry over 5 days leave pro rata into 2021-2022 leave year. This was a collective decision made across all 5 CCGs in west Yorkshire.

6.7 **Flu Vaccinations**

SMT agreed last year for 2 drop-in sessions to take place during October 2021 with Flu Xpress. The use of local pharmacies at the individuals' convenience and the claim back of costs has been encouraged for a high uptake of flu vaccinations in addition to obtaining a vaccination at the local GP.

The flu clinics took place at Westgate House and full consideration around safety measures to administer the vaccinations was considered. Spaces were limited to 24 per session and all bookings were made available via the Flu Xpress online booking system. The current uptake stands at 60%.

6.8 **Mental Health First Aiders**

The CCG has several employees who have been trained as Mental Health First Aiders (MHFA). Their role is to provide initial support and signposting to employees who may be experiencing mental health problems. The role of a MHFA is not to provide clinical support and this must be accessed through the individual's GP. To date the MHFA's have: -

- Worked with Communications for the introduction of the Check in Campaign and produced a new video for a staff briefing and sharing of own personal stories relating to mental health.

- The Train the Trainer undertook instructor refresher training on the 16 September 2021 and delivered the refresher training to two of the original Mental Health First Aiders on the 03 November 2021.

- Been contacted by staff averaging 53 over the last 2 years with no decrease in numbers considering staff are working from home. There has been recognition that staff are increasingly becoming comfortable with talking within their own teams or other staff members within the organisation.

- MHFA network meet informally on a bimonthly basis to check in on each other and discuss contacts made with staff.

- The Train the Trainer is currently preparing to send out an email across both CCGs for staff to express an interest in becoming a MHFA. This will bring the numbers back up to 10 across both organisations. A panel representing both CCGs will meet to review expressions of interest in mid-February before offering the Champion role. The successful individuals will be offered a tow day training session by the Train the Trainer between 17 and 18 March 2022.

6.9 **Learning and Development**

The current statutory mandatory training dashboard data shows that overall training compliance remains relatively with an expectation that compliance needs to be 95%. The only modules showing compliance at 95% and above are Fraud Awareness, Heath, and Safety, Equality and Diversity, Managing Conflicts level 3, and Conflict Resolution.

Table 8

Fire Safety	88.17%
Health, Safety and Welfare	96.77%
Infection Control	94.62%
Manual Handling	93.55%
Safeguarding Children	94.62%
Safeguarding Adults	94.62%
Equality & Diversity	96.77%
Data Security Awareness (IG)	88.17%
Fraud Awareness	96.77%
Managing Conflicts of Interest - Module 1	90.32%
Managing Conflicts of Interest - Module 2	92.11%
Managing Conflicts of Interest - Module 3	100.00%
Conflict Resolution	96.43%
Corporate Induction	91.40%
Prevent Awareness	94.62%

Staff excluded from reporting figures are those who are on maternity leave.

Line managers are aware of the need to confirm to the Learning and Development team of any additional modules that need to be assigned to the post on ESR in line with the statutory and mandatory training matrix for staff. This includes modules that have differing levels of learning for example Conflict of Interest, Safeguarding or other modules and apply to any members of staff appointed to the new roles that would require higher level of training.

The statutory and mandatory training matrix is reviewed annually by the subject matter experts involved in the delivery of modules and this was approved in quarter 2 by SMT for 2021-22.

The appraisal compliance rate is currently at 53.26%. Staff and line managers have been actively reminded of the importance of appraisal conversations and ensuring these are recorded in ESR. These continue to be reviewed each month by service area.

6.10 **Social Partnership Forum**

The CCG Partnership Forum is held quarterly with the purpose of facilitating and promoting partnership working between all CCGs and Trade Unions across the Calderdale and Kirklees footprint. The meeting provides a platform to enable meaningful consultation, negotiation, and communication. Trade Union representation at meetings is regularly attended by Unison, RCN, PDA and Unite and the CCGs continue to work in partnership with them.

Items of discussion to date in this quarter have focused on horizon scanning, the ICB transition, accommodation update and Trade Union regional and national updates.

6.11 **Integrated Care Board Transition and HR Ways of Working across System**

The HR team for NHS Calderdale CCG has been working closely with other west Yorkshire CCG HR colleagues to support the dis-establishment of the CCGs, ICB establishment and planning of a future in-house HR function. The team have been managing actions and any proposed local/regional and national deadlines as part of the HR milestone project plan.

CCG Closedown

The HR Team is providing fortnightly assurance to the CCG's Senior Management Team on the people workstream actions associated with closedown of the Calderdale CCG. Considering this recent news around the delay - it is likely the delay will mean HR will need to maintain already prepared due diligence information up to the revised target date and the start of staff transfer consultation will not commence in January 2022 as planned. Additionally, actions planned to manage the implications of ICB establishment on non-executive governing body members have not taken place as planned considering the news and will be delayed until a later date to be confirmed.

The revised target date for the Health and Care Bill of 1 July 2022 will not significantly impact on the people plans for the ICB establishment. The CCG statutory arrangements will continue until the passage of the Health and Care Bill and the delay will mean a longer period of shadow working than originally anticipated.

Board role appointment timelines will continue as planned with designate appointments being securely made in advance of establishment. It will be critical that the CCG and the ICS continue to engage and communicate with staff to provide information, assurance, and support staff through a prolonged change process.

7. Recommendations

7.1 It is recommended that the Governing Body:

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

Name of Meeting	Governing Body	**Meeting Date**	27 January 2022
Title of Report	Risk Register Position Statement Risk Cycle 4 2021-22 (8 – 24 November 2021)	**Agenda Item No.**	13
Report Author	Rob Gibson Corporate Systems Manager	**Public / Private Item**	Public
Clinical Lead	Dr Steven Cleasby	**Responsible Officer**	Neil Smurthwaite (Chief Operating Officer)

Executive Summary

This paper presents the high-level risk report at the end of the fourth risk review cycle of 2021-22

The Calderdale Clinical Commissioning Group (CCG) risk register currently contains a total of 33 risks with 1 marked for closure

Of these open risks, there are:

- 3 critical risks (scoring 20) (see 2.7)
- 3 serious risks (scoring 15-16) (see 2.8)

Previous Considerations

Name of meeting	Quality, Finance and Performance Committee	**Meeting Date**	16 December 2021
Name of meeting	Senior Management Team	**Meeting Date**	30 November 2021

Recommendations

It is recommended that the Governing Body:

- Confirms that it is assured that the high-level risk register represents a fair reflection of the risks experienced by the CCG at the end of risk cycle 4 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee on 16 December 2021

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

Implications

Quality and Safety implications (including whether a quality impact assessment has been completed)	No quality and safety implications
Engagement and Equality Implications (including whether an equality impact assessment has been completed), and health inequalities considerations	No engagement has been undertaken as it is not required An equality impact assessment has not been completed as there are no equality implications
Resources / Financial Implications (including Staffing/Workforce considerations)	There are no resource or finance implications
Sustainability Implications	There are no sustainability implications

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

Strategic Objectives (which of the CCG objectives does this relate to?)	▪ Achieving the strategic direction for Calderdale ▪ Improving Governance ▪ Improving Quality ▪ Improving Value	**Risk (include risk number and a brief description of the risk)**	As identified in the risk register
Legal / CCG Constitutional Implications	Risk is managed in line with the CCG's Integrated Risk Management Framework	**Conflicts of Interest (include detail of any identified / potential conflicts)**	Any interests will be managed in line with the CCG's Management of Conflict of Interests policy

1. Introduction

1.1 To provide assurance on the process for the detailed review of the CCG's risks

1.2 To set out all risks rated 15 or above (see Appendix 1)

1.3 To provide a detailed report on critical risks 1493, 187 and 62 (see Appendix 2)

2. Risk Review: Risk Cycle 4

2.1 Risk Cycle 4 commenced on 8 November 2021. Following updates by Risk Owners and review of individual risks by the allocated Senior Manager, the Corporate Risk Register was reviewed by the Senior Management Team (SMT) on 30 November.

2.2 All risks were submitted to the Quality, Finance and Performance Committee for review at their meeting on 16 December 2021.

2.3 There were three critical risks rated 20 at the end of Risk Cycle 4 (see 2.7). These were the same risks that were on the risk register during the last risk cycle.

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

Risk Register Summary: Risk Cycle 4

2.5 At the end of Risk Cycle 4 the CCG had 33 risks on the Corporate Risk Register. There is 1 marked for closure this risk cycle meaning there are 32 open risks.

2.6 30 of total CCG risks (91%) are categorised as quality, finance and performance risks and 3 (9%) are categorised as commissioning of primary medical services (CPMS) risks.

High Level Risks

2.7 There are three critical risks (scoring 20) on the risk register at the end of Risk Cycle 4.

2.8 The three open risks rated as critical this risk cycle are:

Risk ID	Risk Summary	Risk Score	Risk Movement
1493	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on	20	Static for 7 risk cycles

	acute recovery plans which require minimum delayed patients.		
187	There is a risk that reduced access to elective care services, due to the impact of the pandemic (surgery, day case and out-patient) will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution. The risk extends to our ability to commission additional capacity to support improved access, and the associated financial risk of this approach as we go into H2.	20	Static for 4 risk cycles
62	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with: avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	20	Static for 8 risk cycles

See appendix 2 for the critical risk reports

2.9 There were 3 open risks rated as serious (with a score of 15 or 16) during the current risk cycle.

2.10 The 3 open risks rated as serious this risk cycle is:

Risk ID	**Risk Summary**	**Risk Score**	**Risk Movement**
1942	There is a risk of harm to patients with LTC/frailty due to the system's inability to proactively manage patients and optimise their treatments due to the impact of Covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities.	16	Static for 1 risk cycle
1941	There is a risk of harm to patients due to increase demand on same day services as a result of the impact of Covid on capacity and access, resulting in increased morbidity, mortality and widening of health inequalities.	16	Static for 1 risk cycle
1501	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as Delayed Transfers of Care (DTOC). This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	16	Static for 7 risk cycles

2.11 Other risk movement

2.12 During the last risk cycle there were 5 open risks categorised as serious. The other two risks changed as follows:

1866	The risk is we fail to manage running cost spend within the ring fenced allocation of £4.1m which means will not achieve the key NHS England planning requirements and will affect the regulators assurance of the CCG. There are a number of risks within the principal risk which contribute to the overall score which include the uncertainty in relation to the annual pay award. The CCG has received confirmation that the AfC pay increase is 3% and that no additional running cost allocation will be received to cover this increase. *Decreased from 15 to 8 as the cost pressure has been quantified and can be managed this year from slippage on recruitment to vacancies. This will help for this year only.*
240	There is an increased risk due to the COVID-19 pandemic that the lack of availability of Appointment Slots at Calderdale and Huddersfield Foundation Trust (CHFT) exceed the agreed 4% due to CHFT having fewer outpatient appointments available for patients to book into. This potentially results in patients being unable to access their provider of choice, poor patient experience and reputational damage to both provider and commissioner. *Was a score of 15 but then closed as no longer relevant to the CCG. There is no longer a contractual issue. The slot issue is now part of the elective programme risk*

3. Recommendations

3.1 It is recommended that the Governing Body:

- Confirms that it is assured that the high-level risk register represents a fair reflection of the risks being experienced by the CCG at the end of risk cycle 4 of 2021-22. This is following a review of the risks at the Quality, Finance and Performance Committee meeting on 16 December 2021.

4. Appendices

Appendix 1: High level risk log for risk cycle 4 as at 23 December 2021
Please note that this is not currently an accessibly compliant document, but the CCG is working towards making this document more accessible. The information can be supplied in accessible format on request.

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

High level risks - risk cycle 4 - 2021-22

Risk ID	Date Created	Risk Type	Risk Rating	Risk Score	Target Risk Score	Target Score Components	Senior Manager	Principal Risk	Key Controls	Key Control Gaps	Assurance Controls	Positive Assurance	Assurance Gaps	Risk Status
1493	28/02/2020	Quality	20 (I4xL5)	8	(I4xL2)		Neil Smurthwaite1	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on acute recovery plans which require minimum delayed patients. The need to optimise discharge has become more acute during the pandemic, ensuring patients leave hospital as soon as possible to reduce their risk of hospital acquired infection and releasing beds for poorly patients, whilst ensuring the quality of the discharge with the context of the covid pandemic.	(a) UEC Board review performance as a standing item monthly (b) Weekly discharge touchpoint in place across C&GH (c) Optimum range for number of people on TOC list for Calderdale confirmed as 13-21 (same as Kirklees) (d) System call in place weekly to review risks and mitigating actions - continued through C19 period (e) Multiple weekly MADE meetings to continue to support flow (f) Surge and Escalation processes documented and agreed by UEC Board (g) New assurance regime/dashboard initiated by NHSE (h) Risk summit process started on 5/11/21	Finalise outcome risk summit	(a) UECB highlight report considered by QF&P as a standing item, now includes performance (b) Performance updated to QF&P includes TOC performance (c) TOC list reviewed daily during weekdays (d) New System Discharge post recruited to, postholder started (e) Process now in place for reviewing patients on the Reason to Reside list	(c) Mutual aid across Calderdale and Kirklees to mitigate some of risks around any D2A bed capacity (covid beds and EMI covid beds)	(a) Ensuring availability of 7 days services to ensure flow of weekend discharges. (b) Systems' ability to commission for the discharge needs of a EMI patients, particularly those with challenging behavior (c) TOC list remains higher than the agreed level - developing timeline to reduce pre the August Bank Holiday (d) Improvement in the % patients discharged before 17.00 hours (e) The changes needed in our community model to reduce the Reason to Reside list and provide service out of hospital. (f) Quantification of additional CMBC cost associated with additional home care capacity, and risks associated with cease in national DTA bed funding. (g) System is actively managing the delivery of reductions in LOS at 14 and 21 days. We making good progress related to 14 days, but have further actions planned in relation to patients waiting over 21 days	Static - 7 Archive(s)
187	19/03/2012	Finance	20 (I4xL5)	8	(I4xL2)		Penny Woodhead	There is a risk that reduced access to elective care services, due to the impact of the pandemic (surgery, day case and out-patient) will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution. The risk extends to our ability to commission additional capacity to support improved access, and the associated financial risk of this approach as we go into H2	a) Joint C&GH approach to the safe restart of elective services, being clinically led by the Elective Improvement Group b) Joint (GP, Consultant) clinical reviews of patients in high volume specialties c) Joint work between CCGs, CHFT and Independent sector to ensure we maximise all available capacity d) A key element of the CCG Reset Plan and CHFT's Incident Management Plan e) Joint approach to gathering thematic views of patient harm via agreed clinical assurance routes.	No gaps in controls	a) System have agreed joint principles and priorities to underpin reset work b) CCG Reset plan held by SMT and progress shared with QF&P c) Average waiting time is reported to QF&P d) Elective recovery is a key element of the planning submission/assurance; weekly system meeting in place	a) Joint communications group established to oversee messaging to patients and system. b) Joint approach to the roll-out of referral support systems to support minimum data sets for referrals, to support effective clinical assessment and triage c) Series of specialty specific Joint Clinical Interface Sessions across the C&GH system d) CCCG staff supporting CHFT directly through establishment of in/our sourcing team e) Maximizing use of elective recovery fund in H1/2	a) Harm to patients on waiting list b) Sufficient capacity available to deliver on planning expectations c) Financial risk associated with H2 for system	Static - 4 Archive(s)
62	13/06/2013	Finance	20 (I4xL5)	8	(I4xL2)		Neil Smurthwaite1	That the system will return to the pre-C19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised.	(a) Surge & Escalation processes triggered to mitigate performance risk in line with agreed plan (b) UEC Board focus work on understanding and mitigating performance risk at each meeting (monthly) (c) QF&P consider F&FT response rate and satisfaction included in Quality Dashboard reviewed monthly (d) QF&P receives quarterly reports on any serious incidents- including A&E (e) CCG in recipt of daily escalation reports to NHSE on days when performance if below 90%	(a) There are no gaps in key controls	(a) Performance reviewed at QF&P and GB (c) Quality Team have oversight of any learning from 12 hour breaches (d) Approach from 19/20 - 23/24 accepted by NHSE, ie no fully functional UTC established until at least 23/24 (e) Winter Reset action Plan in development	(a) CHFT remain in the upper quartile. (b) Extended access in general practice now in place (c) GPs and A&E clinicians meet formally on acute issues to strengthen working relationships. (d) New interim ED model in place to support large number of minor illnesses and injuries attending, learning for model pre 23/24 model - plan to funds until January 2023 (e) 111 First in place in both A&Es (f) Proactive system communications on use of A&E taking place throughout winter period.	(a) Urgent Treatment Centre new build timeline is 2023/24 - completion and implementation timeline is not yet fully assured (b) Duration of post-pandemic surge in demand on both sites (c) CHFT issuing frequent escalation notifications to CHFT re performance under 90% - performance deteriorating	Static - 8 Archive(s)
1942	31/08/2021	Quality	16 (I4xL4)	8	(I4xL2)		Debbie Robinson	There is a risk of harm to patients with LTC/frailty due to the system's inability to proactively manage patients and optimise their treatments due to the impact of Covid on capacity and access resulting in increased morbidity, mortality and widening of health inequalities.	Amendments to national GP contract to re-prioritise work including a re-focus of the Quality and Outcomes National Framework • Commitment to reduce unnecessary bureaucracy to focus on clinical care • Additional CCG investments made to PCNs to support local winter resilience and increase in demand • Investment of the Calderdale share of the £150million Covid-19 resource to support further increase in capacity and focus on 7 identified goals Additional investment of Calderdale share of the £120 million Covid-19 resource announced from April 2021 to support further increase in capacity and focus on 7 identified goals 2021/22 PCN Priorities have been published including CVD diagnosis, anticipatory care, early cancer diagnosis and personalised care Population Health Management approach working in all 5 localities and identifying and working with patients with a rising risk, particularly around frailty with impact being measured. This involves a multi - agency approach. This will mitigate risk of people further de-conditioning Community/GP meeting established to understand pressures within the system and agree approach to prioritisation when escalation is required PCN Priorities published for 2021/22 with links to the Innovation and Investment Fund Enhanced Health in Care Home Team	Long Term Condition Review Backlog unquantified at Practice, PCN or Calderdale level Staffing pressures in terms of vacancies and sickness within community teams Availability of blood tests has been disrupted due to shortage of blood bottles Prioritisation to be agreed between Community and General Practice Staffing pressures due to continued requirement to deliver the covid vaccination programme Community Pharmacy Role in managing long term conditions and being part of system working Clarity of plans for the community division	Continue to use soft-intelligence e.g. complaints or stakeholder feedback to monitor and address issues. • Continued engagement of CDs, PMs and LMC to respond to feedback and address any concerns • Continued use of datix and serious incident process to identify where this has resulted in harm and ensure cases are reviewed and identified learning implemented National PCN dashboard now available and updated monthly GP dashboard will be fully operational by Sept/Oct 2021 and monitored through CPMSC Operational Group Quarterly Director of Primary Care Report to CPMSC	No rise seen in incidents reported or serious incidents	Unknown level of harm from the pandemic to these patients	Static - 1 Archive(s)
1941	31/08/2021	Quality	16 (I4xL4)	8	(I4xL2)		Debbie Robinson	There is a risk of harm to patients due to increase demand on same day services as a result of the impact of Covid on capacity and access, resulting in increased morbidity, mortality and widening of health inequalities.	Urgent Care hub in place to support A&E with minor ailments and injuries Same day emergency frailty unit at CHFT to reduce admissions Social Care Hospital Avoidance Team at CHFT Additional Funding to General Practice through the Covid Expansion Fund Clear public messaging across the system through "Together we can" and "Choose Well" Campaigns Additional Roles Funding available to PCNs Surge and Escalation processes triggered to mitigate performance risk in line with agreed plan Silver and Gold Tactical System Calls UEC Board focus work on understanding and mitigating performance risk at each meeting (monthly)	Further opportunity to maximise the Community Pharmacy Consultation Service Reliable data to quantify increased demand in General Practice Urgent Community Response – in development for go live Dec 2021 Absences in workforce due to increase of covid 19 infection rates and requirement to isolate – although adoption of recent guidance will potentially reduce that impact Capacity to enable General Practice Voice in system escalation calls.	Provider Quality Dashboards considered quarterly at Quality, Finance and Performance QF&P receives quarterly reports on any serious incidents from all providers delivering NHS Contracts CPMSC ops group will receive quarterly general practice dashboard to be reviewed monthly (from September/October 2021) with CPMSC receiving it quarterly System Silver and Gold Calls as required System Sit rep developed and shared across partners weekly General Practice Weekly Opel Situation Report	Additional roles utilisation Q1 and Q2 Majority of practices reporting level 2 with last few weeks showing a reduction in the number of practices at level 3	Understanding risk associated with 111 demand	Static - 1 Archive(s)
1501	12/03/2020	Finance	16 (I4xL4)	4	(I2xL2)		Neil Smurthwaite1	There is a risk of deterioration in performance in NHS provided and commissioned services due to the impact of NHS required response to COVID-19 virus. This could impact on performance against NHS Constitutional targets, other performance measures such as DTOC. This could also impact on access to other services such as mental health, primary care, community, care home, and home care.	The CCG is working as part of the local and regional systems to respond to the COVID-19 pandemic. The CCG is participating in local place based, regional and national calls and meetings. The CCG is working with providers to understand their plans in responding to the pandemic. The CCG is designing and implementing swab testing processes for drive in locations and home testing. The CCG has identified a site for drive through testing. A new coronavirus monitoring system across WY and Harrogate is being established for coordination of all coronavirus patients and reporting to NHS E. The CCG is identify if the CCG has internal clinical capacity to help in the running of the swab testing drive through service. The CCG has internal communications processes in place with Staff around COVID-19. The CCG is playing a key role in the roll out of the vaccination programme across Calderdale.	The CCG is reviewing own work plans with a view to stopping any low priority work. The CCG is reviewing what staff it has available with a clinical background. The CCG is scoping further sites for drive through swabbing.	Participating in all regional, national and local calls. CCG has implemented appropriate national guidance. CCG is providing specific returns to NHSE regarding response to the pandemic.	The CCG is delivering on the key expectations of NHSE. The Vaccination uptake in Calderdale is performing well.	The national response to the pandemic is changing on a daily basis.	Static - 7 Archive(s)
240	10/06/2013	Finance	15 (I3xL5)	2	(I2xL1)		Martin Pursey	There is an increased risk due to the COVID-19 pandemic that the lack of availability of Appointment Slots at Calderdale and Huddersfield Foundation Trust (CHFT) exceed the agreed 4% due to CHFT having fewer outpatient appointments available for patients to book into. This potentially results in patients being unable to access their provider of choice, poor patient experience and reputational damage to both provider and commissioner.	a) Discussed as part of the CHFT Contract Management Group b) Responsibility of the monthly Outpatient Transformation Group within CHFT Partnership Arrangements c) ASI's filled where possible each day in CHFT Appointment Centre d) Reported within CHFT to their Executive Board meetings within integrated performance report.	a) The 'switch off' of elective work in response to COVID-19 effectively removed all routine slots b) The phasing of routine electives will need to be understood and what impact it will have c) ASI related complaints reported through DATIX d) Managing lower capacity (reset/new normal)	Regular updates on performance against the ASI target included in the F,P and C report (target is maximum 5% of patients awaiting an appointment) and discussed at the following monthly meetings - a) CCCG, GHCCG and CHFT Quarterly Partnership Board b) Discussed at Elective Care Improvement Group	Jan 2021 - 56%. Feb - 73%. Mar - 79%. April - 70%. May - 64%. June - 77%. * Due to the Covid-19 pandemic, CHFT has received more referrals as appointment slot issues (ASI) rather than as direct bookings. In many cases, these have not yet been booked in e-RS. As a result, the ASI per booking percentage shows as a higher proportion than usual, as there may be a higher number of ASIs recorded than bookings performed in e-RS. Sourced from NHS Digital on a monthly basis.	Reduction in Contract governance as a result of NHS Covid Financial Regime has reduced the opportunity for formal review. However discussed as part of the Elective Board arrangements. 1. Pilot Clinical and Referral Assessment Services have been implemented at CHFT to assist with pandemic and post pandemic backlog. There are no appointment slots for patients to book into this service 2. ASI figures in April 2020 onwards will shown a great increase in percentage due to COVID 19 crisis as all routine outpatient booked appointments made via ERS were cancelled for re-referral until post crisis.	Closed - Risk no longer relevant to the CCG

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 62

Risk Type: Quality, Finance & Performance

Risk Category: F&P – Performance

Date first issued: 20th December 2016

Date last reviewed: 18.01.22

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 3 = 15
3	Risk description	The system will not deliver the NHS Constitutional target of 95% of patients seen in 4-hours when attending Accident and Emergency (A&E) units for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in patient care and patient experience being compromised.
4	Current position (include any relevant data as attachments)	• At time of writing (18.01.2022) – the average 7-day A&E performance was 76% • Attendances at A&E significantly increased from March 2021 and have been significantly higher than 19/20 pre pandemic levels, December has seen a 28% increase in attendances compared to the same period in the previous year. • Calderdale and Huddersfield Foundation Trust (CHFT) is still in the

		top quartile regionally and nationally. Pressures are being felt nationally with some trusts delivering close to or below 50% towards the 4 hour standard.
5	Assessment of the issues	Delivery of the 4-hour target is an important element of the NHS Constitution and the local urgent and emergency care system. Whilst performance is challenging locally, CHFT perform well against their comparators. There has been a significant increase in demand from March 2021 to date, which is impacting on performance.
6	Actions	The Calderdale and Greater Huddersfield Urgent and Emergency Care Board continues to have oversight of delivery of the 4 hour target, and the following actions are taking place: • Developed an immediate new offer in both EDs, with additional ANPs, streaming Priority 4 and 5 patients (those whose needs could be met through a primary care intervention). This commenced on 5 July and will run March 22 in its current form. • The learning from this is being built into a longer-term interim offer which will see a more fully integrated ED team working on both sites, in advance of implementation of UTC model. • Continuing to deliver our communications strategy for winter. This includes generic messaging on choosing well, and also targeted approaches for those patients who are awaiting planned care at CHFT. • Winter schemes in general practice to increase capacity and support on day demand
7	Identified gaps	• Clarity of status of current demand wave, and its duration. • Future gunding for the interim Integrated ED model

Relevant data: A&E performance data is available to commissioners and is available on request

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Care)

Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 18.01.22

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 187

Risk Type: Quality, Finance & Performance

Risk Category: Quality

Date first issued: 20th December 2016

Date last reviewed: 18.01.22

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 (L) x 4 (I) = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	16
3	Risk description	There is a risk that reduced access to elective care services (surgery, day case and out-patient care) due to the impact of the pandemic will result in harm to patients, poor patient experience, and non-delivery of patient's rights under the NHS Constitution.
4	Current position (include any relevant data as attachments)	• Our system has taken a clear stance to collectively own elective recovery. CHFT is seen as an outlier in WY in relation to its backlog and its number of long waiters • The rate of referrals into some of CHFT's specialties is much higher than others within WY, particularly where CHFT are the only provider • CHFT, as a previously high performing trust for Referral to Treatment targets, did not necessitate commissioner development

		of a market to support delivery of elective care in the way other systems needed to. This lack of a market is now a key limiting factor in our recovery
-	Assessment of the issues	• Planning guidance indicates that CHFT should increase elective capacity to levels undertaken in 2019/20, and reduce long waiters to a minimum by March 2022 (particularly 104 and 52 week waiters) • Elective Recovery is a critical element of our system recovery work, and work is taking place at pace to mitigate risk and reduce patient harm. However, this is impacted upon by the current non-elective pressures • Our local Independent Sector (IS) capacity, provided by Spire and BMI Hospital capacity is vital, as is other IS capacity
6	Actions	• CHFT is focusing on delivering of elective care on the basis of clinical priority and health inequalities. • Independent sector providers have been contracted directly by CHFT, and by the CCG, through an Any Qualified Provider route. • CCG staff have supplemented CHFT's divisional management by providing additional capacity to support recovery activities (working as an In and Outsourcing team) • The team have quickly identified a range of new and existing providers who can support the system with additional elective capacity – either out-sourcing CHFT activity, or bringing providers into CHFT to maximise the use of their estate theatres. • ENT, Neurology and T&O have been key specialties in the in and out sourcing work • An Advice and Guidance task and finish group is working towards an agreed minimum data set for Advice and Guidance and to explore a pilot for submitting referrals through Advice and Guidance rather than NHS e-Referral Service. The A&G group will also identify the first specialty to test the concept of all routine referrals going through A&G. • Work also continues on implementation of the second wave of

		Evidenced Based Interventions
7	Identified gaps	• A full view of any harm to patients currently waiting for care • A timeline for full elective recovery

Relevant data: CCG has access to a live elective care dashboard.

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Cae)

Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 18.01.22

NHS
Calderdale
Clinical Commissioning Group

Critical Risk Report

Risk ID: 1493

Risk Type: Quality, Finance & Performance

Risk Category: F&P – Performance

Date first issued: 20th December 2016

Date last reviewed: 18.01.22

1	Current risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
2	Previous risk score (*Likelihood x Impact = Risk Score*)	5 x 4 = 20
3	Risk description	Risk that patients being discharged from hospital are subject to delays in their transfer of care due to health and social care systems and processes are not currently optimised, resulting in poor patient experience, harm to patients, and also pressure on acute post-C19 bed plans which require minimum delayed patients
4	Current position (include any relevant data as attachments)	In Calderdale a snapshot of the number of people on the Transfer of Care (TOC) list at any one time increased to a peak of 51 people on the TOC list in December 2021. Throughout Q3 2021, to date, this number has generally been increasing (with the exception of Christmas) There were 6.8 referrals onto the TOC list per day in Quarter 2, compared to 6.9 referrals per day in Quarter 3, an increase of 0.1

		referrals per day on average. With this increased demand the joint discharge teams have been working harder to maintain the position and flex their capacity. This increased demand has had an impact on the average referral to discharge (length of time a patient is on the TOC list) which has been maintained throughout Quarter 3 and is currently at 8.3 days (7.5 days in Q2). This figure was at 14.5 days back in March 2020 (pre-pandemic) however, so this shows that progress is still being made. In addition, new datasets are being developed for the Urgent & Emergency Care Board showing those in hospital for 7, 14 and 21 days, in line with priorities set out in new Planning Guidance, and increased NHS England scrutiny on these metrics through a new data platform. The national ambition is to have no more than 40% of beds occupied by patients with a LOS of 7+ days and no more than 12% of beds occupied by patients with a LOS of 21+ days. Currently CHFT are above this ambition with 44% for 7+ and 12.5% for 21+. CHFT still benchmarks well performing better than the ICS and national position. Another national ambition is to discharge 70% of patients with no reason to reside the same day. CHFT is currently 33% which matches the ICS performance and is slightly better than the national position. It's recognised significant work is required to get to the ambition of 70%
5	Assessment of the issues	• The number of patients whose discharge is delayed is a significant factor in hospital resilience. Current covid cases and patients on the transfer of care list account for 43% of the current CHFT bed base (26% covid, 17% TOC) • These issues are exacerbated by delays in discharging patients from community beds, due to a significant deficit in home care capacity and resilience of the care home market

		• The number of patients delayed currently exceeds the number built into CHFT's bed capacity planning for covid • Our system is currently not meeting requirements for the % of patients discharged the same day or % discharged from the Reason to Reside list.
6	Actions	The UEC plan committed the system to a set of actions to safely reduce transfer of care to a minimum. • Commissioned additional dedicated step down discharge to assess beds for covid patients and patients who have been in contact with covid patients needing discharge from hospital • Set up mutual aid arrangements with Kirklees Council for community beds • Agreed business cases for additional hospital avoidance and assessment capacity in CMBC. • Developed a risk based approach to discharge across the system, which includes a system letter on current community deficits and offers of support through a Single Point of Contact.
7	Identified gaps	• Output of using the Reason to Reside programme in Calderdale to enable us to understand the true scale of patients who could be receiving post-acute care in a different setting and bringing this together with our TOC list • Assurance on our ability to increase the % of patients discharged the same day and % of the reason to reside list discharged

Relevant data; Included above.

Risk Owner: Debbie Graham, Director of Improvement (Strategic Planning and Acute Care)
Senior Manager: Neil Smurthwaite, Chief Operating Officer

Date review completed: 18.01.22

NHS
Calderdale
Clinical Commissioning Group

MINUTES OF THE AUDIT COMMITTEE MEETING
HELD ON 14 OCTOBER 2021, 2PM
SHIBDEN MEETING ROOM, WESTGATE HOUSE

FINAL MINUTES

PRESENT:

Prof Peter Roberts (PR)	Lay Member (Audit) (Chair)
John Mallalieu (JM)	Lay Member (Finance and Performance)
Alison MacDonald (AM)	Lay Member (PPI)
Dr Farrukh Javid (FJ)	GP Governing Body Member (by video link)
Rob McSherry (RS)	Specialist Nurse
Denise Cheng-Carter (DCC)	Lay Advisor

IN ATTENDANCE:

Neil Smurthwaite (NS)	Chief Operating Officer / Chief Finance Officer
Lesley Stokey (LS)	Director of Finance
Martin Pursey (MP)	Head of Contracting and Procurement
Jonathan Hodgson (JH)	Audit Manager, Audit Yorkshire
Perminder Sethi (PS)	Director, Public Sector Audit, Grant Thornton UK LLP (by video link)
Gareth Mills (GM)	Director, Public Sector Audit, Grant Thornton UK LLP (by video link)
Zoe Akesson (ZA)	Corporate Governance Officer (minutes)
Rob Gibson (RG)	Risk Manager (for items 8,9,10)

CONTENTS

045/21 APOLOGIES FOR ABSENCE

Rosie Dickinson (RD)

046/21 DECLARATIONS OF INTEREST

There were no interests declared. JM highlighted that he was on the waiver list, which would be managed appropriately. The CCG's Register of Interests can be obtained from the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#registerofinterests or from the CCG's headquarters by appointment.

047/21 MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 10 JUNE 2021

The Committee **RECEIVED** the approved minutes of the meeting held on 10 June 2021.

048/21 MATTERS ARISING FROM THE MEETING HELD ON 10 JUNE 2021

There were 2 outstanding actions from the previous meeting.

- **022/21** in relation to the poor communication around training materials. PR advised that he was expecting a response from the IG team imminently. **ACTION OPEN**
- **023/21** in relation to Continuing Healthcare Freedom of Information (FOI) breaches and assurance around the process. The issue was raised with the CHC senior team. A clear process has been operating since May 2021. There have been no further breaches of FOIs since that time. It was noted that when the next governance assurance dashboard is presented to committee, if there has been a CHC FOI enquiry it includes a short narrative on how the process was operated. **ACTION CLOSED**

049/21 INTERNAL AUDIT

049/21-a Internal Audit Approach Report

The Committee was advised of a slight change to the Audit Plan 2021-22 in relation to the review of the Mental Capacity Act which has been moved to Q4, as still awaiting guidance.

The team are 16% of the way through the programme, currently undertaking audits and bringing some of the work forward into Q3. The revision to the follow up of recommendations was presented as a colour coded chart. JH provided narrative around the RAG colour ratings and asked for the Committee's feedback. The

Committee felt it best to keep it simple and JH would take back comments to the team.

The Audit Committee was asked to agree to the removal of an unachievable recommendation from the tracker - Budget Holder Acceptance of Budgets. At the beginning of the year budgets would be agreed before the start of the financial year, but this year a recommendation should have a letter and a signed formal acceptance from the budget holder. Due to delays in planning guidance and budgets, it was felt this was no longer achievable as budget holders were being held to account for a budget that they had no visibility of for the first three quarters of the year. LS assured the Committee that budget monitoring is still going ahead.

ACTION: JH to update the tracker, removing the unachievable recommendation and include narrative to reflect the Committee's conversation

The Committee expressed its concern that the guidance had not been made available prior to April 2021 to allow the CCG to implement this piece of work.

The Committee **RECEIVED** the progress report and **NOTED** its contents.

DECISION: The Committee **APPROVED** the changes made to Audit Plan since the last Audit Committee and **APPROVED** the removal of the unachievable recommendation.

049/21-b Audit Yorkshire Annual Report

The final report detailing Yorkshire Audit's work for the last financial year was received by the Committee.

An observation was made that out of the 94 planned days only 74.5 days were completed. JH explained that it was agreed by the Audit Yorkshire Board that any underspend would be absorbed as the team supported other areas of the system during the pandemic, with an extra 250 days seconded time during Covid to other organisations.

The Committee **RECEIVED** and **NOTED** the final Audit Yorkshire Annual report.

049/21-c Counter Fraud Progress Report

In presenting the report, attention was drawn to the following points:

- The Fraud Prevention Masterclass programme was successfully launched.
- With regards to fraud alerts, these mainly involve cyber enabled tactics.

  ACTION: RD to inform practices of GP surgery support for counter fraud training

- The report included updates from the NHS counter fraud authority on the annual fraud bill and an update on their webinar on the national response to the counter fraud standards.

NS provided additional assurance that staff are regularly updated on fraud at weekly team briefs and through staff communications.

A request was made for targeted fraud training for practice managers. Although the CCG does not commission this training LS would explore capacity within the plan to roll this out. A suggestion was made to provide a virtual masterclass.

ACTION: LS/RD to explore and identify fraud training for practices

The Committee **NOTED** the content of the Counter Fraud Progress Report.

049/21-d Anti-Fraud, Bribery and Corruption Policy

The draft policy with minor tracked changes was presented to the Committee for approval.

DECISION: The Committee **APPROVED** the update to the Anti-Fraud, Bribery and Corruption Policy

050/21 UPDATE REPORT ON VALUE FOR MONEY

The Committee received a high-level update on Value for Money (VFM). There were no significant weaknesses identified for the CCG's VFM arrangements following completion of the external auditor's review. The audit certificate has now been signed, closing-off the CCG's audit for 2021, and sent to LS for inclusion in the CCG's Annual Report.

External audit continues to be in regular dialogue with the Director of Finance. It was also confirmed that there will be no external audit of the Mental Health Investment Standard performance in 2022. The year-end draft accounts and audit process will be delivered when the Integrated Care System is in place. Guidance is expected and will be brought for discussion to February's committee meeting.

The Audit Committee **RECEIVED** and **NOTED** the report for assurance.

051/21 AUDITOR'S ANNUAL REPORT 2021

In presenting the report, it was explained that due to the new code of audit practice the annual report now replaces the annual audit letter, which is a more detailed narrative of the CCG's overall arrangements and recommendations. The areas of

interest are financial sustainability, governance, and improving economy, efficiency and effectiveness, plus, for this year, the impact of Covid on the CCG.

External Audit did not identify any significant weaknesses in any of the areas. There were no statutory recommendations issued, however there were 2 improvement recommendations made, which management accepted, and the Committee endorsed. The recommendations were as follows:

1. To continue to monitor planned expenditure and deliver the necessary savings schemes.
2. To continue to engage with the ICS ensuring robust decision-making arrangements are in place, develop local workforce plans and appropriate governance arrangements are in place.

Thanks were given to the finance team for providing very detailed documentation.

The Audit Committee **RECEIVED** and **NOTED** the report for assurance.
The Committee **ENDORSED** the 2 improvement recommendations.

052/21 CONTRACTING REPORT

The report was taken as read. The Committee was informed that since writing the report, of the 6 contracts on the register that were subject to escalation, it was confirmed that signed contracts had been received for 3, 1 was at the holding invoice stage and 2 had been escalated to senior management. From the 49 listed, 4 had been actioned leaving 45 outstanding.
A question was raised about how GP surgeries are informed of Any Qualified Providers in their area. MP confirmed that a list is emailed to practices regularly.
ACTION: MP to re-circulate the current list of AQPs to practice managers

The Audit Committee **RECEIVED** and **NOTED** the report for assurance.

053/21 GOVERNANCE ASSURANCE DASHBOARD

There was a substantial risk assessment undertaken and high confidence was received from the toolkit submission in June 2021. There is a requirement for Integrated Care Boards (ICBs) to submit a toolkit by the end of June 2022, however although there is no mandatory requirement for the CCG to submit, work continues around the documentation.

A Subject Access Request had been received since writing the report and Freedom of Information requests remain constant. There is an emergency planning cyber security tabletop exercise planned for November 2021.

The paper included a recommendation for an update to the Information Governance Policy Handbook. It was a minor amendment making passwords more complex by increasing to 10 characters, to which the Committee agreed.

Performance rates for mandatory training were discussed. The Chair raised concern around the Conflicts of Interest training module for staff and did not feel assured from the data the percentage was correct for the number of people who had completed the training.

ACTION: RG to send a reminder to staff explaining the importance of completing the training. RG to clarify the population, indicating numbers in the action/ mitigation box and send to the Committee outside of the meeting, along with an indication of when the CCG will be compliant at 95%.

The Chair also raised fire safety training. RG assured the Committee that now the new office is open fire safety sessions would resume and staff would be able to complete either online or at a face-to-face session.

DECISION: The Committee **APPROVED** the minor updates to section 4.3 of the Information Governance Policies Book.

The Committee **RECEIVED** and **NOTED** the report for assurance

054/21 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) UPDATE SEPTEMBER 2020 – SEPTEMBER 2021

The following key points were highlighted from the report:

- The guidelines on working from the office during the pandemic have been updated following the office move.
- There is a cyber security desk top exercise on 24/11/21 to test the CCGs arrangements that are currently in place for home working.
- Calderdale CCG now has its own on-call rota, which is working well.

There is a statutory requirement for the CCG formally to assure NHS England (NHSE) of its EPRR readiness. The Committee received the self-assessment and

proposed statement of full compliance within the report and was asked to agree the sign-off by the Accountable Emergency Officer to which the Committee agreed. The signed document would be submitted to NHSE by the end of October.

The Committee thanked RG for the comprehensive report, which they felt reflected his achievement in taking on his new additional responsibilities.

The Committee **NOTED** the arrangements in place to support emergency preparedness and the findings of the self-assessment against the national EPRR core standards.

DECISION: The Committee **SUPPORTED** the self-certification of compliance with the emergency preparedness core standards as '**full'** for sign off by the organisation's Accountable Emergency Officer (Chief Operating Officer).

055/21 VIOLENCE PREVENTION AND REDUCTION STANDARD REVIEW

The CCG is now required to complete a standard compliance assessment that measures what measures the organisation has in place for violence prevention, and reduction. Actions identified from the assessment were detailed in the report. The main actions were around awareness and training, which have since been completed. The Committee felt this was a true reflection of the arrangements that are in place.

Chair asked that staff are reminded about the Lone Working Procedure to ensure individuals remain safe within their workplace.

ACTION: RG to send a reminder to staff about the Lone Working Procedure.

For assurance purposes, a request was made that the mandatory conflict resolution training is on the governance assurance dashboard.

ACTION: RG to put conflict resolution training on the governance dashboard.

The Committee **CONFIRMED** that it is assured that the outcome of the CCG's compliance assessment represents a fair reflection of the arrangements that the CCG has in place for supporting a safe and secure environment for CCG staff.

The Committee **CONFIRMED** that it is assured that the CCG has completed the actions identified as a result of the completion of the compliance assessment

056/21 AUDIT COMMITTEE WORKPLAN 2021-22

The Committee received the work plan. It was acknowledged that 2 audit committees may be required towards the end of the financial year due to close-down.

057/21 ICS TRANSITION - APPROACH TO DUE DILIGENCE

A paper was presented to the Committee which described the recommended approach and framework for West Yorkshire transition due diligence for closedown of the CCG. The senior management team would manage the work through their weekly meetings to ensure the organisation is ready for transition and handover documents are in place. NS, the Chief Operating Officer, has oversight of the transition supported by LS, the Executive Lead. Audit Committee will be the governance function that receives the assurance. Progress will be tracked through reports and tasks that are detailed in the timeline and an update on progress will be provided at February's committee meeting.

NS left the meeting

There is currently a debate taking place around the removal of individual place committees and setting up a 'Committee in Common', which is thought to be more beneficial, helping streamline and avoiding repetition. Audit Committee were asked if they would like to pursue this route, to which the members agreed this was a familiar process and sensible approach going forwards.

It was acknowledged that capacity to manage this will be challenging. Internal Audit confirmed they have dedicated days to support this work by providing advice and support on transition and closedown of place. The Chair made a request to audit colleagues to pass on any learning received from elsewhere and feed back to LS.

DECISION: The Committee **APPROVED** the recommended approach and framework to West Yorkshire transition due diligence.

The Committee **ENDORSED** the audit 'committee in common' approach to providing input and assurance of due diligence process and outputs in February 2022 (Phase 4).

058/21 ITEMS FOR GOVERNING BODY AND/OR OTHER SUB-COMMITTEES

- Received the final version of the Audit Yorkshire Annual Report

- Received the VFM Report and Annual Report from Grant Thornton, with 2 improvement recommendations.
- Received the ICS transition approach to due diligence report. The committee endorsed the Committee in Common approach. An additional meeting of the audit committee may be required.
- Information about GP surgery support fraud to be sent to practices.
- A request was made for support around counter fraud training for General Practice. The Committee will explore the possibility of providing training to member practices.
- Clarity was sought on the mandatory training in terms of numbers affected and the impact.

059/21 DATE AND TIME OF NEXT MEETING

Thursday 10 February 2022

- Pre-meeting of Committee Members and CCG Managers **(1.45pm)**
- Committee Meeting **(2.00pm)**

Audit Committee Meeting 14 October 2021 – Action Sheet

Report Title	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
Standing Financial Instructions	004/21	To update the document with the proposed amendments.	LS	COMPLETE	Presented to GB 29/04/21
Local Security Management Policy review	007/21	To amend the LMS policy to reflect discussion around the LSM role and lone working.	RG	COMPLETE	20/05/21
Governance Assurance Dashboard	008/21	To arrange a flexible online fire safety session. To report the underperformance of mandatory training amongst GB members at April's Governing Body meeting.	RG PR	COMPLETE COMPLETE	20/05/21 Raised at GB 29/04/21
Counter Fraud Progress report	009/21	To research what is available for people without ID who do not fall under the guidance and update the GP Fraud Awareness checklist.	RD	COMPLETE	Feebdack at May's Audit Committee
Conflicts of Interest Policy	011/21-c	To prepare a second draft of the COI policy and circulate to the Committee.	PR	COMPLETE	Final version to May's Audit Committee for approval

Report Title	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
Annual Self-Assessment	012/21	To set up training sessions with internal /external audit	AOC/ZA	COMPLETE	Members to noify ZA of any specific training needs. 20/05/21
Terms of Reference	013/21	To make amendments to terminology in TOR and submit to GB.	AOC/ZA	COMPLETE	Presented to GB 29/04/21
Governance Dashboard	022/21	To take back to team, the poor communication around feedback on training materials.	SB	OPEN	c/fwd
FOI Request AR	023/21	To raise FOI breaches with CHC colleagues and report back to Committee on how this will be resolved. To provide additional assurance through oversight of the review plan by Internal Audit at the next meeting.	MP JH	COMPLETE COMPLETE	A clear process in place since May 2021. There have been no further breaches of FOIs since that time. Internal Audit have reviewed plan but unable to test as no FOIs since that date. For next FOI will include a short narrative on next dashboard on how process was operated. Agreed to close 14/10/21.

Draft Audit Committee AR	026/21	To make amendments to the Draft Audit Committee AR and submit to GB.	ZA	COMPLETE	To be presented to GB 29/07/21
Workplan 2021-22	030/21	To add ICS transition to the workplan.	ZA	COMPLETE	14/10/21
Audit Progress Report	049/21-a	To update the tracker and remove the unachievable recommendation and include narrative to reflect the Committee's conversation	JH	OPEN	
Counter Fraud Progress Report	049/21-c	To explore and identify fraud training for practices	LS/RD	OPEN	
Counter Fraud Progress Report	049/21-c	To inform practices of the GP surgery support fraud	RD	OPEN	
Contracting	052/21	To re-circulate the current list of AQPs to practice managers	MP	OPEN	
Governance Assurance Dashboard	053/21	To send a reminder to staff explaining the importance of completing training. To clarify the population,indicating numbers in the action/ mitigation box and send to the Committee outside of the meeting, along with an indication of when the CCG will be compliant at 95%.	RG	OPEN	

Violence, Prevention & Reduction	055/21 a	To send a reminder to staff about the Lone Working Procedure.	RG	OPEN	
	055/21-b	To put conflict resolution training back on the governance assurance dashboard.	RG	OPEN	

FINAL MINUTES OF CALDERDALE
COMMISSIONING PRIMARY MEDICAL SERVICES COMMITTEE
25 NOVEMBER 2021
VIA MS TEAMS

PRESENT:

John Mallalieu (JM)	Chair, Lay Member (Finance and Performance) and Deputy CCG Chair
Alison MacDonald (AM)	Lay Member (Patient and Public Involvement)
Lesley Stokey (LS)	Director of Finance
Neil Smurthwaite (NS)	Chief Operating Officer / Chief Finance Officer
Rob Atkinson (RA)	Governing Body Secondary Care Specialist

IN ATTENDANCE:

Debbie Robinson (DR)	Director of Improvement - Community and Primary Care
Emma Bownas (EB)	Deputy Director of Improvement - (Primary Care)
Natalie Sykes (NSy)	Senior Primary Care Improvement Manager
Penny Woodhead (PW)	Chief Quality & Nursing Officer
Councillor Tim Swift (TS)	Representative of Calderdale Health and Wellbeing Board
Neil Coulter (NC)	Senior Primary Care Manager - NHS England /Improvement
Karen Huntley (KH)	Healthwatch Representative
Martin Pursey (MP)	Head of Contracting and Procurement (Minute 51/21)
Rob Gibson (RG)	Corporate Systems Manager (Minute 53/21)
Zoe Akesson (ZA)	Corporate Governance Officer (minute taker)

The meeting was enabled, via MS Teams, to allow members of the public to view but not participate.

CONTENTS

61/21 APOLOGIES FOR ABSENCE

Apologies were received from Dr Steven Cleasby and Dr James Gray. The late arrival of Penny Woodhead was noted. The Chair welcomed the new Senior Primary Care Improvement Manager Natalie Sykes to the meeting.

62/21 DECLARATIONS OF INTEREST

There were no interests declared by those present however the Chair made known the following declarations involving GPs Dr Steven Cleasby and Dr James Gray, which on this occasion were mitigated due to them not attending the meeting. The Chair described how these would have been managed had they been present:

Item 6 GP Patient Survey Results - the GPs have a **Direct Professional Interest** as it could be perceived they could influence the process for managing their own performance and in turn practices could benefit from the decision. It was agreed the GPs receive the paper, stay for discussion and the Chair would actively manage the discussion.

Item 7 Policy Review for Discretionary Financial Assistance - the GPs have a **Direct Professional and Financial Interest** as general practice contract holders in Calderdale who may at some point benefit financially from the policy. It was agreed the GPs receive the paper, but as beneficiaries would be excluded from the discussion and decision.

The Committee members agreed to the conflicts being noted in this way.

63/21 QUESTIONS FROM THE PUBLIC

There were no questions received from the public.

64/21 MINUTES OF THE LAST MEETING

The Committee **RECEIVED** the minutes of the following meetings, which had been approved between meetings and submitted to the Governing Body in October:

- Minutes of the public section of the meeting held on 26 August 2021
- Minutes of the single item meeting held on 1 October 2021

The Committee **RECEIVED** and **NOTED** the decision notice dated 5 November about the Winter Schemes 2021/22 and Quality Resilience and Recovery Scheme.

65/21 MATTERS ARISING

The action log was reviewed:

35/21 To share the draft Estates Strategy document at the next CPMSC development session: This would remain open until a date had been agreed with PCNs.

50/21 To raise any significant medicine optimisation issues within the year in the Director's report. To remain open, noting there was nothing to report for this meeting.

The remainder of the actions were recorded as actioned and closed.

66/21 DIRECTOR'S REPORT

The Chair invited Debbie Robinson to present the Director's report. Debbie informed members of the content of the report and welcomed Emma Bownas to talk through the additional roles reimbursement scheme section of the paper.

Additional Roles Reimbursement Scheme

Emma introduced a short film, produced by an Occupational Therapist working in the Upper Calder Valley Primary Care Network. It was developed to inform GP colleagues of the impact of the role so far, demonstrating the potential of these roles and how practices can improve the use of the additional roles as a service.

In terms of the headcount against the use and overall numbers within the report, Emma pointed out there is currently no target for any of the roles. PCNs can spend their allocated budget on any of the identified roles within the scheme.

There remains a challenge around recruitment. It is difficult to find workforce to fill these roles, particularly mental health practitioners and there are concerns around the rest of the system in some of these roles. With regards to retention, there is a need to encourage career progression moving forwards, to have a clear path and

post outline, for those in roles to stay linked into professions and not become isolated.

Comments and questions were invited.

- A point was made that there would still be challenges referring from General Practice into the system. In response, Emma explained although there will still be issues when referrals are made the advantage of additional role posts may prevent the need to refer with their different skill mix and a solution may be found in primary care but as part of primary care team challenges will be fed back to the CCG. **NS added that the benefits of using this workforce are recognised and it would be good to monitor this over the next 12 months to see other impacts.**
- JM raised a question around availability and supply and the oversight of what GPs are trying to recruit if there is no target per role. In response Emma explained the Calderdale workforce strategy and planning would highlight the gaps and show the use of different roles. The work has started for Calderdale around forecasting and showcasing of the roles however this needs to be done at a larger scale than Calderdale and conversations are happening with universities and external bodies of where these roles can be sought. **The Chair asked that information on the roles being sort is brought back to Committee.**
  ACTION: To include in the next Director's report to Committee - EB
- RA questioned if those accessing General practice are aware this is the way forward and understand that a GP may not always be the person they see. Emma agreed to refresh to comms on social media ensuring the language is accurate so people understand it is part of the same primary care provider and will receive the right treatment rather than seeing a GP.
  ACTION: To refresh social media message - EB

The Chair invited Debbie Robinson to continue presenting the report. Debbie highlighted the following key points:

Winter Investment - NHSE have published their plan to improve access for supporting patients and general practice. The West Yorkshire submission has been

made in line with guidance, some elements have been approved to progress to implementation however there is still work to do at a regional level to work through operational details to ensure the schemes are deliverable. The timescales were short for the creation of the schemes and submission of a plan. The locally funded schemes for Calderdale have been approved for implementation under the urgent decision-making arrangements.

Penny Woodhead joined the meeting.

NHS Digital GP Appointment Data - shows that more than 113, 000 appointments were provided during September. Calderdale General Practice is running at pre-pandemic levels, with 60% appointments being face to face. It was highlighted that all activity done at scale is still not captured in this data set and the teams is not able to access this data at practice level.

Estate Strategy for Primary Care Networks – the engagement work undertaken with key stakeholders, is nearing completion. A final draft of the Estate's strategy will be available for consideration in January. Working with external provider, a discussion will take place with each PCN, to help them understand the document and for them to be able to sense check data they have provided.

ACTION: To arrange an Estates Strategy meeting in January 2022 – DR/ZA

There were no further comments.

The Committee **NOTED** the contents of the report.

67/21 CALDERDALE GENERAL PRACTICE PATIENT SURVEY

The Chair invited Natalie Sykes to introduce the report. Natalie presented the GP patient survey results for 2021. Out of 7445 questionnaires sent out, 2793 returned, equating to a 38% response rate. The Committee was reminded that the questionnaire was redeveloped in 2021 to reflect changes to primary care services due to the pandemic, the effect of which should be considered when looking at results over time. It also represents only a small population sample of Calderdale and it is a helpful source of information that can be used in conjunction with other data to help build provide a picture of practice services. Practices are expected to

share the results with patients in their patient participation group to identify any areas for improvement.

The survey results have been reviewed in 2 ways. Firstly, by how Calderdale is performing against the national results with a year-on-year comparison. Many areas showed Calderdale is in line with the national average however for those areas that performed slightly below national average steps have been taken to address these areas, which are outlined in the report. Secondly, it has been reviewed on an individual practice basis. For those practices scoring higher than the CCG average, a recommendation has been put forward to the Committee for their achievements to be acknowledged by letter. For those where the scores are lower it is recommended that a supportive informal visit as part of the quality assurance and surveillance process takes place, to help practices reflect on their model and access review.

A discussion followed and the following comments were made:

- KH questioned the demographics of the people who completed the survey as their responses would be reflective of the population for their specific condition. The Committee requested to learn more about this area
  ACTION: To investigate the results further in relation to demographics / data by protected characteristics - NSy
- Cllr TS reminded the Committee that the satisfaction survey has an expectation, conditioned by press and social media stories, which is a risk. Natalie explained the number of surveys completed doesn't represent population of Calderdale but gives us next steps and this is only one source of information that can help shape practices.
- JM reflected on those practices that are in the lower percentile of questions not just the main 3 questions, that were drawn out in the discussion and asked that these are also picked up as part of the practice conversations, triangulating, so that if a practice is performing well in one area but may benefit from support in another that this is picked up.

The Committee **RECEIVED and REVIEWED** the 2021 national GP patient Survey results and **SUPPORTED** the next steps identified in the paper.

68/21 POLICY FOR DISCRETIONARY FINANCIAL ASSISTANCE TO GENERAL PRACTICES IMPACTED AS A RESULT OF A DISPERSAL LIST

The Chair invited Martin Pursey to present the paper. Martin explained the policy is used in the event of dispersing a patient list, which creates demand on staff and processes. The policy has been previously approved by the committee. This time there is no change in content, it is a request for the continuity of the annual approval to ensure consistency to the approach.

Following a short conversation around review dates and moving into transfer agreement arrangements with a new organisation the review date should be extended to 3 years in line with other policies.

ACTION: To amend the review date of the policy - MP

DECISION: The Committee **AGREED** the policy and change to a 3-year review date**.**

69/21 CONTRACTING UPDATE

The Chair invited Martin Pursey to present the contracting update. Martin highlighted key points from the report including the Extended Access Contract with Pennine GP Alliance and the delay in moving towards the planned transfer of current CCG-commissioned extended access services to PCNs has now been postponed until October 2022.

The Committee **RECEIVED** and **NOTED** the contents of the report.

70/21 FINANCE REPORT

The Chair invited Lesley Stokey to present the report. Lesley reminded the Committee that the financial year had been spilt into 2 and the plan for H2 submitted on 16/11/21 but not yet been approved. There is an expectation that we will break even across the financial year.

Lesley reported that plans have been developed and reserve budgets have been moved into non-GP services leaving a contingency £168K, sufficient to manage other variances for the next 6 months. There is an expectation of additional allocations for the additional roles, which is over and above that which is included in the baseline budget, but Lesley assured Committee this carries a low risk.

The additional roles budget for this year is £2.8m and the CCG is forecasting to spend £2.5m this year. The CCG is currently working with PCNs to bring forward next year's recruitment plans to utilise as much underspend as possible. The team is working proactively with PCNs on recruitment plans. The Chair questioned the remaining contingency and Lesley reassured the Committee that she felt comfortable with this and has a high level of confidence in the well-developed plans of the PCNs.

The Committee **RECEIVED** and **NOTED** the 2021/22 financial position on Primary Medical Services delegated budgets.

71/21 RISK REGISTER POSITION STATEMENT RISK CYCLE 3 2021-22

The Chair invited Rob Gibson to present the report. From the 40 risks on the register, 3 were categorised as CPMS risks, all open and currently scored at 8. Rob drew the Committee's attention to the following:

- R1629 reduced to 8 from 12 during this risk cycle, as personalised care team is now in place with clear supervision and line management.
- R1628 reduced to 8 from 12, following the covid vaccination spend
- R1734 was closed and replaced by 1941 and 1942. It was noted that the request this committee sighted on this and Rob informed committee no development since risks have been created. Rob will keep committee updated.

It was confirmed there had been no significant amendments since the risk report was written.

The Committee **REVIEWED** the Risk Register and the management of Commissioning of Primary Medical Services risks and **APPROVED** for review at Governing Body.

72/21 REVIEW OF WORKPLAN

The Committee **REVIEWED** and **AGREED** the workplan.

73/21 DATE AND TIME OF NEXT MEETING

Thursday 24 February 2022, 3.00 – 5.00pm, venue to be confirmed.

Calderdale Commissioning Primary Medical Services Committee Meeting 25 November 2021 Action Sheet

Agenda item	Minute No.	Action Required	Lead	Current Status	Comments/ Completion Date
HOPC Report	35/21	To share the draft Estates Strategy document at the next CPMSC development session	DR	**Open**	October date to be agreed with PCNs
Quality Assurance and Monitoring Process for General Practice	36/21	To present a first draft of the local dashboard at the next Committee.	DR/EB	Closed	Presented to CPMSC 26/08/21
Risk Register Position Statement Cycle 1	38/21	To redefine R1734 around the risk of harm to patients relating to the backlog of work post Covid and to re-look at the score. To complete critical risk template and re-share definition and score with committee before next meeting in August.	EB	Closed	Revised definition and score shared prior to meeting. Discussed under the risk register item 26/08/21.
Finance Report	41/21	LS to provide a brief overview of previous year's utilisation and role occupancy at the next meeting.	LS/DR	Closed	Covered in the Director and Finance reports 26/08/21.
Director's Report	48/21-a	EB to provide an update on the roles (headcount) filled to target for 20/21 and 21/22 in the next Director's report to Committee.	EB/DR	Closed	Included in Director's report
	48/21-b	DR to make a comparison to 2019 data in the next Director's report to Committee.	DR	Closed	Included in Director's report
	48/21-c	DR to include an update on Serious Mental Illness Health Checks in the next Director's report to Committee.	DR	Closed	Included in Director's report

Medicines Optimisation Programme	50/21	HF/DR to raise any significant medicine optimisation issues within the year in the Director's report.	HF/DR	**Open**	Nothing to report November, to remain on action log.
Finance Report	52/21	LS to work with DR on a timeline for the virtual meeting(s) in private with non-conflicted members to approve any discretionary investment proposals.	LS/DR	Closed	Took place 05/11/21
Director's Report	66/21-a	To include information on the additional roles being sort in the Director's update next meeting	EB	**Open**	
	66/21-b	To refresh social media message ensuring language is accurate so people understand it is part of the same primary care provider and will receive the right treatment rather than seeing a GP.	EB	**Open**	
	66/21-c	To arrange an Estates Strategy meeting in January 2022	DR/ZA	**Open**	
GP Patient Survey	67/21	To investigate the results further in relation to demographics/ data by protected characteristics	NSy	Closed	data regarding the breakdown of people that had completed the GP patient survey, shared with the committee 17/12/21.
Policy for Discretionary Financial Assistance to General Practices Impacted as a Result of a Dispersal List	68/21	To amend the review date of the policy	MP	**Open**	