NHS
Calderdale
Clinical Commissioning Group

NHS CALDERDALE CLINICAL COMMISSIONING GROUP ANNUAL REPORT 2021/22

Abbreviations Used in This Report

A & E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AEDB	Accident and Emergency Delivery Board
AHC	Annual Health Check
APC	Area Prescribing Committee
ASD	Autistic Spectrum Disorder
CAMHS	Children and Adolescent Mental Health Services
CCCP	Calderdale Collaborative Community Partnership
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CKWCCGs	Calderdale, Kirklees and Wakefield CCGs
CPMSC	Commissioning Primary Medical Services Committee
CQC	Care Quality Commission
CRH	Calderdale Royal Hospital
DATIX	Clinical incident review system
DHSC	Department of Health and Social Care
DSPT	Data Security and Protection Toolkit
EAP	Employee Assistance Programme
FTE	Full Time Equivalent
GBAF	Governing Body Assurance Framework
GP	General Practitioner
HR	Human Resources
HRI	Huddersfield Royal Infirmary
ICB	Integrated Care Board
ICS	Integrated Care Service
ICE	Integrated Commissioning Executive
IRMF	Integrated Risk Management Framework
LCFS	Local Counter Fraud Specialists

LeDeR	Learning Disabilities Mortality Review
LTW	Lead The Way
N/A	Not applicable
NHS	National Health Service
NHSCFA	National Health Service Counter Fraud Authority
NHSCHC	NHS Continuing Healthcare
NHSE	NHS England
PALS	Patient Advice and Liaison Service
PCN	Primary Care Network
PLG	Pharmacy Leadership Group
PSED	Public Sector Equality Duty
Q & A	Question & Answer
QFPC	Quality Finance Performance Committee
QRRS	Quality Resilience and Recovery Engagement Scheme
SABA	Short Acting B2 Agonist
SITREP	Situation Report
SMT	Senior Management Team
SNOMED	System of medicine coding
UCR	Urgent Community Response
UTI	Urinary Tract Infection
VCS	Voluntary and Community Sector
VSM	Very Senior Manager
WYHCP	West Yorkshire Health and Care Partnership
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WYUC	West Yorkshire Urgent Care

Contents

Performance Report

ROBIN TUDDENHAM
Accountable Officer
20 June 2022

Overview

This section of the Annual Report provides our Accountable Officer's view of the performance of the CCG over the past twelve months. It contains information about the CCG, including a summary of our purpose and activities and how we have performed during the year. It also highlights any key risks to the achievement of our strategic objectives.

NHS Calderdale CCG is a membership organisation consisting of 21 general practices. Further information about our members can be found on pages 76 to 77.

There is more information about the how the CCG fits into the NHS Structure in the About Us section of the Calderdale CCG website.

The CCG is organised into a series of teams, each with a head. The teams are – primary care, service improvement, quality, finance, corporate, continuing healthcare and contracting/procurement.

Our purpose is to improve the health and lives of the estimated 224,000 people living in Calderdale and/or registered with a Calderdale GP practice.

Calderdale Cares is our approach to bringing together all those that commission and deliver our health and social care in Calderdale. It supports our work to deliver our wellbeing strategy, and critically places our communities at the centre of what we do. In January 2022, the CCG signed an agreement with other partners setting out how the work of Calderdale Cares will be undertaken.

We work with our partners and stakeholders in Calderdale and as part of the West Yorkshire Health and Care Partnership to:

- Ensure that healthcare is available for anyone who needs it
- Keep people safe
- Ensure continued improvements in the quality of care
- Support people to maintain a healthy lifestyle
- Address health inequalities locally

- Ensure financial sustainability

The CCG has a number of strategies that can be found in the Key documents section of the Calderdale CCG website.

The CCG leads the COVID vaccination programme in Calderdale and has made significant progress in carrying out the national requirements, while responding to the specific needs and concerns of the local population, using a proactive creative approach to enable as many people as possible to be vaccinated.

The teams within the CCG have supported the vaccination programme using their knowledge, skills and experience, but have also continued their important work to commission and assure high quality healthcare and support for the local population.

Staff have worked with partners to begin the process of recovery from the impact of the pandemic on access to and availability of services, while locking in changes made in response to the pandemic that have demonstrated benefits.

The CCG has continued its focus on reducing the health inequalities that were brought into focus sharply by the pandemic. Examples of this are provided in the following sections of the report - 'Reducing Inequalities' (pages 35 to 36), 'Keeping People Safe' (pages 38 to 41) and 'Improving Quality' (pages 42 to 43). The CCG has continued to focus on people with a learning disability who have been significantly adversely impacted by COVID-19. More on this can be found on pages 60 to 65.

The CCG has also continued with its usual business, which is also described in the report. With our partners, we have:

- Worked closely with partners to continue to deliver the Calderdale Wellbeing Strategy Living a Larger Life – Calderdale 2022 - 2027 - as part of Calderdale Cares
    - Continued to support the development of a community improvement agenda, which forms the basis of the Calderdale Collaborative Community Partnership

- Continued the implementation of population health management in our system, to enable us to plan integrated services better and improve health outcomes for local people
- Continued our strong partnership working on local safeguarding boards and the Community Safety Partnership
- Continued to work with NHS Kirklees CCG and Calderdale and Huddersfield NHS Foundation Trust (CHFT) to ensure the local health system is resilient
- Continued to work with partners on the hospital change programme (Right Care, Right Time, Right Place)
- Continued to play a full and active role as part of the West Yorkshire Health and Care Partnership (our Integrated Care System)

Further information on our activities during the year can be found on pages 26 to 74.

Our in-year budget allocation was £367 million in 2021/22. We have used this to commission health and care services in the following areas - mental health, learning disabilities, continuing healthcare, emergency and urgent care, hospital and community services, primary care and services for children and young people. The 'Managing finances effectively' section of this report (see pages 71 to 74) contains further detail of our financial position and plan for 2022/23.

The issues and risks being experienced by the CCG reflect those across the system, the region and nationally. The key risks can be summarised as follows:

- Delayed transfers of care due to health and social care systems not being optimised at present, leading to poor patient experience, harm to patients and pressure on acute post-COVID bed plans
- The system returning to pre-pandemic levels of demand, meaning the 4-hour Accident & Emergency target will not be delivered due to pressures associated with avoidable demand, the implications of social distancing and capacity and flow out, leading to harm to patients, patient experience being compromised, and significant harm with patients spending an extended time on a trolley in A&E
- Underachievement of the 18-week waiting time target due to pressures caused by the pandemic, leading to breaches of patients' constitutional rights and potential harm to patients

Further detail on our approach to the management of risk can be found in the Governance Statement, and details of the risks classed as 'Critical' and 'Serious' on our Corporate Risk Register can be found in the Governance Statement: Appendix 2 (pages 121 to 127).

Overall, the CCG and partners have dealt as well as could be expected with the challenge of continuing increased pressure in the system, which has affected all areas of the country. Whilst not all NHS Constitution standards and national targets have been achieved, we have continued to perform well on cancer waiting times and admissions through Accident & Emergency.

The White Paper Integration and Innovation: Working together to improve health and care for all sets out significant changes to the way that local services will be commissioned in the future, with CCGs being disestablished by 30th June 2022, with their statutory responsibilities becoming the role of Integrated Care Systems. The Health and Social Care Act 2022 completed the Parliamentary process and received Royal Assent on the 28th April 2022.

Calderdale CCG is fully represented in this work with the West Yorkshire Health and Care Partnership (our Integrated Care System) at all levels in terms of managerial and clinical leadership, and our Accountable Officer is a core part of the overarching leadership transition group. Calderdale CCG is developing its place based Integrated Care Partnership, through our model of Calderdale Cares, in collaboration with partners in our local system, and alongside other West Yorkshire CCGs and the ICS. We are also working closely with our workforce on engagement and consultation in advance of the statutory HR process for all staff later this year.

This will be the last annual report from NHS Calderdale CCG as the legal responsibilities for the commissioning of NHS services will pass from CCGs to the new West Yorkshire Integrated Care Board (ICB).

Finally, I would like to thank the CCG Governing Body and staff and all of our partners in the health and care system for their hard work and commitment during another very difficult year.

ROBIN TUDDENHAM

Accountable Officer

Performance

Performance reporting

Performance against the NHS Constitution standards and national targets is included in the CCG's finance, contracting and performance report. This is presented to the Governing Body at each of its meetings. The Quality, Finance and Performance Committee also scrutinises our financial recovery plans.

Quality and Safety reports, which focus on commissioned services and highlight any risks and mitigating actions are also presented at each Governing Body meeting and are scrutinised by the Quality, Finance and Performance Committee.

These reports, together with the high-level risk report, enable the Governing Body to receive the right level of assurance about the management of those risks.

System-wide ownership of performance management is enabled through the relevant partnership groups including the Partnership Transformation Board, the Integrated Commissioning Executive (ICE), the Urgent & Emergency Care Board (AEDB) and the Contract Management and Quality Boards. The Senior Management Team provides operational oversight.

Further information about the operation and activities of the CCG's Governing Body and Committees, the Integrated Risk Management Framework, and anti-corruption and anti-bribery matters can be found in the Governance Statement (pages 85 to 137)

Performance against the NHS constitution and national targets

Performance against the NHS Constitution standards and national targets during the pandemic has been challenging. Despite this, cancer waiting times have remained strong throughout the year and NHS services have made good progress with the restoration of access to services during the year. The tables on the next page show the CCG's performance against the NHS Constitution and national targets.

The last two years have been the most challenging in the history of the NHS, and staff across the service have stepped up time and time again to meet the changing demands of the pandemic.

This has included responding to a Level 4 National Incident following the emergence of the Omicron variant. Teams from across the NHS in Calderdale and our partners have been involved:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. As a consequence, this has impeded the recovery and restoration of NHS services and reduction of backlogs caused by COVID that can be noted in the performance levels captured below.

As a service, the NHS has developed its plans to respond to these challenges in 2022/23 which intends to significantly increase the number of people that can be diagnosed, treated and cared for in a timely way. This will require things being done differently, accelerating partnership working through the integrated care systems (ICS) to make the most effective use of the resources available to us across health and social care

Performance against NHS Constitution and national targets

Elective care – position at the end of March 2022

Indicator Details	Target	Outcome
Diagnostics - % waiting over 6 weeks	1% and below	20.2%
Referral to Treatment time - % waiting over 18 weeks	92% and above	N/A (see Note 1)
Referral to Treatment time – Number waiting over 52 weeks	0	1,186

Indicator Details	Target	Outcome
Referral to Treatment Time – Number of people still waiting at the end of the month	0% growth at March 2019	18,461

Note 1: Calderdale and Huddersfield Foundation NHS Trust (CHFT) is part of a national pilot to develop new metrics to assess waiting times. During this developmental phase CHFT and related commissioners (Calderdale and Kirklees) are exempt from reporting Referral to Treatment time

Cancer waiting times – position at the end of March 2022

Indicator Details	Target	Outcome
Cancer - % seen within 2 weeks (breast symptoms)	93% and above	97.8%
Cancer - % seen within 2 weeks	93% and above	97.4%
Cancer - % treated within 31 days	96% and above	93.6%
Cancer - % treated within 31 days (Drugs)	98% and above	100%
Cancer - % treated within 31 days (Radiotherapy)	94% and above	81.0%
Cancer - % treated within 31 days (Surgery)	94% and above	82.4%
Cancer - % treated within 62 days (Screening)	90% and above	100%
Cancer - % treated within 62 days	85% and above	86.1%

Ambulance and urgent and emergency care – position at the end of March 2022

Indicator Details	Target	Outcome
A&E - % waiting under 4 hours	95% and above	87.8%
A&E – No. waiting 12+ hours from Decision To Admit (YTD)	0	11

Financial Duties

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended). The CCG's performance against those duties is included in the 'Managing finances effectively' section on pages 71 to 74.

Sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services.

Sustainable development means building sustainable communities, supporting healthy living for all and for our workforce, the smart and efficient use of natural resources and spending public and other money well. By making the most of social, environmental and economic assets we can improve health both in the immediate and the long term. This will also need to be reflected in the ways in which we work to deal with the problems of climate change.

Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We continue to carry out activities that contribute to sustainable development and we work locally with the Calderdale Council Climate Committee and other sub-regional and regional initiatives in order to implement new policies and ways of working. We have provided a flavour of those below.

Corporate approach

As a commissioning organisation and employer, we have a Governing Body lead for sustainable development – Professor Peter Roberts.

Travel and logistics

Our Expenses Policy sets out our commitment to sustainable development.

We assess the travel, transport and accessibility of locations for engagement and consultation meetings and follow up any events with a questionnaire to participants that informs future choice of venues – our preferred model is to go where people are, rather than expecting people to come to us. This is supported by working with our engagement champions. Engagement Champions are individuals working in the voluntary and community sector who are trained to engage with the local population on our behalf.

Year on year we continue to use technology to reduce the number of journeys being made by our staff, who are increasingly working across West Yorkshire as we develop collaborative working as part of the Health and Care Partnership. Reducing the amount of travelling required contributes to an improvement in staff health and wellbeing, increases efficiency, reduces our impact on the environment and reduces running costs.

Working from home during the pandemic with meetings taking place over Microsoft Teams has made a significant contribution to this ambition, and the new hybrid model of working from home some of the time and in the office for the rest is locking in these benefits.

Resource usage in 2021/22

The CCG moved office from Dean Clough to Westgate House in the centre of Halifax in October 2021. The table below sets out the usage of resources by the CCG at Dean Clough for April to September 2021 compared to April to September 2020. In October 2021 the CCG moved to Westgate House which is a shared building with Calderdale Council and a breakdown of CCG resource usage only is not possible.

Resource	Quantity (kWh) Apr - Sept 2020	Quantity (kWh) Apr – Sept 2021	tCO2 emissions Apr - Sept 2020 (Note 1)	tCO2 emissions Apr – Sept 2021 (Note 1)	Cost incl. VAT Apr – Sept 2020 £	Cost incl. VAT Apr – Sept 2021 £
Gas	4,170	9,220	1	2	168	370
Electricity	11,391	11,524	12	6	2,523	2,551
Water (Note 2)	N/A	N/A	N/A	N/A	N/A	N/A
General waste (note 3)	N/A	N/A	N/A	N/A	N/A	N/A
Recycling (including confidential waste) (note 4)	N/A	N/A	N/A	N/A	N/A	N/A

Note 1: The tCO2 emissions have been calculated using conversion factors for greenhouse gas reporting, published by the Department for Business, Energy and Industrial Strategy

Note 2: The charge for water usage was contained within the general service charge and was not separated out.

Note 3: General waste disposal formed part of the cleaning contract and was not separated out.

Note 4. The contract for confidential waste covered the whole year 2021/22. The cost was £2,906 for 2021/22 compared with £1,170 for 2020/21. The increase was due to clearing out prior to the move to new premises.

Business Travel

The table below compares business travel in 2020/21 and 2021/22. During 2020/21, staff worked mainly from home. As restrictions have eased, more travel has been undertaken but this is still significantly lower than before the pandemic (when business mileage was typically around 50,000 miles per annum) as the benefits of online meetings have been locked in.

Type	Miles 2020/21	Miles 2021/22	Cost (inc. VAT) 2020/21	Cost (inc. VAT) 2021/22
Business Travel	3,135	4,108 (1)	1,755	2,300
Business Travel – Car Share	(2)	(2)	(2)	(2)

Notes
(1) The number of miles is not available from payroll reports; therefore, this figure has been calculated from the average cost per mile in the previous year
(2) It has not been possible to separate out car share miles and cost

Adaptation

Responding to the effects of climate change is embedded in our Emergency Planning, Resilience and Recovery (EPRR) work as part of fulfilling our responsibilities under the Civil Contingencies Act 2004. We work closely with partners across the system on business continuity planning, ensuring that Surge and Escalation Plans as well as heatwave and winter plans are in place.

There was a joint business continuity exercise with Kirklees and Wakefield CCGs in November 2021 on understanding the controls that our organisation currently has in place to support home and remote working and on exploring how it detects and handles a security incident that has originated from a remote workstation

We also take part in regular flood planning exercises with partners across Calderdale. These have been paused during the pandemic but will be resuming later in 2022.

Sustainable care models

Building sustainable care models is central to all our work with partners across Calderdale as a place, across Calderdale and Greater Huddersfield as a shared acute hospital footprint and across the West Yorkshire Health and Care Partnership.

Sustainability principles are embedded in our commissioning plans. Details of our work on Calderdale Cares and the Calderdale Collaborative Community Partnership can be found on pages 66 to 67.

We also have a sustainable engagement model in partnership with our local community which ensures the public voice is central to commissioning. (See the 'Engaging People and Communities' section on pages 32 to 35).

Climate emergency

Calderdale Council declared a climate emergency at the beginning of 2019 and as a response the CCG appointed Professor Peter Roberts as the Governing Body Champion for Climate Change. The CCG is supporting the Council's target of having net zero emissions by 2038 with significant progress made by 2030.

The NHS contributes about seven per cent of carbon emissions through its estate, transport costs of staff and patients and its heating costs, and we aim to do all we can to become a leading organisation in our response to the climate emergency.

We are thinking how as individuals working at the CCG we can reduce our own carbon footprint in our individual lives, how we can use smarter ways of working through digital and other means to rescue our environmental impact and also how, through leadership discussions and through contracting and procurement means, we can influence the wider system.

At the start of 2021/22, staff were mainly working from home due to the pandemic. As restrictions have eased, a hybrid model has been developed where staff spend part of their time working from home and the remainder in the office.

In October 2021, the CCG moved offices from Dean Clough to Westgate House in the centre of Halifax. This has encouraged staff to consider different methods of transport including public transport, cycling and walking.

Our people – Encouraging a healthy workforce

Calderdale CCG's staff forum has, for many years, promoted and led activities that support the physical, social, and psychological wellbeing of all staff. In July 2021, the staff forum re-branded and became known as The Voice.

Although the hybrid approach described above has limited the range of activities that The Voice has designed and promoted, staff wellbeing has been at the heart of how the CCG has operated over the last year. Within days of staff having to work from home, wellbeing activities started being delivered online, with a 'Virtual Kitchen' replacing the physical hub previously accessed by staff.

The Voice has continued meeting online to find ways of supporting colleagues grappling with the effects of working digitally from home, re-deployment, home schooling, loss and bereavement and increased work demands. Our staff have accessed local, regional, and national advice including information and resources to support their psychological, physical, social, and financial wellbeing, and that of their friends, family, and neighbours.

Colleagues have worked hard to stay connected with each other at individual, team, and organisational levels, and have kept each other and our communities safe.

Key Activities during the year

Introduction

During 2021/22, there have been two key areas of focus for the CCG:

- Leading the rollout of the COVID-19 vaccination programme in Calderdale
- Continuing with its usual functions while taking account of the impact of the pandemic and using the learning from it to move forward

The pages below provide more information about the activities contributing to these.

COVID-19 vaccination

At the end of 2020, Calderdale CCG, as local lead, established a group to work at pace with partners to establish local delivery of the vaccination programme as 'Team Calderdale'. The group steers the management and coordination of the programme, leading the strategy on the vaccine programme operations, deployment, reporting and escalation, and ensuring that risks and issues are managed and fed to NHS England. Calderdale began vaccinating on 14th December 2020, and by the end of March 2022 had administered at least 424,000 vaccinations.

By April 2021 the programme was well underway with administering dose 2 of the initial primary course of vaccination to those over 50 years and most at clinical risk.

Since then, the programme has: -

- Listened to our communities about their concerns and anxieties around the vaccine and provided evidence-based approaches to address these concerns and drive vaccination uptake
- Offered a vaccination to everyone in all eligible groups (12 years and above and those age 5-11 at risk), including visiting every care and residential home to offer the vaccination to staff and residents as well as getting to everyone who is registered housebound to administer the vaccine to those that consented
- Established a schools-based 12-15 years programme, visiting every secondary educational setting where children and young people consented to the vaccine
- Provided specialist clinics and innovative ways to administer the vaccine. Our partners have found creative ways to encourage particular groups of the population to attend, for example the cinema-style clinic for people with a learning disability and in-car vaccinations
- Left NO ONE behind by mitigating inequalities, improving vaccine confidence and ensuring underserved populations have ease of access to the vaccine
- Provided a rapid, responsive, roving vaccination service to pre-identified community locations on a regular basis, where there has been a lower take up in vaccination, based on local intelligence and insight and fully supported by our trusted community leaders to help improve vaccination uptake

The photographs below demonstrate the variety of locations/settings that have been used to encourage and enable as many people as possible to get vaccinated.

The photograph below shows a pop-up clinic at Woodfield Grange Care Home.

The photograph below shows a pop-up vaccination clinic at Ravenscliffe School on Christmas Jumper Day.

The photograph below shows St Augustine's Centre, where many pop-up clinics were held to increase uptake among the refugee and asylum seeker population.

The photograph below shows the Oasis bus, which was used for community outreach.

The photograph below shows a pop-up clinic at a local mosque.

Team Calderdale has:

1. Administered 115, 240 Boosters/ 3rd doses since the end of September 2021
2. Achieved 94% booster uptake for eligible Cohorts 1-9 in Calderdale, protecting those most at risk of the worst outcomes of COVID-19
3. Expanded the model to include nine additional Community Pharmacy sites across Calderdale, GP practice level provision and pop-up provision accordingly, including the Piece Hall and Salem Methodist Church

The photograph below shows the queue to one of the Piece Hall pop-up vaccination clinics.

All stakeholders and partners across Calderdale have played an amazing part in the programme and its success can be credited to all partners working to achieve the same goal, where nothing is impossible.

There have of course been challenges. One of the biggest challenges this year has been workforce and the constant risk of sickness, burnout and welfare of staff in the organisations involved, which continues to be a concern. Staff are showing resilience and commitment, heavily supported by an amazing volunteer response. Despite this challenge, Team Calderdale has delivered the biggest and fastest vaccination programme in NHS history.

The other significant challenge we have is despite our best efforts to tackle vaccine inequalities, these still exist. Whilst we have invested energy and commitment into

narrowing the gap, we have heard how we still need to build vaccine confidence and trust with our communities.

The next steps for the NHS COVID-19 Vaccination programme have been set out by the Government and the programme team along with our partners is well into planning for the year 2022-23 and beyond.

The current government advice is to deliver a Spring booster (to those most at risk) and to offer a vaccination to all 5–11 year-olds. We are also planning for an Autumn booster campaign (best and worse-case scenario planning) and surge scenario if advised by the Joint Committee on Vaccination and Immunisation.

There will be a continued focus on tackling vaccine inequalities. Funding for the inequalities roving model is secured into 2022-23 and the programme is reviewing how we use Make Every Contact Count[1] in our outreach approach and at all our vaccination sites.

Team Calderdale continues to engage with our communities, as restrictions have lifted, and would like to thank all its partners, staff and volunteers for their energy, commitment and cooperation and looks forward to working with them all as we learn to live with COVID-19.

Continuing with the CCG's usual functions

As well as leading on the vaccination programme rollout, the CCG also continued to focus on delivering its usual functions, while taking account of the impact of the pandemic, and using the learning from the pandemic to improve healthcare and support for local people. The pages below give more detail about its work.

[1] Making Every Contact Count is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing

Engaging People and Communities

A key priority during 2021/22 for the CCG and partners has been acting on and implementing the principles of the 'Involving People' Strategy to create a strong collaboration for communications, engagement, and equality across Calderdale, working in partnership and coming together to learn from and act on what people are telling us to improve the health and wellbeing of Calderdale population.

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

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

A more detailed statement of involvement report is also produced annually which provides more information about how the CCG, partners, and providers that the CCG commissioned have involved local people in the development, design, and delivery of services throughout the year. This also gives us the opportunity to shout out about the fantastic partnership engagement work that has taken place across Calderdale.

Findings of any engagement and/or consultation can take several months or even years before any outcomes or changes can be reported on. Over the last two years we have asked colleagues and partners for a progress update on previous activity where possible.

This will also be our last annual statement of involvement as NHS Calderdale CCG, as the legal responsibilities for the commissioning of NHS services will pass from CCGs to the new West Yorkshire NHS Integrated Care Board (ICB).

The annual statement of involvement report which can be found on the CCG website sets out who has been involved, what people have told us and what has happened as a result (we asked, you told us, we listened) of the activity. Each section is a summary account of the activity with links to the published reports. An example of how we have involved the public (individuals and communities we serve) and the impact that the engagement activity has had is below.

Supporting the roll out of the COVID-19 Vaccination programme has been a priority for the CCG and partners. Joint working and regular discussions across organisations and with colleagues to ensure consistency of the messages across Calderdale by NHS and council colleagues and all our partners have been integral to the programme.

Calderdale CCG Engagement has led on the coordination of engagement and insight through the system (at place) in relation to the COVID-19 Vaccination programme with as many partners as possible.

Phase one of the engagement activity was to understand the views and experiences of people living in Calderdale of the COVID-19 vaccine. We wanted to give people the opportunity to help influence how we shape the operational delivery of the vaccine delivery model in Calderdale and the messages we share; through understanding and learning what the public views are of the COVID-19 vaccine and understanding any concerns or misinformation that people may have heard.

We wanted to understand people's perspectives of:

- How people felt about the vaccine?
- What has the experience been like for people who have received the vaccine?
- Real stories from people with lived experience

Insight reports produced from all the feedback we received have been used to help create our communication messages and to respond to people's concerns. The insight also informed our vaccination programme – listening to feedback we have delivered live Question & Answer (Q & A) sessions on topics such as pregnancy and fertility and working, listening to our stakeholders we have worked with our local mosques and charity organisations to deliver pop up clinics. We also held vaccination clinics for people with a learning disability and their carers, setting up a cinema style approach with popcorn and films to put people at ease instead of a waiting room and gave longer appointments for people so they didn't feel rushed.

Phase two of the engagement activity was building on our understanding of what communities were telling us about the vaccine. People had already told us what was worrying them, including side effects; how the vaccines were tested / are they safe; whether they affect fertility and pregnancy; allergic reactions; how they work; how long they protect us; and why young people with no health issues need them. People also told us that work, transport and caring responsibilities might make it difficult for them to get vaccinated. We wanted to know more about this so that we could plan vaccination services better.

During this phase most older people had now been vaccinated and different groups of people were starting to be offered the vaccine. We recognised that they might have different worries and we wanted to make sure people have the information about the vaccines that they need in ways they understand and can use to make informed decisions.

Our engagement was more targeted to reach those different groups of people such as working age adults, younger people (under 40) and children. We continued to produce insight reports from all the feedback received to inform the delivery of our vaccination programme and to help create our communication messages and respond to people's concerns. Some examples are given below.

- We provided information about the vaccine and people's concerns in a range of different formats such as easy-read and different languages

- We worked closely with trusted members within our communities such as our engagement champions, COVID champions and community leaders who were able to have conversations in our communities and helped provide the right information about the vaccine
- Housebound patients were offered the vaccine in their own homes
- We recognised the importance of unpaid cares and made sure they were a priority to receive the vaccine, also offering them the vaccine at the same time as the person they care for
- We worked with young people who developed resources to address the concerns that younger people had told us
- We worked with chat health so that school aged children could ask questions or have a discussion about the vaccine with a medical professional via text
- We delivered Question & Answer sessions for a range of people who had concerns about the vaccine

Reducing Inequalities

The CCG has continued its focus on reducing inequalities, including:

- Delivering the refreshed place-based Wellbeing Strategy through four key principles - joining up services to change lives for the better, a focus on prevention, addressing inequalities and empowered and resilient communities. The strategy takes a life course approach and has one priority outcome for each stage of the life course: starting well – children are ready for school; developing well – all 15-year-olds have hope and aspiration; living and working well – good emotional health and wellbeing and fewer suicides; ageing well – older people have strong social networks and live in vibrant communities. Local NHS partners are focusing on the healthcare service contribution to the achievement of these priority outcomes and focusing social value activity on impacting on them
- Implementing priorities for ethnic minorities informed by engagement with our local population about the disproportionate impact of COVID-19 on people from ethnic minority backgrounds and supported by race equality employee networks of partner organisations. These priorities include early identification, support, awareness of risks and how people can protect themselves, addressing underlying health conditions, resilience and inclusive recovery. The work includes

ensuring providers maximise opportunities for data coding which includes ethnic groups and other inclusion health groups wherever possible

- Calderdale and Huddersfield NHS Foundation Trust (CHFT) continuing to connect with systems nationally, sharing work on a Health Inequalities guided recovery framework. This included coding elective data for deprivation score, ethnic groups and learning disability flags. As a result, patients with a learning disability were fast-tracked. CHFT is continuing to develop the enhanced care pathway for people with a learning disability. A clinical review of the whole paediatric waiting list identified children and young people with a learning disability whose access to care was accelerated. An all-aged learning disability dashboard enables divisions to see where people with a learning disability access services and address specific issues with appointments and waiting lists
- Our place-based work on supporting people who live street-based lives, experiencing multiple and complex disadvantage, taking a population health management approach to joining up services to achieve personalised outcomes such as accommodation, employment, substance misuse recovery and mental health. In maternity care, we have two 'Complex Needs' midwives delivering continuity to the most vulnerable women including refugees, teenage mothers and mothers with physical and/or learning disability

Promoting and supporting equality and diversity

We are committed to improving the lives of local people by reducing unfair and avoidable differences in health (health inequalities) and making sure we commission and plan good quality services that meet the needs of our diverse communities. To help us do this we continue to work collaboratively with our partners and ensure that we proactively seek the views of our communities, particularly those groups who are not always heard.

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

Below is a summary of the key activity we have undertaken in the last year to promote equality and reduce health inequalities:

- Supported the COVID-19 vaccination programme by developing and updating the Equality Impact Assessment and creating an inequality action plan to support a more agile response
- Listened to local communities and used their feedback to shape the vaccination offer and ensure the messaging is accessible to all our communities
- Worked collaboratively with local health and care partners to deliver the Equality Delivery System (EDS2) remotely
- Worked with partners and local communities to deliver our equality objectives including improving access to primary care for ethnic minority groups and carers and increasing engagement with both groups
- Continued to support the delivery of a Health Inequalities Grant Fund project led by Voluntary Action Calderdale, to reduce the impact of COVID-19 on the inequality in life expectancy through greater connectivity
- Implemented the Workforce Race Equality Standard (WRES) and developed an action plan in partnership with our Race Equality Network
- Produced an annual Workforce Disability Equality Standard (WDES) report
- Worked with system partners to develop a new delivery model for the Equaity, Diversity and Inclusion function to support the transition to the Integrated care System (ICS)
- Supported the establishment of the Race Equality Network and the Disability and Long-Term Conditions Network for staff
- Developed further guidance, support and training for staff and partners on creating accessible information that meets the needs of our communities
- Reported performance against the delivery of our equality and diversity duties to the Quality Finance and Performance Committee bi-annually, with the Public Sector Equality Duty (PSED) annual report being submitted to the Governing Body

The CCG's Public Sector Equality Duty Report 2022 can be found on its website.

Keeping people safe

Safeguarding

The CCG safeguarding team's work encompasses a range of workstreams including child and adult protection, Mental Capacity Act, Deprivation of Liberty Safeguards, Domestic Abuse, Modern Day Slavery and Human Trafficking and Prevent.

The CCG has a legal responsibility to ensure that the principles and duties of safeguarding children and adults at risk are fulfilled for both the CCG and the providers from which it commissions services. Whilst some statutory duties under the Care Act 2015 were eased during the past year due to the COVID-19 pandemic, the duties relating to safeguarding remained.

The safeguarding functions continued, albeit sometimes delivered in different ways, and highlights included:

- Supportive safeguarding advice: The CCG Safeguarding team offered advice to support professionals in the CCG or primary care and extended the offer to include staff in commissioned health providers
- Responding to urgent statutory safeguarding reviews and Domestic Homicide Reviews: Significant statutory safeguarding cases require responsive actions to ensure that any learning is shared quickly to protect children or adults who may be at risk
- Work to support the Calderdale Safeguarding Boards/Partnerships: The Safeguarding Boards/Partnership Executive meetings continued and the CCG as a statutory member continued to attend and play a full role
- Supporting primary care and other partners with pertinent safeguarding information: Supportive guidance for both safeguarding and adherence to the Mental Capacity Act during the pandemic has been produced by the team and distributed to primary care colleagues
- Seeking assurance that commissioned providers continue to prioritise and deliver safe and effective systems for safeguarding children and adults, including provision for Children in Care and a Child Death Overview Panel, remains a key part of the CCG Safeguarding team role

- Following the publication of the 'Burnt Bridges?', a Safeguarding Adult Review into the death of 5 men living 'street-based lives', the safeguarding team has worked increasingly closely with multi-agency partners to understand and respond to safeguarding needs in the context of health inequalities and the experience of trauma (see pages 39 to 41 for information about the CCG's response as a commissioner to the Review)
- The CCG has engaged in the West Yorkshire 'Every Sleep a Safe Sleep' campaign following the recommendations of a Thematic Review 'Out of routine: a review of sudden unexpected death in infancy (SUDI) in families considered at risk of harm' and has supported the production of a safer sleep risk minimisation tool, multi-agency guidance and training
- The CCG safeguarding team has supported provider organisations including the Children Looked After team to be CQC Children Looked After and Safeguarding Review (CLAS) inspection-ready by seeking provider position statements and providing a series of inspection-ready sessions to enhance closer working together and the production of clear reporting pathways

.

A Safeguarding Adults Review was undertaken by the Calderdale Safeguarding Adults Board into the deaths of five men living street-based lives in Calderdale in a short space of time during the winter of 2018/19. The Review report was called 'Burnt Bridges?'. An overarching multi-agency plan was developed in response to the Review.

Some specific areas of learning were identified as the responsibility of commissioners of services within Calderdale. Actions identified for the CCG are set out below:

- Review commissioning arrangements by health and social care to ensure the needs of the client group are fully embedded in commissioned services
- Consider opportunities for primary care to in-reach / out-reach with services such as The Gathering Place and drug and alcohol treatment services
- Develop opportunities for services and pathways for rapid access to mental health and dual diagnosis services

- Explore how to develop rapid access to services for diagnosis and support with intellectual disability
- Consider how the co-ordination of healthcare commissioning for homeless people can be strengthened, to ensure it works closely with partner agencies and ensure services are joined up, reviewed and monitored as part of the commissioning cycle
- Local GPs and practice staff would benefit from training in relation to treating this patient group to develop understanding of the trauma they have experienced, how they live, the complexity of their health needs and how fragile the nature of their engagement with health services can be

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

The CCG has an action plan and has made some progress against the recommendations. However, we recognise that there is still more to be done to ensure that this vulnerable group of people are able to access the right help and support in relation to their health and wellbeing.

Progress made so far includes:

- 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. in-reach to The Gathering Place from a Calderdale and Huddersfield Foundation Trust Community Matron, who co-ordinates input from a registered GP as required
- Training has been 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 monitoring contracts with service providers
- A Multi-Disciplinary Team approach has been agreed with wider partners to ensure plans are in place for those people known to services who are at risk, and a small group has been set up to understand how to identify those at risk of homelessness

- Progress has been made with partners on data sharing agreements needed to implement the population health management approach. This will benefit not only this project but also the implementation of the population health management approach across Calderdale
- An initial workshop has taken place focused on developing opportunities in offering rapid access for people with multiple and complex needs, and some progress made to understand and identify the key priorities. However, progress is slow and 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 was presented at the GP practice learning event in October 2021, with further approaches to training of GP practice staff being explored

Learning Disability Mortality Review (LeDeR) Programme

The LeDeR programme was established by NHS England in 2017, with delivery of the programme being required and led locally by CCGs. The programme required reviews of the deaths of people with a learning disability aged 4 to 74 across England, the key aim being to identify learning and best practice so that any recommendations for improvement were taken forward.

With the support of local health providers and Local Authority partners, a shared approach across Calderdale and Kirklees to complete the reviews was undertaken with success - all cases were completed (including backlog cases) by the year ending April 2021. An annual report for the delivery of the LeDeR programme within Calderdale CCG (including actions to address national learning for LeDeR cases) was placed on the CCG website in June 2021.

On the 23rd March 2021 NHSE published a new LeDeR policy 2021. Since then the CCG's Local Area Contacts in West Yorkshire who had been responsible for delivering the LeDeR programme locally, have been working together to develop and deliver the new policy to be in place by April 2022, led by the West Yorkshire ICS team.

Improving quality

The CCG remains committed to improving quality and this year has progressed an increasingly integrated approach of quality assurance and surveillance as well as utilising intelligence gathered to inform supportive improvement work.

The CCG also values the valuable involvement of community voices to support the quality agenda and has progressed plans to increase patient representation on quality and safety walkabouts to all services.

Care homes

Care homes continue to be a vital part of the system and have had continued focus on them during differing waves and impact of the pandemic.

During the pandemic the Care Quality Commission (CQC) did not undertake inspections and many other health and social care colleagues who would normally visit homes and contribute to assessment of quality have not been into care home premises. The CCG clinical quality team continued to visit where needed and worked with Infection and Prevention colleagues to continue to provide support where needed.

This led to offering ‘Soft Signs’ training to homes to empower non clinically qualified carers to use their unique knowledge of individual residents to recognise when their clinical condition was changing, thereby allowing them to seek early and appropriate help for deterioration. The training also included a standardised communication tool to ensure succinct sharing of relevant information with clinical care providers.

As the CQC recommenced inspections on a risk-based approach the CCG quality team has provided intensive quality support with significant success where improvement was required. Plans are well underway with Local Authority partners to deliver a consistent proactive quality offer, including ensuring providers can robustly and reliably assure their own quality.

Specialised quality improvement support has also been provided to a Calderdale home in response to safeguarding concerns which have elicited changes and significant improvement in medication safety.

The CCG and colleagues from the council, Public Health and the hospital have continued to work together as Tactical Command in response to concerns relating to the impact of the pandemic and other shared concerns. This efficient sharing of concerns and intelligence allowed prompt supportive responses which always prioritised resident safety.

Maternity

The CCG has continued to work closely with both the Local Maternity System and local maternity services to assure and improve quality in line with national transformation programmes and recommendations from the Ockenden reports. CCG quality visits are being scheduled as COVID-19 restrictions ease, and it has become apparent the impact visiting restrictions have had on service user experience during the pandemic. The Maternity Voices Partnership continues to develop and embed to ensure service user representation into quality oversight and system transformation.

Promoting Wellbeing

The CCG plays an active role on the Health and Wellbeing Board and in the promotion of wellbeing.

The CCG's Chief Operating Officer, Chair and Clinical Vice Chair are members of the Health and Wellbeing Board. The CCG takes an active role in the delivery of the Wellbeing Strategy which builds on Calderdale Cares and is aligned to the Inclusive Economy Strategy as well as national policy and established good practice.

The Strategy takes a life course approach to focus on activities that support: starting well, developing well, living and working well and ageing well, alongside tackling wider determinants of health, reducing inequalities and improving health life expectancy.

In June 2021, the Health and Wellbeing Board agreed that the Strategy would be refreshed. The refresh consisted of the following stages:

- Discussion at an informal Health and Wellbeing Board meeting to agree four ways of working from a shortlist that included issues raised through engagement in communities. From this list, four outcomes, one per life stage, were identified (September 2021)
- Further work was undertaken to shape the draft (October 2021)
- Engagement with partners about proposed priority outcomes and ways of working (November 2021)
- Review/approval of the refreshed Wellbeing Strategy by the Health and Wellbeing Board (December 2021)

Since December 2021, the refreshed strategy has begun to be implemented through agreed delivery mechanisms for the four outcomes.

Improving Local Services

General Practice

Since 2019, GP practices have been working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as Primary Care Networks (PCNs). Each PCN covers between 35,000 and 54,000 patients.

This enabled General Practice to ensure that people were still able to access the care they needed in the early days of the pandemic. 2021/22 has seen General Practice, through PCNs, at the centre of delivering COVID-19 vaccinations to the people of Calderdale, whilst continuing to provide day to day general practice services.

The number of appointments as reported through the General Practice Appointment Data Set shows a 1% increase in appointments delivered in 2021/22 compared to before the pandemic in 2019/20.

General Practice has delivered this through increasing the offer of appointment type available to include, alongside face to face, video, telephone and online consultations.

To support General Practice in its recovery and resilience, funding has been made available to enhance patient access, increase inclusion and for practices to consider how to improve environmental sustainability. The results of this are due by July 2022.

One of the practical ways that we have improved accessibility for patients to general practice is to ensure that all practice websites meet the accessible information standards to support equitable access for people who have a disability, impairment, or sensory loss. Funding was made available for the practice to receive a detailed web accessibility report showing what practices needed to do to their current websites to meet legal requirements.

In addition to this, an offer was made for practices to take up additional support to implement these changes and this allowed for a consistency in patient information across Calderdale and West Yorkshire. All 21 practices within Calderdale have websites that are compliant with the legal requirements.

Alongside this day-to-day work, PCNs and wider partners across Calderdale have introduced a population health management approach to start to identify people within their communities who are at risk of ill health and take a more proactive approach to helping those people manage their health and wellbeing. This work has included one of the PCNs working differently with people who are at risk of frailty, resulting in these people improving their confidence in managing their health and also increasing their independence and wellbeing.

Other work has included aiming to increase uptake in those accessing cervical screening for the first time. This approach has been across a number of PCNs and has involved team members such as care co-ordinators and social prescribing link workers who have been funded through the additional roles scheme. Work is also

underway in multiple PCNs to identify people who are at risk of diabetes and work alongside them to reduce that risk.

Calderdale PCNs have employed additional team members and new roles have been added to the General Practice team. Alongside traditional General Practice roles, new in 2021/22 have been an occupational therapist, physician associates, a pharmacy technician, paramedics and nursing associate. These roles have expanded the skills and type of people that work in General Practice.

Medicines Management

Medicines remain the most common therapeutic intervention in the NHS, with 48% of adults having taken a prescription medicine each week. 95% of patients who attend hospital take one or more medicines and over 80% take four or more medicines. Between 30-50% of medicines prescribed for long term conditions are not taken as intended.

Medicines spend is significant in England with the 2020/21 expenditure being £17.1 billion (of which 55% was spent on medicines prescribed in primary care and dispensed in the community). Primary care prescriptions in Calderdale in 2021/22 cost £35.5 million. Medicines can also cause harm and medication safety incidents account for around 10% of all reported incidents across the NHS.

Medicines Optimisation

Medicines Optimisation means taking a person-centred approach to safe and effective medicines use to ensure people obtain the best possible outcomes from their medicines. The Medicines Optimisation programme for Calderdale CCG supports improvements to the quality, safety and value from the use of medicines in Calderdale.

COVID-19 Vaccination Programme

In 2021/22 the Medicines Optimisation team has provided ongoing pharmaceutical support and oversight to the COVID-19 vaccination programme. This has included:

- Supporting the programme team in approving vaccination sites both within PCNs and to NHS England in approving Calderdale community pharmacy vaccination sites
- Taking part in the West Yorkshire assurance process that has allowed safe movement of vaccines between vaccination sites in line with medicines legislation
- Responding to clinical and pharmaceutical queries around COVID-19 vaccination

Medicines action plan

Calderdale CCG continues to invest in a practice pharmacy team which provides capacity within our practices to support delivery of an annual medicines action plan. This includes measures to improve cost effective prescribing plus quality and safety elements.

Prescribing Audits

The practice pharmacy team carry out quality, safety and antibiotic audits every quarter in each GP practice. In 2021/22 these included Urinary Tract Infection (UTI) in non-catheterised patients over 65, acute sinusitis, UTI in catheterised patients and asthmatic patients receiving six or more short-acting Beta-2 agonist inhalers in the previous 12 months. The results from these audits are shared with individual practices and a CCG summary is discussed at our Medicines Advisory Group with key messages/learning shared with practices where appropriate.

Reducing the use of rescue medication in asthmatic patients

The NHS England Long Term Plan set out an ambition to reduce the use of rescue medication in asthmatic patients. The overuse of short-acting B2 agonist (SABA) inhalers and under-use of preventer medication were highlighted in a UK study as key contributors to people experiencing an increased risk of exacerbations, asthma-related primary care consultations and asthma-related hospital outpatient consultations.

Prescribing data showed that approximately 30% of asthmatic patients in Calderdale were receiving 6 or more SABA inhalers in 12 months, which is significantly above the England average of 19%.

In 2021/22 the CCG has included two medicines safety elements in its Quality, Resilience and Recovery Engagement Scheme (QRRS) for general practice. One of these requires practices to have a policy for the supply of SABA inhalers to asthmatics and to ensure patients who are significantly overusing these medicines are identified, reviewed and supported to improve their asthmatic care.

Reducing the harm from opioid prescribing for chronic pain

Opioid medicines like morphine, oxycodone or fentanyl are good painkillers for acute pain, for example after surgery, and for patients with end-of-life pain. However, there is little evidence that they are helpful for chronic pain that lasts for months and years. Taking these medicines for chronic pain, particularly at high doses, increases the risk of addiction, side effects and even early death.

To support a reduction in harm from high doses of opioids the second medicines element in the QRRS this year requires practices to develop a plan to identify and review all patients on potentially harmful doses of opioids for chronic pain and support them to reduce to a safer level.

Prescribing Support Dietitian

The CCG funded a prescribing support dietitian for 6 hours a week from June 2021 until the end of March 2022. The experienced senior dietitian was seconded from our community dietetic service and has been supporting one practice within each PCN to review those patients who receive oral nutritional supplements without an ongoing dietetic care plan.

This role has been well received by patients and clinicians and supported improvements in care. Outcomes have included stopping unnecessary supplements, changing to more clinically effective and cost-effective options and referring patients on to the community dietetic service where ongoing care or monitoring is required. It is hoped to extend and expand this role further in 2022/23. Benefits of a dietitian in primary care have been shared with PCN Clinical Directors for consideration of future funding to deliver additional skill mix in their practice and PCN teams.

Developing Local Pharmacy Networks

The medicines optimisation team has continued to facilitate networking between PCN Clinical Pharmacists with monthly meetings. This aids the development of peer support and information sharing for this new staff group.

A wider stakeholder group, the Calderdale primary care pharmacy forum, was established in 2020/21 and has continued in 2021/22 for the purpose of improving communication and information sharing between the different pharmacy professionals in Calderdale including practice pharmacists, PCN Clinical Pharmacists and Technicians, Community Services Pharmacists, Community Pharmacists, the practice pharmacy team and the CCG medicines optimisation team. Due to COVID-19 pressures the group only met twice this year but the intention is to re-establish meetings on a quarterly basis going forward.

Collaborative working in West Yorkshire

This year has seen a refreshed vision for the Pharmacy Leadership Group (PLG) for the West Yorkshire Health and Care Partnership, which has re-established a regular meeting schedule to support effective cross-sector working for pharmacy professionals across our system. This includes senior pharmacy leaders from CCGs, acute and mental health trusts, NHS England, community pharmacy, community providers, academia, prisons and the Yorkshire Ambulance Service. Working together the PLG will support the delivery of national, ICB and place-based ambitions to improve patient care and outcomes.

In 2021/22 the West Yorkshire Area Prescribing Committee (APC) has been meeting bi-monthly and will become the successor organisation of the current two APCs in operation (Leeds APC and South West Yorkshire APC). This will provide improvements in care for our patients across West Yorkshire, delivering consistent commissioning policies and prescribing guidance across the area which will standardise access and use of medicines.

Acute and post-acute care

Urgent Community Response team

As part of the NHS long-term plan to support England's ageing population and those with complex needs, local health services and council teams were required to roll out Urgent Community Response (UCR) teams by December 2021.

The UCR team gives to those who need it 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 within two hours to provide the care they need to remain independent and avoid an admission to hospital.

The Standard Operating Procedure for the team was agreed in September by the Quality Finance and Performance Committee, on the understanding that it is subject to change as the work progresses through implementation.

In Calderdale the UCR team has been formed from four service elements:

- Crisis response intermediate care service
- Reablement intermediate care service
- Home-based intermediate care service
- Community-based intermediate care service

The service is open to most people aged 18 and over living in their own home or a residential/care setting who are in a crisis and need intervention within two hours to stay safely at home/usual place of residence. The service excludes people who are acutely unwell or injured requiring emergency care intervention and admission to an acute hospital bed, those who are experiencing mental health crisis and require referral/assessment by a specialist mental health team or those who need acute/complex diagnostics and clinical intervention for patient safety in hospital.

The key benefits include:

- Quicker access and treatment for people's urgent care needs as close to home as possible

- Maintaining people safely in their own home for longer and reducing admission to a care home
- People only having to tell their story once
- Enhancing and investing in community services
- Opportunity to understand the impact of different elements of the model, their links and opportunities for change

The team began work during 2021, and currently operates 7 days a week, from 8am to 8pm.

COVID oximetry at home service

The CCG wanted to support patients in the community with COVID-19 who were at risk of future deterioration/admission, so it set up a COVID oximetry at home service, where these patients could receive an enhanced package of monitoring involving a pulse oximeter (a small piece of kit that can measure the level of oxygen in the blood) being made available to track oxygen saturation, which, when it identifies a problem, prompts the patient and/or their carer to make contact with a local clinical team, their GP or 111/999 for advice. This provides reassurance to the patient and carer that the right help can be obtained quickly. 400 patients have benefitted from this service so far.

Continuing Healthcare

NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding, individuals have to be assessed by Clinical Commissioning Groups according to a legally prescribed decision-making process to determine whether the individual has a ‘primary health need’. In Calderdale, this function is carried out by the CCG Continuing Healthcare (CHC) team.

CHC assessment and reviews have been carried out throughout the year virtually and where possible face to face in a care setting. Despite the ongoing challenges unique to CHC, the team have continued to deliver a high-quality service to the

people of Calderdale. Working in a totally integrated way with the Local Authority has enabled both teams to achieve a high number of joint reviews and assessments.

The CHC team has worked closely with colleagues to support timely discharges from hospital and supported providers and assisted in the management and close monitoring of those services in times of continued pressure due to workforce issues and pressures from COVID-19.

Planned care

The need to respond to the immediate impact of the COVID-19 pandemic in 2020/21 in terms of emergency care required meant there was a significant impact on waiting times for routine/elective care. Early in 2021, national focus began to move to this cohort of patients, and expectations were set around progress in improving waiting times. However, this element of recovery was a challenge for clinical teams at local hospitals as they were still dealing with large numbers of people in hospital with COVID-19.

The local system's response was to embed part of the CCG service improvement team into the divisions at Calderdale and Huddersfield NHS Foundation Trust. These team members were able to focus on identifying and arranging activity with other providers, and on supporting the practical arrangements of moving people to different providers.

This had a significant impact on local performance against targets and constitution standards. There was a strong focus on long waiters, the Trust was on track to surpass the target for no people waiting over 104 weeks by April 2022, (which was recently moved to Summer 2022 following the Omicron wave). There has been a significant amount of learning which is being used to inform future commissioning strategies.

Virtual outpatient appointments, which were introduced at the start of the pandemic to enable access to care while reducing risk of transmission, demonstrated many benefits, and have now become part of the general approach in local hospitals where appropriate. More people are being offered patient-initiated follow-up appointments,

where, instead of clinical teams booking follow-ups when they think patients need them, patients will be encouraged to contact the service to arrange a follow-up if they have any concerns. This is particularly useful for patients with long term conditions.

Other arrangements brought in as a response to the pandemic, for example follow-ups in the community by optometrists for some minor eye problems, have demonstrated their effectiveness and have therefore been left in place.

The rise of Omicron during the winter months of 2021/22 presented a new challenge, very different to that of previous variants. Its main impact was on staffing across the whole health and social care system, with large numbers of staff absence either with COVID-19 or self-isolating due to close contact with someone who had tested positive. The system continued to deliver elective care in this period despite the staffing challenges, with clinical staff going above and beyond to support absent colleagues in urgent and emergency care.

In mid-February 2022, focus returned to elective recovery, and the challenge now is how to maximise capacity to deliver on national targets, whilst taking into account the financial constraints within which the system has to operate.

Cancer

At the start of the pandemic, there was a significant drop in fast-track referrals from primary care. This situation has now reversed - during 2021/22 the number of cancer fast track referrals has increased significantly across all specialties, reaching higher levels than before the pandemic. Despite this, Calderdale and Huddersfield NHS Foundation Trust has continued to meet national cancer waiting time standards, and is one of the top trusts across the country for performance against these standards.

In line with the national cancer agenda and earlier and faster diagnosis of cancers and day 28 for diagnosis, significant work in both secondary and primary care has started through improving the diagnosis pathway for patients. The main change is filter tests within primary care, pre-referral, which then enable a clinical triage and straight to test for patients. We have had great success with new patient navigation roles for those people that go straight to test, feeling supported and aware of their

tests, with a single point of access for any concerns. This will continue for each site-specific cancer pathway through 2022/23.

CHFT have also implemented a number of diagnostic tools:

- Colon capsule endoscopy – a procedure used to record internal images
- Cytosponge – which allows collection of cells from the oesophagus
- Pinpoint testing – a blood test that can indicate a patient's chance of having cancer

All screening services are running again with no limitations, and bowel cancer screening has been introduced for 56-year-olds.

A number of initiatives that were put in place during the pandemic have shown their benefit and are still in place:

- The 'super-green' areas which were established at the start of the pandemic to ensure a safe, COVID-19 free environment for patients
- Professionals referring people with suspected cancer being able to ask for guidance from secondary care prior to making the referral
- Video consultations, brought in to enable appointments to go ahead while reducing transmission risk
- Patient-initiated follow-ups
- The Macmillan online patient education programme which supports people in their cancer journey.

Diabetes

Diabetes education programme

During 2021/22, the CCG continued its funding to provide an enhanced structured education package focussing on gaps around health inequalities. The intention was to increase uptake for people from deprived and ethnic minority communities with diabetes and help address those health inequalities.

The South Asian community is particularly vulnerable to developing type 2 diabetes. According to Diabetes UK people with type 2 diabetes from the South Asian community are two and half times more likely to be under the age of 50 than other communities. The CCG has commissioned an organisation to develop and facilitate a community-driven family-centred initiative that empowers South Asian communities in Park Ward to reduce this risk and to empower those that already have diabetes to improve their management techniques preventing further health complications. One of the objectives is to raise awareness about diabetes and the associated health risks. Work on this is in its infancy, however it is hoped that this will assist in improving health outcomes across the community and ultimately share best practice across Calderdale.

NHS Low Calorie Diet Programme

Calderdale is taking part in the NHS Low Calorie Diet Programme. This is a new, innovative, and free service for people who are overweight and living with type 2 diabetes and is being piloted in West Yorkshire from March 2022.

The one-year programme supports healthier lifestyles, weight loss, and remission of type 2 diabetes by combining specialist nutrition, behaviour change strategies and physical activity to support rapid weight loss and long-term lifestyle changes. It works by offering 12 weeks of a low-calorie diet (shakes and soups) followed by four weeks of gradual food reintroduction and eight months of weight maintenance, achieved through healthy eating, movement and online support.

The pilot is a digital offer and will run for two years. GP practices are being asked to refer potential patients who fit the criteria and are motivated. To help tackle health inequalities across our area, the focus will be on improving access to patients from deprived and ethnic minority communities.

Mental health

Children and young people

Emotional wellbeing and mental health resources and services for children and young people are provided in Calderdale by the Open Minds Partnership, which

includes the local authority, NHS, education, voluntary and third sector providers, parent carers, children and young people. Together they work as a co-operative to ensure children and young people have access to the support and services they need.

Calderdale no longer delivers emotional wellbeing and mental health services under the old ‘tiered’ CAMHS model, but via the Thrive model developed by the Anna Freud Centre. This is a person-centred whole system approach where responsibility for meeting the emotional wellbeing and mental health needs of children and young people is everyone’s business.

At the heart of the Thrive approach is prevention and early intervention, ensuring that the child or young person receives support at any time from the most appropriate services and resources that meet their needs rather than them fitting into a specific service, or driven by a specific diagnosis or severity of the issues.

Compared to the traditional tiered CAMHS model, Thrive is transforming the experiences and outcomes for children and young people plus families and services. Key differences include:

- Services working better together
- A greater focus on prevention
- Recognising that not everyone needs a ‘mental health’ intervention from Open Minds (CAMHS)

Under Thrive children and young people are more likely to:

- Get the support they need when they need it – they don’t have to fit into a service to get help
- Access more than one service at the same time, or over time
- Live healthy and independent lives, secure in the knowledge that, if they need them, services will be there to keep them safe, supported and cared for

This approach has had a significant impact on access to support for children and young people. Since 2019/20, the rolling number of children and young people

receiving at least one contact in the financial year has increased by 49% and the number receiving at least two contacts has increased by 46%.

Public Health England figures show that the percentage of school pupils with social, emotional and mental health needs is 2.2%, compared to the Yorkshire and Humber figure of 2.65%. The figures have shown an improved position since 2018 – in the three years before that, the local position was above the Yorkshire and Humber figure.

The impact of the pandemic on children and young people is shown very clearly, with the numbers of pupils' low scores for life satisfaction, personal wellbeing and self-esteem increasing significantly. Locally there has been a sharp increase in the number of referrals to the Open Minds First Point of Contact, mirrored across the region, and across local partners. Of these referrals, the proportion relating to depression, anxiety and self-harm has increased since the pandemic began.

The CCG has extended the additional funding made available for short-term counselling commissioned for children and young people with mild/moderate needs to respond to increased demand.

To respond to the impact of the pandemic the Partnership delivered the following at pace:

- Promotion of existing services and support
- Partners supporting vulnerable/at risk children
- New resources
- Service developments – additional roles, strengthening links with partner organisations, enhanced signposting to families/parents/carers to help them access support from family services, return to education support, Silvercloud (a digital anxiety guided self-help programme), mental health helplines and the West Yorkshire Night Owls overnight service and workforce initiatives to safeguard the wellbeing of staff so they could continue supporting children and young people
- Mental Health Support Teams providing early intervention on some emotional wellbeing and mental health issues in line with the Thrive Model

- A neurodevelopment action plan aligned to THRIVE principles focusing on providing and promoting early intervention services and support for children and young people and their families. All neurodevelopment assessments were paused by the Government in July 2020, then a reduced number was allowed due to additional measures. This led to a backlog in assessments

The West Yorkshire Mental Health and Wellbeing Hub was launched mid-pandemic to support people who work in health, social care and the voluntary, community and social enterprise sector as they dealt with the impact of COVID-19.

Adults' and older adults' mental health

During 2021 the NHS England Mental Health Transformation plan has progressed towards building and recruiting into the core model with the principle of creating a new, inclusive, generic community mental health offer at a primary care and neighbourhood level. This is part of a wider transformation programme delivered across West Yorkshire Health and Care Partnership. It aims to:

- Provide better care to people already receiving mental health support in the community
- Increase access to these services
- Improve pathways for people with eating disorders, who have community rehabilitation needs and have a personality disorder
- Increase the number of people with Severe Mental Illness (SMI) receiving a comprehensive physical health check

The new offer for Calderdale has been led by a partnership steering group of the Voluntary and Community Sector (VCS), local authority, primary care and health representatives which has reported into the Calderdale Collaborative Community Partnership Board to ensure local governance.

Development of the core model is being achieved by recruiting through the VCS, into new Emotional Health and Well-being posts based on the national pilot of Community Health Workers.

The transformation work is linked to Imperial College, National Association of Primary Care and Westminster and Bridgwater research which is based on the Brazilian model of healthcare delivery. A hyperlocal approach is central to this with workers living in the communities they serve and involved in co-design of the model at a local, Primary Care Network (PCN) level across the whole of Calderdale.

Calderdale is part of the Imperial College and national evaluation research for the new model with regular collaboration and learning events with the Imperial and the other areas. A PhD student is involved in the national evaluation.

This preventative and early intervention approach as an all age, universal offer across identified households aims to give parity of esteem to mental and physical health while creating seamless pathways into both primary and secondary care. This approach aligns with Calderdale's wider policies and aspiration.

Further integration of mental health provision into PCNs, building local mental health hubs, has begun by recruiting specialist mental health practitioners, such as Single Point of Access practitioners and forthcoming Mental Health Additional Role Reimbursement scheme specialists, employed by the specialist mental health trust but working in primary care.

This demonstrates the progress towards dissolving the traditional barriers between primary and secondary care in order that people will be able to benefit from mental health support closer to home and people with a serious mental health condition will be able to access a wider range of services.

The core model of integrated working is making progress in taking account of the wider social determinants affecting people's emotional wellbeing and mental health by employing people from their communities to help co-design the provision, identify training and networks to enable wider access to local support.

The transformation work has made progress in commissioning and all age Disordered Eating scoping piece of work with the aim of developing recommendations for seamless pathways around early intervention and prevention.

The transformation work will develop increased access to transformed models of care for people with serious mental health conditions and 'personality disorder'/emotional complexity conditions, specialist employment support (Individual Placement and Support), complex rehabilitation, and will build on the work over this year to increase the uptake of physical health checks for people with serious mental illness.

The above examples of progress over this year support the aim of making changes across multiple systems to prevent people falling between the gap in services, particularly where their need is higher than primary care/Improved Access to Psychological Therapies/Talking Therapies (IAPT) but they don't currently meet the criteria for secondary care (provided by South West Yorkshire Partnership Foundation Trust and Calderdale Council teams).

Learning Disability

Over the past 12 months the CCG has been working closely with partners in health, social care, the voluntary sector and with self-advocates to improve the health and wellbeing of people with a learning disability. This group has been working on several key priority areas using the data and intelligence from across the local system, including learning from the Learning Disability Mortality Reviews (LeDeR). Examples of some of the great work that has happened is highlighted below:

Promoting health and wellbeing

The CCG have supported Lead the Way to do focused work on healthy living. The sessions are a preventative tool whilst using health coaching and a holistic approach. Research tells us that interventions that have the biggest impact on our populations are ones that help us move, eat, sleep and connect with ourselves and others. People that are not able to manage their own health and wellbeing see their GP more times in a year.

Using feedback from people about what topics they would like more information on, Lead the Way has run a number of wellbeing cafes across the community and led by people with lived experience.

Examples of these are:

- Cancer Red Flag Roadshow – 6th October 2021
- Know your Pecs and Prostate Cancer – 25th November 2021
- Sepsis Awareness – 15th December 2021
- Menopause Awareness – 15th December 2021
- Happy Healthy Relationships – December 2021

The photograph below shows the three presenters at a Happy Healthy Relationships workshop.

Mr A has attended most of the Wellbeing Cafés and has found that they offer 'something extra'. 'Alongside the health check workshops it has been good to get more information about screening and it has re-assured me and given me more confidence with regards to my health'.

Learning Disability Awareness Week

Partners in Calderdale worked hard and many events and different activities took place. An area of focus from health was upon promoting reasonable adjustments.

Reasonable adjustments can be anything from simple changes or more complex changes involving multiple teams. They can be removing barriers or adding something extra to enable a person with a learning disability to access the service. Every person is different therefore the adjustments that are made for people with a learning disability may differ from person to person.

Preventing unnecessary hospital admissions

The CCG has worked with partners to develop new crisis accommodation in the community. The service aims to provide an approach to supporting individuals through periods of crisis near to home, where familiar people and support networks can continue to be valuable components of their lives. The aim is to help people maintain their independence and continue normal day to day activities where possible – such as attending day services etc.

The Crisis Respite Service (Safe Space) is for adults with a primary diagnosis of learning disability who may have additional needs with mental illness and/or autism who have nursing care needs and / or higher support needs. The service is designed to provide an alternative to hospital admission for those who could receive short term enhanced alternative support in the community or who are stepping down from hospital on a pathway into community services.

With added support from specialist learning disability services – the Intensive Support Team - this service will help to prevent unnecessary admissions to hospital.

COVID-19 vaccination

Primary Care Networks (PCNs) have worked hard to enable as many people with a learning disability as possible to access their local vaccination clinics, in line with the local approach of supporting people with a learning disability to access mainstream services where possible. However, it was recognised that some people needed a more personalised approach, and the CCG has been working with local partners to put on bespoke clinics in the PCNs for people with a learning disability.

These clinics have taken place across the community and been able to support many people to access their vaccinations who would not otherwise have been able to. Vaccination teams included staff, volunteers and Abbie the dog!

The photograph below shows the vaccination team at a bespoke clinic.

The photograph below shows Josh Hartley-Conway having his vaccination at the bespoke clinic at Spring Hall Group Practice, Halifax.

Although we have had a formal feedback process most of the engagement has been done by directly talking to patients and their carers in advance of the clinics and during them too. It is a very personalised approach. Some patients have needed frequent short conversations, some longer ones with several different members of staff. We have offered reasonable adjustments that have far exceeded any patient's/carers expectations. An example is given below:

We succeeded in giving a booster to a girl who was desperate to have it done but so scared of having the injection she ran out of the car to get away. One of our team went and chatted to her in the rain and after building rapport found out she loves Arianna Grande so we played some of her videos inside the clinic projected like a mini cinema. The relationship formed with that team member, the lure of the videos and the temptation to see Abbie the 15 year-old Labrador again (Abbie has been a willing, very gentle distraction/reward at all our bespoke clinics) was eventually enough to bring her inside.

Every visit she has made to clinic we took the time to meet her needs, as described by both herself and by her mum, and gradually gained her trust. She got very distressed at times but with sensory distractions, crisps, coke and chocolates she was finally able to have her injection. She was totally thrilled with herself afterwards, apologised for her behaviour – obviously we assured her that was not needed and that we totally understood and were immensely proud of her – and she was congratulated by everyone. She left very pleased with herself and very grateful – not forgetting to give the dog some treats before she left. Mum was possibly even more grateful and both mum and her brother had their boosters done at the clinic at the same time.

Annual Health Checks (AHCs)

The learning disabilities health check is an important tool for us in helping to reduce health inequalities.

Under the national GP contract, GP practices are able to offer an annual health check to all those aged 14 and over on the practice LD register. The learning disabilities annual health check is designed to pick up a range of unmet health needs

and can also help people with a learning disability to use health services better by understanding what their local GP service can provide for them and learning how to use it.

In 2021/22, 78% of people on a learning disability register in Calderdale had an annual health check, compared with the West Yorkshire average of 74%. There has been a focus upon increasing the quality of annual health checks, and ensuring people have a health action plan. During 2021/22 colleagues across primary care have worked hard with support from the Strategic Health Facilitator (employed by South West Yorkshire Partnership NHS Foundation Trust) to deliver this ambition.

One key message that has come up from the work on annual health checks is the importance of them all being done the same way. The photograph below shows Malcolm at a CCG event with a notice emphasising this point.

Integrating services

In February 2021 the Secretary of State for Health and Social Care set out proposals in a White Paper, 'Integration and Innovation: Working together to improve health and social care for all', to build on the response to the pandemic and bring health and care services closer together. Whilst setting out legislative proposals for integrated care systems, the paper also signalled a continued focus on locally determined place-based partnerships, built on collaboration and integration.

Over the last year Calderdale's health and care organisations have begun to come together more formally to develop our local 'place' partnership: the Calderdale Cares Partnership. This is a continuation of our established history of collaboration, whilst also supporting the implementation of the government's proposals. The CCG is a key member of the Partnership, alongside partners such as the council, the voluntary and community sector, Healthwatch, NHS trusts and other providers of services.

The work of the Partnership is driven by a shared vision and is underpinned by a common framework of principles, values and behaviours. These are laid out within the Calderdale Cares Partnership Agreement, which has been developed to describe how partners are committing to working with one another for the benefit of Calderdale's population. The CCG is a signatory to this Agreement following its approval by the Governing Body in January this year.

Our Partnership will be formally led by the Calderdale Cares Partnership Board, which will be a committee of West Yorkshire's Integrated Care Board (once established). Our Partnership Board will take an inclusive approach with representation from independent lay members, Calderdale Metropolitan Borough Council, NHS West Yorkshire Integrated Care Board (once established; currently Calderdale CCG), 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.

Through our Partnership arrangements we are continuing to join up services and our workforce to achieve improved outcomes for our population, both through the delivery of the refreshed Wellbeing Strategy for Calderdale and through progressing other shared priorities.

In 2021/22, building on lessons learned from the pandemic, the Calderdale Collaborative Community Partnership Board explored expanding the integration of preventative services and programmes with other community services to achieve Calderdale Cares outcomes.

Three population groups were identified for adopting a population health management approach:

- Starting well – lost child development as a result of COVID-19, self-harm and suicide
- Working age adult – multi-disadvantage groups
- Older Age people – frailty and respiratory

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:

- The vision of the Partnership and the vision's supporting objectives
- The shared principles, values and behaviours that the Partnership have agreed to adopt through their joint working
- The governance structures and supporting arrangements underpinning the Partnership

The agreement was signed by all organisations in the Partnership and ratified by the Health and Wellbeing Board in March 2022. It came into effect on 1st April 2022.

Reconfiguring services

Plans for the reconfiguration of services in Calderdale and Huddersfield have continued to progress.

Calderdale and Huddersfield NHS Foundation Trust and Calderdale and Kirklees CCGs have undertaken significant work to engage with local people about the plans for service reconfiguration since 2013. This has enabled patients, members of the public, stakeholders and colleagues to share their views on what matters to them. Formal public consultation on the proposed future arrangements for the configuration of services took place in 2016 and the plans were modified to take account of the recommendations of the Independent Reconfiguration Panel in 2018.

A series of public and colleague involvement workshops were held in 2019 that enabled people to describe their aspirations for modern health services, delivered in buildings that offer a healing and therapeutic environment that is welcoming, calm and provides a light environment with external views; is accessible and inclusive supporting diverse patient needs; that ensures privacy and dignity and enables the optimal use of digital technology to deliver care and support. These involvement workshops informed the development of an agreed ‘Design Brief’.

The plans will see investment of circa £200m public capital funding to enable the build of a new Accident and Emergency (A & E) Department and a wider programme of essential upgrades to clinical care facilities at Huddersfield Royal Infirmary (HRI), and the construction of a new healthcare building and multi-storey car park at Calderdale Royal Hospital (CRH). These developments will establish high-quality healthcare facilities across Calderdale and Huddersfield, delivering leading edge clinical services that will improve patient safety and care. The programme of investment will also generate social value by targeting the creation of construction jobs, training and apprenticeships to support local groups and communities and will support action on climate change to reduce carbon use and emissions.

Both hospitals will provide 24/7 A & E services and a range of day-case, outpatient and diagnostic services – although whenever possible, services will be delivered in

the community and closer to people's homes. The total number of hospital beds will remain broadly as they are now.

During 2020/21 further work was undertaken to develop the estate design and service plans taking account of the 'Design Brief' principles developed in 2019. This process provided further opportunity for colleague and public involvement. These plans were brought together in the planning applications submitted to Calderdale and Kirklees Councils in 2021.

A detailed statement of Community Involvement has been published demonstrating that throughout this period a programme of stakeholder engagement with key politicians, officers, civic and community groups and local residents had taken place to either inform about the project or to continue existing dialogue. CHFT colleagues, many of whom live local to the hospital sites, were also engaged through this process.

Full Planning Permission has been given by Kirklees Council for the build of the new Accident & Emergency at HRI. Construction work has commenced with expected completion by Summer 2023. In March 2022, Outline Planning Permission for the new clinical build at CRH (to enable build of a new A&E, additional wards and theatres) and Full Planning Permission for the new multi-storey car park was approved by Calderdale Council. Work is now in progress to enable completion of these developments at CRH by 2026.

The programme of service reconfiguration will:

- Improve patient safety, quality and experience of care for people in Calderdale and Huddersfield to provide better care for patients in modern, comfortable surroundings
- Deliver attractive buildings and surroundings
- Support delivery of leading-edge hospital services
- Provide an exceptional working environment to attract and retain a highly skilled workforce
- Be operationally and environmentally sustainable.

All partners are committed to ensure that local people, colleagues and stakeholders continue to be fully involved in the next steps to implement these plans.

Working across West Yorkshire

The CCG is part of the West Yorkshire Health and Care Partnership. The Partnership, which has been operating successfully for six years, is now enhancing its work due to forthcoming legislative changes, subject to Parliamentary approval. The Partnership won the Health Service Journal Award for Integrated Care System of the Year, 2021.

The Partnership is made up of a wide range of organisations from health, Local Authorities, voluntary and the community sector. The partnership works closely together to plan services and address the challenges that face the health and care sector in the area. The CCG is fully involved in the Partnership's work.

The Partnership takes a place-based approach across Bradford District and Craven, Calderdale, Kirklees, Leeds, and Wakefield that highlights the strengths, capacity, and knowledge of all those involved. This way of working is supported by West Yorkshire wide priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities and children and young people.

Our way of working is supported by our politically led Partnership Board which brings partners together and is supported by the West Yorkshire Combined Authority, and Local Resilience Forum. Our approach is supported by strong provider organisations, including West Yorkshire Association of Acute Trusts, the Mental Health, Learning Disabilities and Autism Collaborative (MHLDA), and the current Joint Committee of Clinical Commissioning Groups.

The Partnership's strength provides greater opportunities to deliver its Five Year Plan ambitions, ensuring that **all** people are given the best start in life, are able to remain healthy and age well. Examples of the positive difference made together can be seen on the Partnership's website.

This collaborative approach has been central to handling the pandemic in maintaining personal protective equipment supply, coordinating testing, helping over 100,000 people shielding, rolling out the vaccination programme with volunteer support, and investing £12million in our social care sector to retain their valuable skills to deliver care in people's homes.

Another example can be seen in the establishment of the Partnership's health inequalities work. This identified a further 53,000 unpaid carers for early vaccine take up, delivering recommendations from our race review, investing £1million in warmer homes, as well as addressing the inequalities for people with a learning disability.

The Partnership is committed to meaningful conversations with people, including colleagues to inform our work. Examples can be seen in the stroke reconfiguration of hyper acute units; assessment treatment units for people with complex learning disabilities; 'Looking out for our neighbours' – an award-winning campaign involving over 400 community organisations; the award winning staff check-in suicide prevention campaign; perinatal mental health work; our anti-racism movement; climate change and improving the uptake of cancer screening and Let's DiaBEAT this.

Managing finances effectively

During 2021/22 the planning cycle continued to operate under a temporary finance regime due to the impact of COVID-19. The planning cycle for the year was split between the period April 2021 – September 2021 and October 2021 – March 2022.

As a result of these extraordinary changes to the NHS finance regime the CCG's budgets and expenditure profile was significantly different to the pre COVID-19 financial plan.

The expectation in 2021/22 was that the CCG was required to deliver a balanced financial plan and to deliver the statutory financial duties and targets against which the CCG's performance is monitored. Although the CCG has experienced significant challenges, we are pleased to be able to report that the CCG has met all its statutory financial duties.

A summary of the CCG allocations and expenditure is shown in the table below:

Description	Allocation £'000	Expenditure £'000	Variance £'000
Accumulated surplus brought forward	-5,569	0	-5,569
Programme allocation	-324,251	327,512	3,261
Primary medical services allocation	-35,298	35,299	1
Running cost allocation	-4,311	4,292	-19
Additional COVID related allocations	-3,245	0	-3,245
Total allocation	-372,674	367,103	-5,571
Change in accumulated surplus	0	0	-2

The table below shows a summary of the CCG's performance against these duties in 2021/22.

Financial duty	Achieved/Not Achieved	Performance in 2021/22
Achieve operational financial balance	Achieved	Delivered an increase in year surplus of £2k
Revenue administration resource use does not exceed the amount specified in Directions	Achieved	The CCG had a notified running cost allocation of £4,311k with expenditure of £4,292k
Maintain capital expenditure within Capital	Achieved	No capital expenditure this financial year
Manage cash within the CCG's Cash Limit	Achieved	Cash balance of £34k
Public Sector Payment Policy – payment of 95% of invoices within 3 days of the invoice date or goods received if this is later (non-statutory duty	Achieved	98.4% on value of invoices / 97.3% on number of invoices

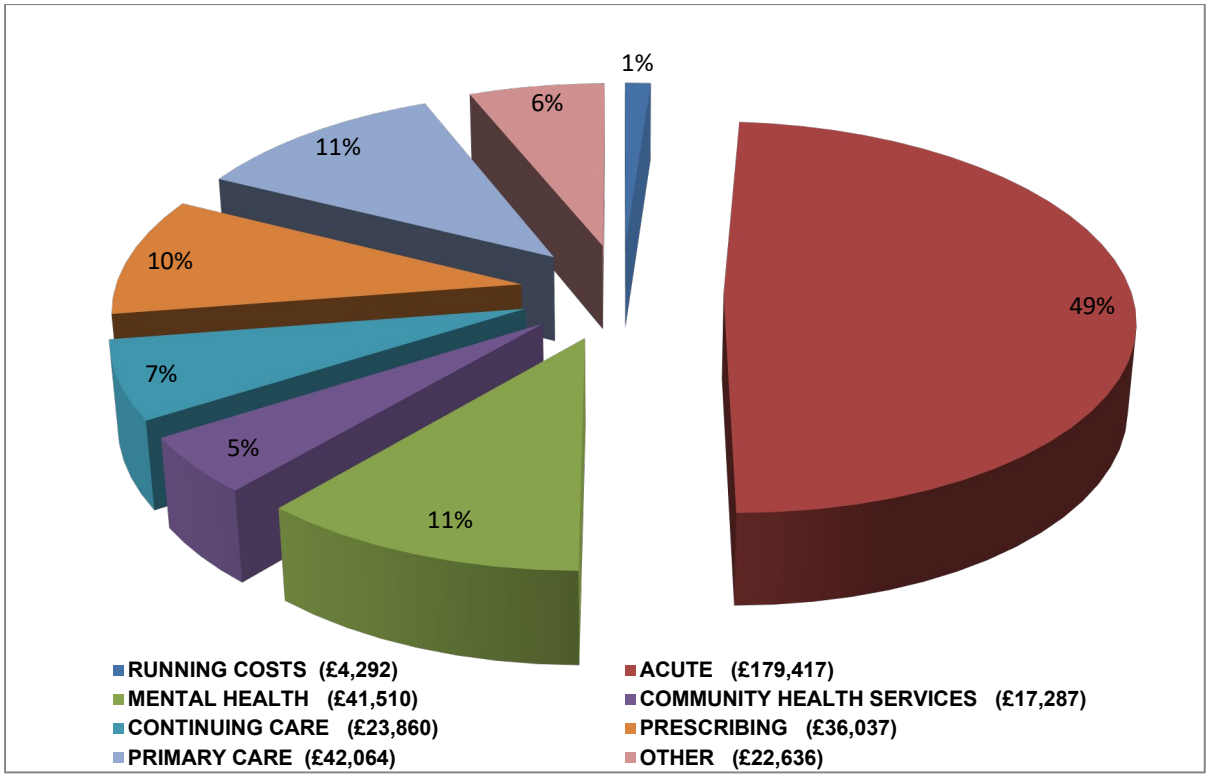
The CCG started the year with an accumulated surplus of £5.569m and had in year allocations of £367.105m including £3.245m of COVID related allocations, giving

total allocations of £372.674m. In year expenditure was £367.103m, giving an accumulated surplus of £5.571m which is an in-year increase of £0.002m.

During 2021/22 we invested over £367m to improve the health and care of local people through the commissioning of high-quality services. The CCG was able to invest in specific priority areas which included:

1. Investments into Primary Medical Services to support the delivery of the GP Forward View
2. Delivery of the Mental Health Investment Standard and investments to support the delivery of the Five Year Forward View for Mental Health

The actual expenditure in the different sectors as well as the proportion of spend against the CCG's management cost allowance is set out in the diagram below:



As shown in diagram: Running Costs 1 % (£4,292) Mental health 11% (£41,510), Continuing Care 7 % (£23,860), Primary Care 11 % (£42, 064), Acute 49% (£179,417), Community health services 5% (£17,287), Prescribing 10% (£36,037), Other 6 % (£22,636)

The publication in February 2021 of HM Government's White Paper Integration and Innovation: Working together to improve health and care for all set out proposals for a future integrated care system.

At the heart of the changes set out in the White Paper is the proposal to establish Integrated Care Boards (ICBs) as statutory bodies in all parts of England and these proposals will be implemented from 1st July 2022 following Royal Assent of the Health and Social Care Act 2022.

In West Yorkshire, NHS Calderdale CCG will be abolished along with four other neighbouring CCGs, and a new statutory entity, the NHS West Yorkshire Integrated Care Board will assume statutory responsibility for the day to day running of integrated care systems for the provision of services to patients.

Although NHS Calderdale CCG will cease to exist as a statutory body, it will retain its identity as a distinct Place with delegated responsibilities within the West Yorkshire Integrated Care System. To support this, financial plans for 2022/23 have been developed for the full year of 2022/23, of which the first three months will be reported as part of the statutory responsibilities of the current CCG and the remaining nine months implemented under the statutory responsibility of the new NHS West Yorkshire Integrated Care Board.

Financial plans for the year 2022/23 have been developed collectively across the West Yorkshire system using agreed principles which have patient and population needs as their primary focus to minimise the impact of COVID-19 on planned and unplanned services (physical and mental health) across the West Yorkshire Integrated Care System, supporting the recovery and reset of services and reducing health inequalities.

Accountability Report

ROBIN TUDDENHAM

Accountable Officer

20 June 2022

Introduction

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises three sections:

The Corporate Governance Report sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The Remuneration and Staff Report describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The Parliamentary Accountability and Audit Report brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members' report

Member profiles

The CCG is a membership organisation. It consists of the 21 GP practices that are based in Calderdale. The practices have formed themselves into five groups known as Primary Care Networks (PCNs).

The Calderdale PCNs are shown in the table below with their populations at March 2022[2].

Primary Care Network	Practices	Clinical Director	Number of patients
Calder & Ryburn	Bankfield Surgery, Brig Royd Surgery, Stainland Road Medical Centre and Station Road Surgery	Dr F Azam	42,600
Central Halifax	Boulevard Medical Practice, King Cross Practice, Rosegarth Practice and Spring Hall Group Practice	Dr N Akhtar	54,100
Lower Valley	Church Lane Surgery, Longroyde Surgery, Northolme Practice, Rastrick Health Centre and Rydings Hall Surgery	Dr A Ross (until 4th July 2021) Dr J Malone (from 5th July 2021)	44,600
North Halifax	Beechwood Medical Centre, Caritas Group Practice, Keighley Road Surgery, Lister Lane Surgery and Plane Trees Group Practice	Dr G Chandrasekaran	46,300
Upper Valley	Calder Community Practice, Hebden Bridge Group Practice and Todmorden Group Practice	Dr N Taylor	34,800

Since the CCG's establishment, strong clinical engagement of the member practices has been enabled through Practice Commissioning Leads meetings, locality meetings, the Medicines Advisory Group and the Practice Managers Action Group.

[2] Derived from NHS Digital **Number of people registered with a GP Practice – March 2022** https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/march-2022

This year as last, to respond to the challenges presented by the pandemic, the Practice Commissioning Leads meetings were paused. Regular virtual meetings have been held with the Local Medical Committee Executive and the Clinical Directors of the Primary Care Networks. The Practice Managers Action Group and the Medicines Advisory Group continued to meet virtually.

Practice Learning Time was reinstated through 2021/22 to enable continued training and development for General Practice.

CCG Chair and Accountable Officer

Dr Steven Cleasby is the CCG's Chair. Robin Tuddenham is the CCG's Accountable Officer.

The Governing Body and its Committees

The CCG's membership has delegated authority to the Governing Body to oversee the work of the organisation and make decisions on its behalf as set out in the Scheme of Reservation and Delegation incorporated in the CCG's Constitution. The composition of the Governing Body as set out in the CCG's Constitution can be found below.

Composition of the Governing Body 2021/22 and up to the signing of the Annual Reports and Accounts on 20 June 2022

Membership type	Name	Role
GP as elected by the member practices	Dr Steven Cleasby	Clinical Chair
GP as elected by the member practices	Dr Caroline Taylor	Clinical Vice Chair
GP as elected by the member practices	Dr James Gray (until 31st January 2022)	GP Member
GP as elected by the Member practices	Dr Farrukh Javid	GP Member

Membership type	Name	Role
Lay member	Professor Peter Roberts	Lay Member (Audit) / Conflict of Interest Guardian and Freedom to Speak Up Guardian
Lay member	John Mallalieu	Deputy Chair/Lay Member (Finance and Performance)/ Chair of Commissioning Primary Medical Services Committee
Lay member	Alison Macdonald (until 31st December 2021)	Lay Member (Patient and Public Involvement)
Lay member	Denise Cheng-Carter (from 27th January 2022)	Lay Member
Lay Advisor to the Governing Body	Denise Cheng-Carter (until 26th January 2022)	Lay Advisor
Secondary Care Specialist	Dr Robert Atkinson	Secondary Care Specialist
Registered Nurse	Professor Rob McSherry	Registered Nurse
Accountable Officer	Robin Tuddenham	Accountable Officer
Chief Operating Officer	Neil Smurthwaite	Chief Operating Officer
Director of Finance	Lesley Stokey	Director of Finance
Chief Quality and Nursing Officer	Penny Woodhead	Chief Quality and Nursing Officer

Invitations to assist the Governing Body

Role	Name	Job title
Director of Adult Services or another Director that holds a health and social care portfolio (Calderdale Council)	Iain Baines	Director of Adult Services
Director of Public Health (Calderdale Council)	Debra Harkins	Director of Public Health

Committees, including Audit Committee

Details of the Governing Body and Committee membership (including the composition of the Audit Committee), terms of reference and attendance during the reporting year can be found in the Governance Statement and in the Remuneration and Staff Report (Remuneration and Nomination Committee).

Register of interests

CCGs are required to make arrangements to manage actual or potential conflicts of interest so that decisions by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest. The CCG has a number of systems and processes in place to manage conflicts of interests. These are set out in the CCG's Constitution, our Management of Conflicts of Interest Policy and our Standards of Business Conduct Policy.

The registers of interest for our Governing Body and Committees, Associates and Subject Specialists, Senior Management Team and CCG members can be found on our website.

Further information on the internal audit of our arrangements for the management of conflicts of interest is contained within the Governance Statement.

During 2021/22, the CCG did not have any personal data-related incidents reported that met the required threshold for notification to the Information Commissioner's

Office. Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject), as defined by the UK General Data Protection Regulation and the Data Protection Act (2018).

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Calderdale CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. At some point in the future public bodies with a budget of £36 million and over will legally be required to complete and publicise a Modern Slavery Annual Statement, as part of Transparency in Supply Chains. Announcement from Government on when this is being legalised is awaited.

The 2021 Government Annual Report on Modern Slavery noted in 2020 there were 10,613 potential victims of modern slavery referred with 47% of those children. The most common nationality of potential victims in 2020 was UK nationals, accounting for 34% of all referrals followed closely by Albanian and Vietnamese nationals.

The CCG's Safeguarding Team plays an integral leadership role on Modern Slavery across the health community and communicates key information across health. The team links into both the West Yorkshire Anti-Slavery Partnership meetings and the Calderdale Modern Slavery Delivery Group to be able to fulfil this safeguarding responsibility.

Key workstreams that the CCG Safeguarding Team have driven around Modern Slavery this year are continuing to raise awareness amongst frontline health professionals to identify and support potential victims. The Team has also linked in with key partners such as police to deliver training on local case studies and the impact on victims.

Key Modern Slavery updates are included in the CCG's Safeguarding Annual Reports.

Statement of Accounting/Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Robin Tuddenham as the Accountable Officer of NHS Calderdale CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money

1. Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
2. Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended)

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year. In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

1. Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
2. Make judgements and estimates on a reasonable basis
3. State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
4. Prepare the accounts on a going concern basis
5. Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Calderdale CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

ROBIN TUDDENHAM
Accountable Officer
20 June 2022

Governance statement

NHS Calderdale CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 31st March 2022, the CCG had not been subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively,

efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The Governance Framework for the CCG is set out in our Constitution. It covers:

1. Statutory duties and responsibilities of the CCG
2. Details of how we are configured, our governance structure and decision-making processes
3. The roles and responsibilities of the Governing Body and committees
4. The vision and values of the organisation and adherence to the Nolan principles on Standards in Public Life and the NHS Constitution

The provisions of the CCG's Constitution are supported by our Standing Financial Instructions and Standing Orders as well as a suite of policies and procedures.

Responsibilities of the CCG membership body

The CCG is a membership body which consists of the 21 general practices in Calderdale. The member practices are responsible for agreeing the vision and values and overall strategic direction of the CCG. A number of decisions are reserved to the membership and these are set out in the Calderdale CCG Scheme of Reservation and Delegation.

These include approval of:

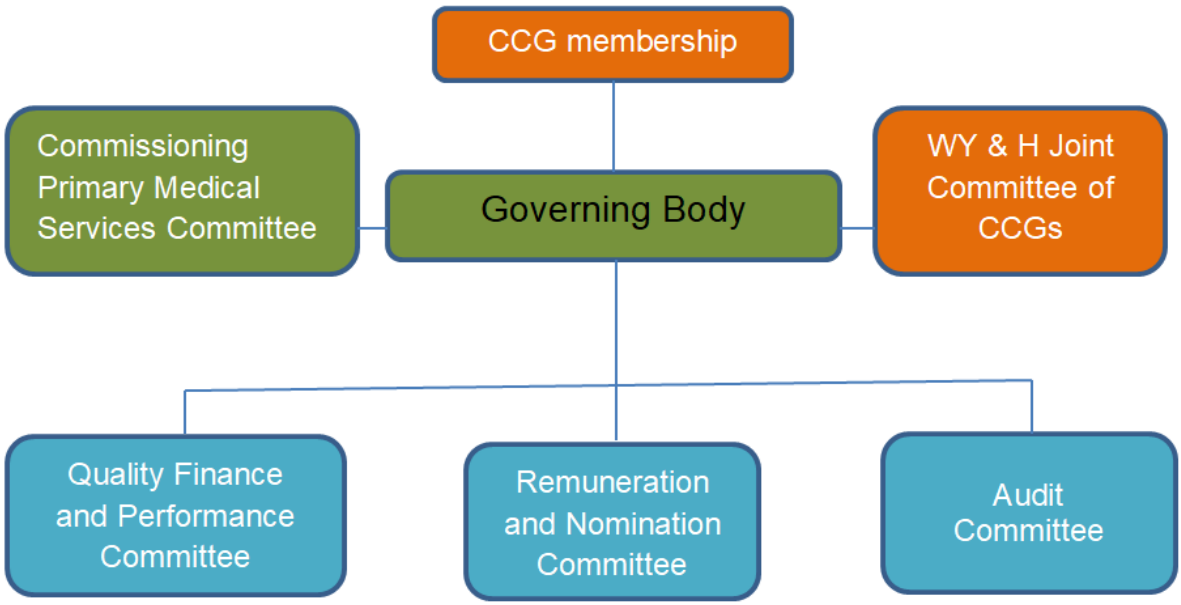
1. Applications to NHS England on any matter concerning changes to the CCG's Constitution
2. The overarching Scheme of Reservation and Delegation
3. The arrangements for appointing GPs or Nurse Practitioners to represent the membership on the Governing Body; and for the recruitment, appointment and removal of non-practice representatives
4. The establishment of committees of the CCG, delegating to them the exercise of any CCG functions as appropriate

Further detail on the key responsibilities, membership, attendance and highlights of the membership's work over the year is contained within the Members' Report on pages 88 to 96, Appendix 1 (pages 117 to 120) and page 138.

The CCG's Scheme of Reservation and Delegation sets out those decisions that are delegated by the membership to the Governing Body and its committees. These include approval of:

- The arrangements for discharging the CCG's statutory duties associated with its commissioning functions
- The CCG's commissioning plan following engagement with member practices
- The CCG's operating structure, corporate budgets and risk management arrangements
- The arrangements for co-ordinating the commissioning of services with other CCGs and/ or with the Calderdale Council, where appropriate
- Arrangements for any risk sharing or pooled budgets
- Process for the appointment of the CCG's external auditors

The diagram below shows the Governance structure of the CCG



The membership of the Governing Body and its committees, together with the attendance records is set out in Appendix 1 at the end of the Governance Statement (pages 117 to 120). Attendance at the Remuneration and Nomination Committee is set out in the Remuneration and Staff Report on page 138.

Work of the Governing Body

The role and responsibility of the Governing Body is to ensure that the CCG has appropriate arrangements in place so that it can exercise its functions effectively, efficiently and economically and with openness, transparency and candour. In practical terms this means that the role of the Governing Body is to formulate and hold the organisation to account for the delivery of its strategy, to provide leadership in terms of shaping a healthy culture across the CCG and to seek assurance that our systems of internal control are robust and reliable.

Governing Body key activities in 2021/22

The Governing Body is actively involved in the formulation of the CCG's strategic priorities and ensuring their delivery. Supported by the Senior Management Team, this activity is taken forward by the Governing Body's clinical leads and through the business of our formal Governing Body meetings held in public.

Key areas of activity this year have been:

1. Continuing to work with partners and the local population to respond to the challenges of the COVID-19 pandemic
2. Assuring themselves of robustness of the CCG's response and its participation in the local, regional and national efforts to tackle the continuing impact of the pandemic
1. Continuing to work with the Health and Wellbeing Board and its partners on the delivery of the Wellbeing Strategy for Calderdale which supports the delivery of Calderdale Cares and Vision 2024
2. Developing primary and community care
3. Working with Calderdale Council and the CCG membership to support the delivery of Active Calderdale and the ambition that everyone in Calderdale is able to live a larger life, for longer through physical activity
4. Continuing to transform hospital and community services

5. Right Care, Right Time, Right Place – hospital service change
6. The CCG's response to the Climate Emergency
1. Oversight of Calderdale Collaborative Community Partnership and the support of Primary Care Networks
2. Performance management and compliance with statutory and regulatory duties

Throughout the year the Governing Body and its committees have continued to maintain a strong focus on the CCG's performance and performance across the system. It has sought and received assurance in five key areas:

1. Quality, safety and equalities
2. Finance, contracting and recovery
3. Performance
4. Risk management and information governance
5. Workforce

The Governing Body has received the following reports: Annual Statement of Public and Patient Involvement 2020/21, the Joint Safeguarding Adults and Children's Annual Report 2020/21, the Complaints Annual Report 2020/21 and the Public Sector Equality Duty Report 2022.

The Governing Body has also had a strong focus on partnership working with its member practices, across Calderdale and with the wider West Yorkshire Health and Care Partnership.

Further information on the CCG's key activities during the year, including our partnership working can be found in the Performance Report on pages 26 to 74.

Governing Body Performance

Under the leadership and oversight of the Governing Body, the CCG has delivered its financial plan and has met all its statutory financial duties. Whilst there have continued to be real challenges in terms of performance on some of the NHS Constitution standards and national targets, the level of performance in the Calderdale system remains strong when benchmarked with others nationally.

The committees have demonstrated the right level of focus and grip, enabling them to provide the Governing Body and NHS England with the assurance needed on the quality of services being commissioned, the financial position, system-wide performance and compliance with statutory and regulatory duties.

In summer 2021, the CCG received its annual assessment letter from NHS England, based on rigorous place assurances. The letter reflected the good leadership work over the previous 12 months across place.

The focus of the Quality Finance and Performance Committee this year has been on the quality and financial aspects of the response of the CCG and partners to the COVID-19 pandemic. The Committee has continued with its usual business, approving pathways and specifications, and receiving regular reports on quality and safety and finance and performance, as well as annual reports on joint safeguarding adults and children, complaints, children looked after and care leavers health, Learning Disabilities mortality reviews and the Public Sector Equality Duty.

The Commissioning Primary Medical Services Committee has made a number of important decisions about GP practice contracts/premises demonstrating a high level of scrutiny and commitment to ensure that patients are receiving good quality care and that mitigating actions are in place to support those affected including the vulnerable.

The Audit Committee has continued to provide important assurance to the Governing Body about the robust risk management arrangements and systems of internal control that are in place. This assurance is supported by the independent audit reports produced by Audit Yorkshire.

Finally, the Remuneration and Nomination Committee has considered and made recommendations to the Governing Body on remuneration and made good progress on discharging its responsibilities for nominations matters under its wider remit.

There has been excellent attendance at meetings by Governing Body members, advisors and officers, providing the right level of scrutiny and discussion in the meetings.

Further detail on the performance and activities of the CCG can be found in the Performance Report on pages 12 to 74.

Governing Body and Committee effectiveness

The Governing Body has reviewed and considered its effectiveness during the year, considering its Governing Body's composition, culture and priorities.

Work of the Governing Body committees

Quality Finance and Performance Committee (QFPC)

The role of the Quality, Finance and Performance Committee is to advise and support the Governing Body:

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

Work of the Quality Finance and Performance Committee: Highlights have included:

- Reviewing and approving service specifications, including Improving Access to Psychological Therapies, Lead Provider for Integrated Community Beds, six enhanced services, Calderdale Choice in All-Age Neurodiversity (ASD/ ADHD) and community dermatology
- Agreeing to implement the interim approach to the personal wheelchair budget pilot
- Approving the Urgent Community Response Service Standard Operating Procedure
- Approving the Trauma Informed Personality Disorder Pathway
- Approving the CCG's procurement policy, a number of safeguarding policies and the complaints policy
- Approving the draft action plan in response to the recommendations made in the 'Burnt Bridges?' Safeguarding Adult Review (see pages 39 to 41) and agreeing to monitor delivery against the action plans going forwards
- Continuing to seek and receive assurance in relation to the quality of services we commission, and financial and performance matters
- Continuing to provide advice and a steer on quality, finance and performance issues relating to the CCG's local response to COVID-19

Commissioning Primary Medical Services Committee (CPMSC)

The Commissioning Primary Medical Services Committee (CPMSC) has responsibility for the management of the functions and powers delegated to the CCG by NHS England. The Committee makes decisions on the review, planning and procurement of primary medical care services in Calderdale. In order to support this, the Committee receives regular financial reports on the delegated and non-delegated budgets, as part of the primary care assurance report and tool, and on work supporting the delivery of the General Practice Forward View and the CCG's strategic intent for primary care. The Committee continues to make sound decisions whilst ensuring that conflicts of interest are managed appropriately.

Work of the Commissioning Personal Medical Services Committee: Highlights have included:

- Approving a quality assurance and monitoring process for General Practice which has led to the development of a local Calderdale General Practice Dashboard
- Ensuring a robust procurement process and evaluation had been followed for for selecting the providers of an Interim Community Phlebotomy Service and approving the identified bidders
- Managing the closure of a branch surgery effectively, in line with the NHSE policy and guidance manual
- Reviewing and approving the continuation of the Special Allocation Scheme procedure
- Reviewing and approving a proposal to create a General Practice Primary Care Network hub for North Halifax at Mixenden
- Reviewing and approving a direct award of an Alternative Provider of Medical Services contract for Calderdale Community Practice to the current provider for a further two-year period
- Receiving updates on key areas of work that support the delivery of General Practice services

Remuneration and Nomination Committee

The Remuneration and Nomination Committee has the following key functions:

1. To advise the Governing Body on determinations about the appropriate remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it and on provisions for other benefits and allowances under any pension scheme established by the CCG
2. To advise the Governing Body on any arrangements for termination of employment of the Chief Officer or the Chief Finance Officer/Deputy Chief Officer
3. To review and approve Human Resources policies on behalf of the Governing Body in accordance with the CCG's scheme of reservation and delegation

4. To ensure that the Governing Body and its committees have the appropriate balance of skills, experience, knowledge, perspectives and independence to enable them to discharge their respective duties and responsibilities effectively

Work of the Remuneration and Nomination Committee: Highlights have included:

1. Undertook the annual review of Non Agenda for Change pay awards for Very Senior Managers (VSMs) and Governing Body members, managing conflicts of interest appropriately and making recommendations to the Governing Body
2. Oversaw the performance review process for Very Senior Managers and all Governing Body members
3. Made recommendations on final reviews for Governing Body members
4. Reviewed and approved all HR policies
5. Approved a new policy - Mandatory Coronavirus Vaccinations in Care Home Policy and Procedure, developed to comply with the national Government mandate, and extended to include those who carry out regulated activity in regulated establishments (the legislation was revoked in March 2022 and the policy is no longer applicable nor a requirement for staff to be fully vaccinated)
6. Made recommendations to the Governing Body on changes to Committee membership
7. Received information and assurance concerning the work being undertaken by the CCG and HR colleagues in support of CCG staff during the pandemic and the move to home working

Audit Committee

The role of the Audit Committee is to provide the CCG's Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions directing the CCG in so far as they relate to finance and conflicts of interest. The Governing Body has approved and keeps under review the terms of reference of the Audit Committee.

In addition, the Governing Body has delegated scrutiny of the following functions to the Audit Committee – audit, governance, risk management and internal control, and Emergency Preparedness and Business Continuity

Work of the Audit Committee: Highlights have included:

1. Provided the Governing Body with the necessary assurances that there are effective systems and processes in place to keep the organisation safe, to comply with statutory and constitutional requirements and to be able to deliver the CCG's objectives
2. Approved the CCG Annual Report, Annual Governance Statement and Accounts 2020/21 on behalf of the Governing Body
3. Approved updates/revisions to policies on Management of Conflicts of Interest, Anti-Fraud, Bribery and Corruption Policy, Standards of Business Conduct and a minor update to the Information Governance Policies book

West Yorkshire Joint Committee of CCGs

The Committee has delegated authority from the West Yorkshire CCGs to take joint decisions on agreed priorities. The Committee also makes recommendations when a collaborative approach across West Yorkshire will help to achieve better outcomes. The Committee has an independent lay chair, three CCG lay members and two representatives from each West Yorkshire CCG. As a result of COVID-19, all meetings have continued to be held virtually in 2021/22 and have been live streamed.

Information about the meetings of the Joint Committee can be found on the WY&H Health and Care Partnership website.

Work of the Joint Committee of CCGs: Highlights have included:

1. Endorsed commissioning arrangements for Assessment and Treatment Units for people with a learning disability
2. Agreed the extension of the Healthy Hearts project for a further twelve months, to support the implementation of phases two and three
3. Agreed Diabetes Treatment Guidance for adoption across West Yorkshire and Harrogate
4. Supported the NHS England Evidence-Based Interventions guidance for adoption as commissioning policy

5. Supported joint work on autism across West Yorkshire and supported a proposal to use additional resources collaboratively to make the greatest impact in the short-term and to establish the basis of future collaboration
6. Agreed the commissioning statement on Lidocaine plasters for the treatment of pain in children as policy across the West Yorkshire CCGs
7. Agreed an amendment to the Hydroxychloroquine and Chloroquine Pathway and Policy to reflect clinical guidance

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, as the UK Code is based on the underlying principles of good governance (accountability, transparency, probity and sustainability of the organisation over the longer term) the CCG has ongoing regard for the code and takes the principles relevant to the CCG into account when reviewing its systems, processes and governance arrangements.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Further information on how the CCG has fulfilled its statutory duties can be found in the Performance Report (pages 12 to 74). This includes compliance with the duty to consult the Health and Wellbeing Board when reviewing the extent to which the CCG has contributed to the delivery of the joint Wellbeing Strategy.

Risk management arrangements and effectiveness

The CCG's Integrated Risk Management Framework (IRMF) describes its approach to managing risk.

The CCG manages and reports on risk in two ways:

1. The Governing Body Assurance Framework (GBAF), which focusses on principal risks to the delivery of the CCG's strategic objectives. The GBAF is seen as a 'live' document but is formally reviewed and updated twice a year. More detail regarding the GBAF is provided in the Internal Control Framework section of this report on pages 107 to 108
2. The Corporate Risk Register focusses on operational risks that may rise and fall within relatively short time periods. The CCG now operates four risk review and reporting cycles per annum

The process that we use to identify, evaluate and control risks is set out below.

Risk Identification

A risk can only be managed if it is identified. Bringing together information from different sources provides assurance that all significant risks have been captured. The key sources of information used by the CCG to check completeness of risk capture are:

1. Performance indicators reporting variance from plan within commissioning performance contracts and related reports
2. The results of planned reviews of compliance with statutory and regulatory requirements, e.g. Care Quality Commission (CQC) standards and reviews, Ofsted reviews, fire and health and safety regulations, information governance systems including the Data Security and Protection Toolkit
3. Routine review of serious incidents and complaints to identify emerging risks, themes or specific concerns
4. Use of intelligence through partners and stakeholders
5. Ensuring contact with regional and national professional associations that provide early warning of serious adverse events
6. Review of the West Yorkshire Community Risk Register

7. Risk review and discussion through operational meetings (Senior Management Team, project or programme management or contract management meetings), and the formal governance arrangements, i.e. the Governing Body and its committees, which highlight risks that need to be reflected in the risk register, assessing the mitigating/management actions and risk rating

Risk assessment and risk rating

A 5x5 (Likelihood x Impact) matrix is used to arrive at the risk rating. The target score is identified by assessing the additional controls that can be put in place together with level at which the risk can be accepted (risk tolerance) - taking into account the CCG's risk appetite.

Risk rating matrix

As shown below in Table 1, risk scores (both current and target) are calculated by multiplying the potential impact or consequence by the potential likelihood or frequency level to provide a risk score utilising a 5 x 5 matrix scoring system which produces a range of scores from 1 to 25. Likelihood multiplied by Impact equals Risk Score.

Table 1: Risk Matrix:

Likelihood	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Impact: Insignificant 1	1	2	3	4	5
Impact: Minor 2	2	4	6	8	10
Impact: Moderate 3	3	6	9	12	15
Impact: Major 4	4	8	12	16	**20**
Impact: Catastrophic 5	5	10	15	**20**	**25**

The risk scores obtained from the risk matrix at Table 1 are assigned grades and priorities as follows in Table 2 shown below.

Table 2: Risk Grading and Priorities

Risk Grading	**Colour coding**	**Priority**
Critical Risk (20-25)	**Black**	1
Serious Risk (15-16)	**Red**	2
High Risk (8-12)	**Yellow**	3
Moderate Risk (4-6)	**Green**	4
Low Risk (1-3)	**White**	5

Risk Recording, Reviewing and Monitoring

The CCG has an integrated approach to risk, supported by the risk register system. This system consists of an auditable review process and supports the monitoring and updating of risks within review deadlines.

Once every risk cycle, the Senior Management Team (SMT) reviews all the risks on the register, identifies any new risks and assesses the actions to manage/mitigate the risk and the risk rating. Any risks rated 15 or above are reported to SMT by exception only outside this quarterly review. The Quality Finance and Performance Committee reviews the risks relating to its remit. Risks rated as 'Serious'(i.e. at 15 or above) are submitted to each of the Governing Body meetings. All Commissioning Primary Medical Services risks are reported into the Commissioning Primary Medical Sservices Committee. A 'Critical Risk' report, with an associated action plan is produced for risks rated 20 or above.

Risk Appetite

The CCG's aim is to minimise the risk of harm wherever possible to service users, the public, staff, members and other stakeholders. However, the CCG also recognises the need to take considered risks in some areas (for example, transformation / re-design of services) and that an overly risk averse approach can be a threat to the achievement of some strategic objectives.

All risks on the CCG Risk Register specify the target risk rating (i.e. the level at which the risk can be tolerated). The acceptability of the target risk score is subject to review by the Senior Management Team and relevant committee as part of the normal review and reporting process for the Risk Register. Our risk appetite informs our approach to decision making

Embedding risk management in the CCG's activity

Our risk management system is complemented by other control mechanisms which are designed to deliver assurance on the identification, mitigation and/or management of risks. These control systems include our systematic approach to completing impact assessments in equality, quality and data privacy as part of our service improvement processes and recovery plans.

The risk management of potential fraud, bribery and corruption, data security and conflicts of interest are all supported with appropriate policies, mandatory training, briefings as well as compliance audits. These systems are audited on an annual

basis by our internal auditors (Audit Yorkshire), External Audit (Grant Thornton) and NHS Counter Fraud Authority.

All these mechanisms, together with the use of the intelligence provided by performance, quality and safety and primary care assurance dashboards as well as partner and stakeholder engagement put us in a stronger position to prevent/manage risks to the CCG.

Incident reporting

An indicator of good staff and patient safety management is the incident reporting culture. One of the key complementary systems is the CCG's incident reporting system.

The CCG uses the DATIX online reporting system and encourages all staff to report incidents or near misses in order to provide learning and enable the CCG to reduce the likelihood of the incident re-occurring. Feedback on the learning is provided to staff in an anonymised form through the CCG's communication channels including the monthly staff workshop where appropriate.

GP practices are actively encouraged to report all incidents on DATIX. The more incidents that are reported the more information the CCG has to act upon in order to learn from incidents and consequently prevent recurrence.

Involving partners and other stakeholders

The CCG has close working relationships with a number of stakeholders and has a strategic risk management objective to develop risk management arrangements for key partnerships and for major programmes of work.

The CCG has adopted a programme management approach for all major transformation activities. Risk and issues logs are produced for all programmes and are reported to the relevant Programme Board and through to the corporate risk register as required.

Key partnerships for the CCG include a number of NHS providers, Pennine GP Alliance, Calderdale Council and the third sector, voluntary and community groups, and patient and service user groups. In addition to having robust internal scrutiny arrangements, partnership organisations are required to contribute to relevant joint programme / project risk registers and frameworks.

The CCG endeavours to manage risk across organisational boundaries and involve partners in aspects of risk management as appropriate to support the delivery of system-wide objectives.

This is achieved by the following:

1. Maintaining a corporate record of the key partnerships for the organisation
2. Prioritised implementation of programme / project risk registers for those areas categorised as high risk. The risk registers are reviewed through appropriate opinion and external governance frameworks

Risks relating to the provision of commissioning support services are managed through contract management meetings.

The CCG has a robust and systematic approach to risk management. Leadership is provided by the Governing Body and Accountable Officer to ensure that the CCG has a positive and open approach to the identification and management of risk. The Integrated Risk Management Framework (IRMF) sets out the governance structures and responsibilities for risk management.

Effectiveness of Governance Structures

The Governing Body receives assurance on the effectiveness of the governance and risk management structures, systems and processes through its internal assurance processes.

The Governing Body is responsible for approving the Governing Body Assurance Framework (GBAF) and for receiving reports on 'serious' risks (i.e. those rated 15 or above) at each of its formal meetings as well as a separate report on 'Critical' risks (i.e. those risks rated 20 or above).

The Commissioning Primary Medical Services Committee receives reports on all its risks at each of its meetings in public and an update on all relevant risks on a quarterly basis.

Responsibilities of the Senior Management Team and Committees

The roles and responsibilities of staff as risk owners, and Senior Management Team as reviewers are clearly set out in the Integrated Risk Management Framework. This ensures that there is clarity about the levels of accountability for the management and monitoring of risks. The Senior Management Team ensures that there are robust control measures in place and that the appropriate assurances are generated. This risk review process includes an assessment as to whether the risk should be incorporated into the Governing Body Assurance Framework or the corporate risk register – depending upon the strategic or operational nature of the risk.

Reporting lines and accountabilities between the Governing Body, its Committees and the Senior Management Team

The Senior Management Team undertakes the first formal review of all risks at the beginning of each reporting cycle and identifies any new risks or changes to risk score as they arise.

This is followed by a review in the Quality Finance and Performance Committee. The Committee has clear responsibility for the monitoring of existing risks and identification of further risks as set out in its terms of reference. The same approach is used for the GBAF, with senior managers and Governing Body leads reviewing the principal risks prior to review by this Committee and Governing Body.

The Audit Committee has the responsibility for providing assurance to the Governing Body on the effectiveness of the CCG's governance and risk management systems and processes.

It is supported in fulfilling its responsibilities by our internal audit providers (Audit Yorkshire) who report on the findings of the annual mandated audit of governance and risk management.

Timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's statutory obligations

The assessment of risks is a continuous process informed by:

- Senior Management Team identifying new risks or changes to risk profile
- Financial, contracting, recovery, performance, quality and safety reports, which are submitted to the Quality Finance and Performance Committee
- Finance, contracting and primary care assurance reports submitted to each Commissioning Primary Medical Services Committee meeting in public
- Scrutiny of the Risk Register and the Governing Body Assurance Framework at the Committees and Governing Body

Degree and rigour of oversight of CCG performance by the Governing Body

The Governing Body provides challenge and scrutiny of the suite of performance reports referred to above. These reports focus on the delivery of the key performance targets, quality and safety, financial and contractual requirements.

This level of oversight, which has been supported by the detailed work of the Committees, enables the Governing Body to maintain a clear grip on our performance, quality and financial targets.

Staff and Governing Body training

All risk owners, senior reviewers and Heads of Service are trained and equipped to manage risks in a way that is appropriate to their authority and duties. Bespoke training is provided to individuals and teams as required.

The Governing Body continues to assess its risk appetite in response to the ongoing shifts in our operating environment.

Learning from good practice

Our CCG is committed to the principles of creating a positive learning environment which is open and honest and which seeks to improve our systems and processes - keeping local people and staff safe. Whilst we work hard to put systems and processes in place that prevent incidents, we recognise that on occasion things go wrong. When that happens, we want to learn from those incidents, improving the way that we do things.

We also seek to learn from good practice elsewhere. Valuable learning information is provided to staff and our member practices through a variety of systems and activities:

- Incident and post-incident reporting;
- Complaints received;
- Issues raised via Patient Advice and Liaison Services (PALS);
- Feedback from Independent Contractors and their associated bodies.

Risk Assessment

Risk assessments in relation to governance, risk management and internal control are carried out through a number of mechanisms including:

1. Through internal governance arrangements taking account of self-assessment activity, the review of the CCG Constitution and standing financial instructions, new national guidance or regulations and the findings from external inquiries
2. Through the annual internal audit and anti-crime audit plans carried out by Audit Yorkshire. These include the annual mandated reviews of the CCG's risk management and governance arrangements as well as audits in specified areas as identified following a risk assessment of all areas of the CCG's activities
3. Audit Yorkshire also attends the Audit Committee and meets with the Audit Committee members twice a year to discuss any concerns without the officers being present
4. Through external audit activity carried out by Grant Thornton which includes attendance at the Audit Committee, meeting with Audit Committee members twice a year to discuss any concerns without the officers being present and

focused pieces of external audit work as set out in the auditor's annual work plan, culminating in the risk review undertaken prior to annual reporting and accounts.

The outputs and recommendations from each of these reviews are presented to the Audit Committee.

Major Risks to Governance, Risk Management and Internal Control

The risks classed as 'serious' 'major' or above on the Corporate Risk Register, (i.e. those with a score of 15 or above), that have been managed during the reporting year are summarised in Appendix 2 of this Governance Statement on pages 121 to 127.

Appendix 2 not only includes more serious risks where risk mitigation meant that they were able to be closed this year but also the three critical risks that are currently on the CCG's risk register. It should be pointed out that none of these risks are unique to Calderdale and they also impact on other stakeholders. These risks have not always been categorised as critical and will regularly fluctuate in risk scoring.

The CCG continues to take a rigorous approach to the management of the risks across the system. The pressures on the system and progress being made in managing or reducing those pressures are discussed at the weekly Senior Management Team (SMT) meetings, the financial recovery meetings and work taken forward through the different teams within the organisation including primary care, service improvement, continuing healthcare, quality, finance, corporate and contracting/procurement.

The pressures, together with the actions being taken to address these whilst staying true to the values of the CCG in providing high quality, effective and safe care, are discussed on a regular basis with staff, the Governing Body and the member practices through the Practice Commissioning Leads' meetings.

The Quality Finance and Performance Committee maintains a robust oversight on the relevant risks through regular finance, performance and contract, quality and safety, primary medical commissioning reports and the review of the risk register.

The CCG is also proactive in working with partners across the system to discuss and find effective solutions to the pressures. The mechanisms for these performance management discussions include the Accident and Emergency Delivery Board, The Partnership Board, the System Recovery Group and contract management meetings.

Other sources of assurance

Internal Control Framework

The system of internal control is the set of processes and procedures in place that ensures that the CCG delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the potential impact, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Governing Body Assurance Framework (GBAF)

The GBAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the CCG. The GBAF deals with strategic and long-term risks / threats whereas the Risk Register is used to identify and manage performance based (operational) risks that may rise and fall within relatively short-term periods. The GBAF makes reference to relevant operational risks if they relate to the ability of the organisation to deliver on one or more of its strategic objectives.

All risks on the GBAF have a named Senior Manager Lead, Governing Body Lead and responsible Committee. The GBAF also details:

1. The key controls in place to manage the risk;
2. Mechanisms to provide assurance on controls (i.e. specific evidence that controls are effective and the risk is being managed);
3. Any actions being taken to address gaps or the need to strengthen controls or assurance.

The GBAF is considered by the relevant Governing Body Committees twice a year prior to submission to the Governing Body for approval. This enables a detailed review of the strategic objectives, to ensure that these sufficiently reflect, for example, the increasing focus of our work with partners on the Health and Wellbeing Board to deliver the Single Plan for Calderdale, work with the West Yorkshire Health and Care Partnership and system financial recovery. An online GBAF was developed and launched in August 2021.

In December 2020 a review of the GBAF by Governing Body and the Senior Management Team commenced with the support of internal audit colleagues. The main objective of this review was to consider the strategic objectives of the organisation; however it is recognised that with the NHS White Paper there will be changes that will impact on the governance and assurance framework over the next 12 months. With this in mind the CCG will continue with its existing framework and the review will conclude once further development of Integrated Care Partnership (ICP) and Integrated Care System (ICS) governance is known.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

We have received an internal audit opinion of ‘significant assurance’ about the systems and processes in place to manage conflicts of interest.

Data Quality

The Data Quality Team is responsible for developing and improving quality, consistency and assurance in relation to primary care records and their management. It ensures the implementation of consistent approaches to data recording including the use of templates and structured data sets. The team supports the information requirements of clinicians and commissioners, supporting quality, consistency and assurance through summarising and SNOMED coding training.

Working with the three local CCGs (Calderdale, Kirklees and Wakefield) and their member practices the team also works closely with West Yorkshire Research and Development and the West Yorkshire and Harrogate Healthy Hearts Project developing GP reports, resources and data extracts for these projects.

The team has provided specialist support to the West Yorkshire and Harrogate Health and Care Partnership in meeting the data requirements of the NHS Diabetes Prevention Programme, and more recently has been working closely with data quality colleagues across the Integrated Care Board to standardise the data quality training offered to GP practice staff.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect personal and corporate information.

Due to the delay with Integrated Care Boards (ICB) becoming statutory organisations, the mandated requirement to complete and submit a DSPT for the West Yorkshire Integrated Care Board by end June 2022 for the period 2021/22, has been withdrawn. NHS Digital announced in January 2022 that CCGs should follow contingency arrangements and complete a DSPT self-assessment for the period 2021/22.

Throughout 2021/22 the CCG has been undertaking its annual assurance work to support the DSPT submission and this has put the CCG in a strong position to make a toolkit submission for 2021/22 by the end of June 2022.

Over the year as well as supporting routine business as usual information governance assurance activities, we have continued to support colleagues to cover the exceptional demands placed upon health systems during the pandemic. Awareness raising of good data security practice as well as cyber and data security risk, continues to be a priority.

We have an information governance management framework in place and have developed information governance processes and procedures in line with the DSPT. We have a robust annual information governance work programme and work to ensure that all staff and Governing Body members complete the Data Security Awareness training.

The information governance handbook is available to all staff so that they are aware of their information governance roles and responsibilities. All staff are required to complete Data Security Awareness training annually and this is monitored by the Senior Management Team and Audit Committee. As referred to earlier in this report, there are processes in place for incident reporting and investigation of serious incidents.

We have information risk assessment and management processes in place to fully embed the information risk culture throughout the organisation against identified risks. Assurance is provided through the Governance Assurance Reports to the Audit Committee. This includes the reporting of corporate incidents (such as those

involving personal data security) on a routine basis, together with any learning points.

Business Critical Models

In line with best practice recommendations of the 2013 Macpherson review into the Quality Assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

For functions that are carried out on behalf of the CCG by third parties, we receive assurance from the organisation or their auditors that appropriate systems and internal control are in operation. We receive services from the following organisations and details of assurances received for 2021/22 are provided below:

1. NHS Shared Business Services (provision of financial and accounting services and primary care payments services) – service auditor's report: reasonable assurance with the exception of a qualified opinion in relation to one control objective set out in the report. The CCG reviewed the detail in the report of the control weakness identified. The CCG believe the identified control weakness does not pose a significant risk to the CCG.
1. NHS Business Services Authority (prescription pricing services) – service auditors report: reasonable assurance with the exception of qualified opinion in relation to one control objective set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified. This combined with the CCG's monthly management accounts processes and medicines management team review of prescription cost and activity gives assurance that we believe that the identified control weaknesses do not pose a significant risk to the CCG.
1. NHS Digital (payments to GP contractors) – service auditors report: reasonable assurance with the exception of qualified opinion in relation to two control objectives set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified. This combined with the CCG's monthly management accounts processes and internal audit review of delegated primary care gives assurance that we believe that the identified control weaknesses do not pose a significant risk to the CCG.

2. Electronic Staff Record (ESR) – service auditors report: reasonable assurance except for a qualified opinion in relation to one control objective for part of the financial year set out in the report. The CCG has reviewed the detail in the report of the control weaknesses identified and we believe that the identified control weaknesses do not pose a significant risk to the CCG.
1. Leeds Teaching Hospitals NHS Foundation Trust (provision of payroll services) – assurance on payroll services provided the CCG via contract management arrangements and internal audit testing.
1. North East Commissioning Service (provision of human resources support services) – assurance provided via contract management arrangements.

Control Issues

At 31st March 2022, no significant internal control issues or gaps in control had been raised.

Review of economy, efficiency & effectiveness of the use of resources

The Director of Finance has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Governing Body receives regular reports from the Quality Finance and Performance Committee regarding finance, contracting, performance and system recovery. In order to provide the necessary level of rigour and governance in support of the CCG's financial plan, an update is also submitted to the Quality, Finance and Performance Committee.

These processes, with the opinions available from the work of the CCG's internal and external auditors and the assurances from the Audit Committee, enable the Governing Body to make a determination on the economic, efficient and effective use of resources by the CCG.

Further information on our financial planning, in-year performance monitoring, central management costs and efficiency controls is included in the Performance Report (see pages 12 to 74).

We maintain efficiency controls through our recovery and resilience processes and through the role of the Quality Finance and Performance Committee.

Delegation of functions

The CCG has delegated some of its functions to the West Yorkshire and Harrogate Joint Committee of CCGs (part of the West Yorkshire and Harrogate Health and Care Partnership). The extent of the delegated authority and responsibilities are set out in the Memorandum of Understanding and Terms of Reference. The Chair and Accountable Officer represent Calderdale CCG on that committee.

The minutes and reports of key decisions taken by the committee and its annual report are received by the Governing Body for scrutiny and assurance. The CCG's Accountable Officer and Chair report back to the Governing Body on these at each public meeting. At 31st March 2022, no issues of concern had been identified from this feedback in-year.

Further information on the role of the Joint Committee and highlights of its work during 2021/22 can be found on pages 95 to 96.

Counter fraud arrangements

The CCG has a team of accredited Local Counter Fraud Specialists (LCFS) that are contracted to undertake counter fraud work proportionate to identified risks. The LCFS team are all accredited and appropriately nominated to the NHSCFA to carry out counter fraud work on behalf of the CCG.

In January 2021 the NHS Counter Fraud Authority (NHSCFA) issued the NHS Counter Fraud Standard which provided detailed information on how the Government Functional Standard 013 Counter Fraud must be applied across the NHS. The Standard is made up of 13 "NHS Requirements" which outline an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In May 2021 the LCFS produced an annual counter fraud plan aligned to the standards.

The CCG's Audit Committee reviews and approves the annual counter fraud plan identifying the actions to be undertaken to promote an anti-fraud culture, prevent and

deter fraud, and investigate suspicions of fraud. The LCFS also produces an annual report and regular progress reports for the review and consideration of the Chief Finance Officer and the Audit Committee.

The Chief Finance Officer for the CCG is proactively and demonstrably responsible for tackling fraud, bribery and corruption and the LCFS regularly attends the Audit Committee. The CCG has also appointed an officer at the CCG as a Counter Fraud Champion to assist and support the work of the LCFS.

The CCG's counter fraud arrangements are currently in compliance with the NHS Counter Fraud Standard published by the NHSCFA. These arrangements are underpinned by the appointment of the LCFSs, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's Counter Fraud Standard, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA.

The 2020/21 assessment for the CCG was completed with reference to the NHS Counter Fraud Standard. The assessment was submitted in May 2021 with an overall rating of Amber.

The LCFS will be providing a response to the Counter Fraud Functional Standard Return on behalf of the CCG in May 2022. This will look at the CCG's compliance to the NHS Counter Fraud Standard within the 2021/22 financial year and will be reviewed by the Chief Finance Officer and Audit Committee Chair prior to submission.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

The overall opinion for the period 1st April 2021 to 31st March 2022 provides High Assurance, that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

During the year Internal Audit issued the following audit reports:

Audit Area	Assurance Level
Governance and Risk Management Arrangements	High
Financial Systems and Management	High
Primary Care Co-Commissioning	High
Conflicts of Interest	Significant

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed. I have been advised on the implications of the results of this review by:

- The Governing Body which keeps under review the systems of internal control through reports on risk management and the review of the Governing Body Assurance Framework (GBAF). It also receives performance, contracting, finance, quality and safety reports at each of its meetings in public. The GBAF is formally

reviewed by the Governing Body twice a year. The GBAF provides me with evidence that the effectiveness of controls that manage principal risks to the CCG achieving its strategic objectives have been reviewed.

- The Audit Committee which has oversight of the CCG's financial systems, financial information, risk management and systems of internal control, audit, information governance and business continuity. It is supported in its role by independent audit reports produced by Audit Yorkshire and regular meetings with the internal and external auditors.
- The Quality Finance & Performance and Commissioning Primary Medical Services Committees, which are responsible for keeping under review the governance arrangements relating to their remit. This includes review of all relevant operational risks and review of the principal risks as set out in the GBAF.
- The external and internal auditors provide independent assurance through the delivery of their annual work plans, as well as recommendations for further development of the system of internal control.
- Self-assessment of the risk management system and Committee governance arrangements is undertaken on an annual basis. An external review of different aspects of our governance arrangements is commissioned every three years.
- Third Party Assurance. Together with the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as NHS Shared Business Services, NHS Digital (payments to GP practices), and Leeds Teaching NHS Foundation Trust (provider of payroll services). Further details can be found on pages 111 to 112.

It is my conclusion, based on the information submitted and my belief about the effectiveness of the systems and processes within the CCG that no significant control issues have been experienced during the year.

ROBIN TUDDENHAM
Accountable Officer
20 June 2022

Governance Statement – Appendix 1: CCG Governing Body and Committee Membership and Attendance

The table below provides the composition of the Governing Body and its committees throughout the financial year and up to the signing of the Annual Report and Accounts on 20 June 2021 and attendance for the 2021/22 financial year.

Name	Role	Attendance
Dr Steven Cleasby	CCG Chair and GP Member	4/4
Dr Caroline Taylor	CCG Clinical Vice Chair and GP Member	3/4
John Mallalieu	Deputy Chair / Lay Member (Finance and Performance) / Chair of Primary Medical Services Committee	4/4
Robin Tuddenham	Accountable Officer	3/4
Neil Smurthwaite	Chief Operating Officer	3/4
Lesley Stokey	Director of Finance	4/4
Penny Woodhead	Chief Quality and Nursing Officer	3/4
Prof. Peter Roberts	Lay Member (Audit)	4/4
Dr Rob Atkinson	Secondary Care Specialist	4/4
Dr James Gray	GP Member (until 31st January 2022)	3/4
Dr Farrukh Javid	GP Member	4/4
Alison Macdonald	Lay Member (Patient and Public Involvement) (until 31st December 2022)	3/3
Denise Cheng-Carter	Lay Member (from 27th January 2022)	1/1
Prof. Rob McSherry	Registered Nurse	4/4

Notes:

Alison Macdonald left the Governing Body on 31st December 2021, so was not required to attend the January meeting. For her, this meeting has been excluded from the attendance column

Denise Cheng-Carter began her role as Lay Member on 27th January, therefore for her the meetings previous to that have been excluded from the attendance column

Advisors to the Governing Body and attendance

Name	Role	Attendance
Denise Cheng-Carter	Lay Advisor (until 26th January)	3/3
Debra Harkins	Director of Public Health (Calderdale Council)	3/4
Iain Baines	Director of Adult Services (Calderdale Council)	3/4

Note.

Denise Cheng-Carter left her role as Lay Advisor on 26th January, therefore for her, the 31st January meeting has been excluded from the attendance column

Quality, Finance and Performance Committee

Name	Role	Attendance
Dr Farrukh Javid	Committee Chair and GP Member	4/4
John Mallalieu	Deputy Committee Chair / Lay Member (Finance and Performance)	4/4
Neil Smurthwaite	Chief Operating Officer	3/4
Penny Woodhead	Chief Quality and Nursing Officer	4/4
Dr Caroline Taylor	GP Member	2/4
Alison Macdonald	Lay Member (Patient and Public Involvement) (until 31st December 2021)	3/3
Denise Cheng Carter	Lay Member (from 27th January 2022)	1/1
Prof. Rob McSherry	Registered Nurse	4/4
Dr Rob Atkinson	Secondary Care Specialist	1/1
Lesley Stokey	Director of Finance	4/4

Notes.

Alison Macdonald left the Governing Body on 31st December 2021 so was not required to attend the March meeting. For her, this meeting has been excluded from the attendance column

Denise Cheng-Carter joined the Governing Body as Lay Member on 27th January 2022 so, for her, only the March meeting has been included in the attendance column

Dr Rob Atkinson was not required to attend the Committee's meetings in June, August and December. For him, these meetings have been excluded from the attendance column

Commissioning Primary Medical Services Committee

Name	Role	Attendance
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	3/3
Alison Macdonald	Committee Vice Chair and Lay Member (Patient and Public Involvement) (Until 31st December 2021)	2/3
Neil Smurthwaite	Chief Operating Officer	2/3
Dr Steven Cleasby	GP Member	1/2
Dr James Gray	GP Member (until 31st January 2022)	1/2
Dr Rob Atkinson	Secondary Care Specialist	3/3
Lesley Stokey	Director of Finance	3/3

Notes.

Alison Macdonald left the Governing Body on 31st December 2021 and was therefore not required to attend the meeting in March. For her, that meeting has been excluded from the attendance column

Dr James Gray left the Governing Body on 31st January 2022 and was therefore not required to attend the meeting in March. For him, this meeting has been excluded from the attendance column.

Drs Steven Cleasby and James Gray did not attend the meeting on 1st October 2021 due to a conflict of interest. For them, this meeting has been excluded from the attendance column.

Audit Committee

Name	Role	Attendance
Prof. Peter Roberts	Committee Chair / Lay Member (Audit)	4/4
John Mallalieu	Deputy Committee Chair / Lay Member (Finance and Performance)	4/4
Neil Smurthwaite	Chief Operating Officer	4/4
Denise Cheng-Carter	Lay Advisor	4/4
Dr Farrukh Javid	GP Member	4/4
Alison Macdonald	Lay Member (Patient and Public Involvement) (Until 31st December 2021)	2/3
Prof. Rob McSherry	Registered Nurse	4/4
Dr Rob Atkinson	Secondary Care Specialist	2/2
Lesley Stokey	Director of Finance	4/4

Notes.

Alison Macdonald left the CCG Governing Body on 31st December 2021 so was not therefore required to attend the meeting in February. For her, this meeting has been excluded from the attendance column.

Dr Rob Atkinson was not required to attend the meetings in October and February. For him these meetings have been excluded from the attendance column.

West Yorkshire Joint Committee of CCGs

Name	CCG role	Attendance
Dr Steven Cleasby	Governing Body Chair	3/3
Robin Tuddenham	Accountable Officer	1/3
Neil Smurthwaite	Chief Operating Officer (deputising for the Accountable Officer)	2/3

Governance statement – Appendix 2: Summary of major risks to CCG governance, risk management and internal control

Critical risk (scoring 20) movement during 2021-22

Risk no	Risk summary	Action to manage risk	Means to assess outcomes
1493 Risk at beginning of 2021-22, initial score of 20 remains static	Patients being discharged from hospital are subject to delays in their transfer of care (TOC) due to health and social care systems and processes are not currently optimised, resulting in poor patient experiences, harm to patients, and pressure on acute post-COVID-19 bed plans which require minimum delayed patients. The need to optimise discharge has become more acute during the pandemic, ensuring patients leave hospital as soon as possible to reduce their risk of hospital acquired infection and releasing beds for poorly patients, whilst ensuring the quality of the discharge with the context of the COVID-19 pandemic.	- Accident and Emergency Delivery Board (A&EDB) review performance as a standing item monthly - Weekly discharge touchpoint in place across Calderdale and Greater Huddersfield - Optimum range for number of people on TOC list for Calderdale confirmed as 13-21 (same as Kirklees) - System call in place weekly to review risks and mitigating actions; continued through COVID-19 period - Multiple weekly integrated home first huddles to continue to support flow	- A&EDB highlight report considered by Quality, Finance and Performance Committee (QF&P) as a standing item - Performance updated to QF&P includes TOC performance - TOC list reviewed daily during weekdays Implementation of new guidance is in final stages - Process now in place for reviewing patients on the Reason to Reside list CCG has funded GP input into CHFT virtual ward rounds to optimise discharge

		- Surge and Escalation processes documented and agreed by A&EDB	
62 This was already a critical risk at the end of 2020-21. Initial score of 16 has fluctuated between 12 and 20, currently 20	The system will return to the pre-COVID-19 levels of demand and will not deliver the NHS Constitution 4-hour A&E target for the next quarter, due to pressures associated with; avoidable demand, implications of social distancing measures and capacity and flow out - resulting in harm to patients and patient experience being compromised. There is also a risk of significant harm associated with patients spending extended time on a trolley in A&E awaiting a bed within the context of COVID-19 -related bed pressures.	- Surge and Escalation processes triggered to mitigate performance risk in line with agreed plan (daily or weekly) through winter - A&EDB focus work on understanding and mitigating performance risk at each meeting (monthly) - QF&P consider F&FT response rate and satisfaction included in Quality Dashboard reviewed monthly - QF&P receives quarterly reports on any serious incidents including A&E	- Performance reviewed at QF&P and Governing Body - Quality Team have oversight of any learning from 12-hour breaches - Winter reset action plan agreed, with focus on reducing A&E attendances, including comms work
187 This became a critical risk during	Under-achievement of 18 weeks performance (Incomplete referral to treatment (RTT)) at specialty level due	- Joint Calderdale and Kirklees CCG approach to the safe restart of elective services,	- System have agreed joint principles and priorities to underpin reset work

the last risk cycle of 2020-21, increased from an initial score of 16	to pressures caused by the pandemic resulting in breaches of patients' constitutional right to access certain services within maximum waiting times and potential harm to patients	being clinically led by the Elective Improvement Group, which reports to Outpatient Transformation Board - Joint (GP, Consultant) clinical reviews of patients waiting over 16 weeks - Joint work between CCGs, CHFT and Independent sector to ensure we maximise all available capacity - A key element of the CCG Reset Plan and CHFT's Incident Management Plan - Joint approach to gathering thematic views of patient harm via agreed clinical assurance routes	CCG Reset plan held by SMT and progress shared with QF&P - 18 weeks' performance is reported to QF&P - Notes of Outpatient Transformation Board to be considered at QF&P

In year serious risks (scoring 15 or 16) that have a reduced risk rating at the end of March 2022

Risk no	Risk summary	Action to manage risk	Means to assess outcomes
1729 Initial score of 12, increased to 16	The care provision planned for a new specialist service across CKWB Transforming Care Partnership (TCP) for people with a Learning Disability may not be robust and fit for purpose in line with commissioning intentions resulting in the CCG having to revisit the outcome of the procurement process.	- Initial contract performance meeting held 12/2/21 and the provider given clear actions that must be delivered The situation is being monitored closely at regular contract performance meetings by CKB senior commissioners and contracts management - Each responsible commissioner must review all transition details and sign off an agreed checklist for their clients - Monitoring and oversight of implementation plans through weekly quality assurance meetings with all commissioners and the provider - Now being monitored under	- Monthly updates are provided to TCP partnership Board with regards to this new service Any concerns are reported through this board or if required are escalated to Kirklees CCG as the lead commissioner on this project - Escalation of concerns to Director level within each organisation and on corporate risk registers - Service now under NHSE Quality Surveillance process and multi-agency meetings led by Chief Nurse, awaiting detailed action plan from the provider in response to

		NHSE Quality Surveillance process due to ongoing and increased concerns Admission of the residents has been delayed until the required assurance is in place and can be evidenced	detailed concerns - Collaboration and sharing of all relevant information between commissioners on an ongoing basis - Minimum of weekly meetings between the provider and commissioners to ensure close monitoring
1866 Initial score of 12, increased to 15, reduced to 4	The CCG 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	- The CCG developed plans for meeting the required reductions in running costs in 2019/20. The CCG has met its running cost allocation target in 2020/21 - The draft plan for 2021/22 was agreed by Governing Body in April 2021. A more detailed running cost plan was considered at Q,F&P committee outlining the draft detailed budgets and further savings	- Monthly Financial Reporting systems - Internal Audit reviews on financial systems and processes. Regular budget holder meetings to review running cost budgets - Discussion of risk and position in monthly F&P paper - Detailed review of impact of

	increase is 3% and that no additional running cost allocation will be received to cover this increase.	plans agreed to be implemented. These plans will be agreed with budget holders. - Plans will be further reviewed in light of the AfC pay award which is unfunded.	pay review scenarios - work undertaken to mitigate impacts - Heads of Service are reviewing budgets in light of savings target, work to be completed on reviewing vacant posts
1688 Reduced from 16 to 8	The CCG is unable to deliver national expectations on uptake of the COVID-19 vaccine due to; the lack of workforce, vaccine supply, or the appetite of our population, resulting in our population not being protected from the virus, higher morbidity and mortality, increasing inequalities, continued high demand for health and care services, and in inability to restart the local economy.	(a) WY ICS SRO Programme established at WY (meetings twice weekly) (b) Calderdale Programme structure in place; key roles filled, Programme Risk Log in place (c) Calderdale Health Protection Advisory Group receiving updates for assurance and oversight (d) Interpreting JCVI Guidance groups meets weekly to consider	(a) Calderdale programme includes workstreams/leads for, IM&T, workforce, communications and engagement (b) Weekly programme updates being provided into key forums (CHPAG, Safe Communities Silver, SOG, SMT, LMC)

		cohort eligibility and inequalities (e) Weekly meetings separately with each of the key delivery model providers (PCNs, CHFT, Boots) (f) Data flows created to understand programme performance (g) Proactive, multi-agency comms and engagement activities which include insight work to support future actions (h) Links created with the Calderdale flu programme (I) Calderdale is connected to Kirklees programme to ensure consistency of approach as required	

Governance Statement - Appendix 3: Head of Internal Audit Opinion

FINAL HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS CALDERDALE CLINICAL COMMISSIONING GROUP FOR THE YEAR ENDED 31 MARCH 2022

1. Introduction

The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Governing Body in the completion of its Annual Governance Statement, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS have faced unprecedented challenges due to COVID-19.

2. Executive Summary

This Head of Internal Audit Opinion forms part of the Annual Report for NHS Calderdale Clinical Commissioning Group, in which the planned internal audit coverage and outputs during 2021/22 and Audit Yorkshire's Key Performance Indicators (KPIs) are detailed.

Key Area	Summary
Head of Internal Audit Opinion	The overall opinion for the period 1st April 2021 to 31st March 2022 provides High Assurance, that there is a strong system of internal control designed to meet the organisation's objectives,

Key Area	Summary
	and that controls are being applied consistently in all areas reviewed. In the Head of Internal Audit Opinion for 2020/21 we reported that the Internal Audit Standards Advisory Board (IASAB) had issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020). The pandemic has continued to have an impact on the progression of the audit programme during 2021/22 but not to the same level as in 2020/21. We have delivered the planned audit work, subject to agreed changes, and have continued to follow the advice provided in the above guidance to ensure we remain compliant with the PSIAS. Where there has been an impact on the audit programme this has been communicated to and agreed with the Audit Committee and clear records of any changes have been maintained via our progress reports. The audit programme at the CCG has also been undertaken in the context of the imminent transition to Integrated Care Boards (ICBs). An element of our audit work during 2021/22 has been to support and provide assurance on this transition process and the associated due diligence work.
Planned Audit Coverage and Outputs	The 2021/22 Internal Audit Plan has been substantially delivered as planned. This position has been reported within the progress reports across the financial year and any changes to the audit programme have been captured in these. Audit coverage in 2021/22 has been focussed on:

Key Area	Summary
	1. The strategic and operational risks and assurances within the CCG's Governing Body Assurance Framework and Risk Register. 2. Core and mandated reviews, including follow-up audits 3. A range of individual risk based assurance reviews 4. Management and oversight of transition to the Integrated Care Board. The following change was made to the planned coverage: 1. Cancellation of the QIPP review due to current financial regime and Integrated Care Board transition.
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

3. Roles and Responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accounting Officer, on behalf of the Governing Body, setting out:

1. how the individual responsibilities of the Accounting Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
2. the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Governing Body Assurance Framework process;
3. the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together

with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Governing Body Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Governing Body Assurance Framework. As such, it is one component that the Governing Body takes into account in making its Annual Governance Statement.

4. The Opinion

My opinion is set out as follows:

1. Basis for the opinion
2. Overall opinion
3. Opinion Definitions
4. Commentary
5. Considerations for your Annual Governance Statement
6. Looking Ahead.

4.1 The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Governing Body Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Unless explicitly detailed within our reports, third party assurances have not been relied upon.

4.2 **Overall Opinion**

Our overall opinion for the period 1st April 2021 to 31st March 2022 is:

High assurance can be given that there is a strong system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are being applied consistently in all areas reviewed.

4.3 **Opinion Definitions**

The following potential opinion levels are available when determining the overall Head of Internal Audit Opinion. These levels link closely with our standard definitions for report opinions:

Opinion Level	HOIA Opinion Definition
High (Strong)	High assurance can be given that there is a strong system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are being applied consistently in all areas reviewed.
Significant (Good)	Significant assurance can be given that there is a good system of governance, risk management and internal

	control designed to meet the organisation's objectives and that controls are generally being applied consistently.
Limited (Improvement Required)	Limited assurance can be given as there are weaknesses in the design and/or inconsistent application of the framework of governance, risk management and internal control that could result in failure to achieve the organisation's objectives.
Low (Weak)	Low assurance can be given as there is a weak system of internal control and/or significant weaknesses in the application of controls that will result in failure to achieve the organisation's objectives.

Where limited or low assurance is given the management of the Governing Body must consider the impact of this upon their overall Governing Body Assurance Framework and their Annual Governance Statement.

The design and operation of the Governing Body Assurance Framework and associated processes

An audit of the Governance Framework, operation of the Governing Body Assurance Framework and associated Risk Management processes has been undertaken in 2021/22 for which a High Assurance opinion was awarded.

The review confirmed that the governance and risk management arrangements at NHS Calderdale CCG appear to be robust. An Integrated Risk Management Framework (IRMF) is in place which outlines how the CCG manages risks and how risks are scored and categorised in line with the defined process.

There is regular review of the Corporate Risk Register and oversight by the Governing Body, Senior Management Team, Quality, Finance and Performance Committee and Commissioning Primary Medical Services Committee.

A key element of the 2021/22 audit plan has been to review the transitional arrangements relating to the closing down of NHS Calderdale CCG and the setting up of the West Yorkshire Integrated Care Board. As required by the due diligence checklist, Audit Yorkshire and senior officers from the CCG have been active members of numerous programme boards, in particular, those tasked with the closing down of governance, Information Governance and Financial arrangements. The CCG has put in place a programme management structure, which considers and responds to transition risks. Governance of the programme includes regular reporting to the Audit Committee and the Governing Body. Audit work has also considered the design and operation of shadow governance arrangements, Place readiness and progress against the Due Diligence checklist. Further work is planned in this area and will continue into the first quarter of 2022/23 as a result of the delayed transition to Integrated Care Board.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

Core & Risk Based Reviews Issued

We have issued to date:

3 high assurance opinions:	Governance and Risk Management Arrangements Financial Systems and Management Primary Care Commissioning
1 significant assurance opinions:	Conflicts of Interest
0 limited assurance opinions:	N/A
0 low assurance opinions:	N/A
2 reviews without an assurance rating	Mental Capacity Act – Benchmarking exercise on readiness

	Recommendation Tracking – Benchmarking exercise

The following areas of support have been completed:

The following areas of support have been completed:

1. Data Security & Protection Toolkit – days have been used to support developing the information governance arrangements at the shadow West Yorkshire ICB.
2. West Yorkshire and Harrogate ICS and System Governance – days have been used to support the due diligence process and provide transitional support to developing place arrangements.

Follow Up

A total of 18 Internal Audit recommendations have been live during 2021/22 (this includes recommendations from previous years' reports that were still live at 1 April 2021).

During the course of the year we have undertaken work to track the implementation of Internal Audit Recommendations. The implementation of recommendations summary for 2021/22 was as follows:

Overdue	Overdue with Revised Date	Not Yet Due	Implemented	Total	% Overdue
0	1	2	15	18	0

We can conclude that the organisation has made good progress with regards to the implementation of recommendations. The vast majority of recommendations are implemented on a timely basis. There was one recommendation that was overdue in comparison to the original agreed action date. We can confirm that we have received appropriate support from the Executive Directors in relation to these and these

recommendations have been regularly reviewed by the Audit Committee throughout the year.

4.5 Consideration for your Annual Governance Statement

The Head of Internal Audit Opinion is one source of assurance that the organisation has in providing its Annual Governance Statement and other third party assurances should also be considered. In addition, the organisation should take account of other independent assurances that are considered relevant. We recommend that the Executive Summary above is used in your Annual Governance Statement, having regard to the areas as identified as follows:

A High overall opinion has been provided. Attention is drawn to the fact that no final reports have been issued in 2021/22 with a “limited assurance” opinion. Please note that the overall opinion is based on, and limited to, the audit work undertaken during the year and the CCG’s response to our agreed recommendations.

4.6 Looking Ahead

This opinion is provided in the context that NHS Calderdale CCG, like other organisations across the NHS, continues to face a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic response and COVID-19 recovery. The COVID-19 pandemic continues to impact the NHS financial framework and the roll out of the vaccine programme and the emergence of COVID-19 variants has continued to require significant focus and effort.

During the COVID-19 response, there has been increased collaboration between organisations as they have come together to develop new ways of delivering services safely and to coordinate their responses to the pandemic. This has continued during 2021/22 and subject to the passing of legislation collaboration will be placed on a statutory footing from 1 July 2022. At this point the CCG will transition to the West Yorkshire Integrated Care Board and will no longer be a statutory body in its own right. The Integrated Care Board will become the statutory body, supported by five places. Calderdale will form one of these places and the CCG continues to plan for this

transition and further develop its existing place based partnership arrangements. The formal move to system working at West Yorkshire and place level will require robust accountability and assurance arrangements to ensure statutory functions and the system wide financial envelope are delivered.

Helen Higgs

Head of Internal Audit and Managing Director

Audit Yorkshire

10 June 2022

Remuneration and Staff Report

Remuneration report

This section of the Annual Report sets out the CCG's remuneration policy for Governing Body and Very Senior Managers and reports on how that policy has been implemented. It also sets out information about staff numbers and costs, policies, activities, relations and the CCG's approaches to engagement.

Remuneration and Nomination Committee

The table below shows the composition of the Remuneration and Nomination Committee throughout the financial year and up to the signing of the Annual Report and Accounts on 15 June 2021 and attendance for 2021/22 financial year.

Name	Role	Attendance
John Mallalieu	Committee Chair and Lay Member (Finance and Performance)	3/3
Alison Macdonald	Committee Vice Chair and Lay Member (Patient and Public Involvement) (until 31st December 2021)	2/2
Dr Rob Atkinson	Secondary Care Specialist	3/3
Dr Steven Cleasby	GP Member	2/3
Dr Farrukh Javid	GP Member	3/3

Notes:

Alison Macdonald left the Governing Body on 31st December 2021, so was not required to attend the meeting in January. For her, this meeting has been excluded from the attendance column

The meeting in October had a single-item agenda. Dr Steven Cleasby was not required to attend this meeting. For him, this meeting has been excluded from the attendance column.

The Remuneration and Nomination Committee is supported in its considerations by Human Resources Managers and Business Partners. The CCG's Human Resources, Learning and Development and Organisational Development service is

commissioned from the North of England Commissioning Support unit (NECS). The committee is supported by the Director of Finance.

Policy on the remuneration of senior managers

For the purpose of this report, the senior managers of Calderdale CCG are defined as:

- Very Senior Managers (VSMs) i.e., the Accountable Officer, the Chief Operating Officer and Director of Finance.
- GPs on the Governing Body – including the Chair of the CCG;
- Registered Nurse and Secondary Care Specialist;
- Lay Members;
- Chief Quality and Nursing Officer

Very Senior Managers

The post of Chief Quality and Nursing Officer is shared with Calderdale CCG, and the post-holder is engaged by Kirklees CCG under a contract of employment. The arrangement is governed by a Memorandum of Understanding between the CCGs.

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above, with the exception of the Chief Quality and Nursing Officer, who is engaged under the Agenda for Change framework.

There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement. These, together with a review of comparative data across CCGs, any recommended rates of remuneration for Very Senior Managers and legal advice, are used to inform the determinations of the Remuneration and Nomination Committee.

Hutton Review Fair Pay Principles (2011):

- Remuneration should fairly reward each individual’s contribution to their organisation’s success and should be sufficient to recruit, retain and motivate

executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;

- Remuneration must be set through a process that is based on a consistent framework and independent decision making based on accurate assessments of the weight of roles and individuals' performance in them;
- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay is being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay;
- Remuneration must be based on the principle of equal pay for work of equal value.

GP Members of the Governing Body

For GP Governing Body members (including the Chair of the Governing Body) remuneration should be either:

- At a reasonable rate, in line with practice earnings; or at a rate commensurate with allowing backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary; or
- In line with any local sessional rate.

Registered Nurse and Secondary Care Specialist

For the Registered Nurse and Secondary Care Specialist posts on the Governing Body, remuneration should be:

- If still in NHS employment, at a rate commensurate with their salary or as needed for replacement costs; or at a rate commensurate with the average rate for their profession and level of seniority;
- If retired/not working, at the same rate as lay members;
- If self-employed, in line with earnings.

Lay Members

For Lay Members, remuneration is based on benchmarking with other CCGs.

Remuneration of Very Senior Managers (VSMs)

No senior managers are paid more than £150,000 per annum pro rata. The posts which are subject to VSM terms and conditions at Calderdale CCG are the Accountable Officer, Chief Operating Officer, and the Director of Finance. In considering the remuneration for these posts the committee takes account of the following factors:

- Pay guidance provided by NHS England;
- Benchmarking with other CCGs;
- Complexity factors;
- Availability of guidance on recruitment and retention premiums;
- Prevailing economic climate and local market conditions;
- Any joint management arrangements;
- Public and internal perception to others in the CCG;
- Performance of the individuals and the CCG.

This approach has been applied for 2021/22 and will also be applied for future years.

Senior manager remuneration (including salary and pension entitlements) 2021/22

Name & Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000)
Dr Steven Cleasby, Chair	55-60	0	0	0	0	55-60
Dr Caroline Taylor, GP Member	30-35	0	0	0	0	30-35
Dr Farrukh Javid, GP Member	30-35	0	0	0	0	30-35
Dr James Gray, GP Member	25-30	0	0	0	0	25-30
Dr Rob Atkinson, Secondary Care Clinician	15-20	0	0	0	0	15-20
Rob McSherry, Registered Nurse	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member and Deputy Chair	15-20	0	0	0	0	15-20
Professor Peter Roberts, Lay Member	5-10	0	0	0	0	5-10
Alison Macdonald, Lay Member	5-10	0	0	0	0	5-10
Denise Cheng Carter, Lay Member	5-10	0	0	0	0	5-10
Robin Tuddenham - Accountable Officer	75-80	0	0	0	0	75-80
Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	125-130	0	0	0	37.5-40	165-170

Lesley Stokey - Director of Finance	105-110	0	0	0	30 - 32.5	135-140
Penny Woodhead - Chief Quality and Nursing Officer	35-40	0	0	0	27.5-30	65-70

Note 1 - Penny Woodhead is employed by Kirklees CCG but is a shared post also with Calderdale CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £110 - £115k; however only 34% has been included in the salary column. The above table includes the full pension information not a proportion in relation to the shared post.

Note 2 – Dr James Gray left the Governing Body on 31st January 2022

Note 3 – Alison Macdonald left the Governing Body on 31st December 2021

Senior manager remuneration (including salary and pension entitlements) 2020/21

Name & Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total
Dr.Steven Cleasby, Chair	55-60	0	0	0	0	55-60
Dr.Caroline Taylor, GP Member	35-40	0	0	0	0	35-40
Dr Farrukh Javid, GP Member	35-40	0	0	0	0	35-40
Dr. James Gray, GP Member	30-35	0	0	0	0	30-35
Dr. Rob Atkinson, Secondary Care Clinician	20-25	0	0	0	0	20-25
Rob McSherry, Registered Nurse	5-10	0	0	0	0	5-10
John Mallalieu, Lay Member and Deputy Chair	15-20	0	0	0	0	15-20
Peter Roberts, Lay Member	5-10	0	0	0	0	5-10
Alison MacDonald, Lay Member	5-10	0	0	0	0	5-10
Denise Cheng Carter, Lay Advisor	5-10	0	0	0	0	5-10
Robin Tuddenham - Accountable Officer	30-35	0	0	0	0	30.35
Matt Walsh - Accountable Officer	60-65	0	0	0	0	60-65

Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	130-135	0	0	0	72.5-75	200-205
Lesley Stokey - Director of Finance	100-105	0	0	0	82.5 - 85	185-190
Penny Woodhead - Chief Quality and Nursing Officer	30-35	0	0	0	25-27.5	55-60

Note 1 – Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95 – 100k; however only 33.3% has been included in the salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 2 – Robin Tuddenham joined the Governing Body on 16th October 2020

Note 3 – Neil Smurthwaite was Interim Chief Officer for the period 16th April to 15th October 2020 and Chief Operating Officer and Chief Finance Officer from 16th October 2020

Note 4 – Matt Walsh left the Governing Body on 15th April 2020

Note 5 – Lesley Stokey was Interim Chief Finance Officer for the period 16th April to 15th October 2020

Pension benefits as at 31 March 2022 are set out in the table below.

Name and Title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age as at 31st March 2022 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension as at 31st March 2022 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 1st April 2021 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31st March 2022 £000	Employers Contribution to Stakeholders Pension
Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	2.5-5	0-2.5	25-30	0-5	311	22	354	0
Lesley Stokey - Director of Finance	2.5-5	0-2.5	25-30	45-50	406	23	445	0
Penny Woodhead - Chief Quality & Nursing Officer	0-2.5	0-2.5	5-10	0-5	88	15	119	0

Note 1: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore not included in the table.

Note 2: Penny Woodhead is employed by Kirklees CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. The above table includes the full pension information, not a proportion in relation to the shared post.

Pension benefits as at 31 March 2021 are set out in the table below.

Name and Title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age as at 31st March 2021 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension as at 31st March 2021 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 1st April 2020 £000	Real Increase in Cash Equivalent Transfer Value £000's	Cash Equivalent Transfer Value at 31st March 2021 £000's	Employers Contribution to Stakeholders Pension
Neil Smurthwaite - Chief Operating Officer and Chief Finance Officer	2.5-5	0-2.5	25-30	0-5	249	58	311	0
Lesley Stokey - Director of Finance	2.5-5	5-7.5	25-30	45-50	334	66	406	0
Penny Woodhead - Chief Quality & Nursing Officer	0-2.5	0-2.5	5-10	0-5	60	13	88	0

Note 1: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore not included in the table.
Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £95k - 100k, however, only 33.33% has been included in the Salary table. The above table includes the full pension information, not a proportion in relation to the shared post.

Cash equivalent transfer values
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.
The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Remuneration of Very Senior Managers

This is covered on page 141.

Compensation on early retirement or for loss of office

No payment has been made in compensation for loss of office or early retirement during 2021/22.

Payments to past members

No payment has been made to past senior managers during 2021/22.

Fair pay disclosure

Percentage change in remuneration of highest paid director

Description	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	1%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0%	N/A

Note. The CCG does not pay performance pay or bonuses

Despite a general Agenda for Change inflationary pay rise in 2021/22, the average annualised full-time equivalent remuneration of all staff has remained the same due to an increase in lower banded staff in 2021/22.

Pay ratio information

As at 31 March 2022, remuneration ranged from £20,330 to £163,558 (0% against 2020/21: £19,737 to £161,159) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Despite a general Agenda for Change inflationary pay rise in 2021/22, the average annualised full-time equivalent remuneration of all staff has remained the same due to an increase in lower banded staff in 2021/22.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Remuneration of CCG staff is shown in the table below:

Description	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£39,027	£47,126
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£31,534	£39,027	£47,126

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in the CCG in the financial year 2021/22 was £160k-165k (1%+/- against 2020/21: £160k-165k) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	5.2	5.2	4.2	4.2	3.4	3.4
2020/21	5.3	5.3	4.3	4.3	3.1	3.1

In 2021/22, 0 (2020/21, 0) employees received remuneration in excess of the highest-paid director/member.

Staff report

The CCG's workforce profile is shown below. The information is based on the directly employed staff of the CCG as at 31st March 2022. Information relating to the Governing Body is reported separately.

Number of senior managers

Information relating to individuals classed as senior managers for the purposes of this annual report can be found on pages 139 to 149.

Staff numbers and costs

The average number of people employed and engaged by the CCG at 31st March 2022 is shown in the table below.

Permanent employees	Other	Total
91	3	94

Staff costs and employee benefits

The staff costs and employee benefits as at 31st March 2022 are set out below.

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
Salaries and wages	4,073	3,658	415	2,405	2,327	78	1,668	1,330	338
Social security costs	397	397	0	257	257	0	140	140	0
Employer contributions to the NHS Pension Scheme	658	658	0	495	495	0	163	163	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	5	5	0	5	5	0	0	0	0

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	5,133	4,717	415	3,162	3,085	78	1,970	1,633	338
Less: Recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
Net employee benefits expenditure including capitalised costs	0	0	0	0	0	0	0	0	0
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	5,133	4,717	415	3,162	3,085	78	1,970	1,633	338

The staff costs and employee benefits as at 31st March 2021 are set out below.

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
Salaries and wages	3,951	3,543	409	2,289	2,224	65	1,663	1,319	344
Social security costs	377	377	0	244	244	0	133	133	0
Employer contributions to the NHS Pension Scheme	616	616	0	449	449	0	167	167	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	3	3	0	3	3		0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	4,948	4,539	409	2,985	2,920	65	1,963	1,619	344
Less: Recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure	0	0	0	0	0	0	0	0	0

Staff costs and employee benefits	All staff Total £000	All staff Permanent Employees £000	All staff Other £000	Admin staff Total £000	Admin staff Permanent Employees £000	Admin staff Other £000	Programme staff Total £000	Programme staff Permanent Employees	Programme staff Other £000
including capitalised costs									
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	4,948	4,539	409	2,985	2,920	65	1,963	1,619	344

Staff composition

As of 31st March 2022, the CCG directly employed 94 staff (excluding Governing Body but including the Very Senior Managers (VSMs)). This equates to 86.61 whole time equivalent (WTE).

Gender profile of the organisation

The following table sets out the gender profile of the organisation as of 31st March 2022

Gender	Governing Body (excl. Very Senior Managers)	Very Senior Managers (VSM)	Staff Excl. Governing Body and VSMs	Total
Female	2	1	76	79
Male	6	2	15	23
Total	8	3	91	102

Note 1: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay report.

Sickness absence data

The yearly average sickness figures for the CCG between 1 April 2021 and 31st March 2022 are shown in the table below.

Total FTE Days lost:	664.07
Total FTE Staff	29,955.35
Rolling 12 month period average	2.21%

The CCG recognises the importance of balancing the health needs of employees with the needs of the CCG, and it is the considered view of the management team of the CCG that the pertinent overarching strategic priority is to create the kind of organisational culture within which people can be the best that they can possibly be.

As such the CCG has policies and procedures in place to support employees with sickness absence and continues to develop a positive and pro-active approach in supporting employees through sickness absence or difficult periods in their lives.

This has recently been evidenced by reviewing the Managing Sickness Absence Policy in not only aiming to reduce the levels of sickness through improvement plans but providing supporting mechanisms to employees during periods of short, and long, term sickness.

The CCG commissions an Employee Assistance Programme (EAP) to further support the needs of the workforce and this service has been recently renewed for a further year. The aim of EAP is to help employees deal with personal problems that might adversely impact their work performance, health and well-being. This service provides confidential advice and counselling support to employees which makes available an early source of practical and emotional support for employees facing issues in their home or work life. This is viewed by the CCG as being important in supporting the health and wellbeing of employees.

The CCG is committed to the health and wellbeing of its staff and works hard to promote a healthy working environment.

During the COVID-19 pandemic, the CCG has continued to focus on staff wellbeing. The Virtual Kitchen, Wall of Wellbeing and The Voice meetings help staff stay connected with each other and the senior management team. Staff regularly share advice and support, such as hints and tips about working virtually, practical, and financial support, activities for families, and how to stay physically well. This has remained a strong focus as individuals support each other during the pandemic. When it was safe and permissible, staff were welcomed at a Picnic in the Park lunchtime event and an office-based lunchtime event which included a quiz.

As COVID-19 pandemic restrictions further ease, The Voice plans to organise more events for staff to enjoy either at lunchtimes, or after work.

Staff turnover percentage

Information about the CCG's staff turnover can be found on the NHS workforce statistics website.

Staff engagement

The CCG engages with its staff through a variety of mechanisms, including an active staff forum (The Voice), weekly updates with the Chief Operating Officer and Accountable Officer, monthly staff workshops, and through a staff intranet, which includes discussion forums and regular news.

The CCG also participates annually in the national NHS Staff Survey in order to gain staff feedback and understand how the CCG benchmarks against other NHS organisations. 86% of staff responded to the survey in 2021. Overall, the CCG's results were positive, with the engagement index score being higher than average when benchmarked against other CCGs.

Particular highlights related to the organisation taking positive action on health and wellbeing, reasonable adjustments for disabled staff, clarity of responsibilities, and a focus on organisational values and behaviours in appraisal conversations. The results will be discussed with staff in order to build on the CCG's ongoing staff engagement plan, focusing on strengths and areas for improvement.

Staff policies

The CCG has a suite of 26 staff policies providing clarity on the CCG's vision, values and expectations. These include policies on health and safety, trade union recognition and time off for representation, whistleblowing and flexible working. All the CCG's policies can be found on its website.

The CCG's commitment to recruitment, continuing employment, training and career development of disabled people is set out in a number of policies and procedures. These include:

Requirement	Policy or procedure
Giving full and fair consideration to applications for employment by the CCG made by disabled persons, having regard to their particular aptitudes and abilities.	1. Equality and Diversity in Employment Policy; 2. Recruitment and Selection Policy.
Continuing the employment of, and arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company.	3. Equality and Diversity in Employment Policy; 4. Managing Sickness Absence Policy; 5. Flexible Working Policy; 6. Learning and Development Policy.
Training, career development and promotion of disabled people employed by the company.	7. Equality and Diversity in Employment Policy; 8. Recruitment and Selection Policy; 9. Learning and Development Policy; 10. Pay Progression Policy; 11. Appraisal Paperwork.

Policy review

The CCG has a rolling programme of policy review and awareness-raising, as well as the appraisal procedure to further improve the focus on the quality of conversations taking place. The implementation of these policies together with occupational health input supports the continuation of employment and provision of appropriate training to any employee who becomes disabled and ensures access for all CCG employees, including disabled staff members to training, career development and promotion opportunities.

Equality impact assessments have been carried out on all the above policies. Over the past 12 months monitoring has taken place to ensure there has been no detrimental effect with regard to implementation of these workforce policies on CCG

staff and to ensure that the CCG has proactively identified and addressed any inequalities.

Diversity and Inclusion

The CCG is committed to promoting diversity and inclusion within its workforce and has taken a number of actions in relation to this. These include:

- The introduction of a working carers passport, and five days paid leave per annum for carers
- The setting up of networks across Calderdale, Kirklees and Wakefield focused on carers, disability and race equality, with protected time for staff to participate in them
- The promotion of the CCG's commitment to diversity and inclusion in job advertisements and the staff induction process
- The development and implementation of action plans to support achievement of the Workforce Race Equality and Workforce Disability Equality Standards

Disability Confident Employer

In 2016, the government made a commitment to halve the employment gap for disabled people and in order to achieve this it introduced a new Disability Confident scheme. We are extremely proud to say that our CCG was awarded the level 2 Disability Confident Employer badge for 2 years from August 2019.

Due to COVID-19 pandemic the Disability Confident Employer status was extended by the additional 12 months to August 2022.

The award is based on us being able to demonstrate that we:

- Have undertaken and successfully completed the Disability Confident self-assessment;
- Are taking all of the core actions to be a Disability Confident employer;
- Are offering at least one activity to get the right people for the business, and at least one activity to keeping and developing employees.

As a Disability Confident Employer, we are able to use the logo below which lets people know that we have made a commitment regarding recruitment, training, and retention of people with disabilities and the promotion of disability awareness across the organisation. We will continue to work to make this a welcoming and accessible place for people with a disability.

Trade Union relations and representation

Having good working relationships with trade union representatives is important to us. HR representatives and CCG senior managers from Calderdale and Kirklees CCGs meet with the relevant trade union representatives at the Joint Partnership Forum to discuss any staff issues or test proposals that might have a direct impact on staff.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974.

During 2021/22, there were two members of staff, who were accredited Trade Union representatives. These representatives provided a service across the two CCGs – Calderdale and Kirklees. One of these representatives is employed by Calderdale CCG.

Relevant union officials during 2021/22

Total number of employees who were relevant union officials during the period of 1st April 2021 to 31st March 2022 (FTE)	2

The table below contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Percentage time spent on facility time

Percentage of time spent	No. of Employees
0%	0
1-50%	2
51-99%	0
100%	0

Percentage of pay bill spent on facility time

Description	£
Total cost of facility time (note1)	2,818
Total pay bill (note2)	15,739,000
% of total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.017%

Note1: This is based on actual salary of the two trade union representatives
Note 2: This is the combined total pay bill for Calderdale and Kirklees CCGs.

Paid Trade Union Activities
The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2020/21, on paid trade union activities.

Paid Trade Union Activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100	100%

Other employee matters

The CCG works closely with partners in health and social care and is a leader in a number of initiatives to develop the current and future workforce of Calderdale and beyond.

The CCG is also instrumental in leading other pieces of system-wide work. For instance, providing leadership to work which will support the development of relationships across multi-disciplinary teams, and forming part of a group to bring stakeholders to discuss and agree actions in relation to workforce.

The CCG's approach to human capital management is supported by a robust set of policies and procedures, which underpin the full employee cycle. This includes a fair and transparent approach to recruitment and learning, and a well-embedded appraisal process, to assist individuals and teams with career management in support of the strategic aims of the CCG and the health and care system.

The CCG is an active participant in a Calderdale-wide Future Leaders programme. This venture is in partnership with public and private sector employers across Calderdale. It provides existing managers with the opportunity to develop leadership skills and gain a qualification and contributes to human capital management and employability across the CCG's local area. The programme is now moving towards its fourth cohort and has been very successful in attracting and providing leadership skills via this programme to managers.

The CCG's approach to pay is included in the remuneration report. With the exception of Very Senior Managers, all staff are engaged under Agenda for Change terms and conditions. There is a clear pay progression policy, ensuring that employees are performing to the standards required in their role, in order to progress up the pay scale.

Employee consultation

The CCG recognises the benefits of joint partnership working through the Social Partnership Forum across Calderdale and Kirklees CCGs. The purpose of this forum

is to allow a mechanism to formally consult and negotiate on a range of CCG business that directly impact on staff.

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 provided by Unison, Royal College of Nursing, Pharmacists Defence Association and Unite and the CCGs continue to work in partnership with them.

Expenditure on consultancy

Expenditure on consultancy (2021/22)

Description	Costs (£)
Expenditure on consultancy in 2021/22	0
TOTAL	0

External Audit

NHS Calderdale CCG appointed Grant Thornton as their external auditor from 1st April 2020. The cost of the work performed by the auditor in respect of the reporting period 2021/22 is £81,000 (including VAT).

Services from Grant Thornton (2021/22)

Description	Cost
Audit Services: Statutory audit and services carried out in relation to the statutory audit, e.g. reports to the Secretary of State	£63,000
Further assurance services – Compliance with the requirements of the Mental Health Investment Standard	£18,000
Other Services	£0
Total	£81,000

Before agreeing to carry out any non-audit work, Grant Thornton's risk and quality policies require all independence issues to be considered and reviewed by senior partner to ensure that the non-audit work is in line with ethical standards/AGN01.

Off payroll engagements

Length of all highly paid off-payroll engagements
For all off-payroll engagements as at 31st March 2022 for more than £245 per day (see note 1) and that last longer than six months:

Description	Number
Number of existing engagements as of 31st March 2022	5
Of which the number that have existed:	
For less than one year at the time of reporting	4
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	1

Note 1 - The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

We can confirm that all existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary that assurance has been sought.

Off payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1st April 2021 and 31st March 2022, for more than £245 per day (see note 1)

Type	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	0
Of which	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35 (see note 2)	0
Number not subject to off-payroll legislation and determined as out of scope of IR35 (see note 2)	0
The number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

Note 1 - The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant

Note 2 – A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of intermediaries legislation (IR35) or out-of-scope for tax purposes

Off-payroll Governing Body member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2021 and 31st March 2022

Description	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (see note 1)	2
Total number of individuals on payroll and off-payroll that have been deemed ‘board members, and/or, senior officials with significant financial responsibility’, during the financial year. This figure must include both on and off-payroll engagements.	14

Note:

(1) There are two senior off payroll engagements in place. The first relates to the Secondary Care Specialist on the CCG Governing Body, Dr Rob Atkinson, who is employed by Barnsley Hospital NHS Foundation Trust and his costs are recharged to the CCG under a secondment agreement and as such he does not sit on the CCG payroll. The second relates to Robin Tuddenham who was appointed as Accountable Officer on 16th October 2020, for the period until 31st March 2022 his primary salary was paid by Calderdale Council and recharged to the CCG.

Exit packages, including special (non-contractual) payments

The table below shows no exit packages or other departure, requiring exit packages or severance payments during 2021/22.

Exit package cost band (incl. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £	Number of other departures agreed	Cost of other departures agreed £	Total number of exit packages	Total cost of exit packages £	Number of departures where special payments have been made	Cost of special payment element included in exit packages £
Less than £10,000	0	0	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £200,000	0	0	0	0	0	0	0	0
Over £200,000	0	0	0	0	0	0	0	0
Totals	0	0	0	0	0	0	0	0

The table below shows one exit package or other departure, requiring exit packages or severance payments during 2020/21.

Exit package cost band (incl. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £	Number of other departures agreed	Cost of other departures agreed £	Total number of exit packages	Total cost of exit packages £	Number of departures where special payments have been made	Cost of special payment element included in exit packages £
Less than £10,000	0	0	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	1	73,581	0	0	0	0
£100,001 - £200,000	0	0	0	0	0	0	0	0
Over £200,000	0	0	0	0	0	0	0	0
Totals	0	0	1	73,581	0	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where NHS Calderdale CCG has agreed early retirements, the additional costs are met by NHS Calderdale CCG and not by the NHS Pensions Scheme. Ill- health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Redundancy and other departure costs	Agreements 2021/22 Number	Total Value of agreements 2021/22 £000s
Voluntary redundancies including early retirement contractual costs	0	N/A
Mutually agreed resignations (MARS) contractual costs	0	N/A
Early retirements in the efficiency of the service contractual costs	0	N/A
Contractual payments in lieu of notice	0	N/A
Exit payments following Employment Tribunals or court orders	0	N/A
Non-contractual payments requiring HMT approval	0	N/A
Total	0	N/A

ROBIN TUDDENHAM
Accountable Officer
20 June 2022

Parliamentary Accountability and Audit Report

NHS Calderdale CCG is not required to produce a Parliamentary Accountability and Audit Report. The CCG has no remote contingent liabilities and for losses and special payments, gifts, and fees and charges see Financial Statements note 19. An audit report is also included in this Annual Report at pages 128 to 137.

ROBIN TUDDENHAM
Accountable Officer
20 June 2022

Annual Accounts

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2022 have been prepared by Calderdale CCG under the Health and Social Care Act 2012 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Please note: The formatting for this section of the document may not be accessible to all users. Should you require the content in a different format that is accessible to you, please email: wyicb-cal.contact@nhs.net

Calderdale Clinical Commissioning Group - Annual Accounts 2021-22

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(937)	(857)
Total operating income		**(937)**	**(857)**
Staff costs	4	5,133	4,948
Purchase of goods and services	5	362,175	339,173
Depreciation and impairment charges	5	29	15
Provision expense	5	528	-
Other Operating Expenditure	5	175	182
Total operating expenditure		**368,040**	**344,318**
Net Operating Expenditure		**367,103**	**343,461**
Comprehensive Expenditure for the year		**367,103**	**343,461**

The notes on pages 182 to 203 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:	8		
Property, plant and equipment	13	-	29
Total non-current assets		-	29
Current assets:			
Trade and other receivables	9	948	1,233
Cash and cash equivalents	10	34	105
Total current assets		**982**	1,338
Total assets		**982**	1,367
Current liabilities			
Trade and other payables	11	(25,147)	(20,827)
Borrowings	12	-	(3,524)
Total current liabilities		**(25,147)**	(24,351)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(24,165)**	(22,984)
Non-current liabilities			
Provisions	13	(528)	-
Total non-current liabilities		**(528)**	-
Assets less Liabilities		**(24,692)**	(22,984)
Financed by Taxpayers' Equity			
General fund		(24,692)	(22,984)
Total taxpayers' equity:		**(24,692)**	(22,984)

The notes on pages 182 to 203 form part of this statement

The financial statements on pages 178 to 181 were approved by the Audit Committee on the 20th June 2022 under delegated authority from the Governing Body and signed on its behalf by:

Accountable Officer
Robin Tuddenham
20 June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(22,984)	**(22,984)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(22,984)**	**(22,984)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(367,103)	**(367,103)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(367,103)**	**(367,103)**
Net funding	365,395	**365,395**
Balance at 31 March 2022	**(24,692)**	**(24,692)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(26,705)	**(26,705)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(26,705)**	**(26,705)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating expenditure for the financial year	(343,461)	(343,461)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(343,461)**	**(343,461)**
Net funding	347,182	347,182
Balance at 31 March 2021	**(22,984)**	**(22,984)**

The notes on pages 182 to 203 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(367,103)	(343,461)
Depreciation and amortisation	5	29	15
(Increase)/decrease in trade & other receivables	9	285	(923)
Increase/(decrease) in trade & other payables	11	4,319	(6,238)
Increase/(decrease) in provisions	13	528	0
Net Cash Inflow (Outflow) from Operating Activities		**(361,941)**	(350,606)
Net Cash Inflow (Outflow) before Financing		**(361,941)**	(350,606)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		365,395	347,182
Net Cash Inflow (Outflow) from Financing Activities		**365,395**	347,182
Net Increase (Decrease) in Cash & Cash Equivalents	10	**3,454**	(3,424)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(3,419)**	5
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**35**	(3,419)

The notes on pages 182 to 203 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The Health and Care Act received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to West Yorkshire ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022, on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities. The accounts for 2020-21 have been calculated under a net accounting basis.

1.3 Joint arrangements

The clinical commissioning group has no joint arrangements other than one pooled budget see note 1.4.

1.4 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Calderdale Council under Section 75 of the National Health Service Act 2006.

The pooled budget is jointly controlled between the CCG and Calderdale Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.9.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. The CCG has assessed that there is no material impact from the introduction of IFRS16 on 1st April 2022.

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.14 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.16 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

· Financial assets at amortised cost;

· Financial assets at fair value through other comprehensive income and ;

· Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. Management does not consider that there are any critical accounting judgements or material sources of estimation uncertainty.

1.21 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group’s incremental borrowing rate. The clinical commissioning group’s incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**789**	760
Other Contract income	**148**	97
Total Income from sale of goods and services	**937**	**857**
Total Operating Income	**937**	**857**

3 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies 2021-22 £'000	Other Contract income 2021-22 £'000	Non-patient care services to other bodies 2020-21 £'000	Other Contract income 2020-21 £'000
Source of Revenue				
NHS	77	40	103	-
Non NHS	712	108	657	97
Total	**789**	**148**	760	97

	Non-patient care services to other bodies 2021-22 £'000	Other Contract income 2021-22 £'000	Non-patient care services to other bodies 2020-21 £'000	Other Contract income 2020-21 £'000
Timing of Revenue				
Point in time	789	148	760	97
Over time	-	-	-	-
Total	**789**	**148**	760	97

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**3,658**	**415**	**4,073**
Social security costs	**397**	**0**	**397**
Employer Contributions to NHS Pension scheme	**658**	**0**	**658**
Apprenticeship Levy	**5**	**0**	**5**
Gross employee benefits expenditure	4,718	415	5,133
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	4,718	415	5,133
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,718	415	5,133

4.1.1 Employee benefits

	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,543**	**409**	3,951
Social security costs	**377**	**0**	377
Employer Contributions to NHS Pension scheme	**616**	**0**	616
Apprenticeship Levy	**3**	**0**	**3**
Gross employee benefits expenditure	4,539	409	4,948
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	4,539	409	4,948
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,539	409	4,948

4.1.2 Recoveries in respect of employee benefits

	2021-22 Total £'000	2020-21 Total £'000
Employee Benefits - Revenue		
Salaries and wages	**0**	**0**
Social security costs	**0**	**0**
Total recoveries in respect of employee benefits	**0**	0

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**80.55**	**6.08**	**86.63**	**60.59**	**19.03**	**79.62**

4.3 Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	73,581	1	73,581
Total	**-**	**-**	**1**	**73,581**	**1**	**73,581**

Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	-	-	1	73,581
Total	**-**	**-**	**1**	**73,581**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs are accounted for in accordance with relevant accounting standards in full in the year of departure. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018 updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016.
The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	453	364
Services from foundation trusts	189,745	182,913
Services from other NHS trusts	22,427	21,741
Purchase of healthcare from non-NHS bodies	72,772	63,005
Prescribing costs	36,006	34,393
General Ophthalmic services	208	171
GPMS/APMS and PCTMS *(1)	34,896	32,300
Supplies and services – clinical	4	14
Supplies and services – general	2,535	1,221
Consultancy services	-	-
Establishment	1,075	1,004
Transport	11	9
Premises	1,665	1,822
Audit fees *(2)	63	59
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services *(3)	18	12
Other professional fees	239	111
Legal fees	27	6
Education, training and conferences	28	28
Total Purchase of goods and services	**362,171**	**339,173**
Depreciation and impairment charges		
Depreciation	29	15
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**29**	**15**
Provision expense		
Provisions	528	-
Total Provision expense	**528**	**-**
Other Operating Expenditure		
Chair and Non Executive Members	175	182
Other expenditure	4	-
Total Other Operating Expenditure	**179**	**182**
Total operating expenditure	**362,907**	**339,371**

Admin Expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or
healthcare services.

***1** GPMS/APMS and PCTMS included £35.299m for delegated responsibility for commissioning Primary Medical Services for 2020/21 (£31.650m in 2020/21).
***2** Audit fees stated are inclusive of irrecoverable VAT.
***3** Fee relates to compliance work in relation to the Mental Health Investment Standard.
In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the CCG's contract with its auditors provides for a limitation of the auditor's liability of £2m.

6 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,849	114,017	9,351	99,555
Total Non-NHS Trade Invoices paid within target	8,614	108,902	9,132	92,904
Percentage of Non-NHS Trade invoices paid within target	**97.34%**	**95.51%**	**97.66%**	**93.32%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	597	212,996	1,087	210,073
Total NHS Trade Invoices Paid within target	577	212,881	1,049	209,927
Percentage of NHS Trade Invoices paid within target	**96.65%**	**99.95%**	**96.50%**	**99.93%**

6.1 The Late Payment of Commercial Debts (Interest) Act 1998	2021-22 £'000	2020-21 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Operating Leases

7.1 Payments recognised as an Expense	Buildings £'000	2021-22 Total £'000	Buildings £'000	2020-21 Total £'000
Payments recognised as an expense				
Minimum lease payments	949	**949**	904	**904**
Contingent rents	-	**-**	-	**-**
Sub-lease payments	-	**-**	-	**-**
Total	**949**	**949**	**904**	**904**

7.1.1 Future minimum lease payments	Buildings £'000	2021-22 Total £'000	Buildings £'000	2020-21 Total £'000
Payable:				
No later than one year	826	**826**	870	**870**
Between one and five years	3,267	**3,267**	3,096	**3,096**
After five years	2,320	**2,320**	2,841	**2,841**
Total	**6,413**	**6,413**	**6,807**	**6,807**

The CCG occupies property owned and managed by NHS Property Services. The two most significant leases are in relation to Westgate House and to Todmorden Health Centre. The CCG has assessed that there is no material impact from the introduction of IFRS16 on 1st April 2022.

8 Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	185	700	884
Cost/Valuation at 31 March 2022	**185**	**700**	**884**
Depreciation 01 April 2021	156	700	855
Charged during the year	29	-	29
Depreciation at 31 March 2022	**185**	**700**	**884**
Net Book Value at 31 March 2022	**-**	**-**	**-**
Purchased	(0)	-	(0)
Total at 31 March 2022	**(0)**	**-**	**(0)**
Asset financing:			
Owned	(0)	-	(0)
Total at 31 March 2022	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2021	-	-	-
Impairments	-	-	-
Balance at 31 March 2022	**-**	**-**	**-**

2020-21	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	184	700	884
Cost/Valuation at 31 March 2021	**184**	**700**	**884**
Depreciation 01 April 2020	140	700	840
Charged during the year	15	-	15
Depreciation at 31 March 2021	**155**	**700**	**855**
Net Book Value at 31 March 2021	**29**	**-**	**29**
Purchased	29	-	29
Total at 31 March 2021	**29**	**-**	**29**
Asset financing:			
Owned	29	-	29
Total at 31 March 2021	**29**	**-**	**29**

Revaluation Reserve Balance for Property, Plant & Equipment

8.2 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000	2020-2021 £'000
Information technology	185	139
Furniture & fittings	700	700
Total	**885**	**839**

8.3 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	1	3
Furniture & fittings	3	15

9 Trade and other receivables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	861	-	1,209	-
Non-NHS and Other WGA receivables: Revenue	49	-	16	-
Non-NHS and Other WGA prepayments	38	-	-	-
Non-NHS and Other WGA accrued income	-	-	-	-
VAT	-	-	8	-
Total Trade & other receivables	**948**	**-**	**1,233**	**-**
Total current and non current	**948**		**1,233**	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

9.1 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	-	-	14	-
By three to six months	-	-	3	12
By more than six months	-	1	-	-
Total	**-**	**1**	**17**	**12**

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2022.

10 Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	(3,420)	5
Net change in year	3,454	(3,424)
Balance at 31 March 2022	**34**	**(3,419)**
Made up of:		
Cash with the Government Banking Service	34	105
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**34**	**105**
Bank overdraft: Government Banking Service	-	(3,524)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**(3,524)**
Balance at 31 March 2022	**34**	**(3,419)**

11 Trade and other payables	Current 2021-22 £'000	Current 2020-21 £'000
NHS payables: Revenue	2,812	232
NHS accruals	-	117
Non-NHS and Other WGA payables: Revenue	11,946	7,382
Non-NHS and Other WGA accruals	9,749	12,697
Social security costs	62	56
Tax	46	46
Other payables and accruals	532	297
Total Trade & Other Payables	**25,146**	**20,827**
Total current and non-current	**25,146**	**20,827**

The CCG has no liabilities for early retirement.

Other payables include £201k outstanding pension contributions at 31 March 2022 (2020-21 £292k).

12 Borrowings

The Clinical Commissioning Group has no bank overdraft as at 31 March 2022, there was a bank overdraft as at 31 March 2021 (£3,524K) which are the payments made on the 31st March 2021. The payments were made to meet contractual commitments which are included in the cash book and ledger but will not clear until after the 1 April 2021. This has resulted in the CCG having a credit ledger cash position which is acceptable and only reflects a timing difference in the drawdown process and cash being made available in the bank. This is acceptable within NHSE guidance.

13 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Other	-	528	-	-
Total	**-**	**528**	**-**	**-**
Total current and non-current	**528**		**-**	

	Other £'000	Total £'000
Balance at 01 April 2021	**-**	**-**
Arising during the year	528	**528**
Balance at 31 March 2022	**528**	**528**
Expected timing of cash flows:		
Within one year	-	**-**
Between one and five years	-	**528**
After five years	-	**-**
Balance at 31 March 2022	**-**	**528**

	Other £'000	Total £'000
Balance at 01 April 2020	**-**	**-**
Arising during the year	-	**-**
Balance at 31 March 2021	**-**	**-**
Expected timing of cash flows:		
Within one year	-	**-**
Between one and five years	-	**-**
After five years	-	**-**
Balance at 31 March 2022	**-**	**-**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2022 is nil. (2020/21 nil).

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

14.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

14.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

14.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	861	861
Trade and other receivables with other DHSC group bodies	-	-
Trade and other receivables with external bodies	49	49
Cash and cash equivalents	34	34
Total at 31 March 2022	**944**	**944**

	Financial Assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	1,208	1,208
Trade and other receivables with external bodies	16	16
Cash and cash equivalents	105	105
Total at 31 March 2021	**1,329**	**1,329**

14.3 Financial liabilities	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	3	**3**
Trade and other payables with other DHSC group bodies	2,970	**2,970**
Trade and other payables with external bodies	22,065	**22,065**
Other financial liabilities	-	**-**
Private Finance Initiative and finance lease obligations	-	**-**
Total at 31 March 2022	**25,038**	**25,038**

Bank overdraft	3,524	3,524
Trade and other payables with NHSE bodies	349	349
Trade and other payables with other DHSC group bodies	10,345	10,345
Trade and other payables with external bodies	10,031	10,031
Other financial liabilities	-	-
Total at 31 March 2021	**24,249**	**24,249**

15 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

16 Joint arrangements - interests in joint operations

Better Care Fund – The CCG entered into a partnership agreement with Calderdale Council in April 2015 to manage the Better Care Fund (BCF) as a pooled budget arrangement from 2015/16 onwards. A joint assessment was conducted with the Council on how the arrangement should be accounted for by reference to the Department of Health Group Manual for Accounts 2015/16 (Chapter 3 Annex 1) and the guidance on "Pooled budgets and the Better Care Fund" produced in October 2014 by HFMA/CIPFA. In accordance with this guidance, the CCG recognises this as a joint operation under joint arrangements in accordance with IFRS11 in respect of accounting for the income and expenditure and assets and liabilities proportionate to the risks and rewards it enjoys. The total available BCF funding for the year was £20.3m (2020/21 £18.5m), of which the CCG was allocated and recognised in its accounts £5.8m of income and £5.8m of expenditure (2020/21 £4.9m) (Calderdale Council £14.5m (2020/21 £13.6m). NHS Calderdale CCG's participating cash contribution is £17.3m (2020/21 £15.5m).

16.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in CCG's books ONLY 2021-22	Amounts recognised in CCG's books ONLY 2020-21
			Expenditure	Expenditure
			£'000	£'000
Better Care Fund	NHS Calderdale CCG & Calderdale Council	Reduction of DTOC and Emergency Readmissions	5,804	4,914

On 1st April 2015 Calderdale CCG entered into a pooled budget arrangement with Calderdale Council in relation to the Better Care Fund.

The Better Care Fund (BCF) is a mandatory policy to facilitate integration of service provision between Health and Social Care.

The schemes managed through the BCF include: Disabled Facilities Grants, carers services, supporting social care, reablement and recovery services. Under the policy we have to report on a number of metrics which include delayed discharges from hospital and levels of emergency admissions.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budget is jointly controlled between the CCG and Calderdale Council.

16.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The CCG has no interests not accounted for under IFRS 10 or IFRS 11.

17 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health.

During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practice for which Governing Body members have a relationship have been disclosed below. In 2021/22 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

	2021/22 £'000	2020/21 £'000
Spring Hall Group Practice (Dr Steven Cleasby)	2,456	2,528
Beechwood Medical Centre (Dr Caroline Taylor)	1,250	1,297
Rastrick Health Centre (Dr F Javid)	689	667
Bankfield Surgery (Dr J Gray)	1,320	1,207

CCG Accountable Officer is also the Chief Executive of Calderdale Council.

Robin Tuddenham is employed as the CCG's Accountable Officer. This is a joint appointment with Calderdale Council. The two parties pay 50% of the Accountable Officer's salary

In addition the executive Governing Body and Senior Management Team members have relatives or interests with the following organisations :

Audit Yorkshire
Bankfield Surgery
Barnsley Hospital NHS Foundation Trust
Beechwood Medical Centre
Calderdale and Huddersfield NHSFT
Calderdale Local Medical Committee
Calderdale Metropolitan Borough Council
Caring for Health Ltd
Central Halifax Primary Care Network
Change Housing
Department of Work and Pensions
HomeStart Manchester
Kirkwood Hospice
Lankelly Chase Foundation
Leeds United Foundation.
Local Care Direct
Locala CIC
Lower Valley Primary Care Network
Moorside Pharma Developments Ltd
National Association of Primary Care (NAPC)
NHS Kirklees CCG
Northern Ireland Housing Executive
Optimal healthcare Ltd
Overgate Hospice
Pennine GP Alliance Ltd
Rastrick Health Centre
Rastrick Health Ltd
Rycroft Health Associates
Scientific Advisory Board of UK Prevention Research Partnership
South Yorkshire and Bassetlaw ICS
Spring Hall Group Properties Limited
TCV Employment and Training Services Limited.
University of Chester
University of Teesside
Vita LTD (IAPT)

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

Calderdale and Huddersfield NHSFT
South West Yorkshire Partnership NHSFT
Yorkshire Ambulance NHS Trust
Leeds Teachings Hospitals NHST

In addition the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies:

Calderdale Council

The Clinical Commissioning Group also has transactions with organisations who are linked to individuals considered to be related parties of the Department of Health. For Calderdale these organisations are:
Leeds Teachings Hospital NHST

18 Events after the end of the reporting period

The Health and Care Act received Royal Assent on 28 April 2022. Subject to the issue of an establishment order by NHS England the CCG will be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations will transfer to West Yorkshire ICB.

The Clinical Commissioning Group has no other post balance sheet events which will have a material effect on the financ statements.

19 Losses and special payments

	2021-22 £'000	2020-21 £'000
Losses	4	-
	4	**-**

The CCG has incurred one loss of £4k in the period in relation to interest on a VAT payment.

Special payments
The CCG has had no special payments during the period.

20 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2021-22 Target £'000	2021-22 Performance £'000	Duty Achieved	2020-21 Target £'000	2020-21 Performance £'000	Duty Achieved
Expenditure not to exceed income	368,042	368,040	Yes	344,365	344,318	Yes
Revenue resource use does not exceed the amount specified in Directions	367,105	367,103	Yes	343,508	343,462	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,311	4,292	Yes	4,295	4,294	Yes

The CCG received total revenue resource allocation of £367,105k and had net expenditure of £367,103k delivering an in year surplus of £2k.

Auditors Report on Annual Accounts

Independent auditor's report to the members of the Governing Body of NHS Calderdale Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in

accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 18 to the financial statements, which indicates that the Health and Care Act received Royal Assent on 28 April 2022. Subject to the issue of an establishment order by NHS England, the CCG will be dissolved on 30 June 2022. The assets, liabilities and operations of the CCG will transfer to the West Yorkshire Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a

period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the

guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We

determined that the principal risks were in relation to closing journal entries around expenditure in order to possibly manipulate the year-end financial performance and surplus.

- Our audit procedures involved:
  - journal entry testing, with a focus on unusual closing journal entries around expenditure that could manipulate the year-end financial performance and surplus;
  - challenging assumptions and judgements made by management in its accounting estimates;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in expenditure recognition, and the accounting estimates related to for example prescribing accrual.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England’s rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG’s operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

- The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements

for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Calderdale CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the

Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Gareth D Mills

Gareth Mills, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Leeds

20 June 2022